Reflecting on a new type of Community coordination: in search of the optimum interaction between the EC judiciary and legislature[1]

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The fear of "opening the floodgates of "peripatetic" patients picking and choosing health care services in various MSs".
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The wish, "policy in this area to be driven by patients' needs not what they can afford to pay".

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1. Introduction

Starting from the very wording of the title, actually the search, what do we imply – what are we seeking for, in principle and/or in practice? Do we accept the existence of two different ways and in what way? As long as there may remain two pathways of patient's

[1] Prague Conference "50th Anniversary of Coordination of Social Security", Round table discussion, *Dorina Tsotsorou*, respondent to J.-C. Fillon "Cross-border health care: towards a coordination of the two ways of patient mobility", May, 2009.
[2] *Tamara K. Hervey, Jean V. McHale*, Health Law and the European Union, Law in Context, Cambridge University Press, 2004.

mobility, are they going to exist as parallel, complementary or supplementary? In other words, given the nature, the scope and aims of Community coordination, what the specific content, scope of a future Directive[3] would be? In particular, would it be "necessary" or best matching Community coordination's perspective, to cover exclusively aspects/issues other than those falling within the health services domain?

If, on the other hand, the concept of coordination is used expressing the outmost wish to arrive at establishing one single instrument and that under the extended mechanism of coordination, by including under the latter's scope ECJ's interpretation of the Treaty's internal market freedoms as well, then such a political commitment should urge us to enrol brains and talent in order to address as positively – creatively as possible all legal and/or technical aspects, "obstacles" of such an endeavour – initiative.

Lastly, if a holistic approach is still not feasible a target (at Council's level) or if the proposed attempt is actually deficient in covering effectively and efficiently the "gap" of uniform interpretation and/or implementation of ECJ's settled case-law, then a conservative, yet, cautious approach would be to remain under (to continue "living" with) the existing legal instruments, i.e. EC Regulations, which following modernisation have partly included the Court's jurisprudence and, in parallel, the Treaty provisions on the internal market fundamental freedoms, which as such are in force and have an undisputable impact on the interpretation and implementation of Community secondary legislation as it stands. Another way is to name that converging implementation as the Treaty-influenced broader teleological interpretation of Community coordination mechanism's scope.

What we urgently need is to adopt a pragmatic approach. Obviously, the dilemma we are confronted with is:

- either to adopt the *"maximum/maximalist"* approach, an idealistic hypothesis, which would imply incorporating the Court's case-law under a broader form of Community coordination, as the single response to the Treaty's broader socio-economic imperatives;
- or to retain the *"minimalist/minimum" approach*, as lastly stated above, which could be summed up that a patient within a medically justifiable time limit has not been offered, *as a matter of fact*, an adequate medical treatment in the home State, each time that State refuses to cover treatment abroad in a situation where it has not been able, within a medically justifiable time limit, *to honour an obligation under its own social security law to provide the treatment to the patient in one of its own establishments*[4].

Indeed, we are confronted with the need to choose a legal, a major political or a pragmatic approach in a field, which remains in principle of national competence, although it is actually amidst *the winds of Aiolos* (Aeolus), i.e. under the conflicting interference of internal market rules and competition law otherwise, social security – health insurance systems find themselves in the uneasy situation to have to successively pass *the Symplegades* (Clashing or Cyanean Rocks, of Greek mythology) by making the right choice in time and motion.

[3] Commission of the European Communities, Proposal for a Directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare, Document COM(2008) 414 final, 2 July 2008.

[4] Paraphrasing the EFTA Court's judgement of 19 December 2008, in joined Cases E-11/07 and E-1/08.

A major difficulty we face in parallel, making the right choice particularly subtle is that internal market and competition rules on *services – economic activity* are in a constant evolution, the jurisprudence-based *moving sand*, where health – social security systems have to find the ideal equilibrium. The still pending major question is how one could find the *golden mean,* if the EU social model is not to be undermined *inadvertently* by the inappropriate application of EU law designed to meet needs *in other sectors* or a *piecemeal* series of rulings *on health care*[5]. It is generally recognised that "*the case law lengthy, highly technical and politically controversial* has led to spectacular developments" (since the Court indirectly established that health services constitute services in the sense of the Treaty, as a follow-up to a historic also ruling whereby it recognised that "medical patients, students and tourists moving to another MS (Member State) are service recipients, in the sense of Article 49 EC and should be allowed to carry around the necessary moneys, in an effort to enhance the initially limited movement of capital, at a time that Treaty freedom was completely idle")[6].

Indeed, it is understandable and highly recommended, especially for the purposes of Community coordination that the *European* concept of social security, inspired by and serving the Treaty's general principles and fundamental freedoms but also the Union's general aims, obviously differs from the *national* concept. "However, it is very remarkable that exactly an important aspect of what is social security is answered differently by the Court, most of the time depending on the European instrument in question"[7].

2. Perspectives of a structured relationship between two legal instruments

> *Are we moving towards instituting a system of assumption of costs contrary to or even undermining universal health care goals?*
> *Do we fail to acknowledge incompatibility between policies of charging and universality?*
> ***Allyson Pollock***[8]

The fact, that the ECJ's case-law has been partially only adopted for the purposes of modernisation, was the result of MSs' conservative more or less position, in defence of their own system's "interests" (mostly financial, although unilaterally assessed), thus reaching consensus just on a partial improvement of the "Community mechanism/criteria" on authorised scheduled treatment, under the provisions of Article 22(1)(c)(i) and mainly

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[5] *Elias Mossialos, Martin McKee, Willy Palm, Beatrix Karl, Franz Marhold*, The influence of EU law on the social character of health care systems in the European Union, Report submitted to the Belgian Presidency of the EU, Final Version, Brussels, 19 November 2001: http://www.ose.be/health/files/corereport.pdf.

[6] See ECJ's judgment of 31.01.1984, in joined cases 286/82 and 26/83, *Luisi and Carbonne*, in: *Vassilis Hatzopoulos*, The ECJ Case Law on Cross-Border Aspects of Health Services, European Parliament, Document IP/A/IMCO/FWC/2006-167/C3/SC1: http://www.europarl.europa.eu/comparl/imco/studies/0701_healthserv_ecj_en.pdf; *Vassilis Hatzopoulos*, Current Problems of Social Europe, Research Papers in Law, College of Europe, Brugge 7/2007: http://www.coleurop.be/file/content/studyprogrammes/law/studyprog/pdf/ResearchPaper_7_2007_Hatzopoulos.pdf.

[7] See *Yves Jorens, Michael Coucheir, Filip van Overmeiren*, Access to Health Care in an Internal Market: Impact for Statutory and Complementary Systems, Bulletin luxembourgeois des questions sociales, Volume 18, 2005.

[8] *Allyson Pollock, David Price, Sarah Boesveld, Iain Law*, Response to the Scottish Government's consultation on the European Commission's proposal for a Directive on the Application of Patients' rights in Cross-Border Healthcare, The Centre for International Public Health Policy, 2 December 2008: http://www.scotlandeuropa.com/19-12-08%20MC%20CIPHPresponse.pdf.

(2), of Regulation 1408/71[9], as set out in Article 20 of Regulation 883/2004[10], and on the inclusion of the Court's jurisprudence regarding reimbursement of costs for such healthcare, by virtue of Articles 25 and 26 of the new Implementing Regulation, almost implicitly.

That stance led the Commission to take the initiative (at least to make an effort) to codify the Court's case-law and integrate under transparent and legally certain provisions ECJ's teleological interpretation on cross-border healthcare, not yet included within Community coordination, by means of another, additional legal instrument, under the scope of a Directive; an initiative which had been encouraged also by the European Parliament.

Among the range of complex and sometimes controversial areas, covered by the Proposal, which touch on significant issues of Community as well as national competence, under both sectors of health and social security alike[11], we would like to raise two points, which we shall try to analyse further on:

- the proposed duality, two different pathways existing in parallel, is neither a feasible nor a transparent or legally certain alternative;
  and
- the Directive as such is creating more problems than the ones it is expected/supposed to solve.

For the purposes of implementing Article 49 EC, (a generally speaking, exhaustive establishment of the freedom to provide (health) services), there will be two EU's legal instruments which could be considered, on the one hand, as in principle equivalent (since both are equally binding for MSs) and, on the other hand, of a typically different legal order. More specifically, the Regulation is an European legal instrument binding in its entirety and directly applicable in all MSs, having a "direct effect" horizontally, with no other implementing measure being required due to its self-executing nature, whilst the other main EU's legislative act, the Directive has direct effect but only vertically, and in principle, requires MSs to achieve a particular result-objective, normally leaving them with a certain amount of leeway as to the exact rules to be adopted; in fact, MSs dispose some degree of discretion in the way they transpose ("translate") a Directive into national law, since the said instrument can actually be adopted by a variety of legislative procedures depending on its subject matter. From the moment, however, all legislative regulations required are enacted within the explicitly defined deadline, actually "incorporating" the said Community provisions within national legal order, the Directive per se "metamorphosed" into national social security "legislation" (an integral part of the latter) may be deemed as falling also under the scope of Community Regulation 883/2004, being thus subject to coordination.

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[9] Council Regulation (EEC) No 1408/71 of 14 June 1971 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community, OJ, L 177, 07.07.2008, p. 1.

[10] Corrigendum to 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 200, 07.06.2004, p. 1.

[11] On the highly complex background and the delicate issues to be addressed on the way forward -towards a coherent framework for patient mobility-, see *Yves Jorens, Michael Coucheir*, Europe for patients (E4P) – Options for legal change in the field of patient mobility, Ghent, 2007; on the conflicting situations between primary and secondary law, economic/internal market and social law, national and supranational level, and "hard"- and "soft"-law legal and economic regulatory instruments, see *Ulrich Becker*, Sozialrecht in der europäischen Integration – eine Zwischenbilanz, ZFSH/SGB, Sozialrecht in Deutschland und Europa, 03/2007.

Yet, in the context of that broadly speaking coordination, such a Directive does not seem "well-disposed" towards enhancing the establishment of the right to the free provision of services, in conformity with ECJ's teleological interpretation. In fact, the Directive may end up in "extending/broadening" the scope of each MS's (national) legislation regarding the implementation of the patient's respective rights, but such an internal "extension" is totally "abstracted" from the overall and enforceable "umbrella" of Community coordination, since it is strictly limited to the assumption of costs for cross-border healthcare separately by each competent institution (MS of affiliation) involved, which cannot be coordinated with any other MS's respective reimbursement; otherwise stated, the said financial costs, cannot be included within the recently adopted under Regulation 883/2004 *system of fair distribution of costs* between all MSs involved with cross-border healthcare. In more general terms, that type of reimbursement is not in conformity – does not comply with the very "spirit" of coordination, since it creates additional costs, partly outside coordination (non-reimbursable) and partly inside (reimbursable).

Member States social security legislation/systems' coordination is a feasible objective, since the mechanism on which it is based, Council Regulation, is a Community mechanism based on a legal instrument of direct and overriding effect in all MSs[12]. The question, however, remains whether "coordination" of these two distinct, yet of an equivalent legal value (ensuring also an "equivalent level of protection") Union's legal acts could be still deemed feasible an aim. In other words, the question is which (further) mechanism, which EU Institution(s) could be in a position -would be deemed appropriate and dispose the authority required- and under which (Community) procedure, to manage, monitor and guarantee such an in parallel and/or complementary implementation, the coordinated function of those separate yet interrelated initiatives. If the only hierarchically superior Institution is the European Court of Justice, then the outcome in respect of transparency, smooth implementation of the extended Community acquis (raising obstacles to any type of free movement), and legal certainty in general, would be less than what would have been expected, i.e. inferior to the overall aim of such an endeavour.

Consequently, it is for the purposes of the best possible implementation of the Treaty's imperatives (Article 49 EC not), that the "coordination" of those two EU instruments is being sought. In other words, although we have tried to identify the role (complementary or supplementary) of a Directive possibly functioning in parallel with Regulation 883/2004, yet we consider that expanding the scope of the latter is a *smoother*, in terms of transparency and legal certainty, and *more comprehensive* task than pretending offering a viable and uniform solution by means of a Directive as the one under examination. Besides, as the Court has repeatedly held (in respect of the sector-specific directive on recognition of professional qualifications) the directives as well as its judgements, are specific expressions of the general Treaty rules, merely the expression (also in judicial decisions) of a principle inherent in the fundamental freedoms of the Treaty, and so the legal effect of that principle cannot be reduced as a result of the adoption of such directives.

Yet, before making a step forward, we should undertake a more in-depth analysis on how the Council's commitment to the overarching values of universality, access to good quality care, equity and solidarity, as set out in 2006[13], should be explicitly upheld by a Directive,

[12] Article 288 EC, ex 249 TEC, also ECJ's doctrine of the Supremacy of EU law.
[13] Council Conclusions on Common values and principles in European Union Health Systems, OJ, C 146, 22.06.2006.

ensuring EU's respective commitment, debating further on the content and issues underlying the Community concept of patient's mobility, its nature and its extent.

3. Cases of health care under "other circumstances"

> *Community coordination in between ECJ's dynamic interpretations and political backlashes either through collective political decisions or mostly, via reluctant implementation or even pre-emption through counteractive national legislation, the latter being more frequent political/administrative responses. Nevertheless in a long-run perspective such national responses do not constitute sufficient strongholds, as both the Commission and the Court continue to lay down dynamic means and ends for the Community. National responses do not stand against governance and enforcement procedures of the supranational actors.*

The accomplishment of the objective of coordination of Community legal instruments, Regulation 883/2004 and possibly a Directive (or other soft-law instrument) based on the Treaty's fundamental freedoms as interpreted so far by the Court's settled case-law, to our opinion, requires a more in-depth examination and further analysis of the term/concept "other circumstances" (Article 3(2) of the Proposal) already used in the context of the Commission's proposal for a Directive and covered exclusively by the latter as the Treaty's alternative pathway, vis-à-vis all other circumstances which already fall or should be (deemed) covered by the Regulation 883/2004 (the existing/main instrument of secondary legislation).

3.1. Health care granted by a contracted provider under a private status – non-implementation of Regulation 1408/71

To start with, Community coordination of the MSs' social security systems, covers, in principle, those cases where healthcare in another MS (*of stay or residence*) is provided in the context of that State's system (*in accordance with the provisions of the legislation administered by the institution of the place of stay or that of residence*) on the basis of documents (*issued by the competent -quasi competent- institution*) which certify that the patient is subject to the legislation (*insured person*) of the home MS, i.e. the competent one or that of residence (e.g., the EHIC, or other Community documents/certificates such as E 112 or E 106). Under these circumstances, the objective of such a mechanism (under the provisions governing the sickness benefits chapter) is to guarantee continuity and legal certainty to mobile persons while preventing the insured, eventually as a patient, from being forced to pay him/herself the costs corresponding to the benefits received in another MS.

Progressively, however, as our 25-years-plus experience proves it, all the more frequently and in an increasing number of cases, in which Regulation 1408/71 should (or could, following a broad/teleological interpretation) have been implemented, the patient concerned *is obliged by a provider, contracted with his//her institution of the place of stay or residence* (if the said patient is not at the end driven by the former to proceed even to a non-contracted health professional – to seek health care under a private regime), or *by that very institution*, sometimes, *the competent* not excluded, to prepay him/herself the bill, i.e. to pay in advance the total costs for the health care received in that territory. This means that the said health care is granted under *a private regime*, i.e., outside the rules-provisions of the MS's of treatment legislation/health insurance scheme, and, thus, does not fall within the legal framework/scope of application of the Regulation 1408/71. Consequently, the

patient pays out-of-pocket, is charged with upfront payments, which go beyond the provider's remuneration, covering also other costs, naturally, at private rates/tariffs (applied by the latter-medical acts).

Receiving such health care implies for the patient a substantial/significant economic burden, since,

- *on the one hand*, it is not at all sure/guaranteed that the person concerned shall, at the end of the day, *be reimbursed* for such costs (he/she has been exposed to) by the institution of the place of stay, or usually, the competent institution[14], even following an a posteriori implementation of the Regulation (1408/71 and 883/2004) and the Implementing Regulation respective provisions (Article 34, under the existing Regulation 574/72[15], Article 25, under the Implementing Regulation-to-be) or the said reimbursement is too time-consuming in every-day practice (may take up to 6 months to be accomplished), due to the complex administrative procedures between institutions involved (the procedure provided for the implementation of the form E 126, at present) and,
- *on the other hand*, costs reimbursement to the patient at the national tariff rates applied by the institution of the place of stay *may amount to 30 to 50%*, whilst according to the tariffs applied by competent institution such coverage *may represent up to 10%* of the costs actually being born by the patient (the provider's private rates), especially where the competent MS is one of the Southern or Eastern Europe[16].

It is worth noticing that when we refer to the institution (MS) of treatment we use the Community term "institution of stay" instead of "institution of residence", because it is only very rarely (if not at all) that we are confronted in the MS of residence with such cases, in particular where health care is sought under a totally private regime, since the person insured with another MS's legislation (the competent) is always treated on an equal footing (assimilated) with the persons subject to the MS's of residence social security system, thus receiving sickness benefits in kind by virtue of the latter's legislation and on the basis (at the submission/presentation) of a national document, issued by the said MS instead of a Community document issued by the competent MS/institution (e.g., the EHIC in cases of stay in another MS).

In the above-mentioned cases, *private* health care or sickness benefits in kind granted under a *private regime/status* is mainly due:

- *either* to the wrong, partial/fragmented or even non-implementation of the (Basic) Regulation's respective provisions from one or more of the above-stated actors, because:
    - the health care in question has not been recognised as "medically necessary", by virtue of Article 22(1)(a)(i) provisions, in spite of the fact that the patient possessed a valid Community document (certifying his/her entitlement to sickness benefits in kind), or

[14] See also, Flash Eurobarometer, Cross-border health services in the EU, Analytical report, Series #210, June 2007, providing an indicative example of insured persons' confused perception on their entitlements and reimbursement for health care costs incurred in another MS (Chapter 1): http://ec.europa.eu/health-eu/doc/crossbordereurobaro_en.pdf.

[15] Council Regulation (EEC) No 574/72 of 21 March 1972 laying down the procedure for implementing Regulation (EEC) No 1408/71 on the application of social security schemes to employed persons, to self-employed persons and to their families moving within the Community, OJ, L 31, 05.02.2008, p.1.

[16] Very often the case between Greek and German tariffs.

- it had not been possible to promptly certify the patient's right to receive health care, regardless of whether this lack of timely valid information was the patient's responsibility (had missed to fulfil a task) or not (or somebody else's);

➢ *or* to an arbitrary or unjustified violation of Regulation's 1408/71 respective provisions[17], regarding the recognition of the said patient's entitlement to access health care services, despite him/her having submitted a valid Community document (e.g., an EHIC). That arbitrary refusal to recognise and accept, for instance, a valid EHIC[18] is still, unfortunately after a five-year period of its full implementation[19], based

- *either* on completely ridiculous, anyhow extremist grounds, in other words, that the data contained in it are written in another, "foreign" language – such an argument being completely contrary and incompatible with the very philosophy of Community documents, i.e., to be readable in every MS, especially the data figuring on the EHIC, in conformity with the Decision No 190[20] of the Administrative Commission,
- *or* to the reason mostly set off, deliberately or due to lack of valid information on the provider's side, that the patient may be reimbursed for the health care costs incurred by "his/her" institution, sometimes without further specifying the concrete institution responsible for such a (Community) "task"; yet, that last approach being of no substantial significance, since even the institution of the place of stay, in case the patient turns to it for information, is usually asking (misdirects) the said patient to address him/herself to the competent institution, making no effort to implement the Community provisions at stake even a posteriori, perhaps driven itself by the above-mentioned (sheer economic) concerns.

The most important underlying reasons for the aforementioned *problematic* implementation of the Basic Regulation (actually 1408/71), are:

(1) *The provider's fear, that the responsible institution, that of the place of stay*, is not going to recognise the health care sought and granted as a "medically necessary" sickness benefit in kind, and, thus, shall not be reimbursed by the latter the costs incurred; similar concerns are also shared by the institution of the place of stay in respect of the competent

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[17] See also, *Franz Bittner*, Obmann der Wiener Gebietskrankenkasse, in: "Patientenmobilität – Chance oder Risiko?", Diskussionsveranstaltung der SPÖ-Parlamentsfraktion (Austrian Social-democratic Party), Wien, 16.03.2009, where it has been stated that only exceptionally Austrian tourists' EHIC is being smoothly accepted by contracted health care providers during their vacations, without the card holders being asked to pay a private fee/participation: http://klub.spoe.at/bilder/d270/Statement_Bittner.pdf; AOK-Bundesverband – Presseservice Gesundheit, Risiken und Nebenwirkungen für Patienten und Gesundheitssysteme, Bonn, 18.05.2009, which refers to the broader dimensions of the above-stated phenomenon and, expressing its strong concerns that such a Directive could even reinforce the "financial incentives" for non-respecting EHIC's implementation, concludes that "instead of reinforcing patients' rights, the Commission's proposal leads to exactly the opposite results": http://www.webweiser-gesundheit.de/presse/psg/politik/index_01454.html.

[18] See also, *Helena Legido-Quigley, Martin McKee, Ellen Nolte, Irene A. Glinos*, Assuring the quality of health care in the European Union – A case for action, World Health Organization 2008, on behalf of the European Observatory on Health Systems and Policies: http://www.euro.who.int/document/e91397.pdf.

[19] Apart from the Adminstrative Commission's Secretariat's Annual Reports on "Monitoring the introduction of the European Health Insurance Card (EHIC)"; see also, Deutscher Gewerkschaftsbund, Bundesvorstand (DGB-Vorstand, Bereich Europapolitik – Sozialpolitik), Stellungnahme zum Richtlinienvorschlag der EU-Kommission über die "Ausübung der Patientenrechte in der grenzüberschreitenden Gesundheitsversorgung", 1/2009: http://www.dgb.de/themen/europa/dokumente/patientenrechte_grenzueberschreitend.pdf.

[20] Decision No 190 of 18 June 2003, concerning the technical specifications of the European Health Insurance Card, OJ, L 276, 27.10.2003.

MS's likely response, especially so where the latter is aware of the patient's overall medical condition, on the basis of his/her insurance file, including data on the insured person's e.g. chronic illness, or where, regardless of any thorough control or valid justification, the competent institution holds that the said health care is a planned treatment (should fall under Article's 22(1)(c)(i) provisions, Regulation 1408/71), mostly seeking to avoid the assumption of a usually highly expensive hospital treatment.

(2) *The provider's fear* that the *responsible institution, that of the place of stay*, is going to delay excessively his/her reimbursement of the health care costs incurred, (over passing the contractually provided for deadlines), mainly in cases of hospital treatment implying high expenditure; the reluctance shown by the institution of the MS of stay is the outcome of the latter's serious concerns about the competent institution's late payments, i.e., the latter's practice to delay too much the settlement of the institution's of stay claims[21], in particular those concerning the coverage of costly hospital care (amounting under the existing legal framework, even up to 10 years, which turns to a 2 – 6 years deadline period in the future, under the new Implementing Regulation-to-be); it should be noted that the negative economic impact such excessive late payments (settlement of claims) between institutions involved may have is to end up creating a considerable deficit in the institution's of stay budget, thus preventing the latter to be able to cover the costs (remuneration etc) incurred for health care granted by its contracted providers/health professionals concerned (mostly, where the use of highly specialised and cost-intensive medical infrastructure/equipment is required).

(3) *The provider's purely economic interest*[22] who, in such a way, is being reimbursed at the rates of the private tariffs applied by him/her and misdirects the patient concerned to *"his/her institution"*, *either* because of partial or wrong information the said provider believes that the competent, finally, institution (to whom also the institution of stay leads him/her) is responsible to refund fully or the greatest part of the costs incurred and already born by the patient *or*, deliberately so, where the provider is fully aware that costs reimbursement by the competent institution is at a rate, relatively close to the private remuneration or, again, that the difference between the amounts in question offers to the patient the possibility to have access to private treatment[23]; the above-mentioned

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[21] See also, *Franz Bittner*, op.cit., where it is stressed that a number of MSs as a rule delay their reimbursements for too long periods, even where these MSs' respective institutions have concluded with the Austrian ones bilateral agreements in the spirit of Regulation 1408/71 on accelerating payments and settling mutual claims within an expressly stated fixed period; the speaker underlines the systematic violation (non-implementation) of Community Regulations' provisions while recognising that "paper is more patient than man", which, in other words means that, as long as the rights to the provision of sickness benefits and their reimbursement ("the vital blood circulation in cross-border health care") are not smoothly implemented, the quest for "fresh paper" (e.g. a Directive) stops at national borders.

[22] See *Luigi Bertinato, Reinhard Busse, Nick Fahy, Helena Legido-Quigley, Martin McKee, Willy Palm, Ilaria Passarani, Francesco Ronfini*, Policy brief: Cross-Border Health Care in Europe, World Health Organization 2005, on behalf of the European Observatory on Health Systems and Policies, where it is pointed out that well before the implementation of the EHIC "some providers have shown themselves unwilling to accept E 111 forms in practice, with patients instead being cared for privately": http://www.euro.who.int/Document/E87922.pdf.

[23] See also, Deutsche Sozialversicherung – Arbeitsgemeinschaft Europa e.V. (European Representation of German Social Insurance in Brussels), Joint opinion of the German Social Security Umbrella Organisations to the CEC's proposal for a directive on the application of patient's rights in cross-border health care, Brussels, 02.09.2008, whereby it is even stated that "in exceptional cases authorised healthcare providers do not accept a valid EHIC from foreign patients, but compel them to receive care based on the basis of the reimbursement-principle"; the said Organisation underlines that "this problem of not recognising the EHIC could further intensify with the entry into force of the directive":

derogations are very much influenced by the different reimbursement mechanisms existing in various MSs or even co-existing within the same MS, depending on the type of care, the type of health care provider and/or the latter's preference: mostly, the *ex post reimbursement of the patient* (the latter is asked to pay the whole bill upfront and then to claim partial or full reimbursement to the social security system) and *co-payments* (the patient is asked to pay his/her share of the bill and the health care provider asks the complement to the social security system).

Apart from the fact that these mechanisms may be exclusively applied to patients insured in another MS (deviation from the principle of equal treatment), they may also function as incentives for the providers' enhanced participation in the system and/or the "smoother" implementation of the EHIC – moreover, the institution's of stay "silent/implied consensus" regarding the said practice, may be deemed as reflecting also the latter's administrative-economic interest (see below).

(4) *The patient's neglect (failure)* to get[24] the appropriate *Community document* which certifies his/her entitlement to health care in the MS of stay (EHIC), or *the fact* that the said document has been *lost, destroyed or outdated*,[25] since the patient's declaration that he/she is subject to the legislation of another MS is not by itself sufficient for the latter to avoid receiving health care as a private patient and/or the patient or the institution of the place of stay usually do not dispose enough time to ask and get on the spot (a posteriori) a valid Community document, unless the treatment in question lasts long enough (mainly, hospital care) as to allow the competent institution to be contacted accordingly; yet even in that case, the institution of the MS of stay many times asks from the patient or his/her family to address themselves to the competent institution asking from the latter to issue the Community document required and send it directly to them personally.

(5) *The institution's of the place of stay administrative burden, implying cumbersome and costly procedures*; on that ground, the said institution usually misleads the patient to the competent institution instead of intervening itself in its capacity as the *mediator institution* pursuant to the applicable provisions of the Implementing Regulation, to the health professional concerned or to the competent institution, undertaking itself the complicated and cumbersome task to certify the patient's entitlement and refund the health care costs incurred in accordance with the national tariffs applied by it; thus, the economic burden born by the patient is really high, not so much due to the significant difference existing between the rates applied by the institution of stay and the provider's private tariffs but mostly because the provider's rates are usually much higher than the ones applied by the competent institution, as the institution of the MS of stay, even under the procedure laid down in Article 34 (on the basis of E 126), due to the administrative costs implied, does not

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http://www.deutsche-sozialversicherung.de/de/europa/dokumente/dl1/Positionspapier_DSVAE_Directive_Proposal_Patientsrights_COM_2008_414_final.pdf; see from a different perspective, Association of British Insurers (ABI), Call for evidence: inquiry into the European Commission's proposed directive (the Directive) on the application of patients' rights in cross-border healthcare, London, October 2008, where it is being highlighted, as an issue concerning UK patients with travel insurance, that the latter are advised to completely disregard the EHIC for two expressly mentioned reasons and whereby all MSs are thus called "to recognise the intent of the EHIC and not erode State entitlements merely because alternative funding might be available from Travel insurance or a supplementary insurance product": http://www.parliament.uk/documents/upload/ABI%20Oct%2008.doc.

[24] See also, *Luigi Bertinato, Reinhard Busse, Nick Fahy, Helena Legido-Quigley, Martin McKee, Willy Palm, Ilaria Passarani, Francesco Ronfini*, op.cit.

[25] See also, *Helena Legido-Quigley, Martin McKee, Ellen Nolte, Irene A. Glinos*, op.cit.

proceed to the necessary control and recognition or refusal of the nature of the health care granted as *"medically necessary"* and responds rather indifferently and usually too quickly to the competent institution's request that *the said health care has been granted under a private status and that institution has no competence to intervene further*.

(6) *Lastly, the long waiting lists* mostly in cases of hospital care and where *the patient's state of health is seriously at danger,* existing in the MS of stay where the patient moves usually disposing the Community document E 112, as well as on the territory of one or more of other neighbouring MSs or in those which could offer the patient appropriate health care within a medically justifiable period of time; consequently, the patient is (at the end of the day) "forced" to address him/herself to a private health professional, a private establishment or private sections (beds-clinics) within public hospitals in one of those MSs (private health care); a case where neither the competent institution nor the responsible institution of stay make any effort to implement the Regulation, especially when the latter institution is being asked to actually "certify" the fact that the patient is indeed "forced" – "obliged" (has no other way) to have (direct and urgent) access to private health care, for the above-stated reasons (due to *force majeure*).[26]

3.2. Private health care granted by a non-contracted provider (in the private sector)

All above-standing cases concern par excellence granting of sickness benefits in kind (health care) under a private regime and outside the scope of the Regulations, despite the fact that the provider has a contract with the institution of the place of stay. This means that, although the patient wishes to receive health care in the context of the public, legal system of the MS of stay, in conformity with the provisions of Community coordination, he/she is finally driven, for the aforementioned reasons under each specific case, to receive private medical treatment and bear him/herself the costs implied (private tariffs).

On the contrary, the present case regards a patient turning to a non-contracted health care provider (in the private sector). The patient's conscious behaviour may be the outcome of a deliberate decision from the outset, i.e. to visit a non-contracted rather than the contracted provider, or the said insured may have been driven to that "choice" by one or more key factors. Consequently, the concept of "seeking to receive healthcare in another MS *in other circumstances*" (i.e. different from the requirements set under the Regulation) is a rather *grey area*, whereby the demarcation line between free/deliberate/informed choice and a "forced decision" is really faint.

A quite exceptional situation is where the patient seems to "choose" sickness benefits in kind under a "private" regime, just because the said benefits fall within the scope of the competent institution's legislation but are not covered by the legislation of the institution of the place of stay. Thus, the patient deliberately seeks to receive these benefits exclusively *"in private"* even by a contracted healthcare provider.

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[26] *Nikos Sklikas, Dorina Tsotsorou*, 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", trESS Seminar 2008 (Athens, 28.05.2008), in: Scientific Society for Social Cohesion and Development (EPEKSA), Working Group "European Coordination of Social Security Systems", July 2008, http://www.epeksa.gr/en_files/Page4552.htm; see also ECJ's judgement of the 12.04.2005 in case C-145/03, *Keller*.

Before starting to examine closer the sickness benefits in kind falling under the aforementioned *grey areas*, we would like to highlight and try to juxtapose healthcare received abroad, as the patient's *preferred choice*, despite the latter's accessibility to the same or equivalent health care within the scope of the legislation of the institution of the place of stay. Amongst the main reasons leading the patient to choose deliberately the sickness benefits in kind he/she considers as *medically necessary* (Community concept) may be stated the following:

- One's financial standing, mentality, way of living and overall approach on the social status of persons having access to private healthcare;
- The patient's general confidence (irrespective of his/her financial standing) on private healthcare providers, who are usually deemed to be "better" than the contracted ones (in his/her opinion);
- The previously established trusting patient-physician relationship[27], by analogy to defined cases of continued treatment in respect of ex-frontier (or ex-mobile) "workers", already covered by the Basic Regulation, and/or the patient's confidence or need to rely personally on concrete provider(s) in respect of certain or rare diseases;
- Patient's awareness that the difference between a provider's private remuneration and the reimbursement at the rates applied by the competent institution's legislation is not that significant.

Although persons on temporary stay (yet, comparatively longer stay) outside the competent MS (e.g., posted, pursuing parallel activity, students and pensioners) are generally expected to address themselves, when seeking to receive healthcare becoming necessary on medical grounds, to the institution most *familiar* to them, i.e., the institution of the place of stay, it is worth examining closer the cases/situations where insured persons may "interrupt" their relationship with the system administered by the institution of the MS of stay and turn to a non-contracted provider, on the grounds that the health care thus sought is *better, quicker or more convenient – efficient*[28]:

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[27] For the key role of the relationship between a patient and a treatment provider, based on the patient's trust in the service provider as an individual or in a healthcare establishment and the need for quality in respect of such services (versus the common relationship with a product, just based on the consumer's habits), also highlighted from the perspective of the significant obstacles of free movement encountered within the unique healthcare sector/"market", see *Prodromos Mavridis*, La libre circulation des patients: La boucle est-elle bouclée? Etat des lieux et nouveautés, Cour de cassation, Cycle de droit européen, Avril 2007, whereby the author refers to Advocate General's Bot Opinion in case C-446/05, *Doulamis*: http://www.courdecassation.fr/colloques_activites_formation_4/2007_2254/intervention_m._mavridis_11276.html?idprec=9863.

[28] *Leonhard Hajen*, Europäischer Wachstumsmarkt – Gesundheitsdienstleistungen zwischen Vision und Realität, CIS Papers No 21, Centre of International Studies, University of Hamburg, Januar 2009: http://www.wiso.uni-hamburg.de/fileadmin/sozialoekonomie/cis/CIS_Papers/CP21_Hajen.pdf; similar terms also used by the Commission's services, yet from a different perspective and in order to justify exactly the opposite approach, i.e. the material scope of the said Directive, see Commission Staff Working Document, Accompanying Document to the Proposal for a Directive, Impact Assessment, SEC(2008) 2163, 02.07.2008; regarding interested persons' willingness to seek medical treatment in another EU country (53% of all those asked), see Flash Eurobarometer #210, op.cit., whereby the reasons stated are *inability to receive such treatment at home* by 91%, *better quality* of treatment by 78%, *more efficient* treatment (by a "renowned specialist") by 69%, *quicker* treatment (to reduce waiting time) by 64% and *cheaper* treatment by 48% (Chapter 4); see also for other interesting classifications Chapter 5; on patients' needs-driven potentially increasing mobility, giving them access to a wider range of healthcare, thus contributing also to the protection of public health, see the Opinion of Advocate General Bot, op.cit., whereby it is further pointed out that, according to ECJ's settled case-law, the health and life of humans rank foremost among the property or interests protected by the Treaty providing for possible derogations from the prohibition of restrictions on the freedoms of movement.

(1) The patient's current state of health (e.g. degree of pain, specific medical condition) or, mostly, the need for continued medical treatment, whereby the patient is not in a position to travel long distances, e.g. cases of chronic diseases.[29]

(2) The nature of the patient's disability may also not allow his/her access to a contracted provider (could put at risk his/her health) who is at a longer distance compared to the place where a private one is situated (exchange of different means of transport – problems of accessibility to the provider's actual dispensary, particularly in cases of continued medical treatment.

(3) The "family doctor" (the specific terminology varies under each system), with whom a trusting patient-physician relationship has been established, may be indeed contracted with the institution of the MS of stay but only regarding non-hospital care. On the contrary, for hospital care the said doctor may be employed in a private establishment (in the private sector); so, driven by that trusting relationship[30], the patient decides to address him/herself to the same provider even for benefits in kind not always falling under the institution's of stay legislation.

(4) The contracted establishment, in cases of hospital care, may dispose excellent doctors but come short of nursing personnel, hospital installations (comfort in accommodation and in-patient treatment) and in particular, of medical infrastructure or medical/hospital equipment ensuring safer and more efficient healthcare; most of the times, the shortage of nursing personnel, the nature of the patient's medical condition and/or the highly specialized healthcare required lead to the engagement of equally specialized private nursing staff.

(5) The contracted provider is (temporarily) short of some highly specialised medical equipment, which is absolutely necessary for the patients' diagnosis/treatment, whilst his/her current state of health does not allow his/her illness to be promptly addressed. In some cases, the provider usually refers the patient to another provider/infirmary, eventually contracted with him/her but non-contracted with the institution of the MS of stay (private healthcare professional), or, in the worst case, where the contracted provider makes an appointment with such a doctor on behalf of the patient, but without informing the latter respectively, who continuous to consider that he/she is addressing him/herself to another contracted provider.

(6) The waiting period for access to certain examinations or specific medical equipment, provided in the context of the contracted provider's services, is too long (or causing discomfort), while the patient's medical condition, the nature of eventual disability, his/her ability to carry out a professional activity or other personal reasons do not allow for such a delay.

(7) The patient's disease requires the application of a new method of medical treatment provided for, exclusively, in the private sector or by a contracted healthcare provider but under a private status, since the institution of the place of stay has not yet included the said benefits in kind in its scope, although the said institution is already aware of the method

[29] See also, *Helena Legido-Quigley, Martin McKee, Ellen Nolte, Irene A. Glinos*, op.cit., a comprehensive research, covering (mostlly Chapter 3) all points respectively (1 to 13).
[30] See also, *Prodromos Mavridis*, op.cit.

and although it intends to cover also that type of benefits (healthcare) by the legislation it administers, may be at the preceding transitional stage.

(8) The patient's current state of health (possibly at risk) does not allow him/her to follow the long-lasting and cumbersome administrative procedures applied by the legislation of the institution of the MS of stay.

(9) The highly specialised and cost-intensive medical infrastructure of the non-contracted provider opposite to the contracted professional's medical equipment lead to safer and more efficient and effective diagnosis and/or medical treatment for the patient, mainly in cases, where the disease and/or the patients' current state of health demand such an upgraded diagnosis – medical treatment.

(10) The contracted provider is on leave (e.g. holidays, medical training, participation to a medical Conference etc) and the patient's medical condition, especially in cases of continued medical treatment, demands immediate provision of appropriate health care.

(11) Urgent recourse/access to a non-contracted provider, outside the timetable of the contracted one, in particular where the patients' degree of pain or the latter's fear that his/her health could be put at risk, contribute to the patient choosing the provider who is at a closer distance from the place he/she lives or the one with the easiest possible access.

(12) Cases (some countries are particularly concerned) where the patient is on an island where there is no contracted provider available or the latter is at a significant distance.

(13) Lastly, cultural, more generally social, or other problems due to religious convictions and societal values – way of living, even language impediments making access to health care dependent e.g., on the coverage of interpretation costs.[31]

4. Is a Directive really necessary? Further brainstorming on the aims and means of such an initiative

> *Das Wahlrecht begünstigt eine sozialpolitisch unerwünschte „Rosinenpickerei" zwischen den unterschiedlichen Gesundheitssystemen der Mitgliedstaaten.*
>
> ***Thorsten Kingreen***[32]

4.1. Problems – General observations

To start with, the Commission's Proposal sets out overall targets and provides for criteria – cooperation procedures which are Community in nature but their "definition" is so deeply general and qualitative, that their implementation – the way they are going to be transferred ad hoc in applicable national legislation and/or mainly in every-day practice, is a crucial issue which remains quite uncertain or even non-realistic. Otherwise, the said Proposal

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[31] *Leonhard Hajen*, op.cit.; in particular, from migrants' health perspective, see *Philipa Mladovsky*, Migration and health in EU health systems, Euro Observer (The Health Policy Bulletin of the European Observatory), Volume 9, Number 4, Winter 2007: http://www.euro.who.int/Document/Obs/EuroObserver_Winter2007.pdf; *Philipa Mladovsky*, Migrant health in the EU, Eurohealth (Research, Debate, Policy, News), Vol. 13, Number 1, 2007: http://www.euro.who.int/document/OBS/Eurohealth13_1.pdf.

[32] *Thorsten Kingreen*, Vorschlag der Europäischen Kommission für eine Richtlinie über die Ausübung der Patientenrechte in der grenzüberschreitenden Gesundheitsversorgung, Rechtsgutachten für den Deutschen Gewerkschaftsbund, 12/2008: http://www.dgb.de/themen/europa/dokumente/kingreen_patientenrichtlinie.pdf.

introduces new concepts or recapitulates the terminology used by the Court, which remain too general and theoretical in character, so again their uniform implementation would require all actors involved to predispose a sufficient knowledge and a common understanding of the latter; but this is not the case, i.e. the Proposal is not simpler or more concrete in practical terms compared to the Court's jurisprudence, which it is supposed to transpose and clarify. On the other hand, it is dubious whether the above-mentioned Proposal's drafting arrives successfully at providing an exhaustive and comprehensible codification of the settled case-law.

On the question of the added value – the extent of the Directive's scope

Following the "service revolution" whereby the Court had undertaken the task to ensure an ever expanding application of the Treaty rules in the said field (its case-law having revolutionised all three elements of the definition of services: the concept of services itself, the existence of remuneration and the residual relationship with the other Treaty freedoms, initially empirical and negative, as laid down in Article 50 EC) the development of the service economy, the diversification of existing services and mostly the creation of new ones (enhanced by new technologies) has radically changed the economic reality.

Extending the scope of that Treaty provision to embrace social security and health services is the most significant recent development, which is considered to be the most spectacular evolution. Consequently, a modest regulatory content would be in retreat from the case-law and would most probably create more problems than the ones reckoned to solve.[33]

Following one of the most dynamic criticisms regarding the politics lagging behind the present Commission's initiative, is that the latter "fundamentally affects the division of power in the EU with respect of public health policy". In parallel, it is "a renewed attempt to bring health services under internal market rules" and "has the potential to increase health systems' exposure to European competition law and the role of markets in health services organisation".[34] The crucial question to be addressed by planned, integrated health systems is whether the proposed Directive provides sufficient protection as the use of commercial providers comes within the play from the back door, while providing for user charges, co-payments or top-up-charges leads to a situation contrary to universal health care goals.

Although the Directive on patient's mobility places health services reform in the context of the renewed European social agenda, whereby "the health systems of the Community are a central component of EU's high levels of protection and contribute to social cohesion, social justice and sustainable development, forming also integral part of the broader framework of services of general interest", the substance of the Proposal is to codify ECJ judgements on freedom of movement under Article 49 EC, thus primarily governed by one of the liberalizing provisions of the Treaty.

Even so, however, the above-mentioned jurisprudence is quite improbable to be finally incorporated in its entirety, firstly, within the Directive and, secondly, under national

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[33] *Vassilis Hatzopoulos*, Legal aspects in establishing the Internal Market for Services, Research Papers in Law, College of Europe, 6/2007: http://www.coleurop.be/file/content/studyprogrammes/law/studyprog/pdf/ResearchPaper_6_2007_Hatzopoulos.pdf.

[34] *Allyson Pollock, David Price, Sarah Boesveld, Iain Law*, op.cit.

legislation, as it becomes apparent from the ongoing debate at Council (the French Presidency compromise proposal included[35]) and J. Bowis's report on Patients' Rights[36], constituting more or less "conservative" approaches focussing mostly or exclusively on a narrow definition of *patient*'s mobility and leaving, at least for the time being, outside the most potential and broader aspect of health *professionals*/*services'* mobility. Such a piece-meal conduct from the Community legislature's part is, though, quite uncertain how compatible may prove or best addressing an equally problematic piecemeal approach from the ECJ's counter-part.

The proposed Directive sets out a legal framework establishing access to cross-border health care *as a general principle.* So, for benefits-in-kind systems/national health systems – services, the Proposal is of crucial concern since the MS of affiliation, although preserving the power to determine which services are included in the publicly funded "health care basket", is yet obliged to set up a system for reimbursing patients who obtain treatment from the basket in another MS. The mechanism, though, for calculating costs (Article 6(4)) is being drafted in a too general-abstract way, since mention is only made to "objective, non-discriminatory criteria known in advance" as the ones which should govern such mechanism: i.e. apart from leaving open these crucial issues to the probably diverging interpretation, assessment, and, thus, implementation by each MS, the Proposal also sets out conditions for a charging code.

Yet, there is *no agreed costing or accounting method* and is unlikely agreement to be reached in the foreseeable future in Europe for *hospital care* (according to a recent research for the Commission), neither is there agreement *on the costs that should be included* in reimbursement calculations. Thus, there are widespread concerns that "reforms will be required irrespective of the volume of patient movement or the non-comparability of health systems costs"[37].

A last but major point raised is that providing for user charges, co-payments and top-up charges is contrary to universal health care goals: whilst the Commission states that *reimbursement should respect principles of universality, access to quality care, equity and solidarity, it also allows for reimbursement below the full cost of treatment,* actually drafted in the most perplexed way, i.e. the assumption of costs shall not be less than "what would have been assumed had the same or similar treatment been provided" in the MS of affiliation, (a possible by-effect for governments being to allow or even give incentives for top-ups of publicly funded care where full costs exceed reimbursement rates).

Consequently, the utter impact of the proposed Directive could be to foster two-track health provision and unequal care, in other words, to institute a system that undermines universal goals if it *fails to acknowledge incompatibility between policies of charging and universality*. Strong concerns quite widely expressed about the *level and obligation of*

[35] Council of the European Union, Note from the General Secretariat to Working Party on Public Health, Document 15655/08 (13.11.2008).

[36] European Parliament, Committee on the Environment, Public Health and Food Safety, Document A6-0233/2009 (03.04.2009), adopted by EP on 23 April 2009.

[37] *Allyson Pollock, David Price, Sarah Boesveld, Iain Law*, op.cit., whereby, in respect of the Scottish health system, an additional repercussion she states as inevitable is the establishment of a quasi national tariff system applied uniquely to overseas patients "one of the building blocks of the market-orientated approach adopted by the English NHS".

reimbursement for care purchased abroad, finally call on EU institutions and MSs to *"guarantee that patient mobility is driven either by medical opinion or patient choice"*.

4.2. Specific remarks focussed on crucial issues

Our intervention shall focus on the issues which are standing opposite or touch upon the Community coordination – forming part of the latter, in other words, we shall deal with the patient's right per se to receive health care ("abroad") within the Community and his/her entitlement to reimbursement of costs for health care thus granted in another MS, considering all aspects of ECJ's interpretative approach and overall orientation regarding the fundamental freedoms' dynamic.

4.2.1. Cross-border health care: a problematic definition

The definition provided under the said proposal is much narrower than the one serving the purposes of coordination, i.e. it covers unilaterally the patient's physical movement to receive or seek health care outside the MS of affiliation (according to the Commission exclusively the competent MS, under the French Presidency compromise proposal, covering also the MS of residence[38]); for example, insured persons staying in another MS, who move temporarily back to the competent or who receive there benefits from a provider established in another MS, are not covered by the proposal (Article 49 EC does not apply, although these persons have exercised their Treaty right under Article 39 EC; otherwise, health care in the competent MS is no longer considered as "cross-border" healthcare).

On the other hand, under the French presidency compromise proposal health professionals' mobility is totally excluded. So, the definition under examination (the Commission's as well as that of the French presidency) falls short of the Court's settled case-law on the overall scope of the fundamental freedoms taken as a whole. Persons residing in another MS and receiving sickness benefits there are considered as entitled to exercise, on the one hand the rights conferred by the Treaty on the free of movement of persons as well as on the freedom of establishment (Article 39 and Article 43 EC), and on the other, the rights of freedom to provide services and free provision of goods (Article 28 and Article 49 EC); thus, those persons should enjoy all respective rights deriving from corresponding secondary law provisions.

4.2.2. Residence vs affiliation – further compromise proposals within the Council's Bodies[39]

Given the philosophy and economy of the provisions of the Regulations on Community coordination (both Basic and Implementing, existing or forthcoming) on the applicable legislation, entitlement to health care, the scope of sickness benefits as well as the assumption of health care costs (in the light of the principle of sharing of responsibilities between institutions involved), i.e., a legal framework ensuring the free movement of persons, in their broader capacity as insured, the non-inclusion in the definition (laid down in the Commission's Proposal) of the "MS of affiliation" (*competent* for the purposes of Community coordination) also of the MS of residence as *quasi competent*, is expected to create a series of substantial problems influencing the future implementation of that very

[38] Council of the EU, Note from the General Secretariat to Working Party on Public Health, op.cit.

[39] Reflecting the state-of-play of the discussions, in order to provide orientation for the continuation of the work under the incoming presidencies.

Directive(-to-be) as well as its interrelation/interaction with the in-parallel implementation of Regulation 883/2004.

Apart from the problems which will arise also in other cases such as *insured persons residing* outside the competent MS (even in cases of simple stay in another MS), and especially so in respect of *frontier workers*[40], we shall focus on problems related with the MS of residence *as quasi competent*, in conformity with Community Regulations, concerning specific categories of persons such as pensioners and members of their family as well as members of the family of an insured person, who reside neither in the same MS as the insured person nor in the competent MS. It is worth noticing that the general rule underpinning the said legal fiction under the existing Regulations, according to which reimbursement of health care costs for these categories is based on fixed amounts for all MSs, is limited under Regulation 883/2004 only to those MSs which exceptionally opt for reimbursement on the basis of fixed amounts, due to their legal or administrative structures (Article 35(2) of Regulation 883/2004 and Article 63(2) of the new Implementing Regulation-to-be).

So, focussing on the above-stated problems is in our opinion the best way to reveal all "obstacles" or the most representative problematic situations arising when mostly pensioners exercise their right to fundamental freedoms – principles of the Treaty:

(1) A pensioner, subject to another MS's legislation, is entitled to the assumption of his/her health care costs incurred under *"other circumstances"* (Article 3(2)) in the MS of (his/her) residence (Article 6 of the Proposal). On the contrary, the pensioner who is a national of the said MS and the "foreign" pensioner is assimilated with, has no such/similar entitlement, since the health care granted to the latter within his/her MS of affiliation is not considered as "cross-border" health care. So, whilst the provision of sickness benefits in kind under Regulation 883/2004 (i.e. for the purposes of Community coordination) is governed for both insured by the principle of equal treatment in its particular expression as principle of assimilation, under the proposed Directive, the non-mobile pensioner is the person who is being discriminated against (reverse discrimination), although both persons receive health care from non-contracted providers (outside the public health/insurance system are treated "in private") on the same grounds, i.e. eventually because the benefits provided for pursuant to the legislation applied by the institution of the place (MS) of residence are not considered by them as appropriate treatment, suiting their personal condition.

(2) The same discriminatory, anyway, different treatment is opposed against (is to the detriment of) a pensioner, who returns temporarily to (stays in) the competent MS – he/she does not fulfil the conditions for "cross-border health care", whilst the pensioner, with a proper right in the MS of residence has also a right to costs reimbursement for "private" health care received outside the public health system in *any* other MS (the first pensioner's MS included). It is worth noticing, however, that under Regulation 883/2004, the former pensioner's right to sickness benefits in kind is maintained and that person is covered during his/her stay back to the competent.

(3) Both two categories of pensioners have right to health care under "other circumstances" in a third MS. Yet, their corresponding right to reimbursement of costs is at different rates. The pensioner with an independent/proper right to health care in the MS of his/her

[40] See also, Deutsche Sozialversicherung – Arbeitsgemeinschaft Europa e.V., op.cit.

residence is reimbursed at the rates of tariffs applied by the MS of residence (as the competent MS), which may be even at the level of the costs actually paid. On the contrary, the EU pensioner (residing in the same MS and) assimilated with the former, is reimbursed at the rates applied by the competent MS which may be at too low a level (sometimes trivial amounts), representing even up to 1/10 of the actual costs.

The above-mentioned registration of an EU pensioner with the health insurance system of the MS of residence means that the said person is included/taken into consideration for the purposes of planning as well as financing of that MS's health care system, so as to ensure the maintenance of a balanced and high quality medical and hospital service sufficiently accessible to all its insured on a permanent basis. Consequently, in the context of coordination, authorisation for planned hospital treatment to a third MS is granted by the MS of residence (Article 27(5) of the new Implementing Regulation-to-be).

Furthermore, if the said pensioner has already paid the bill (the health care costs incurred), the reimbursement of costs by the MS of residence, on the basis of an a posteriori authorisation, is at the rates of the third MS (of treatment), the difference between the tariffs applied by the two MS involved being taken also into consideration (according to *Vanbraekel* ruling[41], Article 26 of the new Implementing Regulation-to-be). On the contrary, authorisation for hospital care under a private status (outside the contracted regime) in a third MS is granted by the patient's MS of affiliation. This means that, although the patient falls within the MS's of residence planning carried out in the hospital (overall health care sector), which is also responsible for checking whether the ad hoc demand for health care is able to undermine the health system under its competence, the authorisation asked for is each time granted/refused by another MS (the competent – of affiliation), in spite of the fact that the said patient has not been taken into consideration by the second MS (competent) for ensuring its health system's financial balance and planning.

However, for the purposes of applying the criteria for prior authorisation under the Proposal for a Directive **(**Article 8(3)) the question which may arise is whether the financial stability of the competent MS's health system is likely to be undermined – or whether the MS of affiliation bears a disproportionate economic burden, since the said MS is responsible for the reimbursement of costs to a pensioner under its legislation (Article 6), without this very obligation being combined, in any respect, with health care planning in the competent MS. Obviously, for some MSs, granting prior authorisation would be always given, since the outstanding/unique criterion would be that the costs of the health care under question are by far lower (even 10 times) than the reimbursement of costs under the Community coordination mechanism. It is worth noticing, however, that the said criterion is beyond and outside any criterion applied or aim pursued either in the of coordination or in the framework of the proposed Directive, and especially, contrary to the whole spirit of ECJ's jurisprudence, analysing thee scope and aims of Article 49 EC.

Apart from that, it is equally a question of discriminatory treatment between these two (types of) pensioners in the MS of residence. Whilst both are granted authorisation and on the same grounds under either the Regulation's or the Directive's legal framework, the pensioner who has a right under the competent MS's legislation, gets the authorisation by another MS (of affiliation), i.e. based on other grounds/criteria irrespective of the fact that there is no rational/logic coherence between the pensioner concerned and the competent

[41] ECJ's ruling of the 12.07.2001, in case C-368/98, *Vanbraekel etc*.

MS's health system. On the other hand, whilst the pensioner, who has a direct (proper) right to sickness benefits in kind by virtue of the legislation of the MS of residence, is reimbursed according to Article 6 of the Proposal by the MS of residence, coinciding in that patient's case with the competent (eventually at rates reaching even the full amount of actual costs), reimbursement of costs to the pensioner, who is subject to another MS's legislation, differs from the previously stated one (according to the competent institution's tariffs), i.e. being eventually much lower or even trivial.

(4) Every MS reimburses under Article 6 of the proposed Directive to its insured-pensioner the costs for health care received under "other circumstances" (i.e. outside Regulation 883/2004), in other words, these costs are refunded on the basis of internal (national) legislation. MSs who have opted determining and effecting reimbursements on the basis of fixed amounts, are counting such (private/individual) costs in the aggregate expenditure for health care occurring in their territory for the sake of their pensioners. By dividing that aggregate expenditure by the total number of pensioners under the schemes involved, MSs concerned arrive at calculating the per capita annual fixed amount on the basis of which the latter (MSs of residence) claim to be reimbursed from the other MSs on behalf of which benefits in kind have been provided to their pensioners residing in the territory of the said MS of residence (provided by the institution of the place of residence). In such a way, the amount of reimbursable costs is significantly increased. It could be argued, of course, that by virtue of Decision No 175 of the Administrative Commission (point 6)[42], counting in, for the purposes of calculating the annual fixed amount, of costs which have been already reimbursed to other MSs, is being excluded.

Yet, in the case under examination, we are dealing with reimbursement of costs to that very patient (directly), i.e. we have to do with an "internal" (more or less) reimbursement. But even if that type of reimbursement would be considered as constituting "external" expenditure, thus its counting within the fixed amount being forbidden, our 25 years of experience have taught us that, still, costs under the Directive shall continue to be taken into account for determining the fixed amount by each MS concerned, since the majority of MSs have no means – appropriate mechanism in their accounting system which would allow them to separate/isolate those costs or, in the exceptional case they avail themselves with such an instrument/tool, the said MSs will continue counting in the above-stated costs, since it is technically almost impossible for another MS of even a Community Institution or Instrument to prove (to bear the *pronus probandi*) that such an aggregation has taken place; mostly politically, however, pursuing such a control would be too delicate an intervention (infeasible).

In the opposite, the MSs which determine reimbursements on production of proof of actual expenditure (for each individual case of health care received on their territory by other MSs' pensioners), obviously, cannot charge any other MS with the costs they are responsible to bear for cross-border health care (under the Directive) received by their pensioners (subject to their legislation), since the latter function in their capacity as

[42] Decision No 175 of 23 June 1999, on interpretation of the concept of "benefits in kind" in the event of sickness or maternity pursuant to Article 19(1) and (2), Article 22, Article 22a, Article 22b, Article 25(1), (3) and (4), Article 26, Article 28(1), Article 28a, Article 29, Article 31, Article 34a and Article 34b of Council Regulation (EEC) No 1408/71 and on calculation of the amounts to be refunded under Articles 93, 94 and 95 of Regulation (EEC) No 574/72 as well as the advances to be paid pursuant to Article 102(4) of the same Regulation, OJ, L 047, 19.02.2000.

competent States, as the ultimate debtors and not as MSs of residence (or even of stay) for pensioners insured under another MS's system.

In such a way, the diversification existing between MSs in so far as the aggregate health care costs to be mutually reimbursed is concerned, undermines the very foundations of the so much looked for equitable distribution of costs achieved in the context of Regulation 883/2004. Otherwise, the Commission proposes a supplementary Community legal Instrument for the purposes of fully implementing Article 49 EC, which seriously risk to knock down the functioning/implementation of another legal Instrument (Regulation 883/2004), i.e. secondary law for the purposes of Community coordination of social security systems, which was among the first Instruments (then, as Regulation 3/58), which the Council decided to establish right from the very beginning (almost in parallel with the construction of EEC), with the aim to conform with Article's 42 EC imperatives.

Furthermore, in the present case, another significant issue arises for that very Proposal for a Directive. In other words, following from the aforementioned, in the MSs with fixed amounts the economic burden deriving from Article 6 of the Directive-to-be, is being reduced significantly since a great part of these costs is reimbursed to them by other MSs. So, the said MSs could not even dispose a valid justification for maintaining a prior authorisation system for cross-border hospital-specialised care (Article 8(3) and (4)), from the moment the financial balance of their social security systems is not substantially undermined or upset, although eventually their planning might be deemed somewhat touched, yet easily prone to effective corrective interventions, slight amendments bringing back the equilibrium previously established. Moreover, if there is no need for installing or maintaining a prior authorisation system then the MSs concerned are dispensed with the significant administrative costs that mechanism entails.

Of course, this is another, substantial aspect proving the discriminatory "treatment" in the interest of certain systems, which is indirectly sustained by the Commission, where the latter establishes a parallel Community mechanism – instrument without taking into consideration the already existing Regulation, favouring the said MSs. Summing up, we would conclude that a Community legal instrument per se may be theoretically a perfect solution but its parallel implementation – interaction with another Community legal instrument may result in seriously undermining the balanced/harmonised simultaneous functioning of one or both of these instruments, generating deficiencies, in particular where the latter have significant negative and unjustified financial repercussions. The aforementioned favourable impact/regime coming out of the interaction between the Directive and the Regulation, could lead also the rest of the MSs to move progressively towards opting for the fixed amounts as the only reasonable method of costs reimbursement.

Consequently, if that evolution would come true, then its outcome would run totally counter to the main target of the respective parameters of modernisation, i.e., the very spirit which predominated during the tough negotiations at Council preceding the adoption of a modernised Community coordination mechanism governed as much as possible by the principle of fair distribution of health care costs, the initial Commission's proposal reflecting in the most representative way such a difficult effort. In fact, that proposal was based on the reimbursement of costs exclusively on the basis of actual expenditure (introducing also a system based on a fully proportionate distribution of health care costs, which finally proved too cumbersome and bureaucratic), since according to the

Commission, reimbursement on the basis of actual expenditure is the most efficient method ensuring full coverage of the costs actually incurred (Article 35(1) of Regulation 883/2004). If MSs reintroduce in the future, as general, the method of costs reimbursement based on fixed amounts,, then we should re-examine the restricted scope of the existing regime governing the Community criteria of authorisation under Regulation 883/2004, taking into consideration that in cases of refusal, the patient, as a rule, would seek recourse to the solution offered by the Directive.

(5) Another issue of crucial importance, dealing with the aforementioned fixed amount, regards MSs' permanent concern, i.e., double payments – reimbursement of health care costs, which was at the centre of the tough negotiations preceding the adoption of Regulation 883/2004 by the Council, actually leading MSs to agree (by implementing the special parameter of modernisation "8"[43]) on establishing the above-stated equitable distribution of financial costs (e.g. Article 20(4) and Article 27(5) of the said Regulation). To the MS having opted for fixed amounts as the method of costs reimbursement, all other MSs reimburse the fixed amount of costs for the sickness benefits provided during a 12-months period to their pensioners residing in the said MS. Since, however, each MS remains always the competent one, it reimburses in addition health care granted to its pensioner in a third MS or bears the costs for health care received back in its territory.

Given that those additional double payments are a fact, in the light of the principle of fair distribution of health care costs, the amount reimbursed to the MS of residence is thus reduced by 15% for MSs which provide for the said pensioner merely the sickness benefits in kind becoming "medically necessary" in their territory, and by 20% for the MSs which provide for the full coverage of such pensioner (on stay back to the competent MS, Article 64(3) of the forthcoming new Implementing Regulation). Since additional double payments shall anyhow result between MSs involved from the costs to be assumed (and reimbursed) on the basis of the respective provisions of the proposed Directive, the Administrative Commission should undertake the responsibility to re-examine the extent to which the determination of the aforementioned percentages (reductions) remains still correct, or whether all previously stated financial inequalities/imbalances between MSs concerned should once more be taken into consideration from the outset.

(6) An additional major issue is raised in respect of the material way cross-border health care costs are going to be reimbursed by the competent MS (of affiliation) to its pensioner residing in another MS. In the context of Community coordination, a costs reimbursement mechanism has been established, which is continuously improved (simplified structure and accelerated procedures), whereby the mobile insured is not him/herself personally involved with any respective process and, mainly, is free from the need to move between MSs involved, all required activities being duly and promptly undertaken by the competent – responsible institutions of the MSs concerned (one of the mechanisms instituted by the forthcoming new Implementing Regulation).

On the contrary, while the Commission provides in the framework of its Proposal, that MSs are responsible to create a mechanism for the patients' information, of mutual assistance, collection and exchange/transmission of data and mostly of mutual and prompt cooperation (Articles 9 to 14), nowhere is expressly provided the obligation for establishing a mechanism of costs reimbursement, in order to avoid any administrative trial (even in the

[43] Council of the European Union, Document 15045/01 (03.12.2001).

banks sector) for the patient, or even the latter's need to move between MSs involved and finally be charged with additional financial burdens. Obviously, in the context of mutual cooperation, it is up to the MSs to conclude such agreement (-s) or to foresee reimbursement mechanisms in the broader context of a more general agreement (on cooperation).

However, given on the one hand, the MSs' steady efforts to avoid (or minimise) the disproportionately high administrative costs implied by such a mechanism, especially where the latter is going to function in parallel to the already existing one (-s) for the purposes of Community coordination, and on the other hand, the unavoidable high banking – mailing costs that initiative implies, we are really afraid that reimbursement of costs under the Directive shall always be to the detriment – economic disadvantage of the patient. In such a case, though, it is worth wondering if that excessive economic burden is justified, especially where the reimbursable amount is comparatively low. In any case, the anyhow multiple-facet intervention of the patient in the process of costs reimbursement may be a significant disincentive, a fact discouraging an insured person to move within the Community, thus constituting a major obstacle (in the light of settled case-law) to the actual exercise (by all stakeholders concerned) of the fundamental freedoms of the Treaty.

(7) Referring very briefly to the French Presidency's compromise proposal (on Chapters I to III), although the latter undoubtedly addresses some of the above-mentioned problematic situations, yet it leaves in suspense serious and urgent problems in respect of:

- the competence/responsibility for the reimbursement of costs between the MS of residence and the MS of affiliation;
- the consequences of the method based on fixed amounts, i.e. the avoidance of double payments in relation to the costs to be included in (in the calculation of) these fixed amounts;
- authorisation criteria.

However, the French Presidency's compromise text introduces a new issue; in other words, it rightfully establishes the concept of the MS of residence, yet, wrongly omits to consider it as *quasi* competent (in the spirit of coordination Regulations) and thus the latter, appearing as exclusively competent, bears the burden of health care costs, irrespective of the fact that there is no equivalent entitlement to sickness benefits in kind under its legislation, as the right of the person concerned to sickness benefits in kind is established by virtue of the legislation of the MS of affiliation, competent by virtue of the Basic Regulation. If, however, that proposal considers indeed the MS of residence as quasi competent, then there is again a crucial gap to be covered: there are neither express provisions establishing explicitly a mechanism of reimbursement of costs between MSs involved nor any reference whatsoever to the respective provisions under the coordination Regulations.

(8) Finally, under the Czech Presidency's compromise text (covering all Articles and corresponding Recitals) the redrafted definition of "Member State of affiliation" (Article 4(b)) raised reservations as it maintains the previous presidency's proposal to assimilate the Member State of residence to that of affiliation, yet following a narrower approach: i.e., only where, due to the application of Article 20(4) and Article 27(5) of Regulation 883/2004, the institution of the place of residence is considered as *quasi competent*. In other words, that alternative definition covers exclusively those MSs which have opted for health care costs' reimbursement on the basis of fixed amounts. However, the above-mentioned

draft proposal, although doing justice to our opinion (broader yet, as it provides for the MS of residence in all cases, where it does not coincide with the MS of affiliation) could result in:

- indirect discrimination of mobile persons (between all other categories apart from the ones falling under the said two Articles), also in respect of the administrative procedures involved (too complicated, time-consuming, implying excessive financial costs);
- creating an unjustified entitlement to health care benefits, on the unique basis of the principle of assimilation and at the expense of the MS of residence, whilst respective acquired rights (the payment of required contributions included) exist under the legislation of the MS of affiliation. In addition, the said Proposal makes no express reference whatsoever to the way the MS of residence should be reimbursed. On the contrary, another Community instrument (the Regulation) is indirectly and in an unprecedented way called to "support" the reimbursement of costs, exclusively by virtue of the above-mentioned (principle of) assimilation (legal fiction).

4.2.3. Authorisation: a national administrative system in the light of Community criteria or a national requirement for a Community role

As a start, the authorisation requirement remaining also under a Directive should in principle be identical to the one under the Regulation, i.e., as the French Presidency's proposal states it, there should be a unique Community system of authorisation, the one in the context of coordination, duly adapted to the criteria of ECJ's jurisprudence (also for the purposes of the freedoms of the Treaty). Yet, neither the French proposal ensures such a uniform approach expressly, creating confusion where it duplicates the same criteria also in the context of a Directive, nor the following Czech Presidency arrives at fully reflecting the case-law and at articulating effectively the said administrative procedure under both legal instruments. Similarly, the drafting of the Directive's proposal on authorisation is highly theoretical, ambiguous, especially to the extent that the substance of the major Community principles to be established is not shared by all parties involved, thus, calling for further interpretation, which does not guarantee the latter's uniform implementation at national level.

However, if the Commission starts from the conviction (based on empirical data) that either the actual percentages of patient's mobility are and will remain comparatively low or that the financial balance of national social security systems is practically impossible or can hardly but only exceptionally be proven being at risk by any MS, then the system of authorisation established under the Directive may be conceived only as a remote possibility, a theoretical construction that could never be applied in real life, which would lead us to the logical conclusion that patients can receive or seek to receive health care (regardless hospital or non-hospital) for the purposes of the Treaty, thus on the basis of the Directive, without any authorisation requirement being legitimately imposed on them by national authorities.

This is the case, especially for MSs, where the responsibility for planning health care capacity is being decentralised to regional authorities while the responsibility for granting/refusing authorisation belongs centrally to social security institutions. In fact, these deciding institutions are not in a position to assess whether the *financial* stability of the social security system as a whole is being at risk. Moreover, these institutions can neither judge whether the criteria laid down in Article 8(3) and (4) of the Directive could possibly

have a negative impact on that regional *planning*. On the other hand, MSs would never accept to establish such an overcomplicated and too expensive infrastructure, i.e. an obligation going far beyond the principle of proportionality.[44]

In conformity with the Court, authorisation is closely related to the ad hoc – concrete sickness benefit which is being sought by the patient: the authorisation must be granted where the treatment at stake is "medically necessary" (where the same or equivalent health care cannot be provided in the competent MS within a medically justified period of time) and "usual" (where the treatment in question is being sufficiently tested and recognised by international medicine).

On the contrary, the Directive merely focuses on and gives priority just to the financial balance and rationalised planning of the social security system each time concerned. Lastly, the said proposal *undermines* the unity of authorization criteria under the Court's case-law (Article 9, partly also laid down in Article 8), braking integral parts of the latter from the criteria identified and established for the purposes of Community coordination.

According to some writers, the Directive goes far beyond the Court's jurisprudence[45] and, if we were to retain the system of authorisation as such, then Article 8(3) should be firmly adapted in conformity with the criteria established by the ECJ's settled case-law. If, however, the dominant opinion were that the very few cases of patients seeking to receive cross-border health care do not risk undermining a system's financial stability or planning, then we would better renounce such an administrative system of authorisation as a whole. The fact that also specialised care, assimilated with hospital care, raises many problems to MSs at national level regarding the definition of several types of treatment as such, pleads also for renouncing authorisation as a particularly cumbersome and red-tape procedure.

From the Commission's point of view, authorisation should not be granted exclusively where a concrete sickness benefit, health care – treatment – method of treatment may undermine the system (this is the *conditio sine qua non* for the introduction or maintenance of an administrative system of authorisation). Yet, the way the said provision of the proposal is drafted (Article 8(3)) does not lead us to the safe grammatical and/or teleological interpretation of such a crucial rule: otherwise, the ad hoc activation or deactivation of (the system) of authorisation depending on the impact the health care each time sought may have on the social security/health system of the MS concerned, is not crystal-clear a conclusion coming out from the express drafting of the said provisions.

Taking into account the insurmountable difficulties for a MS or an institution (individually) to dispose all data -evidence- required in order to prove that the system's financing or planning is undermined and, furthermore, that the reimbursement established is at the rates and on the basis of the tariffs applied by the MS of affiliation (mostly in the interests of MSs with lower rates), then one could come to the obvious conclusion that the system of authorisation introduced by the Commission just as an eventual requirement, along with the

[44] *Thorsten Kingreen*, op.cit.; see also, DGB-Vorstand, op.cit., whereby it is stated that the Directive's implementation would cause high administrative costs; AOK-Bundesverband, op.cit., where it is declared that institutions will never be in a position to prove in every-day practice that their social security/health system's financial stability is undermined and expresses its strong concerns that many patients could be trapped into private payments (in cases of smooth access to too costly health services).
[45] *Thorsten Kingreen*, op.cit.; see also, DGB-Vorstand, op.cit.

other accompanying/supplementary criteria established by Articles 8 and 9 provisions, is only a possibility too rarely applicable/feasible.

In fact, the *utility of prior authorisation*, i.e. a requirement in principle restoring the ECJ's approach in respect of MSs' discretionary power to provide for a financially balanced health care system ensuring a rationalised planning, *is strongly put in question* especially so, where in the Framework Communication accompanying the proposal for a Directive, it has been suggested that MSs will find it extremely difficult to prove that kind of necessity, because "the overall volume of cross-border health care will not have a major impact on health systems as a whole". Is, in the light of that statement, more than obvious that in the Commission's view, there is no case but extremely rare, for legitimately refusing authorisation?

From a technical point of view – in practical terms, it should be noted that such a duality in the way an administrative system of authorisation should function, if its eventual/possible establishment or maintenance in a MS were deemed legitimate, is almost inconceivable. Who, which instrument at which level and how, e.g. on the basis of which data, documented and comparable evidence (regarding methods of treatment, costs, patients' outflows etc) could consider the ad hoc condition of the patient concerned as falling in or exempted from any national authorisation requirement?

So, it is worth wondering whether what lies at the back of the Commission's mind is probably, at least, to facilitate or enhance the creation and to support the functioning of European Reference Networks (under Article 15, ex European Centres of Reference), as asking for authorisation for health care in the framework of these Networks should not be deemed justifiable or proportionate a measure, since access to highly specialised treatment or to high quality and cost-effective healthcare for all patients with a medical condition requiring concentration of resources or expertise (suffering from rare diseases) could not be deemed as prone to undermine a national health system whilst, at the same time, would undoubtedly be medically necessary; if the health system of the MS of affiliation does not include that treatment within its planning, surely only a few insured shall be concerned and could possibly ask for it, thus authorisation may be considered as granted.

4.2.4. Hospital – specialised treatment: Community definitions

That differentiation appears as a unique problem under an eventual Directive whilst there is no problem under the mechanism of Community coordination (principle of sharing of responsibilities[46]) since the scope of health care each time received is uniformly (once and for all) determined by the legislation of the MS of stay – residence, i.e. treatment, along with the determination of the level of health care costs to be reimbursed.

The Commission bases (justifies) its approach under Article 8(1) and (2), treating on an equal footing hospital as well specialised care "for the purposes of reimbursement" (of health care provided in another MS), on the grounds that specialised care, implying use of highly specialised and cost-intensive medical infrastructure or medical equipment, requires planning and rationalisation similar to the one carried out in the hospital sector. The same

[46] General principle of coordination, following respective analysis by the ECJ in its judgment of 12.04.2005, in case C-145/03, *Keller*.

may apply for (highly) rare diseases, the percentage of which as cross-border health care is expected to be high (and increasing).

Regarding also specialised care, the delimitation between hospital and non-hospital care becomes equally critical[47], since the latter is granted partly by health professionals outside hospitals and partly within hospitals. So the question in particular, which arises in most MSs, is whether that type of treatment is taken into account for the purposes of planning in the context of the system of conventional agreements between institutions and health professionals, which is based on the institutions (common) autonomy, or in the context of the (regional) planning of hospital care.[48]

Moreover, there is a high degree of dissent between hospitals and doctors as to what constitutes highly specialised care on the one hand, and rare diseases or chronic illness with heavy case history[49]. The same problems shall arise at European – Community level and further debate is deemed necessary[50]. If however authorisation is deemed appropriate, then it is of crucial importance a specific list to be set up at EU level so as to be uniformly and compulsorily applicable in all MSs.

Both concepts, though, should be determined on the basis of Community criteria, because if their definition is left to each MS's discretion[51], serious problems may arise in the MS of affiliation, apart from the question of whether access to such health care depends on prior authorisation (given the different – conflicting national concepts), also regarding the reimbursable costs (extent and level):

- on the one hand, health care treated as hospital care in the host MS (of treatment), including also accommodation costs, shall be reimbursed at lower rates by the MS of affiliation, which considers it as outpatient care;
- on the other hand, health care treated as non-hospital care in the host MS (of treatment), results in raising the question of whether or not the MS of affiliation shall implement the Court's ruling in *Vanbraekel* case (Article 6(2) of the proposal for a Directive – Article 6(1a) under the French presidency's amended version), i.e. if the said MS will be disposed to cover also accommodation costs provided under the legislation it applies, if the latter considers the care in question as hospital care.

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[47] *Thorsten Kingreen*, op.cit., who stresses that such a delimitation is a fundamental political decision in the health care sector, and provides a brief analysis of the efforts undertaken by the German legislator to derogate from the traditional delimitation between in- and out-patient care, thus, calling for a more in-depth examination of the definition proposed by the Commission.

[48] For an exhaustive overview of the existing forms of hospital/non-hospital care at international level, see *Franz Knieps*, Neue Versorgungsformen, in: Friedrich E. Schnapp, Peter Wigge (Hrsg.), Handbuch des Vertragsarztrechts, 2. Aufl., München 2006, § 12.

[49] In particular, from the German perspective, see *Ulrich Becker, Thorsten Kingreen* (Hrsg.), Sozialgesetzbuch V, Gesetzliche Krankenversicherung, München 2008, Kommentar §116b.

[50] For quite an opposite approach, whereby the Commission, by treating specialised care on an equal footing with hospital care, appears as having surpassed the Court's very jurisprudence, since the latter neither explicitly nor implicitly proceeded to such an assimilation, despite the fact that the decisive arguments, regarding infrastructure and costs, pertain to both types of helath care provision, see *Annett Wunder*, Zum Vorschlag des Erlasses einer Richtlinie über die Ausübung der Patientenrechte in der grenzüberschreitenden Gesundheitsversorgung – Was ist neu?, Medizinrecht Journal (MedR), Volume 27, Number 6, June 2009.

[51] *Ulrich Becker*, *Christina Walser*, Stationäre und ambulante Krankenhausleistungen im grenzüberschreitenden Dienstleistungsverkehr – von Entgrenzungen und neuen Grenzen in der EU, Neue Zeitschrift für Sozialrecht (NZS) 14 (2005), H. 9.

Yet, as already stated, there is no need for such a uniform intervention in the framework of Community coordination, governed by the principle of sharing of responsibilities, according to which the health care provided is treated as specialised care on the basis of the legislation administered by the institution of stay in the MS of treatment.

5. Reflecting on a new type of Community coordination: in search of the optimum interaction between the EC judiciary and legislature

> *A European welfare dimension has for long been a material fact, patched up by judicial activism versus political caution, exemptions and compromises… The coordination scheme is one of the oldest parts of Social Europe […] one of the main areas of controversy concerning that scheme which coordinates welfare across borders has been to define the scope and limits of its material content […] which and how certain social benefits should be coordinated […] essentially, whether free movement should be extended to all groups of people and how?*
>
> ***Dorte Sindbjerg Martinsen***[52]

5.1. Where and how to get next? A Synopsis

Confronted with the dilemma – the perspective of two Community legal instruments having the same aim to be in parallel applicable, we propose *a uniform solution*, the *single framework of the Regulations of coordination*, *reinforced and complemented* with the aforementioned corrective interventions (extending its scope) because Community coordination is the unique instrument which imposes to the MSs the continuous obligation to adopt common – based on unanimous agreements uniform interpretative approaches and practices on issues concerning the implementation of mobile persons' rights within the EU (maintenance of acquired and rights in course of acquisition), patient's rights included.

So, coordination Regulation is the only Community instrument which, via the *principles of sharing of responsibilities*[53] for patient's cross-border health care and of *equal distribution of such health care costs* between all MSs, both of overriding effect, is able to achieve a double target *in the context of patient's free movement*:

- on the one hand, the *implementation of the fundamental principles of equal treatment and that of transparency and legal certainty* both in the MS of treatment as well as in the competent MS,
  - by means of patients' equitable access to health care providers, in the framework of universal access to high quality care in the MS of treatment, which is responsible for the supervision of health providers in respect of the extent and quality of the sickness benefits in kind granted to the patient, and
  - via the (definition and) implementation of patient's entitlements by the competent MS, which is, in turn, responsible for the coverage of health care costs in the context of the latter's planning and supervision for rationally funded and financially sustainable/balanced social security system, on a contiguous basis;

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[52] *Dorte Sindbjerg Martinsen*, The Social Policy Clash – EU Cross-Border Welfare, Union Citizenship and National Residence Clauses, Centre for European Politics, University of Copenhagen, Working Papers Series 2/2008: http://www.cep.polsci.ku.dk/publikationer/workingpapers/wp2.08_samlet.pdf.

[53] See also, DGB-Vorstand, op.cit., whereby it is argued that the implementation of that Directive is expected to enhance the implementation of the principle of the assumption of health care costs to the detriment of the coordination's Community principle of sharing of responsibilities.

- on the other hand, *to ensure MSs' social security/health systems sustainability and, thus, the maintenance of their capacity to cover their insured patients' health care costs occurred within the Union,* by means of a coordination mechanism based *on the principle of equitable/fair distribution of costs* between all MSs – institutions involved; in other words, on the one hand, by avoiding double payment of costs for the same sickness benefits in kind granted to their insured/patients, and on the other hand, by the reimbursement of costs the closer possible to real costs, borne either by the institution of the MS of stay/treatment or by the patient him/herself.

On the contrary, a Directive's target is to comply (for implementation sake) with the Treaty's imperatives on the freedom to provide (health) services or, otherwise, on the free movement of patients, ensuring also to a certain extent the harmonisation of MSs' legislation. However, since the said instrument's role is essentially to ensure the harmonisation of the *patient's very right to cross-border health care*, the Directive leads to just a partial – insufficient and mainly on a case-by-case basis response to the issue of that right's full implementation, given that:

- On the one hand, the competent MS is, rightfully so, only partially/unilaterally responsible to identify the patient's right and to cover the latter's health care costs, in the context of its planning and supervision exercised for ensuring a rational and balanced functioning of its social security system, while leaving aside the responsibility for controlling the quality and quantity of health care delivery to the patient him/herself and to the provider's "consciousness"; the impact of such a partial involvement, most of the times, is legal uncertainty for the patient in respect of his/her entitlements and the degree to which they are protected, i.e., *lack of transparency* regarding his/her *information* about the *legislation which applies* at a time as well as on *what actually is provided for* under the said legislation, and *lack of legal certainty* in respect of *the implementation* of the legislation applied (granting of the right sickness benefits and to the extent/quality of coverage provided by the respective legislation); in other words, the competent institution (the patient is affiliated with) does not ensure, via the mediation of the institution of the place of treatment which is anyhow compulsorily involved, the effective supervision of the health services granted by the provider.

- On the other hand, each competent MS assumes individually/separately the financial responsibility of bearing health care costs in conformity with Article's 49 EC fully implementation (according to ECJ's interpretation), i.e. it covers costs without being able, mainly obliged, in the context of a coordinating instrument – especially when the latter applies in parallel, to combine-coordinate these costs either with the costs reimbursed to other MSs for the same patient's health care occurring under the Regulation's provisions or with the amounts reimbursed by other MSs to the latter. The negative economic impact of that situation is the unequal/unfair distribution of costs between MSs, some of them being in a position to benefit from two Community Instruments working simultaneously in parallel, by claiming and receiving double payments for costs regarding the same sickness benefits in kind granted to the same patient's sake, and some others to be charged with double payments respectively. In other words, we shall be confronted with an unequal distribution of costs which at Community level could in no way lead to the fulfilment of the Commission's aim to promote legal certainty and high quality health care while patients are exercising their right to free movement, assigned by the Treaty.

5.2. General principles to agree upon: eliminating conflict-law situations

> *L'approche suivie par la Cour garantit le modèle social européen des soins de sante. Les exigences des libertés communautaires s'arrêtent aux portes de la protection des objectifs d'intérêt général qui sous-tendent l'organisation structurelle et financière des systèmes nationaux de sécurité sociale.*
>
> ***Prodromos Mavridis***[54]

To start with, one and the same insured, as a mobile person, has *a double status*: one under the coordination Regulation's general and special rules (e.g., *definitions, applicable legislation, sickness benefits in kind, reimbursement*) and another one under the Treaty's interpretation by the Court (in principle, *free provision of health services and goods*), regulating the above-mentioned areas.

In order to avoid or if the aim is to avoid the formal establishment of such a double-status in respect of one and the same mobile person (expressed as free movement of persons versus patient's mobility, health professionals' free movement standing in-between), also within the single framework of Community coordination, we should, in principle and as a start, follow the structure and economy of its provisions (Basic and Implementing Regulation), while including, in parallel, where there is a divergence towards the reasoning – philosophy of the Treaty, the Court's basic principle that fundamental freedoms, each time they are expressed either in terms of accessibility to heath care or in terms of the way of assumption of health care costs, may in no way result in undermining the financial balance – sustainability of MSs' social security/health insurance system.

Consequently, with the above-mentioned endeavour, we have to address the questions:

- Which is the system truly concerned (whose financial stability should not be disturbed) – the competent or that of residence?
- Which institution reimburses the health care costs and on whose behalf, i.e. which institution actually bears the economic burden?
- Is finally the said target achieved?

As *"law masks politics"*[55], the difficulties encountered when trying to incorporate the ECJ' settled case-law within the coordination Regulations' mechanism, arise from the different philosophies governing Community coordination and the Treaty's provisions on freedom to provide services, which become apparent *directly* only when the question of assumption of health care costs arises and *indirectly* where the conditions of access to health services and the administrative system of authorisation come in the forefront.

The impact of health care provision on the establishment of free movement (laid down in Article 39 EC, in the light of extensive jurisprudence), is outstandingly important. On the other hand, apart from the different redistributory mechanisms governing the provision of short-term, *sickness benefits in kind* and those on long-term benefits, *pensions*, also between short-term benefits as such (e.g. Family benefits, based on the complementary intervention of national legislation), the more or less static and cautious character of Chapter 1 is mainly due to the fact that the costs for health care provision are much higher and all the more increasing.

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[54] *Prodromos Mavridis*, op.cit.

[55] *Dorte Sindbjerg Martinsen*, Inter-institutional Dynamics in the Cross-border Provision of Healthcare Services, Arena Centre for European Studies, University of Oslo, Working Paper, No. 5, March 2009: http://www.arena.uio.no/publications/working-papers2009/papers/WP05_09.pdf.

In particular, if under the Treaty (and possibly a Directive) Article 49 EC provides that a MS's health/insurance system offers the patient the right to go to another MS and receive or seek to receive there sickness benefits in kind, the coordination Regulation should ensure to that insured person – potential patient the right to "think/choose" in terms of the system administered by the MS where the mobile insured stays/resides, in other words, on the basis of the system under which he/she is entitled to receive or is actually receiving benefits. "Workers" mobility or in more general terms, free movement of persons should be considered as including "patients" mobility as well. Otherwise, patient's mobility should be deemed as an inferior-subsystem, subject or almost inherent to the superior system of free movement of persons, active and non-active insured, health professionals alike, both as an expression of the freedom to provide goods and services, (in conformity with extensive settled case-law).

As it has been already pointed out, *potential conflict-of-law situations* which may arise from the existence *of two pathways in parallel* are mainly focussing on:

- The concept of "*cross-border health care*" as defined in the context of the proposal for a Directive (by the Commission, the French and the Czech Presidency);
- The entitlement to health care costs' reimbursement by the MS of affiliation-insurance (Directive, Article 49 EC) *versus* the principle of *sharing of responsibilities* (Regulation);
- Residence *versus* long-term stay.

5.3. Towards further extending the scope of Regulation 883/2004: choosing for a more strengthened Community coordination approach

> *Toutefois, avec cette jurisprudence rien ne sera comme avant. La dynamique créée par la Cour force les Etats et les régions à anticiper et collaborer étroitement…*
>
> ***Prodromos Mavridis***[56]

What do we aim at by following the coordination's path? We express our belief that by means of that structured mechanism the elaboration of a unique legal/regulatory framework is the best way to incorporate and manage the implementation of Community acquis (Article 49 EC in the context of Community coordination) in that crucial field. The implied impact of such incorporation would be to support the sustainability of MSs' social security/health insurance systems, which are based on the solidarity principle and are coordinated as such, provided that we can only isolate them from shocks stemming out of other, economic sectors of the Treaty and interfering in a conflicting way with the social security model at national and European level. Thus, Community coordination is proposed as the most efficient mechanism, the most solid/safe instrument towards a more controllable future.

Otherwise, if we follow/trap ourselves within the dualistic approach, in an attempt to incorporate the Treaty's jurisprudential dimensions under a parallel Directive, that intervention, we are afraid, will lead to uncontrollable results. The Directive, as proposed currently, is also going to erode the coordination mechanism's foundations by bringing in from the back-door as the unique generally applicable method of costs' reimbursement that based on lump-sums. Aiming at broader perspectives, i.e., stemming from the Treaty to establish a structured legal framework to counteract, stop the advance of the internal market

[56] *Prodromos Mavridis*, op.cit.

freedoms and competition rules, the economic burden that would arise would be far greater than the one under the coordination mechanism and could influence adversely the systems concerned, while functioning subversively between all MSs.

Community coordination would facilitate the actual and duly incorporation of all initiatives deemed necessary, in its capacity as an instrument based on the *ratio legis* of and providing for the mechanisms which ensure efficient monitoring and supervision of the distribution of costs between all MSs, while maintaining their fair and balanced distribution to the best possible extent. Moreover, outside coordination (e.g., eventually, in the context of a Directive) administrative costs, and thus, burdens are increasingly higher[57], since complying with the Court's settled-case law in that field implies the establishment of procedures and arrangements all the more complicated and cumbersome.

Despite difficulties, burdens and/or different theoretical approaches about the way we should better address the issues raised by jurisprudence so far, we should not forget that *patient's mobility* is a reality (a *factual* situation), which cannot be ignored, be left aside driven by either providers' or institutions' mostly economic interests.

If it is true that "we must salute the wisdom of Community's judges, who have managed to draw a reasonable line between economic freedom and solidarity", it is equally worth recognising that "the ties of solidarity between members of a given society are too important an issue to be addressed indirectly through legal proceedings"[58]. So we are in a way called -it is a real challenge- to take most advantage of the Court's criteria potentially leading towards a protective Social Europe. It is a chance to highlight and integrate those conditions on the basis of which we could subsequently and also systematically establish or rather extend the *anthropocentric philosophy* of Community law, going through the corpus of European citizenship provisions[59].

Issues to be addressed when opting for Community coordination as the most adequate pathway may be identified as falling under a possibly conflicting situation, deriving from the "schism" between:

- on the one hand, mostly the Community context of definitions, the rules on the applicable legislation, the scope of benefits and the regime laid down in the financial provisions' framework, whereby the ECJ's jurisprudence on the Treaty's internal market freedoms shall be incorporated; and
- on the other, potential dysfunctions which may appear in practice, mainly in cases of a comparatively long(-er)-term stay in a MS other than the competent one (where the place of habitual stay-residence, as a matter of fact, has not been altered).

How the concept of such an extended scope could be given a "Community" definition? Departing from the political compromise reached (by Council) in the context of Regulation 883/2004 (Title II, Chapter 1), its expansion regarding *sickness benefits in kind* would aim

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[57] See also, DGB-Vorstand, op.cit.

[58] *Jacques Delors*, Foreword, in: *A. Bosco*, Vers une remise en cause des systèmes nationaux de protection sociale: observations sur la jurisprudence récente de la Cour de justice, Etude, 15.07.2000 : http://www.notre-europe.eu.

[59] See Opinion of Advocate General Cosmas, in case C-378/97, *Wijsenbeck*, whereby the said evolution is presented as a major shift from what previously constituted the central aim of Community rules in principle, i.e. the development of the Community itself and the enhancement of its fundamental aspirations, even in those cases where individuals/persons were directly concerned by the regulatory scope of the rule in question (such as, ex Articles 48 et seq. of the Treaty).

at fully activating ECJ's teleological interpretation regarding freedom to provide services and goods (Article 49 EC inter alia) within the coordination mechanism, while removing all respective provisions from the proposal for a directive, so as only one legal EU Instrument to be applicable and cover the domain of cross-border healthcare costs reimbursement. In practical terms, broadening the scope of coordination would mean to include a significant number of cases so that they do not end up as "*other* cases" (according to the proposal for a Directive), the ultimate aim being the minimisation of mostly patients' legal and financial uncertainty.

Such an attempt could be achieved by "intervening" in the scope of mainly[60] two concepts:

Firstly, in respect of the *"medically necessary"* sickness benefit (in kind), by broadening the scope of "necessary", as a Community concept, deserving a broad teleological interpretation which would ideally combine elements of jurisprudence on the coordination mechanism as well as on the Treaty's other fundamental freedoms.

In particular, what would be considered as "medically necessary" health care, should be defined, so as to correspond, apart from the *strictly medical* elements, also to other, qualitative criteria – requirements, which would respond to the patient's other type of interrelated with his/her state of health, "needs"; in other words, the scope of that key concept should be expanded, so as to identify the *condition concerning the necessity of the proposed treatment* (the condition that the treatment abroad be necessary) and, thus, "cover", to the extent possible and reasonable, all "obstacles" (mainly in the MS of stay) primarily to patients' free movement, such as:

- *the patient's broader physical – psychological/mental state of health* (i.e., pain, fear, incapacity, apart from the concrete illness, lack of confidence towards the contracted provider, due to the latter's behaviour, degree of interest and the level of qualitative and mostly effective provision of health care);[61]
- *the degree to which access* to health care providers encounters significant difficulties – problems, i.e., geographical distances or better, easier, quicker and cheaper access to a health professional[62] taking into account the available means of transport, public facilities, constructional conveniences (facilitating accessibility to the provider's place and surgery), justifying grounds for changing place of treatment;
- *cultural*, more generally *social*, or other problems due to *religious convictions and societal values* – way of living, even language impediments making access to health care dependent e.g., on the coverage of interpretation costs;[63]

[60] Our reference to those concepts to be examined by priority goes along with our belief that there is a range of other problems – issues arising from the interpretation and/or implementation of the Basic as well as the new Implementing Regulation, which should be also addressed, ensuring the smooth implementation of Community coordination per se; see a similar proposal submitted by DGB-Vorstand, op.cit., asking such an approach to precede the debate on any eventual Directive.

[61] See also, *Peter Reichelt, Susanne Agasi*, Die Zukunft der grenzüberschreitenden Gesundheitsversorgung aus der Perspektive der Versicherten, in: Norbert Klüsen (Hrsg), Europäischer Binnenmarkt und Wettbewerb – Zukunftsszenarien für die GKV, Baden-Baden (2003); *Helena Legido-Quigley, Martin McKee, Ellen Nolte, Irene A. Glinos*, op.cit., for a more global approach; *Prodromos Mavridis* and *Advocate General Bot*, op.cit.

[62] See also, Flash Eurobarometer #210, Chapters 4 and 5, op.cit.; *Helena Legido-Quigley, Martin McKee, Ellen Nolte, Irene A. Glinos*, op.cit., for a more global approach.

[63] See also, *Leonhard Hajen*, op.cit.; *Peter Reichelt, Susanne Agasi*, op.cit.; Flash Eurobarometer #210, Chapter 5d, op.cit.; *Philipa Mladovsky*, in Euro Observer and Eurohealth, op.cit.; *Helena Legido-Quigley, Martin McKee, Ellen Nolte, Irene A. Glinos*, op.cit., for a more global approach.

- generally, *the absence of fraud/responsibility* from the *patient's* part, e.g. the provision of adequate health care by a contracted provider is temporarily not available/impossible (due to the surgery's timetable, waiting lists, the doctor being on a leave etc,), the appropriate medical equipment is out of order, not properly functioning, or time-consuming and cumbersome administrative procedures are required[64].

Apart from the above-mentioned qualitative criteria which would significantly contribute to remove too heavy pressure exercised on the respective authorisation criteria, and taking into account the crucial role of the length of a person's stay in a MS when assessing the necessary nature of the sickness benefit claimed, in order to eliminate the continuous conflict situations regarding medical necessity, the Regulation should further provide for the assimilation of *long-term stay* (e.g. above 12 months) with *residence*, mainly for *insured persons* (pensioners' stay exceeding 12 months outside the competent MS is usually considered as the expression of their intention to reside outside the competent MS and may at the outset be declared as residence).

Moreover, a new provision should establish *expressis verbis* the assumption of health care costs without prior authorisation in case of non-hospital treatment[65], yet at the rates applied by the MS of residence or long-term stay, since it is those MSs' systems (as the most "familiar" to the insured, subject to another MS's legislation and assimilated persons) which "oblige" ("drive", in a way) the said insured to seek "private" health care (deliberate, personal choice).

On the contrary, where the period of stay is less than 12 months (entitlement to medically necessary benefits), then the case at stake should be examined by express priority criteria under the Regulation and a sufficient justification should be provided for, eventually where the latter has not been applied (has been deemed inapplicable). In cases where the competent institution raises serious doubts – reservations about the nature of the health care granted as "medically necessary" according to the institution's of stay evidenced approach (usually in cases of chronic or pre-existing illness, where the competent institution appears particularly suspicious), then an explicit provision in the context of the new implementing Regulation should recognise priority to the re-assessment of the nature of the sickness benefits provided by the institution of the place of stay, which should be binding for the competent institution.

Secondly, in respect of the *"authorisation"* mechanism, as the administrative system of national origin, compatible requirement for "planned" hospital (in principle?) care in another MS, whereby the conditions set by national legislation and applied in combination with Community criteria under the Basic Regulation (Article 20), need to be carefully redrafted, in a further loose, yet coherent and comprehensive way, so as to reflect the wide range of settled case-law's principles and criteria (mainly the ECJ's rulings in *Smits and*

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[64] See also, *Helena Legido-Quigley, Martin McKee, Ellen Nolte, Irene A. Glinos*, op.cit., for a more global approach.

[65] See also, *Karl-Jürgen Bieback*, Neue Rechtsprechung des EuGH zur grenzüberschreitenden Beanspruchung von Gesundheitsleistungen – zugleich eine Anmerkung zum Urteil des EuGH in der RS C-372/04, *Watts*, Zeitschrift für Europäisches Sozial- und Arbeitsrecht (ZESAR) 7/2006, where the writer underlines that the insured person's integration – assimilation within the social security system of the MS of stay and/or residence is not feasible only on the sole basis of Article 49 EC but depends on the previous establishment of specific provisions under Community coordination (thus, referring to ECJ's judgment of the 23.10.2003, in case C-56/01, *Inizan*).

Peerbooms[66] and *Watts*[67]). Regarding the eventual implementation of the administrative authorisation scheme also in case of outpatient health care, further attention should be paid to the aim underlying any possible activation of the Regulation's respective provisions; in other words to ensure that the patient concerned has the optional right to invoke the respective provisions of the Regulation in so far as the latter ensure a higher level of social protection.

With regard to that *second concept*, due attention should be paid so as to reflect the *complex character* of such an administrative system, i.e. the fact that it requires-presupposes the existence (which means the "creation – construction" in time) of an active trusting "relationship" between the institution concerned and the insured/patient.

Coming back to the Court's *theoretical treasury*, explicit provisions should determine the criteria and objective as well as justifiable conditions under which such a measure, restrictive in nature, could actually prove objective. This is particularly so, since Community coordination, even after reform, (Regulation 883/2004) dictates that an authorisation is always to be sought each time (usually *a priori*) and regardless of the nature of planned healthcare (sought or received) in another MS, and given that the conditions to be fulfilled for obtaining the said authorisation are restrictive from the moment the above-mentioned principles and criteria of ECJ's jurisprudence have not yet been incorporated in any instrument of secondary EU legislation and their implementation in every day practice is not yet guaranteed (do not constitute yet Community acquis).[68]

If the spirit of the proposal for a Directive were to be transferred within the coordination mechanism, such an authorisation should be provided *expressis verbis*, as an exception rather than as a general or unique rule applying in each scheduled treatment, even hospital care (under Regulation 1408/71 and its reformed version, Regulation 883/2004). Otherwise, as the Court's case-law does not introduce a general prior authorisation requirement but allows MSs to provide for such a system for the assumption of costs for inpatient care, Article 20 of the basic Regulation should be amended and explicitly provide that *authorisation is excluded* in cases – domains of health services, medical treatment, certain types of illness/diseases, *in so far as evidence* can be provided that *neither* the financial equilibrium of the social security system/health insurance scheme *nor* the planning and rationalisation in the hospital sector – the maintenance of a balanced medical and hospital service open to all, or the maintenance of treatment capacity or medical competence on the territory of the MS concerned, *can be seriously undermined*.

To put it in other words, the urgent need for transparency and also legal certainty in respect of the authorisation requirement, which is still pending or where ongoing debate leads to

[66] ECJ's judgment of the 12.07.2001, in case C-157/99, *Smits and Peerbooms*.
[67] ECJ's judgment of the 16.05.2006, in case C-372/04, *Watts*.
[68] See also, *Karl-Jürgen Bieback*, op.cit., whereby it's been marked that Community coordination provisions on authorisation should be reformed in conformity with Article 49 EC following the Court's teleological interpretation, with a view to raise the conflict-law situation existing between the said Article of the Treaty and the provisions of Article 22(2) of Regulation 1408/71; for a critical approach on the Court's case-law regarding the *ratio* of waiting lists vis-à-vis compatible authorisation criteria, see *Ulrich Becker*, op.cit., whereby the author expresses the view that social rights are thus extended beyond the scope of national law, traditionally governed by the territoriality principle, but also admits that, after reform, ECJ's case-law has been successfully integrated within Community coordination (expressly under the provisions of Article 20, Regulation 883/2004), an evolution which shall apparently contribute to the smooth implementation of the fundamental freedoms of the Treaty.

diverging and conflicting positions, is the question of which methods, which types of treatment are to be considered as adequate/appropriate and where the patient should have unhindered access. It is crucial to make a distinction, to draw a dividing line and define, what "recognised (method of) treatment" means in the light of national and international medical science, a concept we should agree all upon.

We should shed light to the scope of "sickness benefits" from medicine's scientific perspective. We, really, need to clarify *what exactly* the legislation of the institution concerned actually provides for, especially where a certain type/method of treatment is not fully or unconditionally recognised by a number of MSs, in the sense that there is no entitlement to such treatment under their legislation.

Given that the authorisation administrative scheme concerns "sickness benefits" (in kind), as the latter materialize in each concrete situation, it is of crucial importance for us all to agree, both for the patient's informed choice and the institutions' concerned efficient and effective cooperation, on more tangible criteria that institutions concerned should apply (on top of or for ensuring their being objective, non-discriminatory – without differentiation depending on the origins of services and known in advance), based on the state of the art and on scientific thinking at international level, *according to the state of international medical science and medical standards generally accepted at international level* (in the light of the state of national and international science)[69].

More specifically, it is necessary to certify that the treatment which is *sufficiently tried and tested by international medicine* has to be *recognised* and health care thus received to be considered as falling within the *basket of benefits*[70] provided by the legislation of the MS of affiliation (residence). Since scientific research and developments concerning methods of treatment applied (normally or experimentally) in the field of medicine differ to a considerable extent between MSs, we should try to reach agreement -this being the major political issue we are confronted with- on whether we are disposed, willing and committed

[69] See ECJ's ruling in case *Smits and Peerbooms*, on the condition that the proposed treatment be "normal"; for a more holistic approach, linking the cardinal significance of the Court's case-law in bringing the patient and the citizen at the centre of European politics, looked at from the international medicine's perspective, with Hippocratic ethics and humanities, see *Prodromos Mavridis*, op.cit.; for a further analysis focussed on the rising expectations of modern medicine, medical practice and the concept of "patient", see *Spyros Marketos*, Medicine and humanities, Archives of Hellenic Medicine 2000, 17(5), International Hippocratic Foundation of Kos (IHFK), Athens, Greece: http://www.mednet.gr/2000-5/pdf/446.pdf, and *Spyros Marketos*, Hippocratic ethics in modern medicine, The Greek Legal and Medical Conference, Crete, May 2004, Papers: http://www.greekconference.com.au/papers/2004/marketos.htm.

[70] See *Luigi Bertinato, Reinhard Busse, Nick Fahy, Helena Legido-Quigley, Martin McKee, Willy Palm, Ilaria Passarani, Francesco Ronfini*, op.cit., for an overview of the delicate issues policy-makers are called to address and the qualitative data they need to dispose for the purposes of comparing health expenditure between MSs; although it is stated that the analysis of benefits defined in the various EU countries reveals a clear trend towards a more explicit definition of benefit baskets and benefit catalogues, yet the lack of clear and transparent decision criteria makes it still delicate, yet not unfeasible in the long-term to agree on explicitly included or excluded benefits, on a more harmonised definition of the baskets of health goods provided by MSs; however, in order to overcome, in the near future, the complexities arising from the existing variety of definitions in combination with patterns of decentralised decision-making, "a minimum basket of benefits has to be defined by all countries at the national level", subsequently "to be harmonised at an EU level… in relation to increased cross-border flows"; in fact, as it has been pointed out, "for rational decision-making, knowing how many persons "consume" health care goods and services across borders… is not sufficient (although a first, necessary step); rather, national and EU policy-makers need reliable comparisons about available health services (the "benefits package"), how these are defined (the "taxonomy"), what their costs are, and which prices they will have to pay for them.

to grant the best healthcare/treatment actually provided under the health system of a MS which is not always that of the competent.

Granting authorisation for such health care (i.e. not sticking only to treatment carried out on national territory and to scientific views prevailing in national medical/professional circles) is another way to express compliance with the Community principle of "sharing of responsibilities" in the broader sense of the term; another way for the institution of affiliation to prove its trust and respect towards the "sickness benefits" in kind, provided under the health insurance system of the institution of the place of stay, in the MS of treatment.

The overall question of "recognised treatment" – qualifying benefit at the end, from the patient's perspective seems to be essentially a *medical* issue. On the opposite, looked at from the perspective of the actors (institutions and providers) involved with the administrative system of authorisation, it could mainly constitute a *political and economic* issue. Its *economic* dimension is in particular present where a MS's health professionals' community finds it difficult to recognise experimental but sufficiently tried and tested treatment provided by health professionals in another MS, out of the fear of potentially considerable outflow of patients (towards their "foreign" rivals), a reason for which patients under their contracted health insurance system may choose to leave the MS of affiliation, seeking treatment in that other MS. On the other hand, (competent) institutions are not eager to recognise such methods of treatment out of the fear that this would obviously, although indirectly, lead to further expanding in practice the material scope of the legislation they administer (the number-extend of qualifying benefits), thus increasing the economic burden to be potentially assumed by them for that type of healthcare exclusively occurring "abroad".

Lastly, that decisive step would be a key political problem for Governments, since MSs are called, before taking their critical decisions, to go beyond the aforementioned parties' mere interests and examine/assess the patient's very interest, to balance the pros and cons, so as to be in a solid position to recognise and authorise those treatment types/methods, on the basis of objective criteria and in the light of the common principles and values which are supposed to govern national health systems, as reflected and confirmed by the Council's Statement respectively.

These political decisions constitute the key factors for the creation, the support and evolution of European Reference Networks (ERNs), for the purposes of promoting high quality health care in that European context. Otherwise, one of ERNs' domain of outmost importance, research/experiment where qualitative health care mainly lies, would have no chance to develop. Unless, we have decided that ERNs as well shall be destined exclusively to the well-off patients, the happy few!

6. Concluding Remarks

Jamais poète n'a interprété la nature aussi librement qu'un juriste la réalité.[71]

[71] Translated: *no poet ever interpreted nature as freely as a lawyer interprets the truth,* as quoted by *John Bowis* (EPP-ED), in his Report, op.cit., where, among the areas of legal uncertainty demanding further clarification, he underlines, "we would make it crystal clear that the present initiative is an opportunity for patients, it is actually patient centred, based on need and not means and on informed choice and not compulsion".

Giraudoux

The lawyers of Europe have being making policy on patient mobility, because the politicians have failed to do so.

John Bowis[72]

Concluding, in case Community chooses finally for two parallel pathways in that crucial area, we would like to point out that:

(1) In MSs with comparable – higher-level rates/tariffs, patient's mobility shall be enhanced and increased, as it shall be encouraged both by the providers (being interested in promoting private access to health care services) and the patients (since reimbursement of health care costs will be sufficiently high). In that case, the proposed Directive favours the development of private health care or health care under a private status, which further means, that in the aforementioned context, the latter functions in favour of access to *better, quicker* and *more convenient* health care services[73].

(2) In MSs where the rates or tariffs applied are highly diverging, then the said Directive functions in favour of access to *cheaper* health care, where patients' mobility from MSs with higher costs/rates towards MSs applying lower rates but providing for a sufficient level of health care coverage, particularly regarding certain types of health care/services, is probably going to be increased since costs reimbursement is also expected to be high – as it is actually being observed by recent ad hoc/pilot studies at European level[74].

(3) On the contrary, in respect of MSs with lower rates/tariffs and comparatively lower level of health care services, patient's mobility will concern only the better-off[75]. Mostly means instead of needs will be the decisive factor for seeking and actually receiving health care in another MS. As it becomes apparent, the Commission's basic aim is essentially not the expressly stated one, i.e., to safeguard high quality health care but another more specific target. In fact, given the high level of health care provided by the northern more or less MSs and its expected evolution, the proposed Directive's substantial aim is the establishment, support and development of European Reference Networks, a sector of private health care which has not yet been developed within the EU or where it is developed, access to it is still not feasible or not so easy. Thus, via the Directive, the Commission tries to enhance patients' mobility in that specific and highly specialised sector of health services.

However, that endeavour targeting, as a start, to promote patient's mobility, would inevitably result in favouring actually private health care (even if only limited to those Networks), since the initiative undertaken is to improve, on the basis of Internal Market rules though, the quality of health services rather than quality of peoples' health as such (at least not ex officio). The main aim is for health services to be transformed into common services, becoming also even more attractive. However, the Commission, via the Directive proposed, paves the way for removing health services from the "close circuit" of health/social security systems, whereby these services maintain a certain level of quality

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[72] *John Bowis* (EPP-ED), A healthy attitude to treatment, European Voice, Policies, Health & society, 12.02.2009: http://www.europeanvoice.com/folder/healthquarterlypatientsrights/101.aspx?artid=63939.

[73] See respective reference under the Explanatory Report to the Commission's proposal.

[74] See also, *Leonhard Hajen*, op.cit.; Flash Eurobarometer #210, Chapter 4e, op.cit.; *Helena Legido-Quigley, Martin McKee, Ellen Nolte, Irene A. Glinos,* op.cit.; *Luigi Bertinato, Reinhard Busse, Nick Fahy, Helena Legido-Quigley, Martin McKee, Willy Palm, Ilaria Passarani, Francesco Ronfini*, op.cit.

[75] See also, *Leonhard Hajen*, op.cit.; Flash Eurobarometer #210, Chapter 4e, op.cit.; *Helena Legido-Quigley, Martin McKee, Ellen Nolte, Irene A. Glinos*, op.cit.

under the rules and processes governing the said systems, leaving these services to develop independently as services in the context of competition rules.

In the opposite, our proposal to strengthen Community coordination as a flexible and exceptionally dynamic but unique instrument:

- on the one hand by extending the scope of what should constitute medically necessary health care, mostly by assimilating long-term stay to residence or by establishing improved, more qualitative and broader criteria in respect of authorisation, and
- on the other hand, by incorporating settled case-law under the coordination mechanism's principles of sharing of responsibilities and of equidistribution of financial costs,

attempts to maintain health services and their perspective evolution within health/social security systems. As these systems are based on the solidarity principle and function as the constitutive elements of the European Social model (Beveridge/Bismarck), thus as patient-centred mechanisms, obviously their coordination at Community level by the long-standing and recently modernised Regulations, is expected to improve that patient-oriented dimension, more so as it will stand in the context of the mostly guaranteed Community legal framework.

The crucial question we are urgently called to address is what are the rules of the game and which direction they are going to follow, that of the providers or that of patients, under the "high supervision" of health systems. If patient's needs is the key issue and the latter's health care in the context of the European model/models of health insurance/social security systems, then we reiterate that Community coordination is the best defensive mechanism already at our disposal, which could in practice (it is not a mere theoretical hypothesis) support both national health systems and patients. From the moment ECJ's case-law is a matter of fact, a step we cannot avoid to take/accomplish, then we should be more daring, right at the start, and incorporate it in a smooth and harmonious way within the Community coordination mechanism. Opting for a straightforward and coherent "political" position in that decisive area, we do not let *disguised conflicts of interest and their metamorphosis into "neutral debates" on the interpretation of law* to further weaken the political process at EU level, transforming *"citizens' democracy"* to mere *"judicial democracy"* (according to opponents' arguments).

It is far more clear that the proposed Directive (a services-driven instrument based on an market-orientated jurisprudence) does not (cannot) by itself drive us to the far reaching aims set out in the Council's statement on common principles and values[76] (despite the fact

[76] See also, European Economic and Social Committee (EESC), Opinion on the Proposal for a Directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare, Document SOC/322 – CESE 1927/2008 – 2008/0142 (COD) FR/MEV/RS/hn, Brussels, 4 December 2008, for a comprehensive approach putting special emphasis on the qualitative aspects and considerations of such an initiative, stressing amongst others ignorance of the complexity, variety and divergence of MSs' (27) health systems as a major obstacle to uniform implementation and legal certainty, the risk of inequality remaining thus omnipresent; although EESC recognises that the Proposal reflects the values of EU and of the Tallinn Charter, it still points out a series of prerequisites, such as the incorporation into national legislation of the principles of a European Charter of reciprocal rights and duties of the various actors in the sphere of public health, which would only guarantee the application of real patients' rights, as the decisive step forward, in order to enable the patient to make free and enlightened choices rather than being prey to customer poaching and commercialisation practices (see mainly, Comments and recommendations – General comments):
http://eescopinions.eesc.europa.eu/viewdoc.aspx?doc=//esppub1/esp_public/ces/soc/soc322/en/ces1927-2008_ac_en.doc.

that the latter are highlighted into the Directive's *whereas*); on the contrary, the Community coordination mechanism has an overall target to guarantee *in fine* a high level of protection of the persons falling under its scope, to contribute towards improving their standard of living, for all potentially "mobile" insured and in the light of jurisprudence, persons being in a "cross-border" situation.[77]

However, it is worth bearing in mind, that "EU's major challenge is that its secondary legislation and their interpretation by the Court must be based on what is in the Treaties and, indeed, the social character of European health systems is not embedded in the Treaties. So, an explicit European health policy would bring considerable benefits, setting out an agreed position among MSs, which would enshrine the goals of European health systems, would balance the internal market with social goals and could be incorporated in a future Treaty"[78].

In the meantime, as long as the *inter-institutional dynamics*, the interplay between Community Institutions involved, does not prove as politically holistic as expected, patient's mobility in the light of settled case-law, may be looked at as a byword, as the opportunity grasped by the Court to aim at bringing human beings in the centre of attention of the European construction, without ignoring the Treaty's other objectives and Community's interests.[79]

[77] For an overall critical approach on most of the topics raised in the present paper, see also, European Trade Union Confederation, ETUC Position on the proposal for a directive on patients' rights in cross-border healthcare, Brussels, 3 – 4 December 2008: http://www.etuc.org/IMG/pdf_ETUC_Position_Proposal_for_a_directive_on_patients_rights.pdf.

[78] *Elias Mossialos, Martin McKee, Willy Palm, Beatrix Karl, Franz Marhold*, op.cit.

[79] *Prodromos Mavridis*, op.cit., "à l'ère de la mondialisation, le remarquable équilibre trouvé par la Cour de justice entre protection sociale et libertés du marché, entre les droits fondamentaux des citoyens et le bien être de la collectivité fondé sur le principe de solidarité doit, au stade actuel de l' intégration européenne, être préservé par le législateur communautaire. Il s'agit d'un aspect essential de l'Europe sociale qui n'existe nulle part ailleurs" as it is particularly stressed in his *Conclusions*; see also, Evelyne Gebhardt, MEP, Socialist Group, the so-called "Mother of the Services Directive", "Gesundheitssektor ist kein europäischer Markt!", 11.03.2009, who, on the occasion of the Opinion of the Committee on the Internal Market and Consumer Protection (for the Committee on the Environment, Public Health and Food Safety), declared that the essential priority of the Commission's endeavour is not peoples' health but an unstoppable Market: http://www.evelyne-gebhardt-fuer-europa.de/index.php?nr=20589&menu=9.