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Comments-Intervention as a follow-up to Mr. B. Gertsos' contribution on *"Freedom to provide services in the sector of health services – Regulation 1408/71 and Directive 2006/123/EC"*

Nikos Sklikas, Dorina Tsotsorou
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1. Mr. B. Gertsos, judge of the Council of State, developed European Commission's effort to incorporate in derived Community legislation the ten years Court's case-law as well as the Community criteria put forward by the latter, in respect of the fundamental freedom to provide services of the Treaty (Articles 49 and 50 EC), concerning, mainly:

- on the one hand, the provision of sickness benefits in kind (healthcare benefits: hospital/in-patient and non-hospital/outpatient care) in a member State other than the Competent (Member State of mobile patient's affiliation);
- on the other hand, and more specifically, the reimbursement of costs of that type of hospital or non-hospital health care, received/provided either pursuant to Article 23 of the initial proposal for a Directive (reimbursement in conformity with the above-stated provisions of the Treaty EC) or by virtue of Article 22, paragraph 1, Regulation (EEC) 1408/71.

Although Mr. Gertsos recalled that health services, as a sector, was, at the end, totally excluded from the Directive's scope of application, focused his approach on the Commission's initial/original proposal *(see document COM(2004) 13.01.2004 final, Article 23)*, and concluded that such an evolution could be explained by the following reasons:

- "It would be legally odd and unaccepted to attempt supplementing Regulation 1408/71 by means of a Directive covering free provision of services within the Community (Directive 2006/123/EC), introducing, in other words, exemptions and amendments in the scope of a Regulation by virtue of provisions and rules established in a Directive; moreover, the issues for which an initiative for enacting legislation was undertaken, either had not been totally clarified by Court's case-law (e.g. no clear-cut distinction between hospital and non-hospital treatment) or, on the opposite, had been solved in a sufficiently transparent and legally secure way, leaving no space for ambiguities and, thus, no room/need for any legislative intervention (e.g. the principle of minimum protection, rules and criteria for granting or refusing (restrictive conditions) an authorisation for scheduled treatment (for the reimbursement of healthcare) in a Member State other than the competent – rules governing a system of prior authorisation)".
- "What is worth pointing out in relation to the said legislative initiative is the dynamic relationship –interaction between Regulation 1408/71 and the rules on freedom to provide services (Articles 49 and 50 EC), as well as that the said Regulation is a means for fulfilling free movement of patients and cross-border provision of services between Member States; therefore, national authorities should take seriously into consideration, that raising unjustified obstacles and hindering patients' mobility could have a negative/adverse impact on the creation of conditions of fair competition in the market

of health services and, at the same time, prove being to the detriment of patients' state of health per se".

2. The underlying aim of the present intervention is, primarily to redress (re-establish) the historical dimensions of the question at stake (a pending issue still) and, following that, to put forward (highlight) a number of key elements, at least to the commentators' own opinion, which gave reason to reflection at the time where the Council worked arduously towards integrating the so-far settled case-law of the Court into derived Community law. In the light of what has been stated above, it is essential to point out that the said written contribution is exclusively based on the Commission's original/initial (1st) proposal and, hence, no reference has been made to two significant efforts-developments, which took place in the meantime with a view to establishing direct implementation of the freedom to provide services also in the health sector (freedom to provide health services):

- the definition of "hospital care" and
- the incorporation of the Court's overall settled case-law in the Commission's proposal for a new implementing Regulation *(laying down the procedure for implementing Regulation (EC) 883/2004).*

In fact, following the first exchange of views in the framework of the Council's Working Party on Competitiveness and Growth (Services), and due to the expressly raised demand to provide, amongst others, for a sufficiently transparent definition, distinguishing between hospital (in-patient) and non-hospital (out-patient) treatment, the then Presidency, in close collaboration with the Commission, drafted a consolidated version of the aforementioned Proposal, to be discussed thoroughly in meetings of the said Working Party, an updated text, containing further clarifications (additional recitals and/or provisions) on the basis of Council's (DG C) Working Document No 1 of 15 November 2004, and incorporating, amongst others, the definition of "hospital treatment" *(see document 1561/05, 10.01.2005, COMPET 1, ETS 1, SOC 4, JUSTCIV 1, CODEC 5: Article 23, new paragraph 1a, ex Article 4, paragraph 10).*

The introduction of such a definition had been supported also by the Greek competent Authority in the framework of the debate, taking place in parallel at meetings of the Administrative Commission, on the more specific question, of whether the interpretation followed by the Court and covered by "Article 23" should remain in the Proposal for a Directive or should it be preferable for all parties concerned, especially the patients, to have the Court's integral case-law incorporated, as a whole, in the scope of the Community mechanism on the coordination of social security systems, i.e. Regulation 1408/71 or after its derogation (modernization and simplification) Regulation (EC) 883/2004.

The Commission stated its willingness to withdraw Article 23 from its Proposal for a Directive, under the condition that a unanimous decision could be reached at Administrative Commission's or at Council's level on the incorporation of settled case-law under Regulation 1408/71 or its successor Regulation (EC) 883/2004 (following the modernization and simplification of the former). Our country contributed significantly to the formation and consolidation of such an approach, mainly via three respective Notes of the Greek delegation. The basic Greek position was that a partial refund of healthcare costs on the basis of (the status provided for under) a Directive and reimbursement of its greatest part in parallel by virtue of regulation 1408/71 or 883/2004 respective provisions, would definitely be a source of major problems, of administrative as well as interpretative nature. On the contrary, inclusion of the Court's jurisprudence in the Community coordination

mechanism would guarantee the correct, uniform and balanced implementation of the whole set of rules on reimbursement of healthcare costs (for the purposes of establishing the general principle of free movement).

Yet, in the context of the co-decision procedure, health services have been excluded from the scope of application of the Directive *(see amended Proposal transmitted by the Commission on 06.04.2006, COM(2006) 160 and following that the common position of the Council, adopted on 24.07.2006, responding to the European Parliament's amendments)*. Moreover, the said case-law has neither been incorporated in the basic Regulation 883/2004, as a result of the position adopted by the Social Questions Working Party to postpone settlement of those pending questions until the Commission introduces all remaining aspects of that issue in the scope of the latter's Proposal for a (new) Regulation laying down the procedure for implementing Regulation (EC) No 883/2004 (to replace existing implementing Regulation 574/72), and more specifically, in the broader context of reimbursement of healthcare costs occurring during an insured person's stay in a Member State other than the competent one (the Member State of affiliation).

In that way, and in the light of the foregoing second significant development, the Commission incorporated the Court's respective case-law in the scope of application of its Proposal for a new implementing Regulation, actually under examination in the SQWP, more specifically, under Article 25 (5) to (7b) provisions ("Stay in a Member State other than the competent Member State") and Article 26 provisions ("Scheduled treatment"), Part B, paragraphs 4b and 5 ("Meeting the cost of benefits in kind incurred by the insured person"), and Part C, paragraph 6 ("Meeting the costs of travel and stay as part of scheduled treatment") *(see, document from Permanent Representatives Committee (Part 1) to EPSCO 9752/07, on 22.05.2007, SOC 215 CODEC 546: Proposal for a Regulation of the European Parliament and of the Council laying down the procedure for implementing Regulation (EC) 883/2004 on the coordination of social security systems – Title III, Chapter I (Sickness, maternity and equivalent paternity benefits – Partial general approach).*

It is, actually, on those particular Articles' provisions that we focus our attention, trying to consider how far the Court's overall case-law has actually been integrated in Community coordination and whether such integration has been fulfilled in a sufficiently effective and efficient way, above all, whether such a major adaptation is in compliance mainly with the spirit of Community legislator (the fundamental freedoms of the Treaty).

It is true that the provisions of Article 25, paragraph 7a, of the new implementing Regulation, on which the Council has only reached partial general approach on a chapter-by-chapter basis, cover reimbursement of costs (for benefits in kind) by the competent institution (of the Member State under the legislation of which the person concerned is insured), *"…under the conditions of the rates in its legislation…", "if the legislation of the Member State of stay does not provide for reimbursement pursuant to paragraphs 5 and 6 in the case concerned"*.

The unclear or ambiguous grammatical drafting– syntax of the said sentence (its final part) allows for two types of interpretation:
a) that the Member State of stay provides healthcare by virtue of a system which is essentially or exclusively of the type providing *benefits in kind or even a national health service* (e.g. UK, NL, as indicative examples), which out of its nature – organisational

structure does not dispose any mechanism of reimbursement of healthcare costs, in other words, it is impossible for the said system to reimburse to the insured person the costs of benefits in kind where the insured concerned has him/herself actually borne all the costs of his/her treatment, and/or
b) the legislation of the Member State of stay does not provide for reimbursement of costs of benefits in kind in certain cases e.g. in cases where healthcare has been provided in a *private* establishment (a non-contracted medical service provider: hospital/clinic/unit of a public hospital), with which the insured person's sickness insurance scheme/particular fund has not entered into (concluded) an agreement, i.e. treatment has been provided under *a regime* which falls *outside* the scope of national health/social security system (sickness insurance scheme/fund of affiliation).

Regarding the first possible interpretation (a), it recalls the argument put expressly forward by the then Dutch competent institution (ZFM – the Netherlands being the Member State of affiliation) in the case C-358/99, *Müller-Fauré and van Riet*, that it is impossible for a benefits in kind system to reimburse healthcare costs incurred, due to actual particular features of that scheme, i.e. the absence per se of such a mechanism. The Court, in its judgement of 13.05.2003, rejected the above argument and held precisely that it is not acceptable by Member States with benefits in kind systems (or even a national health service) to deny reimbursement of costs (incurred), simply invoking that their legislation does not provide for such a specific mechanism, taking into consideration:

- on the one hand, that those Member States dispose a public-national system of tariffication (tariffs) with regard to medical services;
- on the other hand, their legislation does indeed provide for a (certain) mechanism of reimbursement of healthcare costs, given that, when applying Regulation 1408/71, those Member States reimburse costs charged by other Member States (the respective institutions of stay) in cases of *necessary* or *scheduled* (and authorised) treatment received by their insured in their territories, on the basis (by means) of Community Forms E 125 (by virtue of Article 36 provisions, Regulation 1408/71 and Article 93 provisions, Regulation 574/72), as well as where it has not been possible to complete the formalities during the relevant person's stay outside the competent Member State *(see Article 34 provisions, Regulation 574/72).*

Consequently, following the foregoing observations, it could be soundly sustained that the said provision of the new implementing Regulation legitimizes, in a way, the rejection by respective institutions involved (concerned) of insured persons' (patients) claims for reimbursement of costs incurred, based on the (well-rejected by the Court) argument that there exists under the legislation they administer no whatsoever provision for such a mechanism.

It would be interesting to take seriously into consideration the draft statement put forward by the Spanish delegation on the approach to be followed by the said Member State in relation to Article 25(6), (7) and (7a) provisions, as set out in Annex III to the Note submitted to the Council (EPSCO) for a Partial general approach *(see above document 9752/07).*

Yet, that sort of *reaction* is already not in conformity with settled-case law and has a further negative impact, i.e. to "shift" the whole burden/ "responsibility" of costs reimbursement on competent Member States, the latter reimbursing to the persons affiliated with their legislation costs at the level of the (reimbursement) rates-tariffs administered by the

legislation of the scheme of affiliation. Such an evolution, however, has serious economic implications for patients (the mobile insured persons), mainly in cases where national tariffs applied in the competent Member State are of a very low level, disproportionate to the level of actual costs (prices) of medical acts (services); the Greek systems' reimbursement rate – tariffication could serve as a representative example, since reimbursement rates of healthcare costs usually do not exceed, on average, 10% of actual costs.

Consequently, in our view, it would in no way be excluded as a possible evolution, that someday, that very Court declares eventually invalid or reverses such an interpretation, based on the above-stated provision, where, under similar circumstances, a question *ad hoc* were referred to the latter for a preliminary ruling on the correct interpretation of that specific provision, more precisely on whether the interpretation followed *de jure* or *de facto* by Member States concerned is considered to be in compliance with the interpretative guidelines held by the Court so far.

Regarding the second possible interpretation (b), according to which the institution involved refuses to reimburse costs under certain circumstances, e.g. where treatment is received/provided in private establishment -by a non-contracted provider- we would like to recall the discussions on the specific question, already held in the context of trESS 2007 Seminar in Athens, on the occasion of a respective written contribution on the impact of the Court's ruling of 19.04.2007 in case C-444/05, *Stamatelaki*; the said issue concerns a continuously rising number of cases, in which the patient does not actually chose him/herself the treatment received in a *private* establishment (or in a private unit of a public hospital, as is usually the case, e.g. in Germany or Switzerland), moreover, in most of the cases following the competent institution's prior authorization (and the issue of Community Form E 112, accordingly). In fact, the patient is, on the contrary, forced to have access to such treatment (under a regime outside the scope of the national sickness insurance shame), mainly because his/her state of health is seriously at danger and appropriate treatment can neither be promptly provided in a public establishment outside the competent Member State (under the institution's of stay health/social security system), especially due to the fact of the long waiting lists existing in that territory.

It is worth mentioning, that waiting lists in each Member State are not considered as "national" but as "Community" ones, which in turns means that nationals of a Member State should in no way have precedence in the waiting list existing under the latter's legislation, over patients having the nationality of any other Member State. In the opposite and in conformity with the principle of equal treatment and its specific expression, the principle of assimilation of facts and events, (pursuant Article 22, Regulation 1408/71 – new Articles 5, 19 and 20 under Regulation 883/2004, as well as corresponding Articles 25 and 26 of the forthcoming new Implementing Regulation), nationals – insured persons of any Member State are entitled to an equivalent treatment, according solely to those persons state of health.

It should be pointed out that the Court's statements regarding the aim, which waiting lists should serve, as well as, mainly, the objective criteria on the basis of which the insured persons' current state of health (along with the probable course of illness) should always be assessed, before estimating whether and how the latter should or should not be included (and/or classified) in such lists, do not concern merely the competent Member State's health/social security system but also that of the Member State of stay, since it is under the

eventual waiting list(-s) of the latter that the patient (affiliated to another Member State's social security scheme) is registered in order to have on an equal footing the precise date for receiving the appropriate for his/her state of health treatment fixed. Obviously, where such date exceeds also in the Member State of stay the medically acceptable period of time within which the treatment required should be given to the patient concerned (going beyond which would be deemed detrimental for that patient's health), then access of the insured to a private establishment (status) becomes more than inevitable, i.e. a *must* (a *one-way street*).

However, receiving appropriate healthcare within a medically acceptable period of time (acceptable delay) could prove not feasible not only in the Member State of stay but, equally, on the territory of one or more other neighbouring (border) Member States, to which a patient may move seeking access to the provision of appropriate health services. That situation forces the person concerned to have access also to the private sector of the Member State of (initial) stay or any other of the neighbouring Member States (of alternative stay) for the sake of getting the treatment which responds best to his/her state of health at the time. Consequently, the authorization criteria applying (following settled case-law) to the competent Member State (in order to assess the system's availability in respect of the patient's situation and proceed to granting or rejecting the requested authorization), should equally apply to (taken into account by) the Member State of stay or any other, potential Member State of treatment.

Under those circumstances, hospital (mainly/usually) treatment in a private establishment should not be considered as patient's personal choice (it would be contrary to Court's teleological interpretation), but as an "obligatory", "one-way" access to such a *private regime* of in-patient care, private, in that case, being deemed as almost *synonymous* to *appropriate treatment*. As it has already been stated above, it is the institution of stay, applying its own legislation in compliance with the respective Community/jurisprudence criteria, that decides on the patient's quasi obligatory referral to a private hospital-establishment, and it is the competent institution's responsibility to cooperate closely and loyally with the first one in order to grant its authorization for the specific hospital care and, following that, to assume the treatment's costs.

It goes without saying, as expressly laid down by Article 25 provisions, paragraph 6, second subparagraph *(see also reference to the said provisions pursuant to Article 26, paragraph 4b)*, of the forthcoming new implementing Regulation, the institution of the place of stay – where health/in-patient care is received – is obliged to provide the competent institution with all necessary information (documents, data) about the reimbursement rates (or amounts) administered by the said institution's legislation.

Yet, we insist that it is of foremost importance to implement efficiently, always keeping close/faithful to the letter and spirit of Community legislator, all general and special rules on broader, structured cooperation *(see Article 76, Reg. 883/2004)* between Member States' national authorities themselves, national authorities and institutions involved, institutions and persons concerned, in accordance with the principle of good administration -where all actors involved *lend one another their good offices and act as though implementing their own legislation*- the outmost purpose being for the Member State of stay to fully implement its legislation in an essential way.

It is a *Community model* of administrative cooperation, which, we are afraid, is not always encouraged or enhanced, at least to the desirable extent, by the above-stated restrictive provisions of the new implementing Regulation. Our long experience in the domain (also regarding the way administrative cooperation is fulfilled) shows that, the usual and almost spontaneous, sometimes totally uncommitted/"neutral" response of the institution of the place of stay is that the latter has no capacity and/or possibility to implement any national rates of costs reimbursement, just because the in-patient treatment has been given in a private establishment. Such a response, however, should not automatically result in leading the competent institution to the implementation of Article 49 of the Treaty EC, in other words, to the assumption of the costs incurred in accordance with the rates administered by its own legislation whenever treatment is received *in private* (especially where such a reaction would in most cases lead to the above-mentioned, economically disastrous and legally disproportionate implications for the person concerned, as e.g. where a Greek institution is involved).

In fact, it is settled case-law, particularly as the Court held in *Keller*, that, as it follows from the rule of sharing responsibilities, deriving from the very wording of and objectives pursued by Article 22 of Regulation 1408/71 (new Article 19, of Regulation 883/2004) in correlation with the Community measures relating to the mutual recognition of diplomas, certificates and other evidence of the formal qualifications of practitioners of medicine, once the competent institution has agreed that one of its insured persons may receive medical treatment outside the competent Member State, then the whole responsibility for the said person's condition lies in the hands of the doctors authorized by the institution of the Member State of stay (acting within the scope of their office); at the same time, the competent institution is obliged to accept and recognize the findings and choices of treatment made by those doctors as if they had been made by authorized doctors who would have had to treat the insured person in the competent Member State (*general principle of assimilation of facts and events*). It must be recalled in this respect that, according to settled case-law, in the field of the freedom to provide services, doctors established in other Member States must be regarded as providing the same guarantees of professional competence as doctors established within the competent Member State *(see the Court's judgment in Kohll).*

As it follows from the foregoing, the competent institution, which has granted its authorization (even *a posteriori*) for one of its insured persons to receive medical treatment outside the competent Member State, is bound by the findings, relating to the need for urgent vital treatment, made by the doctors authorized by the institution of the Member State of stay, even if, following that choice, the person concerned should be treated in a private establishment, where the urgent treatment necessitated by the insured person's medical condition could not be provided in the framework of the Member State's of stay national health insurance scheme. Under those circumstances, the person concerned (or the file of his/her illness) should not be required to return (sent back) to the Member State in which the competent institution is situated, to undergo there a medical examination (a further control of medical data), when doctors authorized by the institution of the Member State of stay consider that the patient' state of health requires urgent, vitally necessary treatment *(see the Court's judgment of 12.03.1987, in case 22/86, Rindone*). Otherwise, arguing against that practice, would amount to disregarding the rule of shared responsibilities which underlies Article 22 of Regulation 1408/71 (new Article 19, Regulation 883/2004) and the principle of mutual recognition of doctors' professional

skills; such, an obligation would be contrary to the interests of patients – incompatible with due concern for the latter's health (*see, to that effect, Rindone*).

Consequently, both the effectiveness and the spirit of the provisions of the aforementioned Articles dictate that, where it has been established that the patient would have been entitled to have the cost of hospital treatment received in a private establishment borne by the institution of the Member State of stay, and that treatment is among the benefits provided for by the legislation of the competent Member State, then the competent institution is obliged to reimburse directly to the patient the cost incurred following the latter's hospitalization so as to ensure a level of assumption of costs equivalent to that which that person would have enjoyed if the provisions of Article 22 (new Article 19) of the basic Regulation had been applied. The spirit of that kind of reimbursement of costs, at the level of (national) tariffs as provided for under the legislation administered by the institution of the Member State of stay, is also reflected in the new implementing Regulation *(see provisions of Article 25, paragraphs 5 and 6, and Article 26, paragraph 4b)*, yet, under the fundamental condition that institutions involved shall arrive at cooperating closely and efficiently, looking into the substance of the matter/questions raised in each specific case, i.e. going well beyond the limited/restrictive, even ambiguous, in our opinion, scope of the provisions recently adopted at Council level (reflecting political consensus at the moment).

General remarks: problems or perspectives?

A subtle equilibrium

Generally speaking, when assessing from the outset the overall impact and degree of transparency and legal security, guaranteed so far by the regulatory initiatives of Community Institutions vis-à-vis the Court's settled case-law, we find worth pointing out that the above-stated Courts' judgments as well as a series of interpretative approaches and references following them leave a significant gap or create an environment of *embarrassment and ambiguities*, even *legal insecurity* for national administration, a *disproportionate burden* for the finally deciding national judge and more so for the patient or any other insured, moving within the Community for health reasons.

In fact, the legal environment remains quite ambiguous when the Court, in a systematic and rather cautious way, indicates two parameters, perhaps to act as safety-valve-mechanisms, in the light of Article 152 EC, and as legitimate and proportionate boundaries to possibly negative or sometimes even subversive side effects of fundamental freedoms, namely, where the Court points out:

- either to (the cost of) "*equivalent*" hospital treatment under the national system of the Member State in which the person concerned is insured, a hypothesis which becomes void by the reality per se in a number of Member States' systems, i.e. where it is completely impossible for those systems to provide "equivalent" or any (hospital) treatment for that type of disease; in other words, where there is no *comparable* treatment *(see for an even narrower version of the Courts' qualitative criterion opted by the Council under the new implementing Regulation, where Article 26, paragraph 5 expressly refers to "the same" treatment)*;
- or to the comparison, most of the times, of the *amount of costs*, reimbursable under each legislation involved and not (or not always) to the *level of coverage* provided under the national systems of the Member States concerned *(see, again Article 26, paragraph 5,*

of the new implementing Regulation, where the notion of amount of costs has been adopted).

It is obvious, that the "grammatical" interpretation of the said jurisprudence is easier to be followed and far more acceptable by most of the competent institutions, mainly of the Member Sates administering comparatively low reimbursement rates (tariffs), than a teleological approach, which could be deemed as running counter their economic interests; yet, that narrow and restrictive interpretation would undoubtedly bear the risk to be condemned by that very Court, either as disproportionate par excellence or simply as a full misinterpretation/misunderstanding of (derogation from) the Court's case-law.

However, both terms (amount of costs/rates of reimbursement and level of coverage) are still the "grey zones" of interpretation, mainly when what the Court ruled or the Council decided come to be implemented ad hoc, i.e. in relation to concrete/specific types of schemes, which usually differ considerably in respect of their scope of application, organization and financing, and, consequently as to the concepts defining the way benefits are provided and reimbursed by the legislation which applies in each case. In more general terms, the *cas par cas* interpretation of fundamental principles of primary Community Law (e.g. Article 49 EC) is still pending, although *fundamental freedoms guaranteed by the Treaty inevitably require Member States to make some adjustments to their national systems of social security*.

A transparent and uniform implementation of fundamental freedoms is still at stake, although the Court has pronounced itself on both cases, the UK and Spanish systems (i.e. the most difficult case of a National/Public health Service) and the Greek sickness insurance scheme, where hospital treatment is received outside the statutory social security/health system (in another Member State, be it in a public or in a private establishment, in *Stamatelaki*), holding that, regardless the actual particular features of any of the said schemes, Member States concerned must provide *mechanisms for ex post facto reimbursement* in respect of care provided in a Member State other than the competent, by analogy, for instance, to the system created by all Member States when applying other specific chapters of Regulation 1408/71 *(see provisions under Article 34, Regulation 574/72 or respective provisions on unemployment benefits)*.

In fact, the Court reiterated that nothing precludes Member States with a benefits in kind system from fixing the amounts of reimbursement which patients who have received care in another member State can claim, *provided that those amounts are based on objective, non-discriminatory and transparent criteria*. On the other hand, in the aforementioned Greek case, the Court has held that measures which are less restrictive and more in keeping with the freedom to provide services could be adopted, such as *a prior authorization scheme* which complies with the requirements imposed by Community law and, if appropriate, *the determination of scales for reimbursement* of costs of treatment. Such measures would be appropriate and proportionate, in order to remedy the eventual risk of the national social security system being upset (if the insured had the option of recourse to other Member States' non-contracted private establishments), given the high cost of hospital treatment, exceeding, in any event, considerably that of treatment in a public hospital in Greece.

The persistence of grey zones: what is the reasoning behind?

Following the aforementioned, the degree to which misunderstandings in practice or intentional derogations result in the "*grey zones*" of Community coordination, even after modernisation, is reflected in the Spanish delegation's statement on Article 25(6), (7) and (7a): *"Spain considers that Article 25(6), (7) and (7a), of he Proposal for a Regulation of the European Parliament and of the Council laying down the procedure for implementing Regulation (EC) 883/2004 on the coordination of social security systems is related to Article 19 of the Regulation (EC) 883/2004 and has to be understood and interpreted in this way. Therefore, bearing in mind that the Spanish Public Health Services, according Spanish legislation, do not refund, except in exceptional cases of vital emergency, treatment provided by private health institutions, the Spanish Social Security Administrations will apply paragraph 7a and will not be able to provide national reimbursement rates in these cases" (see above).*

Spain declares that no mechanism of reimbursement of costs exists under its public health system and, furthermore, that the latter does not dispose any national scales for reimbursing medical acts. However, it is unconceivable for a Member State, on the one hand to contend being completely unable to have any such mechanism/scales (tariffs) and, on the other, to charge other Member States, by making out invoices on the basis of Community Form E 125, for treatment received in the context of its public health system. If we assumed, as a start, that Spain is unable to price private treatment (as any common treatment outside its public system), Spain's assertion/claim and moreover the latter's above-mentioned declaration are not sound or would prove rather invalid, just because Spain could actually base itself on the aforementioned invoices made out for other Member States (for charges deriving from other Member States' insured persons' treatment under its system), in the framework of its "least" obligation to cover the insured under the Spanish public health system. In other words, we think it unfounded/totally out of thought, for a Member State to dispose/to function or create a mechanism of reimbursement of costs for the purposes of Community Regulations – actually for reimbursement of costs between Member States and that same Member State to keep contending unable to avail itself of a corresponding mechanism, where reimbursement concerns individual insured persons' costs.

Moreover, although Spain charges other Member States, the former declares itself unable/not disposed to cooperate with other Member States' competent institutions for exchanging appropriate information; instead and probably for reducing its own administrative costs, that Member State demands all other, competent institutions involved to cooperate directly with care providers, contrary to the provisions applicable, expressly establishing close and loyal cooperation directly between institutions concerned. In fact, what Spain maintains in the last sentence of its declaration (*"for treatments provided by doctors and hospitals depending on public institutions, taking into account that the sharing of costs by the insured does not exist, the invoices that are issued by public doctors and hospitals correspond to the actual amount referred to in Article 61 of the Regulation (EC) No 883/2004"*), goes actually counter the letter and spirit of both Community Regulations, according to which, it is always the duty and responsibility of Member States' institutions involved to certify or to provide any type of information concerning the legislation administered by the latter.

A risky reasoning/second thought

If we take for granted the following:

- Spain does not approve (thus, does note recognise) in substance treatment in private establishments;
- Spain is not in a position (unable) to inform other Member States' competent institutions about the scales of reimbursement of costs (tariffs) applied by its system, in the sense that no such scales exist;
- that the actual amounts of the invoices issued by its system's doctors and hospitals are deemed by the Spanish competent Authority(-ies) as representing the actual public "prices", where those health service providers are contracted with the public health system;

then, the combination of all those assumptions we have acknowledged for the sake of our discussion, may as well lead us to a hypothesis that the contract/agreement, concluded between Spanish Authorities and (public) healthcare providers includes at least, amongst others, the following two conditions:

- regarding persons insured under its public health system and those affiliated in other Member States' legislation, holding an EHIC or an E 112 form, that those providers shall not charge any fees, instead they shall be paid by the Spanish public system (shall get the remuneration corresponding to the services provided by the latter);
- whilst those providers cannot charge the first category of insured any rates, on the grounds that no "private" treatment is provided under national legislation, the said providers may charge the second category of community mobile insured-patients, when, for any reasons, the persons concerned have recourse to them without disposing an EHIC or other Community certificate, a fixed amount determined on the basis of the said agreement, since under the above-mentioned declaration, that Member State is deemed recognizing that the said amount corresponds to the actual amount under Article 61 (representing its national rates of reimbursement/ tariffication).

If that reasoning is valid, we may then be confronted with a quite risky "treatment" of the issue by the Spanish side, raising some serious questions to be addressed; in particular:
1) Does the Spanish public system allow to contracted – depending on public institutions, health care providers to treat patients "in private" and apply to them "private rates"?
2) In an affirmative case, how could private rates be equal, i.e. not higher, according to international practice, than those concluded under the agreement as above, in other words, than "public" rates, actually?
3) How can Spain assume the risk of (proceeding to) such a declaration (in fact, assimilating private rates to public rates), when healthcare providers everywhere may easily charge patients with an extra (greater number of) medical acts, not necessarily included within the patients necessary treatment?
4) Why Spain prefers maintaining that expensive public control system instead of introducing directly a "cheaper" mechanism by establishing official/formal rates of cost reimbursement?
5) If the control mechanism, already run by Spain, is not deemed to be so expansive, because it is integrated within the overall system of assessing Health's parsimony in general, and public authorities, following systematic investigations, are able to ascertain and confirm (guarantee) that "private" rates always correspond with "public" rates, then it is really to wonder why, at the end, Spain finds it difficult after so many years to "transform" such an agreement into formal rates of reimbursement of healthcare costs (to turn such a practice into an official mechanism).

Finally, if the Spanish declaration aims at avoiding disproportionately high administrative costs at national level, in our opinion, it would be better for Spain to admit this problem

expressly, declaring, at the same time, its willingness to cooperate with all other actors involved, mainly the institutions, perhaps (and why not) on the basis of a more appropriate pattern of exchanging information and coping with ad hoc problems – eventually, a new model of good practices: a code, a bi- or multilateral agreement, which could be shared also by other Member States, facing similar problems. According to both Regulations' horizontal provisions (the principles), two or more Member States may, as the need arises, conclude conventions/agreements/codes with each other based on the principles of the existing coordination mechanism and in keeping with the spirit thereof *(see Article 8 under Regulation 1408/71 and Regulation 883/2004)*.

In that way, the problem of red-tape would be overcome efficiently and, also, in the best interest of mobile patients, by guaranteeing the maintenance of insured persons' acquired rights, in conformity with the fundamental principles of Community coordination (Article 42 EC). Unless the very essence of the problem lies on the *per se* extent and continuity of sickness insurance coverage of persons exercising their right to free movement.

Free movement of services: infringement proceedings against Spain and the UK – "Grey zones", the other way round

Following the European Commission's decision (2007) to send formal requests, taking the form of "reasoned opinions", to Spain and the UK, concerning their rules on reimbursement of urgent hospital treatment in another Member State *(see Commission's press release IP/07/1132)*, the Commission has taken action to put an end to obstacles to the free movement of services by deciding to refer Spain, finally, to the Court of Justice over the Spanish authorities' pertaining refusal to allow and grant an additional reimbursement of costs incurred as a result of urgent hospital treatment received in another Member State *(see Commission's press release IP/08/328)*: the fundamental (Commission's) argument being that this refusal deprived European citizens of a right granted to them by the Court under Article 49 of the Treaty as interpreted in the *Vanbraekel* case *(see above)*.

In its judgement, the Court ruled on the reimbursement of the cost of hospital treatment where a patient is authorised to undergo hospital treatment in another Member State (scheduled treatment). The Court took the view that, in accordance with the principle of freedom to provide services as guaranteed by Article 49 of the Treaty, reimbursement should be *at least the same* as that which would have been granted to the patient if he had received hospital treatment in the Member State in which he is insured. The Court pointed out that this could result in the payment of additional reimbursement if *the rate* of reimbursement in the Member State in which the patient is insured *is more beneficial* than that in the Member State, where the treatment was provided.

The Commission takes the view that the judgement in *Vanbraekel* case must also apply where a tourist, student or any other person temporarily residing in the territory of another Member State requires hospital treatment. It considers that European citizens must enjoy the same rights whether they are authorised to undergo hospital treatment in another Member State or are hospitalized during a temporary stay in another Member State.

That initiative, which in essence goes far beyond (even against) the very political consensus of the Council (EPSCO) on Title III, Chapter 1 of Regulation 883/2004, as established to be implemented by virtue of the corresponding provisions of Title III, Chapter I in the draft new implementing Regulation, after the Council's agreement on a partial general approach

(see above, document 9752/07), is the outcome of an incomplete incorporation under the said Chapter of the Court's overall case-law, interpreting broadly Article 49 EC.

Having failed to legislate in the light of the general/fundamental principle of free movement of patients, as an expression of insured persons mobility in its broadest sense, even after fruitless discussions at length during the negotiations on the Sickness benefits Chapter in the Council, the Commission, as guardian of the Treaty, acted accordingly, regardless the severe implications of the latter's initiative in respect of not only the draft new implementing Regulation but eventually also of the recently adopted basic Regulation (EC) 883/2004.

The extent – the impact of the Court's interpretation on the scope of the said fundamental freedom of the Treaty, covering at the same time *necessary care* in the context of a temporary stay *and/or scheduled treatment* in another Member State, had already been raised formerly, by the then Greek delegation during the debate regarding the scope of Chapter 1 (Title III) of Regulation 883/2004, in the context of the modernisation process at Council level; according to that delegation, it was an issue/an aspect, consisting an integral part of the whole reasoning behind complementary healthcare protection by virtue of the Treaty, a parallel alternative functioning in a supportive way, as a supplement to the maintenance of acquired rights guaranteed under the mechanism of Community coordination (a version of the principle of the more/st advantageous national treatment).

Yet, at those days, even introducing the *Vanbraekel* concept of additional reimbursement was deemed premature given a series of pending preliminary questions tackling substantial ad hoc particularities mostly of national health systems, of a benefits in kind nature. On the one hand, it was the UK delegation's approach to precede progressively, on a step-by-step basis but, also the opposite, more realistic position to avoid any such parallelisms or extending the scope to situations which had never been tackled *expressis verbis* by the Court itself, mainly out of fear that an even larger interpretation of Article 49 EC would have severe financial implications (notwithstanding red-tape) on national systems and/or institutions involved, given the significant number of persons on temporary stay within the Community (for a variety of motives/reasons). Yet, the urging necessity for a safe, transparent and uniform Community regulation was more than evident, at least in Greece, following pressing demands submitted by a great number of competent institutions, with their insured having received necessary care on the basis of their EHICs in the Member state of stay. The competent authority's interpretative circular letter actually "copying" the *Vanbraekel*'s case reasoning, was deemed as an insufficient quasi "legal basis" for competent institutions' governing boards or governors, especially where the costs to be covered in addition, the differential amount, were comparatively high (sometimes, even too high).

Integration or selective transfer of the Court's case-law under the new implementing Regulation?

In an effort to detect and predicate the influence of the Court's extensive, settled case-law on the procedure followed for the purposes of accomplishing Community coordination's modernization, in particular from the perspective of the Chapter, dealing with administrative procedures in the Sickness, maternity and equivalent paternity benefits domain *(see Partial general approach on Title III, Chapter I, doc. 9752/07 (27.05.2007) of the Proposal for a Regulation …laying down the procedure for implementing Regulation*

(EC) No 883/2004 on the coordination of social security systems), we notice, as a start, that the Council, in the course of establishing the basic Regulation's 883/2004 respective Chapter (Title III, Chapter 1), opted to hold out at least for the Court's forthcoming judgments on a series of very important, yet pending, preliminary questions. In doing so, the Council actually referred the integration of the Court's overall jurisprudence, mainly (and/or perforce?) to the (draft) new implementing Regulation, taking also into consideration the (fact of) the deletion, in the meantime, of health services as a whole (Article 23, in particular) from the material scope of Directive 2006/123/EC on services in the internal market.

However, subsequent ECJ's case-law was, as a matter of principle, a natural (more or less expected) evolution, an integral part of – supplement to the initial interpretative approach of the Court's jurisprudence (general guidelines); in other words, there were no surprises, even in respect of the Commission's very first interpretative position, following the post Kohl and Decker period, according to which, the said case-law covers equally national health systems (national health services – benefits in kind systems) as well, although the governments of Member States concerned kept considering/treating the latter systems as *extraordinary* models/cases (justifying even derogations from the rule). Yet, Member States maintained the same rigid position, which had been followed by their governments during the preliminary questions' submission period, also after the Court had ruled on all those questions, in an effort to postpone as much as possible the adaptations required in their corresponding systems mechanism of reimbursement of health care costs. The said Member States opted for a decision-making procedure, as a result of an "*external impulse*" intervention (e.g. by the Commission and/or the Court), so as to give the impression that crucial (both economically and politically) decisions regarding the national health system, have been (are) the outcome of Member States' responsibility for a day-to-day enforcement of Community legislation.

Consequently, when examining (assessing) the aforementioned Chapter of the draft new Implementing Regulation, we ascertain that the Court's case-law has not yet been incorporated/integrated either in the most appropriate way or to the proper extent, so as to function as an organic integral whole. In other words, ECJ's jurisprudence is not integrating well either in the context of Regulation's general or special provisions, whilst, in our opinion, it is more than obvious that integrating certain qualitative criteria of the case-law under the basic Regulation 883/2004, i.e. in the legal framework of substantial rules, would have been far more efficient and effective, instead of "pushing" selectively essential parts of the jurisprudence in the context of formal provisions, laying down the procedures for implementing the Basic Regulation..

In that way, the Community legislature's regulatory acts, consist, in our view, of a technical intervention, a partial incorporation under (within) a larger whole, which does not, however, respond to the way and the spirit of the existing Regulations (both basic and implementing), as if that case-law had been merely "transferred" *ad hoc and ad random*, instead of being substantially integrated in the overall economy of Community coordination provisions (combined together into a united whole).

The draft new Implementing Regulation is to a considerable extent structured in a disproportionate way, i.e. it does not present the expected, proper analogies in the context of each Title or Chapter and/or between them. A representative example of the above-stated

disproportional structure of coordination provisions' economy is Title II, apparently, a key system of provisions, which:

- *on the one hand*, follows, facilitates – enhances both active and non-active persons' mobility (under its continually changing/new forms), the establishment of free movement, in its broadest sense, with the aim of determining, in an unhindered way, the legislation applicable each time (taking into account each particular case's outstanding features, under the already classified categories), and
- *on the other hand*, has a direct impact on all institutions' concerned interests.

Given the concrete range/impact of the said Title's scope, it is obvious, that in the new implementing Regulation there is an exhaustive/extensive integration of all respective AC Decisions, which, by transposing in a detailed (analytical) way, all previous ECJ's rulings, are interpreting Title II key issues.

On the contrary, in Chapter I, Sickness benefits, a particularly complex and multilateral sector, which, mainly for that reason, would need the Court's *"enlightening"* intervention most than any other, the transposition of case-law has been limited to a few provisions only, establishing the absolutely minimum obligations, generally unavoidable, of the institutions involved; their obvious, almost self-explanatory responsibilities on the reimbursement of healthcare costs, incurred during a temporary stay outside the competent Member State, either as necessary or as scheduled treatment. So, while for the purposes of Title II, an effective legal framework has been provided for responding to a series of substantial questions and facilitate the institutions concerned to take the right decisions on time and/or to remedy, even *a posteriori*, eventual misunderstandings/misinterpretations and wrong practices, for the purposes of Chapter I (Sickness benefits, under the following Title III) no corresponding or proportionate legal framework of comprehensive as well as transparent rules has been agreed upon, which would address and provide solutions for equally important and, sometimes, really urgent issues, in the light of ECJ's interpretation.

This is due to the fact, that Title II under the new implementing Regulation reflects Member States' *maximum feasible compromise*, whereby the latter managed to agree on what constitutes their institutions' *maximum possible interest*, i.e. (to guarantee) the collection of social security contributions. In the opposite, under the next Title (III, Chapter I), Member States' agreement has been achieved at (on what constitutes) the *minimum acceptable threshold*, i.e. institutions' least possible economic burden/charge (entanglement) with regard to reimbursement of healthcare costs; the outcome of such a development is that, regarding key provisions, which have multiple – a variety of implications on all factors involved, and, at the end, on the very quality and level of living – the state of health not only of European citizens but all persons subject to a social security system falling under Community coordination' scope, what has been achieved is just a *minimum compromise*.

To put it differently, whenever institutions concerned expect – aim at guaranteeing economic resources, invoking, as the main reason for doing so, the sustainability of their social security/health systems, the political compromise is reached at the highest level of financial profit/benefit; therefore, the new implementing Regulation unavoidably tends to serve, in the most efficient way, institutions' economic interest, their dynamic capacity of collecting contributions. On the contrary, where the major point (raised) is about institutions' economic responsibilities, i.e. in Community coordination sectors, which imply the assumption by institutions concerned of comparatively higher burdens, then the

political compromise is reached at the lowest level of economic loss; consequently, the new implementing Regulation "legitimises", in a way, some Member States' arguments about their systems' financial balance running the risk of being seriously undermined, although the Court, after having examined whether that risk really consists an overriding reason in the general interest, has repeatedly rejected such an appeal, as unfounded, unjustified and at the end disproportionate (not capable of justifying an obstacle to the freedom to provide services). Moreover, the Council's political compromise, drives to disregarding and derogating from the very first recital of both (basic) Regulations (1408/71 and 883/2004), by virtue of which *"the rules for coordination of national social security systems fall within the framework of free movement of persons and should contribute towards improving their standard of living and conditions of employment"*.

Following the aforementioned, when we are looking for the right answers to key issues, we find ourselves *de facto* confronted with the unique, actually, substantial question: what are we really aiming at when dealing with Community coordination as a mechanism: are we trying to establish a Regulation serving mainly the institutions' interests or an instrument, reassuring the appropriate legal certainty and continuity, for the purposes of protecting mobile patients' "interest" as well as guaranteeing the overall harmonious coexistence and balanced implementation of EC Treaty's fundamental freedoms as a whole, the utmost target being European citizens' high standard of living and employment conditions along with a high level of human health protection?

In our opinion, what happens in every-day-practice is a disproportionate management by social security institutions involved of the balanced relationship between insured persons' rights and obligations. Under Title II, mobile insured persons' obligations towards the institutions, they are affiliated with, are perfectly determined, clear-cut and transparent, as the latter have been stated in an express and detailed way by a number of relevant provisions under the said Title. In the opposite, under Title III, Chapter I on sickness benefits, what has been attempted is the delimitation of insured persons' rights within a rather ambiguous and unsafe framework. In that way, when insured persons are exercising their right to free movement, they are confronted with a quasi unbalanced treatment, from the moment priority is given to their obligations rather than to the full range of their rights, in conformity with ECJ's case-law interpretation.

We think that, Community coordination, as a wide range legal framework, called to address such a complex and multilateral European endeavor which remains at stake, although of crucial importance, should be governed by a more or even totally balanced system of rules.

Methodology of the new implementing Regulation: who exaggerates?

As it is well known, the Community mechanism for the coordination of Member States' social security systems (Regulation 1408/71, Regulation 883/2004 and corresponding implementing Regulation of the previous ones) constitutes a system of law (a legal system), which is based on the "deductive" approach, a method followed by Continental Europe (for the interpretation as well as the implementation of legal provisions/law), which is traditionally defined as *reasoning from the "general" to "specific"* (i.e. a method using arguments to move from given statements (premises), assumed to be true, to conclusions, which must be true if the premises are true), having as a model of legal reasoning the application of *general principles* to reach *specific conclusions*. Community coordination does not follow the alternative to the above-mentioned reasoning, the inductive reasoning, a

method of Anglo-Saxon origin, which is *reasoning from the specific to the general*, i.e. an approach starting with a particular observation that is believed to be a demonstrative model for a truth of principle that is assumed to apply generally: the basic difference between the two being summarized in *the deductive dynamic of logically progressing from general evidence to a particular truth of conclusion; whereas with induction the logical dynamic is precisely the reverse*.

Following the above stated, the new implementing Regulation is equally based on the deductive method, notwithstanding its particular nature consisting of detailed provisions of an administrative/procedural character, the appropriate tools for the purposes of implementing the Basic Regulation 883/2004; in other words, the latter does not follow a case-to-case reasoning. This means that the economy of the implementing Regulation's provisions would require encompassing exclusively those detailed procedural provisions, which would contribute significantly, efficiently and in the long-run to the implementation of the Basic Regulation by all stakeholders concerned, i.e., a detailed enumeration of administrative/practical procedures, patterns of loyal cooperation, forms of mobility, rights and obligations between institutions and insured persons concerned and/or exclusively between institutions involved (a quasi "case-to-case" classification of situations into as general as possible categories of rules).

Yet, regarding the structure of the new implementing Regulation, one could notice the previously stated imbalance in the economy of the latter's provisions, following which:

- In some Parts of the said Regulation (e.g. Title II, on the determination of the applicable legislation), listing the conditions required for the implementation of Community provisions has been so detailed – an exhaustive transposition of not only the qualitative but also or mainly the quantitative criteria of the Court's case-law – that we could no longer speak of the jurisprudence's integration within the Regulation, since any such integration should have been in conformity with the overall spirit of Community legislator; consequently, we wouldn't exaggerate stating, that the above development could be deemed as a substantial transformation of the implementing provisions' expected (due) economy into a well structured context of concrete *ad hoc* (diverse facts) cases, which renders that Regulation almost a casuistic system of managing/regulating isolated cases (almost law based on a *"case-to-case reasoning"*, as above).
- In other Parts of the said Regulation (e.g. Title III, Chapter I, on sickness benefits) listing the administrative procedures required each time (under different circumstances) for the implementation of Community provisions, has taken place, following the approach of the above-mentioned *"deductive method"*, the outcome for the implementing Regulation being that it gets to maintain the form of *general – statutes law*.

Obviously, the previously referred imbalance of the legal rules' economy is due to reasons of pure economic interest (sustainability) of national social security systems. This means that:

- In the first of the two cases stated above, Member States aim at registering (including) almost all cases ("grey zones", in their opinion), in respect of which they deem it possible a question to be raised on the ad hoc applicable legislation, guaranteeing, in that way and in each particular case, the most legally safe implementation of Community provisions and, as a result, the collection of contributions.
- In the second case, the intentional (conscious) maintenance of ("grey zones") the general character of implementing provisions drives us to the time-consuming disputes

raised by Member States regarding those situations, which have remained intentionally uncovered (at least expressly), because, otherwise, i.e. if the Council had to enact explicit rules on the matter, then Member States would be obliged, by virtue of those rules, to reimburse (higher) costs of medical/health care either to other Member States or, even worse, directly to the insured concerned.

However, the above-raised disturbance/imbalance which is going to occur to the overall economy of new implementing Regulation's provisions has as an impact the indirect discrimination of mobile persons, as a result of the unequal legal treatment in practice of their every-day situations – forms of mobility, taking into account that:

- In the first of the above-mentioned category of provisions, the case-to-case regulation attributes to individual situations treated ad hoc, an increased formal, *quasi legal* power, from the moment those particular situations are turned into Community provisions, prevailing, as it is well known, over Member States' respective internal legislation, avoiding in such a way, undesirable economic derogations.
- On the contrary, in the second category as above, individual cases, which are usually very important (and, we reiterate, already known by Member States, well in advance, notwithstanding the latter' s unwillingness to address them), are not covered as such by the legitimately established general (in nature) rules, "loosing", in that way, the chance of disposing a particular formal statute (turned into Community provisions), bearing, in the best case, the form of lower formal value, that of an Administrative Commission' s decision and, in the worst case, the form of Guidelines, disposing no formal validity (as indicative examples of the treated cases) in the context of a Code of conduct/of good practices.

It goes without saying, that Decisions as well as the Code issued by the Administrative Commission are generally respected and applied by national administrations. However, those Community instruments leave a great space for misunderstanding, ambiguities and long-lasting disputes of an intense character, mainly regarding the well-founded and the relevance of facts and events under examination or the validity of additional elements of proof, given that, as a rule, Member States shape the criteria invoked and the practices followed as well as their argumentation from a perspective reflecting the particular characteristics of their national legislation and socioeconomic situation (in the light of the practical reality in their territories).

Consequently, recovering the balance of the economy of Title II and Title III, Chapter I provisions, requires either the use of the deductive method also for the purposes of Title II provisions or the conversion of Chapter I (Title III) into casuistic law.

Yet, we think that, in the context of the last Chapter, the more Community legislature would try to enumerate – list exhaustively "all" individual cases which might arise, the less could he be able to grasp the totality of all notional, possible to occur mainly in the future, cases/situations. Following what has been stated, a regulatory intervention based on a case-to-case reasoning, is full of potential gaps in practice, because, *"the more the legislator proceeds towards regulating the least detail, the less such a regulatory intervention is going to be complete"*.

In the opposite, by means of the deductive method, the legislature shapes the appropriate general rules – concepts and formalities, which are applicable in (would cover) a variety of different individual cases (diverse facts), therefore leaving to the judge a wide space for

interpretation at his/her discretion, since the latter is not bound by exhaustively defined provisions. The legislature's aim is to procure always for the maintenance and supervision of the general (generalizing) character of the existing legal system, to provide for the judge's, jurist's and the lawyer's raising consciousness and awareness, so that the latter, professionals in such a complex area, possess a high level of knowledge and interpretative skills, and, as a result, to guarantee legal security and continuity, on behalf of European citizens (mobile insured-patients, *in concreto*), moving within an *invisible* yet *omnipresent* legal context.