

2006

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Recommended Citation

Robert F. Rich & Kelly R. Merrick, *Cross Border Health Care in the European Union: Challenges and Opportunities*, 23 J. Contemp. Health L. & Pol'y 64 (2007).

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CROSS BORDER HEALTH CARE IN THE EUROPEAN UNION: CHALLENGES AND OPPORTUNITIES

Robert F. Rich and Kelly R. Merrick***

I. INTRODUCTION

Spending on health care and health care services within countries belonging to the Organization for Economic Co-operation and Development (OECD) has risen sharply in the past decade.¹ Average health expenditures, as a percentage of Gross Domestic Product (GDP), have risen from 7.1% in 1990 to 8.8% in 2003.² This sharp increase in health care spending is a serious concern for individuals, health care providers, policymakers, and governments across the world. Nowhere is this concern more prevalent than within the European Union, where Member States have been forced to adjust health benefits and reevaluate system financing as a result of the rising costs associated with extensive social protection systems.³ Some countries in the European Union have been actively considering ideas for health care system reform that challenge the assumptions central to

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1. Numbers indicate health spending on OECD countries, which include Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Spain, Sweden, Switzerland, Turkey, United Kingdom, and the United States. ORG. FOR ECON. CO-OPERATION AND DEV., HEALTH AT A GLANCE: OECD INDICATORS 2005 2 (Mar. 7, 2006), available at <http://www.oecd.org/dataoecd/58/47/35624825.pdf> (this is a copy of the Executive Summary, the entire report must be ordered from OECD).

2. *Id.* at 11.

3. See e.g., Markus Wörz & Reinhard Busse, *Analyzing the Impact of Health-Care System Change in the EU Member States—Germany*, 14 HEALTH ECON. S133, (2005) (discussing how Germany has been reforming its healthcare system since 1977).

the traditional social welfare system, including even American managed care models.⁴

Within the European Union, access to health care services is a widely recognized legal right anchored in EU legal traditions such as the 2000 Charter of Fundamental Rights and supported by domestic government systems.⁵ Yet these rising costs, coupled with problems of resource allocation and timely access to treatment, are causing national governments and citizens to seek health care services outside of their own geographic borders. This so-called “cross-border care” raises interesting legal and policy questions for the European Union and its Member States. Currently, health care is not an area subject to EU-wide regulation. Indeed, cross-border health care, that is the ability of nationals from one European Union Member State to access health services in another Member State, was previously a limited and strictly regulated process within each nation-state. Within the last decade, however, the growing cohesiveness of the European Union, an increased mobility of persons across Member State borders, the interest in and need for cross-border health care, and a rise in public and governmental attention, have all resulted in legal claims being brought before the European Court of Justice (ECJ) by patients who wished to access health care outside their Member State of residence.

Recent judgments from the ECJ and administrative action taken by both the European Union and its Member States have led to greater ease of cross-border access to health care services. Initially, cross-border care was typically viewed as an unnecessary burden on domestic health systems and to be used only on an emergency basis. More recently, however, the majority of policymakers and governments have come to view cross-border care as a “right” or “service” that requires cooperation through networking and resource or information sharing. It is thought that this new area of cooperation may alleviate many of the problems involving timely access and treatment now experienced internally by Member State health

4. See generally Yvonne Erdmann & Renate Wilson, *Managed Care: A View from Europe*, 22 ANN. REV. PUB. HEALTH 273 (2001) (discussing how some case studies in Europe show a consideration of the American-style care practices). “There is little doubt that US managed healthcare initiatives are followed with considerable interest in Europe.” *Id.* at 286.

5. See Charter of Fundamental Rights of the European Union, Dec. 18, 2000, 2000 O.J. (C 364) 16 (“Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.”).

systems;⁶ however, it does raise some critical legal issues, as will be shown below. Moreover, these discussions of cross-border care are closely related to on-going debates about health care reform and the need to renegotiate the social contract.

In 1998, the European Court of Justice, through the landmark decisions of *Decker v. Caisse de Maladie des Employés Privés*⁷ and *Kohll v. Union des Caisses de Maladie*,⁸ established that health care was a cross-border service subject to the oversight of European Union treaties and regulations. Moreover, these decisions established that domestic policies that placed restrictions on access to cross-border care were in violation of European Community (Community) law.⁹ In spite of these decisions, Member States still retain the power to organize their own social insurance schemes and generally determine the conditions under which health care can be accessed; however, this new case law, combined with institutional and legislative action, has more fully developed and expanded health care access, making health care not only a right of citizens within their own Member States, but also a right that moves freely with them throughout the EU. Essentially, the European Court of Justice has melded two previously distinct rights: the domestic right to health care and the right to freedom of movement within the confines of the European Economic Community. These two rights, when applied to the health care systems of Member States, create a conflict between the inherent legal right of Member States under domestic law to organize their own internal social security and social welfare systems, and the overarching legal obligations of the Member States to the European Community under EU treaty law. It is this tension that has made the area of cross-border care increasingly controversial.

The development of a more extensive system for cross-border health care raises a number of serious legal and policy-related considerations both for member states of the European Union and for the European Union as a whole. These policy and legal problems include: the autonomy of domestic social insurance systems, disparities in resource allocation and medical practices among the Member States, and successful administration of cross-border movement, not only for those

6. Remarks of Magda Rosenmöller, EUR. PARL. DEB., 3 (Mar. 3, 2005), available at http://www.iese.edu/en/files/6_15042.pdf (public hearing held by the European People's Party and the European Democrats).

7. Case C-120/95, *Decker v. Caisse de Maladie des Employés Privés*, 1998 E.C.R. I-1831.

8. Case C-158/96, *Kohll v. Union des Caisses de Maladie*, 1998 E.C.R. I-1931.

9. See *Decker*, 1998 E.C.R. at I-1843, 1845; *Kohll*, 1998 E.C.R. I-1946.

seeking medical care, but also for students and migrant workers and their families. Larger considerations involve the fundamental structure of the European Union and the proper balance of power between the sovereignty of Member States and their European Union treaty obligations.

This paper is organized into seven sections. First, we present background information on the structure of Member State health care systems. In the second section, we discuss the relevant provisions of applicable European Community law. Third, we discuss the legal framework and utilization of cross-border care prior to the *Decker* and *Kohll* decisions. In the fourth and fifth sections, we present the applicable ECJ cases, namely, the *Decker*, *Kohll*, *Smitts-Peerbooms*, and *Vaenbrakel* decisions. Sixth, we analyze the European Union administrative reactions to these ECJ rulings. The seventh and final section of this paper presents conclusions about the process by which the issue of cross-border care came before the ECJ, implications of the ECJ decisions, projections about the future of cross-border care within the European Union, and the relevance of the European health care problem to the examination of access, equity, and cost-containment in other health systems. We also analyze the implications of cross-border care for broader health care and social welfare system reform. Throughout, we examine the background, development, and expansion of cross-border health care access within the European Union. Specifically, we analyze how the melding of the external, primarily European Union legal right to freedom of movement across Member State borders with the internal, primarily domestic legal right to health care creates an entirely new legal right to cross-border health care. This new right presents complex and uniquely European legal and policy-related questions.

II. STRUCTURE OF MEMBER STATE HEALTH CARE SYSTEMS

Governments' development of respective health care systems varies globally.¹⁰ For example, in Western Europe, health expenditures as a share of Gross Domestic Product range from 11.6% in Switzerland to 6.5% in Poland.¹¹ By comparison, the United States spends 15.3%.¹²

10. See Elias Mossialos & Willy Palm, *The European Court of Justice and the Free Movement of Patients in the European Union*, 56 INT'L SOC. SECURITY REV. 3, 3 (Apr.-Jun. 2003).

11. ORG. FOR ECON. CO-OPERATION AND DEV., OECD HEALTH DATA 2006: HOW DOES THE UNITED STATES COMPARE 1 (2006), <http://www.oecd.org/dataoecd/29/52/36960035.pdf>.

12. *Id.*

The Member States of the European Union are characterized by state managed health care systems, with the recognition of health care as a “right” to be enjoyed by all.¹³ The Ljubljana Charter, introduced in 1996, explicated the fundamental principles that underlie European social welfare and health systems.¹⁴ Among these principles is the concept that “[h]ealth care reforms must be governed by principles of human dignity, equity, solidarity, and professional ethics.”¹⁵ Health care is a right, with an emphasis on “universal coverage and equitable access by all people to the necessary care.”¹⁶ To attain universal coverage, health care systems should be financed in an “efficient” and “sustainable” manner.¹⁷ Additionally, governments are required to “play a crucial role in regulating the financing of health care systems.”¹⁸ The health care systems of the European Union Member States are therefore characterized by high levels of public funding, resource allocation through rationing to control costs, and continual efforts at reform.

Traditionally, the regulation and evolution of health care within the European Union was left to the internal political and administrative mechanisms of the Member States. From such developments, these national health care systems are based primarily on two distinct systems: the Bismarckian system (compulsory social insurance) and the Beveridgian system (national health service).¹⁹

The compulsory social insurance system insures the entire population of a nation state through either a reimbursement or a benefits in kind system.²⁰ Reimbursement systems compensate the patient for outpatient services, and a third-party-payer system, in

13. Robert Rich, *Health Policy, Health Insurance and the Social Contract*, 21 COMP. LAB. L. & POL'Y J. 397, 299 (2000) (stating that health care in the United States is viewed as a privilege, not a fundamental right).

14. See WHO/Europe, *The Ljubljana Charter on Reforming Health Care, 1996*, http://www.euro.who.int/AboutWHO/Policy/20010927_5 (last visited Dec. 17, 2006).

15. *Id.* at art. 5.1.

16. *Id.* at art. 5.5.

17. *Id.*

18. *Id.*

19. WILLY PALM, JASON NICKLESS, HENRI LEWALLE, ALAIN COEHEUR, ASS'N INT'L DE LA MUTUALITÉ, *IMPLICATIONS OF RECENT JURISPRUDENCE ON THE CO-ORDINATION OF HEALTH CARE PROTECTION SYSTEMS 2* (2000), available at <http://www.ose.be/health/files/KDsyntEN.PDF> [hereinafter AIM REPORT]. The study was carried out for the European Commission.

20. *Id.*

which the insurance carrier directly reimburses the hospital or doctor, is employed for more costly procedures.²¹ Thus, reimbursement systems, by not requiring the patient to use a certain provider, allow for the greatest level of patient choice.²² Benefits in-kind-systems, on the other hand, offer direct benefits through specific providers.²³ Patient freedom of choice is therefore limited within this system, and specialist procedures are only performed on a referral basis.²⁴

Member States which have a national health service system provide universal coverage to all residents through a publicly-organized and financed system. This tax-financed system provides all medical services and funds the health care providers.²⁵ Medical services are generally free of charge, but patients must receive their care from providers within or connected to the public health system.²⁶ Key examples of Bismarckian reimbursement systems include Belgium, France, and Luxembourg.²⁷ Countries with Bismarckian benefits in kind systems are Austria and the Netherlands.²⁸ The United Kingdom and Ireland have centralized national health services.²⁹

A. Cost Containment and Health Care Rationing

Due to the emphasis on universal access, national health services must rely on rationing and prioritization of care to reduce costs. This is often accomplished through the use of “waiting lists,” in which patients are prioritized according to the urgency of their medical needs. Waiting lists have received media attention in recent years, especially in Britain where the government had to defend itself against claims of lengthy wait times and perceived insensitivity to the problem.³⁰ A 2001 United Kingdom National Health Service National Audit Office Report found that patients with life-threatening illnesses often face longer wait times so that hospitals can meet government-

21. *Id.*

22. *See id.*

23. *Id.*

24. *See id.*

25. AIM REPORT, *supra* note 19, at 3.

26. *Id.*

27. *Id.* at 2.

28. *Id.*

29. *Id.*

30. *See Ministers Savaged over Waiting Lists*, BBC NEWS, July 26, 2001, http://news.bbc.co.uk/1/hi/uk_politics/1458049.stm.

mandated targets.³¹ For example, the report cited a case of routine reverse vasectomies, where patients with bladder tumors experienced delays in care so that the procedures could be performed before an eighteen month government target.³²

In response to public criticism about long waiting lists, the United Kingdom Department of Health recently set reform goals aimed at reducing patient waiting times.³³ In 1999, approximately 131,000 people had been waiting for nine months or more for admission to a National Health Service (NHS) hospital, and 47,000 of this group had been waiting more than a year.³⁴ By March 2004, fewer than fifty patients were waiting more than nine months for NHS hospital admission.³⁵ Similar improvements were made in the wait times for first outpatient appointments: in October 2002 more than 111,000 patients had waited more than four months for a first outpatient appointments; in March 2004 eighteen patients had waited more than four months.³⁶

The Netherlands has set standards for “acceptable waiting times.”³⁷ For outpatient care, the wait time is five weeks, and for hospitalization, the wait time is seven weeks.³⁸ Patients can, however, select hospitals based on their current wait lists, and this may shorten the wait time by several weeks.³⁹ Life-threatening disorders, such as the need for open-heart surgery and percutaneous angioplasty, entail a much shorter wait time of one to three weeks.⁴⁰ The 2004 waiting list statistics reflect these goals, showing waiting times of 4.2 weeks for outpatient care, 4.9

31. *Id.* See also U. K., DEP'T OF HEALTH, HC 221, Sess. 2001-2002, INPATIENT AND OUTPATIENT WAITING IN THE NHS 1 (2001), available at http://www.nao.org.uk/publications/nao_reports/01-02/0102221es.pdf.

32. BBC NEWS, *supra* note 30.

33. HEALTHCARE COMM'N, STATE OF HEALTHCARE REPORT 34 (2004), available at http://www.healthcarecommission.org.uk/_db/_documents/04006366.pdf. The Healthcare Commission is not a British government agency, but rather an independent inspection agency set up by the government.

34. *Id.*

35. *Id.*

36. *Id.*

37. See DUTCH DEP'T OF HEALTH, WELFARE AND SPORT, NEW FOUNDATIONS FOR HEALTH CARE WITH A SOLID FUTURE: PRELIMINARY NATIONAL REPORT ON HEALTH CARE AND LONG TERM CARE 10, tbl. 3 (2005), available at http://www.npoe.nl/doc/definitief_landenrapport_OMC_gezondheidszorg.pdf.

38. *Id.* at 10.

39. *Id.*

40. *Id.*

weeks for day treatment, and 5.5 weeks for clinical hospitalization.⁴¹ Still, greater access to cross-border care may provide for shorter waiting times, as patients would be able to access care in other Member States, thereby shortening wait lists in their state of residence.⁴²

B. Member State Health Care Reform

The health care systems of the individual Member States have, as a whole, experienced multiple and distinct reform cycles.⁴³ In 1980, reforms focused on reducing costs in the face of low economic growth caused by the oil crisis of 1973-1979.⁴⁴ The most recent reforms fall into two major categories: those of Western Europe and those of the former Soviet bloc, now Eastern Europe.⁴⁵ Western Europe goes through a reform cycle every three to five years. These reforms do not impact health care organization or structure, but rather attempt to resolve problems of equity and access.⁴⁶ Conversely, Eastern Europe has faced more structural challenges, focusing on funding as well as the improvement and delivery of health services.⁴⁷

Key to current reform efforts is the stark difference in health care outcomes experienced between the wealthier, traditionally western Member States and the newly integrated Eastern European Member States. The regional disparity in five-year survival rates for breast cancer illustrates this difference, and may owe its explanation, at least partially, to the region's differing abilities to allocate resources.⁴⁸ For

41. *Id.* at tbl. 3.

42. The ECJ in *Smits-Peerbooms* specifically mentions the idea of patients experiencing undue delay as a potential justification for patients to seek cross-border care. However, studies after *Smits-Peerbooms* indicated that patients still prefer to stay in their Member State of residence to receive care, rather than seeking medical care across borders. See Werner Brouwer et al., *Should I Stay or Should I Go? Waiting Lists and Cross-Border Care in the Netherlands*, 63 HEALTH POL'Y 289, 292, 293-94 (2003).

43. See EUR. PARL. ASS., *The Reform of the Health Care Systems in Europe: Reconciling Equity, Quality and Efficiency*, DOC. NO. 9903 (Sept. 11, 2003), available at <http://assembly.coe.int/Documents/WorkingDocs/doc03/EDOC9903.htm>.

44. *Id.*

45. *Id.*

46. *Id.*

47. See *id.* (discussing what Eastern European countries needed to overcome during this reform period and the success story of Hungary).

48. See Remarks of Nick Fahy, EUR. PARL. DEB., *supra* note 6, at 23.

Swedish women, the survival rate is 81%; this rate drops to 58% in Slovakia and Poland.⁴⁹ Malignant melanoma survival rates show a similar pattern, with 89% survival rates in Sweden, 86% in the Netherlands, to 62% in Estonia and 64% in Poland.⁵⁰ This disparity is mostly due to variations in medical practice, but may also be attributed to resource allocation.⁵¹ With these variations in mind, it can be said that increased access to cross border health care may provide the opportunity to equalize such variations. Such amelioration could occur through resource and information sharing between Member State health systems.

Fortunately, harmonization and unification are ultimately the goal of ECJ jurisprudence, resulting in European-wide legislation and reform initiatives.⁵² Harmonization has occurred extensively in areas of the European Union not explicitly relevant to the European market; however, these areas have symbolic relevance, such as reform in higher education systems.⁵³ Yet, complete harmonization of Member State health systems into a uniform system of health coverage for all Europeans is unlikely, as the unification of national social protection systems is not yet one of the aims of the European unification process; instead, Member States are developing health programs with their own country's goals in mind.⁵⁴ Limited harmonization may be necessary to coordinate Member State health systems if utilization of cross-border care increases.

III. APPLICABLE EU LAW

Cross-border health care raises several legal issues within the EU. The largest issue is the interaction between the autonomy of Member

49. *Id.*

50. *Id.*

51. *See id.*

52. Harmonization is the process through which the laws and regulations of Member States are shaped to conform with the Treaty of the European Community and the laws and regulations of other Member States. *See* GEORGE A. BERMAN ET AL., *CASES AND MATERIALS ON EUROPEAN UNION LAW* 536-38 (2nd ed. 2002).

53. Programs such as the European Action Scheme for the Mobility of University Students (*Erasmus*), 1987 O.J. (L 166) 20, and the Lingua programme, 1989 O.J. (L 239) 24, previously utilized to encourage education in foreign languages, were created to promote the mobility of students across Member State borders. *See* Koen Lenaerts, *Education in European Community Law after "Masstrich,"* 31 COMMON MKT. L. REV. 7, 19-20, 28 (1994).

54. *See* Mossialos & Palm *supra* note 10, at 3.

State social security systems and the treaty-based structure of the European Union.⁵⁵ For half a century, Member States have formed a contructive community with the treaties of the EU serving as an emerging constitution.⁵⁶ The treaties that formed the European Community emphasize both the freedom of movement and the right to provide (and thus receive) services in the Member States.⁵⁷ Yet, health care and other social security systems have traditionally remained under the exclusive jurisdiction of Member State governments.⁵⁸ It is this balance between the sovereignty of Member States to organize their own social security systems, the Member States' recognition of the right to health care access, and the EU emphasis on freedom of movement and freedom to receive services that is central to the problem of cross-border care.

Initially arising out of the unification of the European coal and steel industries in the 1951 Treaty of the European Coal and Steel Community, the European Union was created by the Treaty of Maastricht, which became effective on November 1, 1993.⁵⁹ The treaty-based structure of the EU is basic to the legal and policy questions raised by cross-border care. The EU is a unique

55. The balance between Member State domestic health law and European Union treaty obligations can not be easily harmonized. See Antonio Segura Serrano, *Improvements in Cross Border Access to Health Care in European Union*, 43 HARV. INT'L. L. J. 553, 561-62 (2002).

56. See BERMANN ET AL., *supra* note 52, at 30. See also Carlos Closa Montero, *Between EU Constitution and Individuals' Self: European Citizenship*, 20 LAW & PHIL. 345, 351-53 (2001)

The reference to the EU Treaties as a constitution relies basically on the utilization of the formal concept of constitution: the Treaties have a constitutional-like legal supremacy which has been solidly constructed by the ECJ case-law through the principals of supremacy . . . the doctrine of pre-emption, and the principle of direct effect and direct applicability.

Id. at 351.

57. See Treaty Establishing the European Community, 2002 O.J. (C 325) 33, 54-55 [hereinafter EC Treaty]. See generally, D. Bruce Shine, *The European Union's Lack of Internal Borders in the Practice of Law: A Model for the United States*, 29 SYRACUSE J. INT'L. & COM. 207, 212-26 (2002) (providing both a review of the European Union right to freedom of movement, establishment, and to provide services, and how these rights have had implications upon the Member States).

58. AIM REPORT, *supra* note 19, at 2.

59. EUR. COMM'N, *The ABC of Community Law 7-8* (5th ed. 2000), available at http://europa.eu.int/eur-lex/en/about/abc_en.pdf (prepared by Dr. Klaus-Dieter Borchardt).

organization in which the twenty-five Member States have ceded many sovereign rights to the European Union.⁶⁰ The EU, through its treaty structure, is able to enact laws and regulations that have a similar effect to domestically enacted laws within the individual states; community laws also supplant national laws when the two are in conflict.⁶¹

The EU's legal framework is comprised of a series of treaties and subsequent regulations enacted by the European Commission and the EU Parliament. The 1957 Treaty of Rome⁶² established "four fundamental freedoms" which have become the basis for the freedom of movement in the European Union. The four freedoms are 1) freedom of movement; 2) freedom of people; 3) freedom of goods and services; and 4) freedom of capital.⁶³ The right to freedom of movement between the borders of Member States is stated in Article 18 of the European Community Treaty: "Every Citizen of the Union has the right to move and reside freely within the territory of the Member States, subject to the limitations and conditions set out in this Treaty and by the measures adopted to give it effect."⁶⁴ The concept of free movement and free access to goods and services forms the legal basis for the *Kohll* and *Decker* decisions, as the prior regulations that governed cross-border care were found to be a violation of these fundamental freedoms.⁶⁵

Additionally, the EC Treaty's Articles 49 and 50 apply to the free movement of goods and services within the then European Community. Article 49 states the principle of freedom of movement of goods and services within the Community. Restrictions against providing services on the basis of Member State nationality are prohibited:

Within the framework of the provisions set out below, restrictions on freedom to provide services within the Community shall be prohibited in respect of nationals of Member States who are established in a State of the Community other than that of the person for whom the services are intended.

The Council may, acting by a qualified majority on a proposal from the Commission, extend the provisions of the Chapter to

60. *Id.* at 7.

61. *See id.* at 58-59, 100-02.

62. Treaty Establishing the European Economic Community, Mar. 25, 1957, 298 U.N.T.S. 11 [hereinafter EEC Treaty].

63. *See id.* tits. I, III.

64. EC Treaty, *supra* note 57, at 45.

65. *See infra* page 4.

nationals of a third country who provide services and who are established within the Community.⁶⁶

The definition of what services fall under Article 49 is provided in Article 50:

Services shall be considered to be 'services' within the meaning of this Treaty where they are normally provided for remuneration, in so far as they are not governed by the provisions relating to freedom of movement for goods, capital and persons. 'Services' shall in particular include: (a) activities of an industrial character; (b) activities of a commercial character; (c) activities of craftsmen; (d) activities of the professions.⁶⁷

This Article therefore defines services as all commercial, profession, industrial, and craftsman activities, and requires that these services be provided in a Member State under the same standards and regulations that would be available to a national of that Member State providing the same service. In 1984, the European Court of Justice case *Luisi and Carbone v. Ministero del Tesoro* established that health care was a "service" under EC law.⁶⁸

Cross-border health care prior to *Decker* and *Kohll* was regulated by Article 42 of the EC Treaty. Article 42 relates to the free movement of workers across Member State borders, and is the basis for European Union Regulations 1408/71 and 574/42.⁶⁹ Article 42 specifically guarantees social security rights by including periods of insurance, residence, or employment in another Member State.⁷⁰ Together, Article 42 and EU Regulations 1408/71 and 574/42 allow for the export of some social security benefits, forbid discrimination based on nationality or Member State of residence, and determine what Member State legislation should be applied to social security rights.⁷¹

The type of coordination between Member State social security systems described in Article 42 regulates pensions and health care services of migrant workers and their dependents.⁷² The mobility of

66. EC Treaty, *supra* note 57, at 54.

67. *Id.* at 55.

68. Case C-286/82 and C-26/83, *Luisi and Carbone v. Ministero del Tesoro*, 1984 E.C.R. 377, 403.

69. *See infra* pp. 4-5.

70. EC Treaty, *supra* note 57, at 52.

71. *See id.*; Council Regulation 1408/71, art. 22 (EC), available at <http://eur-lex.europa.eu/LexUriServ/site/en/consleg/1971/R/01971R1408-20050505-en.pdf>; AIM REPORT, *supra* note 19, at 4.

72. *Id.*

workers within the EU and the removal of barriers to their free movement were essential to the development of a strong economic system. Workers who went cross-border for their employment are covered by two health care systems: that of their resident Member State and their Member State of employment. This coverage is no longer valid once employment ceases.⁷³

Article 22 of Regulation 1408/71, which originates from Article 42 of the EC Treaty, describes two circumstances for a European Union resident to receive care outside his/her Member State: temporary stay or planned care.⁷⁴ A person temporarily staying in a Member State who requires immediate medical attention can do so, on location, at the expense of the state.⁷⁵ These health services are provided under the laws and regulations of the state in which the patient is located.⁷⁶ Reimbursement is based on the established tariffs of the state where treatment was provided.⁷⁷ An E111 form must be completed prior to care and charges must be initially paid by the patient with the ability to be reimbursed upon return to the home Member State.⁷⁸ This delayed reimbursement would allow the home state to reimburse according to the price for medical services within that home state.⁷⁹

Take, for example, the case of Mr. Y, a resident of Germany who is vacationing in Italy. During his holiday, Mr. Y is injured in a car accident. Mr. Y is entitled to immediate medical attention in Italy, and the medical care will be given to him under the laws and regulations of Italy. If Mr. Y fills out an E111 form (because his stay is a temporary one), his insurer will directly reimburse the Italian medical providers. Alternatively, if Mr. Y fails to fill out this form, he must initially pay the medical costs in Italy at Italian rates. He can later apply for reimbursement when he returns to Germany, where he would be reimbursed at the German rates.

Planned care is another option for patients wishing to utilize cross-border health services. In this case, prior authorization from one's health insurance institution, via the E112 form, must be obtained and presented to the institution from which health care will be received.⁸⁰ Member States generally have wide discretion in determining if prior

73. *Id.*

74. *Id.* at 4-5.

75. *Id.*

76. *See* Mossialos & Palm, *supra* note 10, at 11.

77. *See id.* *See also* AIM REPORT, *supra* note 19, at 5.

78. *See* AIM REPORT, *supra* note 19, at 4-5.

79. *See id.*

80. *See id.* at 5.

authorization should be granted, however, there are specific situations under the regulations in which prior authorizations cannot be refused, specifically:

[t]he treatment required by the interested party is part of the health care package covered by the social protection system in the area of health care; and [] this treatment cannot be given to him in his State of residence within the period that is normally necessary, in view of his current state of health and the probable course of his disease.⁸¹

For example, if Ms. X, a resident of Spain, would like to obtain health care in France for ovarian cancer, she may do so if her treatment is covered by her insurer in Spain, and she would not be able to have this care in Spain in a period that is “normally necessary.” Under this definition, insurers would have wide discretion to reject or accept claims for cross-border care because “normally necessary” is left to broad interpretation.

IV. CROSS BORDER CARE PRIOR TO *DECKER* AND *KOHL*

Prior to *Decker* and *Kohll*, studies published by the European Commission indicate that the financial impact of cross-border care within the European Union was negligible.⁸² In fact, in 1999 cross-border health care was only between 0.3% and 0.5% of total expenditures on health care, averaging less than €2.00 per inhabitant of the European Union.⁸³ In the smaller Member State of Luxembourg, the financial situation was atypical, with cross-border utilization of health care accounting for 9% of health care spending.⁸⁴ This averages to a more substantial €116 per inhabitant. This higher cost was most likely due to the limited medical infrastructure in this small Member State, which leads to a greater use of authorized health care in other states. The highest proportion of cross-border claims was France, with 40% of all claims.⁸⁵ The tourism industry is largely responsible for these claims, as tourists use the French health care system during their time abroad.⁸⁶

81. *Id.*

82. *Id.* at 6.

83. *Id.*, citing J. Hermesse, *The Opening of Frontiers to Patients*, Symposium, Association Internationale de la Mutualité, Luxembourg, (November 18, 1998) 49-58.

84. AIM REPORT, *supra* note 19, at 6.

85. *Id.*

86. *Id.*

Planned health care in another Member State using prior authorization from the home country was also limited. As mentioned earlier, E112 forms are used for such a request. In 1999, the numbers of planned health care abroad cases that were authorized via E112 forms were 850 in Austria, 40 to 50 in Denmark, 20 in Sweden, there were 789 authorizations and 451 refusals in France from the period of 1996 to 1999.⁸⁷ Requests for prior authorization were generally refused if the procedure was already available in the patient's state of residence.⁸⁸

Two possible explanations for such a limited use of cross border care exist. Either the limited use of cross-border care was due to restrictive policies, or, in general, there is a low demand for treatment outside one's own Member State.⁸⁹ With these explanations in mind, it is important to note that the utilization of cross border care seems to be limited to border areas, highly specialized services, medical procedures for which a patient faces waiting lists in their own member state, and medical products "for which comparisons between price and quality are possible or which can be purchased remotely."⁹⁰

Increased accessibility to cross-border care and additional information about what medical care is available in other countries may encourage patients to use more cross-border care than previously. This may be especially relevant in health care systems that rely on waiting lists to manage health services, such as in the Netherlands and Great Britain.⁹¹ Another increasingly relevant issue is the growth of specialization, in which a specialized center, doctor, or clinic actively seeks patients both outside and within their national borders.⁹²

V. CROSS-BORDER HEALTH CARE AS A RIGHT: *DECKER v. CAISSE DE MALADIE DES EMPLOYES PRIVES* AND *KOHL V. UNION DES CAISSES DE MALADIE*

In the landmark cases of *Decker v. Caisse de Maladies des Employes Prives* and *Kohll v. Union de Caisses de Maladie*, the European Court of Justice held that prior authorization for care abroad was not a necessary prerequisite for reimbursement in one's own Member

87. *Id.*

88. *Id.*

89. *See id.* at 7.

90. AIM REPORT, *supra* note 19, at 7.

91. *See* Brouwer et. al., *supra* note 42, at 292.

92. *See* AIM REPORT, *supra* note 19, at 21.

State.⁹³ Moreover, as will be shown, the process of seeking prior authorization conflicted with the freedoms essential to the European Community/Union. In *Kohll*, a Luxembourg citizen wished to obtain reimbursement for orthodontic treatment provided in Germany without prior authorization;⁹⁴ in *Decker* a Luxembourg citizen was awarded the right to obtain reimbursement for prescription glasses provided in Belgium without prior authorization.⁹⁵ The two cases of *Decker* and *Kohll* were pivotal in that they marked a turning point in European law. After these landmark cases, cross-border health care was recognized not as a privilege of those who could afford to pay, but as a universal right for all citizens of the European Union.

The European Court of Justice looked to three main sources of law to reach its decision in *Decker* and *Kohll*: Articles 49 and 50 of the EC Treaty;⁹⁶ existing jurisprudence that established health care as services under these articles;⁹⁷ and Article 42, which relates to the free movement of workers across Member State borders and is the basis for European Union Regulation 1408/71.⁹⁸

The question under consideration by the ECJ in *Decker* and *Kohll* was essentially if EC Treaty Articles 49 and 50 are the dominant laws under which Member State domestic prior authorization laws should be analyzed:

[a]re Articles 59 and 60^[99] of the Treaty establishing the EEC to be interpreted as precluding rules under which reimbursement of the cost of benefits is subject to authorization by the insured person's social security institution if the benefits are provided in a Member State other than the State in which that person resides?¹⁰⁰

The Court was therefore deciding if the pre-authorization requirements of Member State health care systems for care abroad

93. See *Decker*, 1998 E.C.R. at I-1831; *Kohll*, 1998 E.C.R. at I-1931.

94. *Kohll*, 1998 E.C.R. at I-1838.

95. *Decker*, 1998 E.C.R. at I-1834.

96. See *id.* at I-1839. See also *supra* nn. 66-67 and accompanying text.

97. See e.g., *id.* at I-1841 (citing *Luisi and Carbon*, 1984 E.C.R. 377).

98. See *id.* at I-1839. See also *supra* nn. 72-74 and accompanying text.

99. The revision and subsequent renumbering of the Treaty Establishing the European Community in 2002 resulted in the fact that the Court in *Decker* and *Kohll* refers to Articles 49 and 50 by their previous numbering, which was Articles 59 and 60, respectively. The content of the articles did not change. Such a treatment by the Court is found in all of the decisions herein.

100. *Decker*, 1998 E.C.R. at I-1839.

were subject to the freedom of movement provisions of Articles 49 and 50.

In its decision in both *Decker* and *Kohll*, the European Court of Justice stressed that Member States have the power to regulate and organize their own social security systems.¹⁰¹ Yet, the Court continued, the freedom to organize one's own social security system cannot "give rise to discrimination between nationals of the host state and nationals of the other Member States."¹⁰² These social security provisions are not exempt from the oversight of European Law, and therefore are subject to the basic EC Treaty principles of free movement.¹⁰³ The Court concluded that although Member States have the authority to organize their respective social insurance systems, these systems impact free movement within the community, and are thus subject to the freedom of movement principles of the EC.¹⁰⁴

In fact, the requirement of prior authorization, by discouraging patients from seeking care outside of their Member State, constitutes a barrier to the free movements of patients.¹⁰⁵ Such a barrier cannot be legitimately justified on the basis of either public health or the financial stability of the Member States' internal social welfare system.¹⁰⁶ In terms of reimbursement, the Court specifically held in *Kohll* that Article 22 of Regulation 1408/71, which requires prior authorization for coverage of care provided in another Member State and provides for reimbursement according to the tariffs in the state where care was provided, does not prevent reimbursement at the tariff of the home state in the absence of prior authorization.¹⁰⁷

The Court in *Decker* and *Kohll*, therefore, found that there were no sufficient reasons to justify the restrictions placed upon cross-border health care in the prior authorization system.

[While] Community law does not detract from the power of the Member States to organize their social security systems . . . [they] must nevertheless comply with Community law when exercising those powers . . . [T]he fact that national rules . . . fall within the sphere of social security cannot exclude the

101. *Decker*, 1998 E.C.R. at I-1843, 1845; *Kohll*, 1998 E.C.R. at I-1942-43. See also Mossialos & Palm, *supra* note 10, at 8.

102. *Decker*, 1998 E.C.R. at I-1843 (internal quotations omitted).

103. *Decker*, 1998 E.C.R. at I-1843; *Kohll*, 1998 E.C.R. at I-1943.

104. *Decker*, 1998 E.C.R. at I-1843; *Kohll*, 1998 E.C.R. at I-1943.

105. *Decker*, 1998 E.C.R. at I-1857; *Kohll*, 1998 E.C.R. at I-1946.

106. See *Decker*, 1998 E.C.R. at I-1855-56; *Kohll*, 1998 E.C.R. at I-1947-48, 1949, 1950.

107. See *Kohll*, 1998 E.C.R. at I-1943-44.

application of Articles 59 and 60 of the Treaty . . . [T]he fact that a national measure may be consistent with a provision of secondary legislation, in this case Article 22 of Regulation No 1408/71, does not have the effect of removing that measure from the scope of the provisions of the Treaty.¹⁰⁸

Finally, the Court recognized that its ruling would have ramifications concerning Member State policy. The Court therefore encouraged the EU to harmonize its efforts on cross-border health care:

Action by the Community legislature aimed at harmonizing the area in question so as to allow genuine and effective freedom of movement for patients, which would be a significant factor in the creation of a single integrated market, would be welcome . . . [T]he Community legislature should at least act, and do so promptly, to broaden the range of circumstances in which authorisation may not be refused. There is no doubt that it would be advantageous in many respects for authorisation to be granted in all cases in which the insured person could receive more effective treatment in another Member State¹⁰⁹

VI. CHANGES IN EUROPEAN JURISPRUDENCE AFTER *DECKER* AND *KOHL*: THE *GERAETS-SMITS/PEERBOOMS*, *ABDON VANBRAEKEL A.O.*, AND *WATTS* DECISIONS

Decker and *Kohll* left several major questions unresolved that were addressed by later ECJ jurisprudence. The two key issues were: (a) do the rulings in *Decker* and *Kohll* apply to both benefits-in-kind and reimbursement health care systems within the European Union and (b) do the rulings apply to both outpatient services (that do not require pre-authorization) and hospitalization services (that do require pre-authorization). Moreover, it was unclear if health services should be reimbursed at the tariff of the home Member State or the state in which the health care service was provided.¹¹⁰ In 2001, the ECJ combined the next two cases, *Geraets-Smits v. Stichting Ziekenfonds* and *Peerbooms v. Stichting CZ Groep Zorgverzekeringen*.¹¹¹ The ECJ holdings in these cases resolved the questions left from *Decker* and *Kohll*.

In the case of *Geraets-Smits*, Smits received treatment for Parkinson's disease from a specialized clinic in Germany. Prior authorization was

108. *Kohll*, 1998 E.C.R. at I-1943-44.

109. *Decker*, 1998 E.C.R. at I-1869.

110. See AIM REPORT, *supra* note 19, at 17.

111. Case C-157/99, B.S.M. Geraets-Smits v. Stichting Ziekenfonds VGZ, 2001-7 E.C.R. I-5473.

not obtained; Smits paid the clinic directly and subsequently applied for reimbursement through the Netherlands sickness fund.¹¹² Mr. Peerbooms received neurological treatment in Austria; this treatment was also available in the Netherlands on a restrictive, experimental basis.¹¹³ In this case, prior authorization was also not obtained; Peerbooms paid directly and later applied for reimbursements through the Netherlands sickness fund.¹¹⁴ The sickness funds rejected both claims, and lower courts supported this decision because such services were available in the Netherlands, and neither patient had followed the pre-authorization requirement.¹¹⁵

The question before the ECJ was twofold: did *Decker* and *Kohll* apply to benefits-in-kind systems (like that involved here with the Netherlands) and not just reimbursement systems; and did *Decker* and *Kohll* apply to both outpatient and hospitalization services?¹¹⁶ *Geraets-Smits* held that the requirement to obtain prior authorization, as required by the Dutch health system, was a barrier on the freedom to provide services under Articles 49 and 50.¹¹⁷ Thusly, the principles of *Decker* and *Kohll* are applicable to both reimbursement and benefits-in-kind health systems and both hospital and outpatient services.¹¹⁸

The Court first restated the fundamental principle that all Member States may organize their internal social security systems as they see fit. The Court held that Community law does not detract from the powers of the Member States to organize their social security systems, and that, in the absence of harmonization at Community level, it is “for the legislation of each Member State to determine, first, the conditions governing the right or duty to be insured with a social security scheme and, second, the conditions for entitlement to benefits.”¹¹⁹ Yet, this allowance is coupled with the EU principle of freedom to provide services, which can only be restricted for three reasons:

(1) . . . by overriding reasons relating to the general interest and are applied to all persons of undertakings pursuing those activities in the territory of the State in question, in so far as that interest is not safeguarded by the provisions to which the Community national is subject in the Member State where he is

112. *See id.* at I-5479.

113. *See id.* at I-5480.

114. *Id.*

115. *See id.* at I-5479, 5480.

116. *See Geraets-Smits*, 2001-7 E.C.R. at I-5486.

117. *See id.* at I-5530-33.

118. *See id.* at I-5529-30.

119. *Id.* at I-5526 (citations omitted).

established; (2) are necessary to ensure that the objective they pursue is attained; and (3) do not go beyond what is necessary to attain that objective.¹²⁰

Here, the Court is highlighting the fundamental conflict between Member State autonomy in the realm of domestic social services, and the European Union right of freedom to provide services, which can only be restricted in limited cases.

The Court did agree, however, that some restrictions on hospital access may be necessary, as the infrastructure, geographical location and planning were local public health issues best handled by individual Member States:

[B]oth the objective of providing a balanced medical and hospital service open to everyone and the objective of maintaining essential treatment facilities and medical services on national territory, apart from being intrinsically linked to the method of financing the system, can be brought within the ambit of the public health grounds which . . . are capable of justifying a restriction on freedom to provide services, as the court held in . . . *Kohll*.¹²¹

The court went further, stating that an influx of cross-border patients would jeopardize the fundamental infrastructure of Member State hospitals:

[I]f insured persons were at liberty, regardless of the circumstances, to use the services of hospitals with which their sickness insurance fund had no contractual arrangements, whether they were situated in the Netherlands or in another Member State, all the planning which goes into the contractual system in an effort to guarantee a rationalized, stable, balanced and accessible supply of hospital services would be jeopardized at a stroke.¹²²

Therefore, the court recognized the legitimacy of restrictions on cross-border care when such restrictions protect the organization of hospital systems. The extent of these restrictions and how they may be balanced with the freedom of movement and the freedom to provide services seems yet to be fully clarified.

Another significant case is *Vanbraekel v. ANMC*.¹²³ In *Vanbraekel*, a Belgian patient, Jeanne Descamps, applied to her sickness fund for

120. *Id.* at I-5501-02.

121. *Id.* at I-5505.

122. *Id.* at I-5535.

123. Case C-368/98, *Abdon Vanbraekel and Others v. Alliance Nationale des Mutualités Chrétiennes*, 2001-7 E.C.R. I-5363.

orthopedic surgery in France.¹²⁴ Upon seeking reimbursement, the sickness fund denied her prior authorization request and she went ahead with treatment in France without approval from the government.¹²⁵ A lower court dismissed her action, as a Belgian professor found that Ms. Descamps' requested procedure could be performed no better in France than in her home state.¹²⁶ An appellate court reversed this decision using its own expert who determined that Ms. Descamps required treatment abroad; she was therefore entitled to reimbursement for her treatment in France.¹²⁷

The issue before the ECJ in this case is how should Ms. Descamps' heirs be reimbursed for her medical costs under Regulation 1408/71.¹²⁸ The court held that Community Regulation 1408/71 and Article 22 guarantee the duly authorized insured person reimbursement of her treatment costs in accordance with the legislation of the State in which the treatment was received.¹²⁹ The court also held, on the basis of the principle of freedom to provide services, that the insured person is entitled to additional reimbursement from their home Member State if their home state has a higher level of reimbursement:

Article 59 of the EC Treaty is to be interpreted as meaning that, if the reimbursement of costs incurred on hospital services provided in a Member State of stay, calculated under the rules in force in that State, is less than the amount which application of the legislation in force in the Member State of registration would afford to a person receiving hospital treatment in that State, additional reimbursement covering that difference must be granted to the insured person by the competent institution.¹³⁰

In cases like this one, Ms. Descamps would be entitled to additional reimbursement from her home Member State (Belgium) if her home Member State had a higher level of reimbursement than the Member State where her medical procedure was performed (France). Hypothetically, if Ms. Z, a resident of the United Kingdom, travels to Spain for medically necessary surgery, she would be entitled to reimbursement at the UK rates of reimbursement, even if the cost of her surgery in Spain was lower than the UK rates of reimbursement. *Vanbraekel* therefore expands upon the rights given to patients in

124. *Id.* at I-5391.

125. *Id.*

126. *Id.* at I-5391-92.

127. *Id.* at I-5392.

128. *See id.* at I-5393.

129. *Vanbraekel*, 2001-7 E.C.R. at I-5397.

130. *Id.* at I-5403.

Decker and Kohll, granting a higher level of reimbursement to patients if their home Member State has a higher level of reimbursement than the level of reimbursement available in the Member State where they receive medical treatment.

The most recent jurisprudence relevant to patient mobility is *Watts v. Bedford Primary Care Trust*, decided by the ECJ in the spring of 2006.¹³¹ In the *Watts* case, Mrs. Watts, a British citizen, applied for E112 preauthorization for treatment abroad from her local health provider, Bedford Primary Care Trust.¹³² Mrs. Watts wished to travel to France for hip replacement surgery to avoid a waiting period in her Member State of residence, Great Britain.¹³³ She was examined by a government consultant, and her E112 request was denied.¹³⁴ The reason for the denial was that Mrs. Watts would be able to have her hip surgery in Britain within one year's time, which was not considered an undue delay under the target waiting times for Britain's National Health Service.¹³⁵ Yet, as Mrs. Watts' health deteriorated further, she was reexamined by the government and moved up to a three to four month waiting period for her surgery.¹³⁶ Repeated requests for E112 authorization were denied, so Mrs. Watts traveled to France for the surgery, and then sought reimbursement.¹³⁷ A question referred to the ECJ from the appeals court was if Mrs. Watts' case falls under Regulation 1408/71 and Article 49 of the EC, thus imposing an obligation on the British health system to reimburse her.¹³⁸

The ECJ concluded that Mrs. Watts' case did fall under the freedom to provide services, and that an institution may not deny an E112 request for treatment abroad merely because the patient would receive treatment in their Member State of residence within government-mandated waiting list target periods.¹³⁹ Such determinations must be

131. Case C-372/04 *The Queen, on the application of Yvonne Watts v. Bedford Primary Care Trust and Secretary of State for Health*, (European Court of Justice May 16, 2006), <http://curia.europa.eu/jurisp/cgi-bin/form.pl?lang=EN&Submit=rechercher&numaff=C-372/04>, (opinion on the second link).

132. *Id.* at para. 24.

133. *See id.* at paras. 28, 31. *See also NHS Told to Fund Treatment Abroad*, BBC NEWS, May 16, 2006, <http://news.bbc.co.uk/2/hi/health/4985190.stm>.

134. *Watts*, *supra* note 131, at para. 25.

135. *Id.*

136. *See id.* at paras. 29-30.

137. *Id.* at paras. 30-31.

138. *Id.* at para. 42.

139. *Id.* at para. 2 (Court ruling).

made, to some extent, on an individual basis, and based upon an individual's specific medical needs:

A refusal to grant prior authorisation cannot be based merely on the existence of waiting lists intended to enable the supply of hospital care to be planned and managed on the basis of predetermined general clinical priorities, without carrying out an objective medical assessment of the patient's medical condition, the history and probable course of his illness, the degree of pain he is in and/or the nature of his disability at the time when the request for authorisation was made or renewed.¹⁴⁰

Regarding reimbursement, the Court determined that a patient is entitled to receive full reimbursements for the cost of the medical procedure received in another Member State even if the procedure was available free of cost in their home Member State. Specifically, if the cost of the medical procedure is higher in the Member State where care is received, the patient is entitled to reimbursement of the difference between the costs; the Court continued:

[W]here the legislation of the competent Member State provides that hospital treatment provided under the national health service is to be free of charge . . . the competent institution must reimburse that patient the difference (if any) between the cost, objectively quantified, of equivalent treatment in a hospital covered by the service in question up to the total amount invoiced for the treatment providing the host Member State and the amount which the institution of the latter Member State is required to reimburse under Article 22(1)(c)(i) of Regulation No 1408/71 . . . on behalf of the competent institution pursuant to the legislation of that Member State.¹⁴¹

The Court summarized its holdings as follows:

The obligation of the competent institution under both Article 22 of Regulation No 1408/71 . . . and Article 49 EC to authorize a patient registered with a national health service to obtain, at that institution's expense, hospital treatment in another Member State where the waiting time exceeds an acceptable period having regard to an objective medical assessment of the condition and clinical requirements of the patient concerned does not contravene Article 152(5) EC.¹⁴²

140. *Watts*, *supra* note 131, at para. 2 (Court ruling).

141. *Id.* at para. 3 (Court ruling).

142. *Id.* at para. 4 (Court ruling). The EC Treaty, Article 152(5) reads: "Community action in the field of public health shall fully respect the

The *Watts* case, much like *Geraets-Smits* and *Vanbraekel*, addressed a specific concern about the practical application of the rights granted in *Decker* and *Kohll*. *Watts* can also be seen as a legal consequence of the *Decker* and *Kohll* decisions, and an indication that the European Court of Justice will continue to reinforce and expand the legal rights guaranteed under *Decker* and *Kohll*. The right of citizens of the European Union to access health care services in another Member State, and be appropriately reimbursed for those services, is no longer a theoretical right, but rather a concrete right, reinforced by an ever-increasing ECJ jurisprudence on the issue. Also reinforcing this right to cross-border care is the development of Member State and European Union law and policy on the issue.

VII. EUROPEAN UNION RESPONSE: COMMUNICATION AND COORDINATION BETWEEN MEMBER STATE HEALTH CARE SYSTEMS AFTER *GERAETS-SMITS* AND *VANBRAEKEL*.

The impact of the *Geraets-Smits* and *Vanbraekel* decisions is quite broad. Now, all Member State health systems are obligated to operate under the rules set out in *Decker* and *Kohll*. Combined with *Decker* and *Kohll*, *Geraets-Smits* and *Vanbraekel* strengthened the concept of health care as a fundamental right, not only within the EU, but also within the Member States themselves. Rather than seeing this as a challenge to their autonomy, as Member States had reacted to the *Decker* and *Kohll* decisions, more Member States now see health care services as a broader issue with more opportunity for cooperation.¹⁴³ Some of this optimism may be linked to the successful growth of the European Union, and how Member States now look to European wide solutions as an opportunity for collective problem solving. This sentiment will most likely strengthen as the European Union continues to become more cohesive and harmonized.

Perhaps the best statement of this transition or change of position by the Member States was made by Robert Madelin, Director General of

responsibilities of the Member States for the organisation and delivery of health services and medical care.” EC Treaty, *supra* note 57, at 101.

143. See AIM Report, *supra* note 19, at 11.

Some people, however, refer to the dynamism and the positive effects that could result from the jurisprudence as hitherto excessively strict national barriers are lifted. By seeking to promote the public interest in the area of health, cross-border co-operation, along with complementarity in the supply of health care, could improve the efficiency of health care systems and broaden the scope of treatment covered.

Id. at 11.

Health and Consumer Protection for the European Commission, during hearings before the European Commission on cross-border patient mobility:

[T]he intuition that patient mobility was a key issue because of . . . the threat of the legal environment has turned, I think, into a perception that this is a thread around which you can weave very much *positive* outcomes. I think that the balance between fear and hope has changed in the last years and that we can now see a willingness to work on this issue as one where we're not trying to defend past practices against the evolution of EU law; we're trying to drive forward an issue that can . . . produce better outcomes for the citizens . . .¹⁴⁴

From Madelin's perspective, cross border health care, through resource and information sharing can be an opportunity to improve health care outcomes for all citizens of the European Union.

The ECJ decisions galvanized the European Community to create a variety of programs, hold legislative hearings, and engage public interest groups in the data gathering process.¹⁴⁵ With the exception of the reform of Regulation 1408/71 and the enactment of the European Health Card to replace the E111 form, the Member State policy and programmatic "reactions" are still in the developing stages. Member States are pooling data and developing information gathering techniques to track how and why their citizens choose to use cross-border care.¹⁴⁶ Ultimately, this information should help to provide care in the most equitable and cost-effective manner consistent with the recent court decisions. As will be discussed, many controversial issues, such as the mobility of health care professionals, and the inequity that exists between poorer and richer Member States still need resolution through the political process of the European Union. The major actions taken by the EU include the High Level Process of Reflection on Patient Mobility and Healthcare, developments of new European Union programs, reform of Regulation 1408/71, the release of the European Union Health Insurance card, the development of the European Charter of Patient's Rights and closer examination and analysis of current cross border coordination.¹⁴⁷

144. Remarks of Robert Madelin, EUR. PARL. DEB., *supra* note 6, at 7.

145. *See infra* Parts VII.A-G.

146. *See infra* Part VII.G.

147. *See infra* Parts VII.A-G

A. High Level Process of Reflection on Patient Mobility and Healthcare Developments in the European Union

In 2004, following the Court decisions, ministers of health from Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, the Netherlands, Portugal, Spain, Sweden, and the United Kingdom took part in a high level reflection process in Brussels.¹⁴⁸ The reflection process was designed to examine the current state of cross-border health care and the directions for future reforms that might be required in Europe after the EJC decisions.¹⁴⁹ The Ministers saw the ECJ decisions as an opportunity to improve health care for all Europeans. Within this context, the “reflection process” focused on five key themes: “[1] European cooperation to enable better use of resources; [2] information requirements for patients, professionals and policy-makers; [3] access to and quality of health care; [4] reconciling national health policy with European obligations and [5] health related issues and EU funding.”¹⁵⁰

In the end, this reflection process generated a formal report which contained concrete recommendations to the European Commission on patient mobility and access to cross-border care.¹⁵¹ The report details the legal consequences of the series of ECJ decisions, and how they impact access to cross-border care and reimbursement schemes. According to the report, non-hospital care that an individual would receive in their Member State can be accessed in any Member State without prior authorization and reimbursement provided at the level of the patient’s home Member State.¹⁵² Previously authorized hospitalized care may be accessed in any Member State with reimbursement levels of the patient’s home Member State.¹⁵³ If a patient plans on accessing cross-border health services, health officials

148. EUR. COMM’N, Health & Consumer Protection Directorate-General, *High Level Process of Reflection on Patient Mobility and Healthcare Developments in the European Union*, 3, DOC. HLPR/2003/16 (Sept. 12, 2003), available at http://europa.eu.int/comm/health/ph_overview/Documents/key01_mobility_en.pdf.

149. *See id.* at 2-3.

150. *Id.* at 4.

151. *See* COMM’N OF THE EUR. COMTY., *Follow-up to the High Level Reflection Process on Patient Mobility and Healthcare Developments in the European Union*, 3, COM(2004) 301 final (Apr. 20, 2004), available at http://europa.eu/eur-lex/en/com/cnc/2004/com2004_0301en01.pdf [hereinafter COMM’N OF THE EUROPEAN COMTY., *Follow-up*].

152. *Id.* at 2.

153. *Id.* at 2-3.

in the patient's home Member State will provide information on relevant reimbursement levels and authorization requirements.¹⁵⁴

A key issue raised by the high level group was how to address the inequities in health systems between Member States.¹⁵⁵ Many of the new EU Member States have populations that experience lower overall health quality, in addition to having limited access to health care resources.¹⁵⁶ Compounding this problem is the fact that many of these Member States under-invest in their health care infrastructure as compared with other countries in the EU.¹⁵⁷ Generally, these acceding countries invest only 4.5% of their GDP on health care compared to 8.5% of the current EU.¹⁵⁸ This dilemma is quite important because the removal of these inequities may lead to a higher demand for cross-border care.

Overall, the European Commission has expressed interest in developing a shared European view of health systems, and continued investment in health and health infrastructure.¹⁵⁹ In addition, in April of 2004, the Commission established the High Level Group on Health Services and Medical Care.¹⁶⁰ The Group was established in response

154. *Id.* at 3.

155. *See id.* at 16-18.

156. *See id.* at 17.

157. COMM'N OF THE EUROPEAN COMTY., *Follow-up, supra* note 151, at 17.

158. *Id.*

159. *See* European Union, Health-EU The Public Health Portal of the European Union, *Policies, available at* http://ec.europa.eu/health-eu/health_in_the_eu/policies/index_en.htm (last visited Dec. 16, 2006).

The EU health strategy focuses mainly on strengthening cooperation and coordination, supporting the exchange of evidence-based information and knowledge, and assisting with national decision-making. To this end, the EU is developing a comprehensive health information system to provide EU-wide access to reliable and up-to-date information on key health-related topics, and hence a basis for a common analysis of the factors affecting public health.

Id.

160. *See* European Comm'n, High Level Group on Care, *available at* http://ec.europa.eu/health/ph_overview/co_operation/mobility/high_level_hsmc_en.htm (last visited Dec. 16, 2006).

The 2003 report of the patient mobility reflection process represented a political milestone by recognizing the potential value of European cooperation in helping Member States to achieve their health objectives. The Commission set out its response to the report of the reflection process in Communication COM (2004) 301 of 20 April 2004. The primary mechanism for taking forward the work set out in the

to a need to have a mechanism to coordinate health services and medical care.¹⁶¹ The role of the Group is to support European “cooperation between the Member States on health services and medical care, in order to help patients to have the high-quality health care they seek and to help health systems to improve their effectiveness and efficiency.”¹⁶² The Group is comprised of senior representatives from each Member State, additional stakeholders, including regional and local authorities, and health care experts.¹⁶³ The stated goals of the Group include:

to promote cooperation between the Member States and take forward the recommendations of the reflection process through activities such as developing a better understanding of the rights and duties of patients, sharing spare capacity between systems and cooperating on cross border care, identifying and networking European centres of reference, and coordinating assessment of new health technologies.¹⁶⁴

The high level reflection process, its report, and the subsequent recommendations and programs of the European Commission can best be summarized in statements by three officials involved in this decision making process.¹⁶⁵ David Byrne, the European Commissioner for Health and Consumer Protection stated:

EU law gives patients the right to go for treatment in other Member States. But exercising that right can prove difficult. A central aim of our proposal is to explain patients’ rights more clearly and ensure that they have the information they need to

Communication was to establish a High Level Group on health services and medical care. This High Level Group started work in July 2004. It brings together experts from all the Member States and it works in seven main areas

Id.

161. See COMM’N OF THE EUROPEAN COMTY., *Follow-up, supra* note 151, at 15-16.

162. *Id.* at 16.

163. *Id.*

164. *Id.*

165. See Press Release, Eur. Comm’n, Healthcare cooperation, Patients to benefit from new Comm’n proposals (Apr. 21, 2004), available at <http://europa.eu.int/rapid/pressReleasesAction.do?reference=IP/04/508&format=HTML&aged=0&language=EN&guiLanguage=en> (click on “EN” under the “PDF row).

make use of those rights. My final goal is to achieve a European Charter of patients' rights to which everyone can refer.¹⁶⁶

Byrne characterizes cross-border care as an opportunity to relieve strain on Member State domestic health systems, as those on waiting lists can use underutilized health resources in another Member States.¹⁶⁷

Stavros Dimas, European Commissioner for Employment and Social Affairs, states that the goal of increased European coordination on health care systems is to ultimately benefit the domestic health systems of Member States:

Health systems play a vital role in combating the risk of disease and poverty and ensuring social cohesion and employment. Bold reforms of funding and provision are vital to cope with demographic pressures, technological change and rising costs and to ensure continued quality, access and financial sustainability. Our aim is to support Member States in ensuring quality care provision for all Europe's citizens.¹⁶⁸

Dimas thus states the position that the role of the European Union is to provide support for domestic Member State health systems, emphasizing the balance that must be struck between the sovereignty of Member State health care systems and the requirements of EU law. This concept, as has been shown, was highlighted by the ECJ.

B. Development of New European Union Programs

In 2002 the European Union established the Community Action Program for Public Health for 2003-2008. Cross-border collaboration is a key component of the new program, which is centered on three key objectives: "health information, rapid reaction to health threats and health promotion through addressing health determinants."¹⁶⁹ Through information sharing and coordination between Member States, the program aims to improve public health infrastructure and outcomes.¹⁷⁰ Public health has long been a concern of the European Union generally,¹⁷¹ but the increased ability of patients to access care

166. *Id.* at 1.

167. *See id.*

168. *Id.*

169. EUROPA - Public Health - Programme 2003-2008, http://ec.europa.eu/health/ph_programme/programme_en.htm (last visited Jan. 5, 2007).

170. *See id.*

171. *See* EC Treaty, *supra* note 57, at 100-01. The European Union is able to oversee public health issues under Article 152. The Programme of Community

across borders will likely lead to a greater need for information sharing and cooperation. The emphasis placed on close cooperation by the Community Action Programme for Public Health for 2003-2008 may well be influenced by this change.

In addition, the EU's Programme of Community Action in the Field of Health and Consumer Protection, adopted by the European Commission on April 6, 2005, aims to provide for multinational-level cooperation on common challenges facing Member State health care systems.¹⁷² Such common challenges include the mobility of patients and professionals, ageing populations, and advances in medical science.¹⁷³ The program will gather data and present various reports from 2007-2013.¹⁷⁴ The program aims to facilitate "cross-border health care provision[s], information exchange, [promotion of] patient safety, support to set up an EU system for centres of reference and [the] providing [of] information on health services."¹⁷⁵ The program aims to improve Member State health care systems and additionally "achieve synergies between national health systems."¹⁷⁶ Mechanisms used by the program include the establishment of "community systems for cooperation on centres of reference," and "information gathering and exchange to enable sharing of capacity and use of cross-border care."¹⁷⁷

C. Reform of Regulation 1408/71

Since the aforementioned ECJ courses were handed down, regulation 1408/71, which provides forms E112 and E111,¹⁷⁸ and the legal structure for cross-border health care, underwent legislative revision to bring these regulations into conformity with current ECJ

action in the field of public health falls under this article as an "incentive measure designed to protect and improve human health . . ." *Id.* at 101.

172. See EurActiv, EU health strategy | European Union Health & Pharma, <http://www.euractiv.com/en/health/eu-health-strategy/article-143281> (last visited Jan. 3, 2007). See also COMM'N OF THE EUR. COMTY., European Parliament & Council et. al., *Healthier, Safer, More Confident Citizens: a Health and Consumer Protection Strategy*, 2, 5, 8, COM(2005) 115 final, available at http://europa.eu.int/eur-lex/lex/LexUriServ/site/en/com/2005/com2005_0115en01.pdf [hereinafter COMM'N OF THE EUR. COMTY., *Healthier, Safer, More Confident Citizens*].

173. COMM'N OF THE EUR. COMTY., *Healthier, Safer, More Confident Citizens*, *supra* note 172, at 8.

174. See e.g., *id.* at 1, 9, 14, 24, 27, 33.

175. *Id.* at 8.

176. *Id.* at 31.

177. *Id.*

178. See *infra* Part III (pointing to the previous discussion of these forms).

jurisprudence.¹⁷⁹ On April 29, 2004, the European Council recommended numerous clarifications to Regulation 1408/71.¹⁸⁰ The E112 and E111 forms of this Regulation have now been replaced by single, personalized European Health Insurance Card.¹⁸¹

Moreover, after this clarification, Regulation 1408/71 was extended to cover “all nationals of Member States who are covered by the social security legislation of a Member State.”¹⁸² The Council also made it clear that coverage under the Regulation was to cover “employees, self-employed, civil servants, students and pensioners.”¹⁸³ The scope of the Regulation was enlarged to cover “statutory pre-retirement schemes.”¹⁸⁴ An emphasis is also placed on cooperation and mutual assistance between the institutions of the Member States for the benefit of citizens.¹⁸⁵ These changes to Regulation 1408/71 were initially tabled in January of 2006, but changes were later enacted by the Council on March 10, 2006.¹⁸⁶

D. European Union Health Insurance Card

As just mentioned, a further development of Regulation 1408/71 is the introduction of the European Union Health Insurance Card. The card is a powerful symbol of both the extent to which patient mobility is embraced as a right and how the formerly bureaucratic process has been streamlined. The European Union Health Insurance Card is used instead of the paper forms, allowing the card-holder to receive

179. See Eur. Parl., *European Parliament Fact Sheet: 4.8.4 Social Security Cover in Other Member States of the Union*, http://www.europarl.eu.int/facts/4_8_4_en.htm (last visited Dec. 17, 2006) [hereinafter EUR. PARL., *European Parliament Fact Sheet*].

180. See *id.*

181. Eur. Public Health Alliance, *European Health Card Launched on 1 June 2004*, June 30, 2004, <http://www.epha.org/a/1333> [hereinafter Eur. Public Health Alliance, *Eur. Health Card Launched*].

182. EUR. PARL., *European Parliament Fact Sheet*, *supra* note 179.

183. *Id.*

184. *Id.*

185. *Id.*

186. Press Release, Council Eur. Union, 2714th Council Meeting Employment, Social Policy, Health and Consumer Affairs 20-21 (Mar. 10, 2006), available at <http://europa.eu/rapid/pressReleasesAction.do?reference=PRES/06/55&format=HTML&aged=1&language=EN&guiLanguage=en> (click on “EN” under the “PDF” option).

medical attention while temporarily in another Member State.¹⁸⁷ Anyone who is insured by a social security system of a Member State is eligible to receive a European Union Health Insurance Card.¹⁸⁸ In its first phase, the card only replaced the E111 form, which is used for temporary stays such as vacations in another Member State.¹⁸⁹ In the second phase, the card will substitute all remaining paper forms relating to temporary stays.¹⁹⁰ These paper forms include those for employees relocated to another country (E128), job seekers (E119), and students (E128).¹⁹¹ This card can only be used for “medically necessary care” occurring during a temporary stay in another member state, and does not relate to the planned care or pre-authorization issues concerning form E112.¹⁹²

The European Union Health Insurance Card was introduced in all EU Member States starting on June 1, 2004 and is currently used all EU Member States. In addition, Switzerland, Iceland, Norway, and Lichtenstein currently use the card in place of the E111 forms.¹⁹³ The eventual goal is that the card will be issued with an electronic chip that will be part of a larger “e-Health” initiative, containing patient records and previous medical history and providing for greater information sharing across borders.¹⁹⁴ Such advances will only lead to the removal of additional barriers to cross-border care.¹⁹⁵

187. Press Release, Eur. Comm’n, Eur. Health Insurance Card: Frequently Asked Questions 1 (Mar. 26, 2004), available at <http://europa.eu.int/rapid/pressReleasesAction.do?reference=MEMO/04/75&format=HTML&aged=0&language=EN&guiLanguage=en> (click on “EN” under the “PDF” option) [hereinafter Press Release, Eur. Union, Eur. Health Insurance Card].

188. *Id.* at 2.

189. Eur. Public Health Alliance, *Eur. Health Card Launched*, *supra* note 181. See also Press Release, Eur. Union, Eur. Health Insurance Card, *supra* note 187, at 1.

190. Eur. Public Health Alliance, *Eur. Health Card Launched*, *supra* note 181.

191. *Id.*

192. See Press Release, Eur. Union, Eur. Health Insurance Card, *supra* note 187, at 1-2.

193. See U.K. Dep’t of Health, *The ECIC: Free or reduced cost treatment*, http://www.dh.gov.uk/PolicyAndGuidance/HealthAdviceForTravellers/GettingTreatmentAroundTheWorld/EEAAnSwitzerland/EEAAndSwitzerlandArticle/fs/en?CONTENT_ID=4114793&chk=KCVYDZ (last visited Dec. 17, 2006).

194. See Press Release, Eur. Union, EU: European Health Insurance Card Officially Launched (June 1, 2004), available at <http://ec.europa.eu/idabc/en/document/2589/330> [hereinafter EU Press Release, European Health Insurance

E. European Charter of Patients' Rights

One of the most fundamental shifts from the view that health care is strictly in the jurisdiction of individual member states to the view that a legal right is tied to European Union treaty law has been the public dialogue surrounding health care and health care reform in almost every country. At this point in time, health care reform is viewed more as a European-wide issue, exemplified by the European Charter of Patients' Rights.¹⁹⁶ The European Charter of Patients' Rights is a list of fourteen patients' rights "currently at risk in all European countries due to the financial crisis of national welfare systems."¹⁹⁷ Fifteen national citizens' organizations compiled these rights. These organizations, along with other appropriate authorities, monitor their respective Member States adherence to the charter.¹⁹⁸

The rights vary and include the right to preventative measures, the right to information, and the right to privacy and confidentiality.¹⁹⁹ The most notable right for the issue of cross-border care is the right of access, which states: "Every individual has the right of access to the health services that his or her health needs require. The health services must guarantee equal access to everyone, without discriminating on the basis of financial resources, place of residence, kind of illness or time of access to services."²⁰⁰

The issue of access is directly related to patient mobility. In March 2005, the European Parliament held a series of hearings entitled "Patient Mobility in the European Union," inviting public policy makers, politicians, patients, insurance companies, and other stakeholders to offer both their views and their current research on the status of patient mobility in the EU.²⁰¹ The fact that these hearings

Card]. See also Eur. Public Health Alliance, *Eur. Health Card Launched*, *supra* note 181.

195. See EU Press Release, European Health Insurance Card, *supra* note 194.

196. See Eur. Charter of Patients' Rights, available at http://www.activecitizenship.net/documenti/European_Charter_of_Patients_Rights_Final_Draft.pdf.

197. Active Citizenship Network, *Eur. Charter of Patients' Rights*, http://activecitizenship.net/projects/project_europe_chart.htm (last visited Nov. 11, 2006).

198. Eur. Charter of Patients' Rights, *supra* note 196 at pt. 4. The countries involved with the Charter include Germany, Belgium, Portugal, Spain, Greece, Italy, Ireland, Denmark, The Netherlands, Austria, and the United Kingdom.

199. *Id.* at pt. 2, secs. 1, 3, 6.

200. *Id.* at pt. 2, sec. 2.

201. See EUR. PARL. DEB., *supra* note 6.

were even held illustrates the trends toward greater patient mobility and cross-border health care.

There is, however, recognition that these developing trends cannot go along unguided; simply opening borders does not provide the best services for patients or providers. Rather, well-defined systems that keep patients informed and organized are necessary.²⁰² Further, programs or initiatives proposed to address these issues need to focus on increased information sharing, with a goal of “health as a part of the fundamental rights of EU citizens, with well defined patients’ rights and duties in Europe.”²⁰³ Forecasts include having an EU-level listing of provider quality and accreditation, networks that would assess medical technology (currently under development), a European health information system with an EU health card, and a defined European “basket” of services.²⁰⁴

In addition to being active regarding policy and program guidance, patient mobility needs actual active cooperation between Member States, especially those who border each other; these neighbors cannot simply remove barriers to free movement.²⁰⁵ At the hearing, one expert cited the example of the emergent border-region coordination of cross-border care between the French and Belgian health systems. This collaboration resulted in a legal basis for the creation of health systems that “complete” each other rather than “compete with” each other.²⁰⁶

A study presented at the hearing by the Picker Institute Europe, an organization that specializes in measuring patient experience with and expectations of European Health systems,²⁰⁷ provided some interesting results. According to the study, patients throughout Europe expressed an interest in greater patient choice and access to cross-border care, as well as favorable responses to the current EU-level reforms.²⁰⁸ The study took place in Germany, Italy, Poland, Slovenia, Spain, Sweden, Switzerland, and the UK and concluded that patients throughout Europe want more information, involvement, choice, and control over their own health care: 92% wanted free choice of primary care doctor, 85% wanted a free choice of specialist; and 86% wanted free choice of

202. See e.g., Remarks of Dorjan Marusic, EUR. PARL. DEB., *supra* note 6, at 12.

203. Remarks of Magda Rosenmöller, EUR. PARL. DEB., *supra* note 6, at 4.

204. *Id.* at 4-5.

205. Remarks of Willy Palm, EUR. PARL. DEB., *supra* note 6, at 15.

206. *Id.*

207. See Picker Institute-Europe, What we do, <http://www.pickereurope.org/page.php?id=1> (last visited Dec. 16, 2006).

208. See Remarks of Angela Coulter, EUR. PARL. DEB., *supra* note 6, at 17, 18.

hospital.²⁰⁹ When patients travel across borders for medical care, they are becoming more discriminating and want information about both the effectiveness and the safety of that foreign care.²¹⁰ Overall, respondents had a positive response to EU health cards as both an electronic version of the E111 form and as an electronic patient record.²¹¹

F. Examples of Cross-Border Coordination

An example of the synergy of the four court rulings in a Member State health care system is illustrated by Luxembourg, which due to its small geographical size and lack of extensive internal health care infrastructure experiences a higher utilization of cross-border care than other, larger, Member States.²¹² According to Robert Kieffer, President of Luxembourg's Union of Sickness and Maternity Insurance Funds, in 1997, the year before the *Kohll* and *Decker* rulings, 2% of the insured population of Luxembourg was approved for cross-border care (8033 patients), with only 300 refusals.²¹³ After *Kohll* and *Decker*, the insurance fund determined that there should be refunds for cross-border out-patient services according to Luxembourg tariffs.²¹⁴ Prior authorization was not required for cross-border out-patient services.²¹⁵ After *Geraets-Smits*, the state insurance fund required pre-authorization for in-patient treatments abroad.²¹⁶ With these changes making access to cross border care much simpler, the government expected a reduction in E112 prior authorization requests, along with an increase in transfers outside the country with refunds.²¹⁷ There was, suprisingly, a rise in E112 transfers between 1997 and 2003, increasing from about 8,032 to over 12,000, a growth of 8% per year.²¹⁸ Still, those seeking transfers outside the country with refunds at Luxembourg tariff rates represented less than 0.5% of the services provided for out-patients, a small proportion of overall care reimbursements.²¹⁹ As the

209. *Id.* at 17.

210. *See id.*

211. *See id.* at 18.

212. Remarks of Robert Kieffer, EUR. PARL. DEB., *supra* note 6, at 24.

213. *Id.*

214. *Id.*

215. *Id.*

216. *Id.*

217. *Id.*

218. Remarks of Robert Kieffer, EUR. PARL. DEB., *supra* note 6, at 24.

219. *Id.*

Luxembourg case indicates, the ECJ rulings have led to an increase in patient mobility; however, such a local reform resulting from the ECJ rulings did not have a large impact on the country's system.²²⁰

Another example of cross-border coordination in health care systems, recently analyzed by the European Commission, is in the "Euregio Meuse-Rhine" region which involves parts of Belgium, Germany, and the Netherlands.²²¹ The Euregio Meuse-Rhine has a population of 3.7 million people, three languages (Dutch, German, and French), four different cultures, and three legal systems.²²² Beginning as early as 1992, under an EU Community initiative, a cross-border network was developed in which patients could seek treatment from providers outside their own country.²²³ The initial program called INTERREG (starting in 1992) and INTERREG II (running from 1996 through 1999) integrated a series of multi-national hospitals and health care insurers.²²⁴ Currently, the INTERREG III program (running through 2006) provides for an expanded health care infrastructure.²²⁵ The current cross-border network involves five hospitals and ten health insurance funds, and patients are recognized by their use of a health care card similar to the EU health card.²²⁶ Services provided range from specialist medical treatment, prescription drugs, and necessary hospital treatment.²²⁷ The major accomplishments of the program include: clinical cooperation of hospitals, cooperation of sickness funds, the international health insurance card, cross-border contracts between sickness funds and hospitals, cross-border contacts of medical specialists, cross-border contacts of patient groups, networks for the care of the elderly, and cooperation of institutes for higher education.²²⁸ Due to these significant accomplishments, the INTERREG programs could be used as a model for how to proactively coordinate between health care systems in the European Union while applying the decisions of *Decker* and *Kohll*.

220. *Id.* at 25.

221. EUR. COMM'N, e-Bus. Mkt. Watch, *Case Study: Cross-Border Cooperation for Healthcare Provision in Euregio Meuse-Rhine* 1, http://www.ebusiness-watch.org/resources/documents/Case%20Studies%202004/CS_SR10_Health_2-Euregio.pdf [hereinafter EUR. COMM'N, *Case Study*].

222. *Id.*

223. *Id.* at 1-3.

224. *Id.* at 2.

225. *Id.*

226. *See id.* at 2, 4-5.

227. *Id.* at 4-5.

228. *Id.* at 9-10.

Yet many questions remain concerning the overall utilization of cross-border care in the European Union as a whole, and the financial impact on Member State health care systems. Research has suggested that there may be increases in expenditures in countries that have embraced cross-border care, such as Belgium, Denmark, France, Germany, Greece, Ireland, Luxembourg, the Netherlands, Portugal, Spain, The United Kingdom, Austria, Finland, and Sweden. Home state expenditures on patients receiving health care services in other EU Member States per capita have risen from an average of €1.31 in 1989 to €1.99 in 1998.²²⁹ Although more recent studies published in 2003 by the European Commission did not detect frequency or cost of cross-border care during 2000-2001,²³⁰ much of this data is considered questionable, incomplete, or skewed due to waiver agreements between countries and underreporting of actual service utilization.²³¹ Perhaps a more complete reporting of cross-border utilization would, in the end, demonstrate a higher level of cross-border expenditures.²³² For example, data suggests that Germany spent €4.70 per capita in 1992 and €5.40 in 2002; this amount is twice as high as reported in previous studies.²³³ Current research, to which we now turn, has focused on case studies of regional areas as a model to understand cross-border utilization in the European Union as a whole.

G. Learning from Experience: Europe for Patients Research Project

In 2006, the World Health Organization, on behalf of Europe for Patients, a research and advocacy organization, published a book, *Patient Mobility in the European Union: Learning from Experience*. This work is an in-depth collection of nine case studies, each dealing with a specific example of cross-border coordination in the European Union.²³⁴ Studies include cross-border care between Slovenia, Austria, and Italy; access to health care for tourists in the Veneto region of

229. See WORLD HEALTH ORGANIZATION, European Observatory on Health Systems and Policies, *Policy Brief: Cross-Border Health Care in Europe*, tab. 1 at 13 (2005) available at www.euro.who.int/Document/E87922.pdf (prepared by Luigi Bertinato et al.).

230. *Id.* at 14.

231. *Id.*

232. *Id.* at 14-15.

233. *Id.*

234. See EUROPE FOR PATIENTS, *PATIENT MOBILITY IN THE EUROPEAN UNION: LEARNING FROM EXPERIENCE* (Magdalene Rosenmöller et al. eds., 2006), available at www.iese.edu/en/files/6_22160.pdf [hereinafter EUROPE FOR PATIENTS, PATIENT MOBILITY].

Italy; and the sharing of health care resources between Malta and the UK.²³⁵ It appears that there are certain common themes that emerge from these studies. These themes highlight both the complexity of the cross-border health care question in addition to a great optimism that increased cooperation and coordination between Member State health care systems will increase positive health care outcomes for all. The Europe for Patients Project, the organization behind the book, views *Kohll* and *Decker*, as well as the subsequent *Watts*, *Geraets-Smits*, and *Vanbraekel* decisions, as a starting point from which to develop more opportunities for patients to access care across Member State borders.²³⁶

According to these studies, most Europeans do not wish to use foreign health systems:

[M]obility of patients across Europe's borders is a somewhat marginal phenomenon as most patients prefer to be treated as near to home as possible, close to their relatives, in a system they are familiar with, and with providers who speak their language, where they know what they can ask for and what they can expect to receive.²³⁷

Nevertheless, as the cases and reports discussed earlier demonstrate, there is a noticeable amount of patient mobility that "can be an important phenomenon in certain areas and contexts, such as tourist areas and border regions"²³⁸

Characteristics of those that seek cross-border medical care are also varied, but the elderly make up a significant portion of the mobile patient population, especially in popular tourist or retirement destinations.²³⁹ This has significant implications for future long term care systems in these regions.²⁴⁰ Conversely, younger patients are more likely to purposefully cross borders in order to obtain medical care because the care is seen to be of "better quality" or "more convenient."²⁴¹ Changing population demographics, as the elderly population increases, and younger patients continue to cross borders to seek care, may well impact the overall number of patients accessing cross-border care.

235. *See id.* at vii-viii.

236. *See e.g., id.* at 19, 106-107, 158.

237. *Id.* at 179.

238. *Id.*

239. *Id.* at 179-180.

240. *Id.* at 180.

241. *Id.*

Key conclusions and recommendations for the future of cross border care are summarized by the principles proposed by Europe for Patients. These principles view cross border health care as an opportunity to strengthen health care for all citizens of Europe, and all Member States in the European Union. The principles rely upon cooperation and information sharing between health care providers and Member States to accomplish this goal. Cross border health care is therefore seen as a way to improve Member health systems and patient health outcomes. The recommendations are as follows:

Patient mobility should be managed . . .

Patient mobility requires trust. Purchasers must be able to rely on standards being upheld by providers . . .

Patient mobility should clearly define specific arrangements necessary to support the mobile patient, in relation to matters such as transport, language and accompanying persons.

Patient mobility should ideally be integrated into larger forms of cooperation involving providers of both countries . . .

Patient mobility should be based on prices set in a manner that is transparent and which minimizes perverse incentives and distortions of the market . . .

The competent authorities or purchasers should define explicit eligibility criteria for patients who go abroad specifically to obtain treatment.

The right to treatment abroad should be consistent with what is included in the benefit package of the Member State that funds the care.²⁴²

VIII. CONCLUSIONS

The European Court of Justice and the decisions of *Decker* and *Kohll* tried to balance two previously disparate legal rights: the domestic right to health care services within one's Member State of residence and the European Union right of free movement and free access to services across Member State borders. The Court found that the restrictions on cross-border care to be in violation of EC Treaty Articles 49 and 50; these portions of the TEC establish the right to freedom of movement and freedom to receive services within the European Community.²⁴³ Further jurisprudence in *Geraets-Smits* and *Vanbraekel* applied the holding of *Decker* and *Kohll* to both reimbursement and benefits-in-kind health care systems, allowing for

242. *Id.* at 185-186 (emphases omitted).

243. *See infra* Part III.

greater ease of patient mobility across the European Union.²⁴⁴ These cases should be viewed within the context of a broader set of tensions surrounding health care reform. The development of the European Union, represents an ongoing renegotiation of the social contract, and the future of the traditional social welfare state.

As already noted, a profound tension is inherent in cross-border health care because the individual State's right to control its social security/social protection system is at odds with the freedom of movement which is at the core of the European Union.²⁴⁵ In the case of health care, this tension is exacerbated by the pressure for cost containment in almost every European country as well as ongoing discussions on health care reform.

Every major Western democracy is engaged in a public discussion of the viability of the "social contract," the possible need to renegotiate this "contract," and the implications of these deliberations for the future of the social welfare state.²⁴⁶ As this author has observed:

This "contract" between the State and society represents a negotiated agreement between the government and citizens over respective responsibilities and duties. The agreement specifies what benefits government agrees to provide to citizens in return for tax-based financing of these benefits; it also recognizes the role of government in designing and administering the programs, which ultimately provide the desired benefits.²⁴⁷

The current economic situation in much of the Western world is calling this social contract into question.²⁴⁸

Reforms such as the introduction of a European Health Card²⁴⁹ and reform of Regulation 1408/71 (the key regulation governing cross-border care),²⁵⁰ have removed many of the barriers to cross-border care previously mentioned by the ECJ that were identified as problematic. These reforms have also firmly cemented the right to cross-border care developed in *Decker* and *Kohll* in European Union law and, correspondingly, within the domestic law of Member State welfare systems. Citizens of the European Union may now travel freely

244. See *infra* Part IV.

245. See *infra* Part V.

246. See generally, Rich, *supra* note 13 (discussing the "social contract," and its place in western society with regards towards healthcare).

247. *Id.* at 397.

248. *Id.* at 420.

249. See *supra* Part VII.D.

250. See *supra* Part VII.C.

between Member States to receive medical goods and services with reimbursements provided under the tariffs of the patient's home Member State.²⁵¹ Successes of cross-border care pilot programs, such as the INTERREG program in the Meuse-Rhine region, have also highlighted the successes of Member State health care system cooperation.²⁵²

The European Health Card is perhaps the most visible change brought about by the *Decker* and *Kohll* decisions. It is emblematic of the very spirit of the rights established by Treaty Articles 49 and 50 and enforced by the Courts in these decisions. The Health Card is currently in full use and is projected to eventually carry patient data electronically.²⁵³ This card symbolizes the ease by which the European patient can now move across Member States borders to receive most foreign health care services without fear of lacking coverage. In fact, cross-border health care was formerly a right granted to only workers moving between Member States for economic reasons. Now it is a right given to all citizens. This expansion of the right is representative of the shift in defining the European Community as simply an economic space to a cultural and social domain. Cross-border health care is also an excellent example of how this shift is occurring through the legal framework, both in terms of decisions of the European Court of Justice and the overlay between the treaty-based structure of the European Union and Member State legal rights. The structure of the welfare state, with rights and benefits often guaranteed in Member State law, is also being preserved and shaped by the European Court of Justice, as has been seen in the *Decker* and *Kohll* cases.

In both Europe and the United States, the nature of the social contract has shifted toward consolidation and retrenchment rather than further expansion.²⁵⁴ Consequently, the traditional "social contract," with its strong social welfare components, has come under increasing attack and its legitimacy has been called into question.²⁵⁵ Indeed, since 1980, policy-makers in many western countries have taken steps to alter the mix and nature of benefits that comprise the social contract; universalistic, service-based welfare states have

251. See *supra* Part VI.

252. See *supra* Part VII.F.

253. See *supra* Part VII.D.

254. See generally, Richard Clayton & Jonas Pontusson, *Welfare-State Retrenchment Revisited: Entitlement Cuts, Public Sector Restructuring, and Inegalitarian Trends in Advanced Capitalist Societies*, 51 *WORLD POL.* 67 (1998) (arguing that the welfare state in Europe is in transition and on the decline).

255. See *id.* at 67.

undergone significant change.²⁵⁶ An expansion of cross-border medical care in the European Union, contrary to this treatment of the welfare-state, would represent a significant development in the opposite direction.

Challenges still exist for the system of cross-border care within the European Union.²⁵⁷ Key difficulties include: expanding quality and access to care in the newer Member States of the European Union, dealing with issues of professional mobility, and increasing information sharing and patient choice within the cross-border care legal structure. Therefore, the issue of cross-border health care in the European Union has in no way been resolved by either the ECJ decisions of *Decker* and *Kohll*, the subsequent jurisprudence, or administrative action by the European Union. However, *Decker*, *Kohll*, and similar decisions do suggest that easing legal barriers to cross-border care access may provide relief to Member States struggling with increasing costs of health care and problems of resource allocation. Unlike previous decisions to open borders on more static European issues (e.g., higher education)²⁵⁸ health care systems are continually in flux as population demographics shift, new technologies develop, and community needs change and adapt. Future decisions on cross-border care likely will reflect such a dynamic and provide insight into the changing health marketplace, the interactions and evolution of the European social contract, as well as the legal evolution of the European Union itself.

256. See generally Michael Moran, *Review Article: Crises of the Welfare State*, 18 BRIT. J. POL. SCI. 397 (1988) (explaining that since the 1970s, the welfare state has transformed in its services, resources, and concept of citizenship that such occurrences may be seen as various forms of crises).

257. See *supra* pp.55-56, Part VII.A.

258. See *supra* note 53 and accompanying text.