EU for the Patients

Developments, Impacts, Challenges

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Publication date:
2007

Document version
Early version, also known as pre-print

Citation for published version (APA):
Martinsen, D. S. (2007). *EU for the Patients: Developments, Impacts, Challenges*. Stockholm: Svenska institutet för europapolitiska studier.

2007:6

Dorte Sindbjerg Martinsen

EU for the Patients:

Developments, Impacts, Challenges

Sieps
Swedish Institute for European Policy Studies

Dorte Sindbjerg Martinsen

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– SIEPS 2007:6 –

Report No. 6
June/2007

Publisher: Swedish Institute for European Policy Studies

The report is available at
www.sieps.se

Cover: Svensk Information AB

Print: EO Grafiska AB

Stockholm, June 2007

ISSN 1651-8942
ISBN 91-85129-51-8

PREFACE

This report analyses the developments end effects of healthcare integration in the European Union. Even though the mobility of patients is fairly low at present this can be expected to change if for example information on available treatments becomes readily available to the citizens and if rules and rights become more transparent. The report also addresses to what extent different national healthcare models are affected more or less by increased patient mobility and what other factors, such as quality and quantity of health care supply, may affect mobility. The report finally looks at the different views of the member states on health services in a European context.

SIEPS conducts and promotes research and analysis on European policy issues within the disciplines of political science, law and economics. SIEPS strives to act as a link between the academic world and policy-makers at various levels. This is the fifth report from the research programme *The EU's Internal Market: Effects on Central Areas* which aims at analysing the impact of the internal market on a number of domestic policy areas and regulatory regimes.

Stockholm, June 2007
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EXECUTIVE SUMMARY

Until recently, healthcare was one of the core policy areas of the welfare state which was held relatively secluded from the impact of European integration. However, since 1998 this state of insulation has been abruptly interrupted by the judicial activism of the European Court of Justice. Through the judicial interpretation of the meaning of the Treaty, internal market principles were applied to the policy field of healthcare. Since then, accumulated legal reasoning has extended the regulatory scope of European patient mobility and intra-European patient rights have gradually materialised, albeit in a rather fragmented and non-transparent way. So far politics has remained passive, observing the developments behind the traditional boundaries of the welfare state – unable to act collectively. However, during autumn 2006 stakeholder contributions have been called for by the Commission and Council negotiations wait ahead.

The present report analyses the developments, impacts and challenges of internal market principles on national healthcare institutions across the EU. The report examines how the development of patient mobility has affected the healthcare systems of EU25. The report concludes that the adaptive pressures on national healthcare models have not forced member states to respond in converging ways. However, this does not mean that EU patient mobility does not bring considerable impact and future challenges. It does. So far, impact and challenges are seen foremost through redefined national means of control and organising principles of public healthcare, as well as by the fact that European patients have been provided a new exit option to opt out of national institutions – an exit option that Union citizens are likely to increasingly make use of as they become better informed and familiar with cross border healthcare supplies. EU patient mobility provides a strong example of a new dimension of European integration, and pinpoints what happens and what is redefined when Union citizens start to practice their European rights.

1 INTRODUCTION

Until recently, the traditional core of the welfare state has been relatively secluded from European integration. Healthcare has been one such core welfare area which for long was held largely insulated from the regulatory acts of the European Union (EU). However, quite recent integration dynamics seem to have definitively ended the nationally insulated status of healthcare and the European polity increasingly impacts on this policy field.

This report analyses the developments, impacts and challenges of internal market principles on national healthcare institutions across the EU. The report analyses how the development of patient mobility has affected the healthcare systems of EU-25. Due to lack of data, the analysis does not include the 2007 enlargement, i.e. it does not include research on Rumania and Bulgaria.

The report is structured through three analytical questions; what are the supranational *developments* regarding patient mobility? To what extent have the developments had an *impact* on the healthcare systems of the EU member states? And which *challenges* do national healthcare systems face? The questions of impacts and challenges are dealt with on the basis of an examination of the national healthcare supplies of EU25, in order to research how individual systems may be challenged in different ways.

The remaining parts of this introduction discusses the theoretical setting for understanding healthcare integration, through the lenses of healthcare convergence versus institutional diversity, Europeanisation as well as through a theoretical frame viewing integration as processes of spatial (re)configuration and new exit options. The report then turns to the empirical analysis. The analysis begins in section 2 by laying down developments. It first describes the politically initiated, but judicially dynamised process through which the contours of a Europe for the patients have been drawn. It includes recent developments where the rights of European patients are increasingly brought into focus and where the Commission has recently closed an open consultation process on health services.

Section 3 examines the national settings, describing the European healthcare families and their mutual reliance on the principle of territoriality, which essentially means that healthcare has been territorially bound within each member state. Against this background, section 4 analyses the extent to which the different European healthcare models face change, i.e. the questions of impacts and future challenges. It does so by questioning which factors in the different national healthcare systems should stimulate

or constitute barriers to EU patient mobility. This is done by addressing what motivates a patient's choice on the individual level, what at the public policy level may motivate patients to seek treatment in another member state and finally by analysing the different political standpoints of the member governments towards patient mobility and towards supranational healthcare competences. This analysis includes different perceptions of non-hospital versus hospital care, of 'undue delay' as well as the specific positions of the newer member states which tend to regard challenges from a very different perspective than older member states.

The report concludes in section 5 that the adaptive pressure on national healthcare models has not forced member states to respond in converging ways. Instead, impacts depend on a set of mediating factors that transmit EU developments to the national outcome. That, however, does not mean that patient mobility does not bring considerable impact and future challenges. It does. By redefining traditional means of control and organising principles and by the fact that European patients have been provided with an 'exit' opportunity to opt out of national institutions, as an addition to their traditional 'voice' as voters. European citizens are increasingly likely to use this exit opportunity as they become better informed about the intra-European healthcare supplies and as rights and rules become more transparent.

1.1 Towards Healthcare Convergence?

Examining the impact of European integration on national healthcare policies addresses the question of Europeanization. The study of Europeanization aims to understand and explain both the *processes* of change that national policies, politics and polities undergo as a result of EU integration together with the specific *challenges* and, eventually, *impacts* of EU integration.[1]

When analysing 'impact', one important question for the present study is whether the Europeanization of healthcare will lead to the convergence of national healthcare policies. A key assumption in the hypothesis of convergence is that embracing common imperatives and common challenges will lead to similar outcomes and national policies and polities will converge in the longer perspective – despite their significant differences. Essentially this means that when member states are exposed to the same challenge and

[1] For the discussion of the different definitions of Europeanization, see among others Radaelli 2003, Vink & Graziano 2007, Lenschow 2006.

adaptive pressure, they will also embark on the same road towards the same final destination (Dubois & McKee 2004, p. 45). Over time, the outcome of being regulated by a common imperative will be convergence.

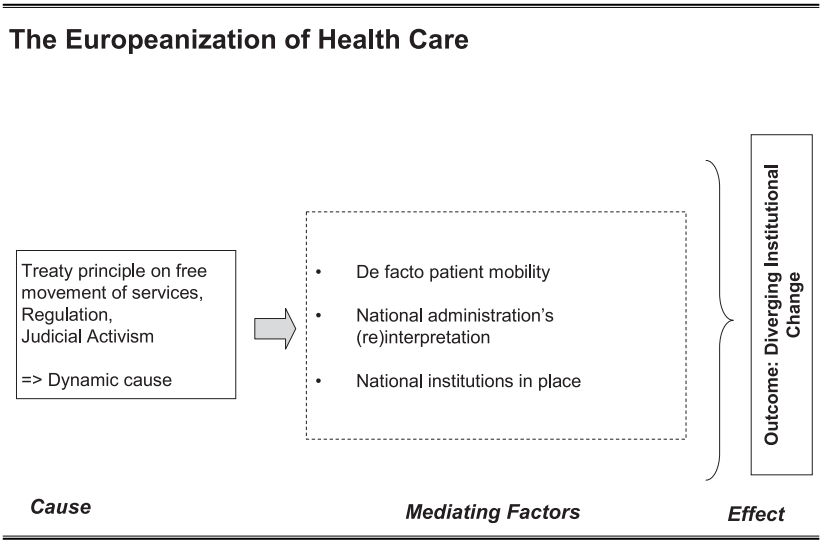
The theoretical insights provided by the study of Europeanization are, however, that converging outcomes are relatively unlikely. The opposing hypothesis to convergence is the one of *institutional diversity*, where national policies and polities are either barriers to – or mediate – EU-induced change. Supranational imperatives will be dealt with through distinct national choices and rationales.

Studies of Europeanization point out that mediating factors, transmitting the Europeanization process, are decisive for the final impact of European integration on national policies. Mediating factors are explanatory variables which explain how the same independent variable, European integration, may have very different outcomes. These variables bring domestic factors back into focus. They cover a wide range of both national actors and institutions, including administrative capacity, national legacies, veto points and cultures of compliance (Schmidt 2002; Haverland 2000; Börzel 1999, 2005; Falkner et. al 2005). Some may facilitate the process of Europeanization while others limit it.

There are above all three mediating factors in the present context which stand out as being decisive to the Europeanization of healthcare. The first is *de facto patient mobility*. The extent to which European citizens receive treatment in another member state constitute the *de facto* adaptive pressure on national healthcare institutions. If patients are not willing to move, the right of free movement has no impact in reality. The second factor is a *veto point,* i.e., the way in which the *national administration (re)interprets* EU-relevant decisions for health. This veto point limits Europeanization from the start, as it provides the national administration with interpretive discretion which may hinder the full impact of EU integration. However, the analysis will point out that such a veto point is dynamic and the national discretionary scope may narrow as EU integration continues. The third mediating factor concerns the *national institutions in place*, i.e., the healthcare model/family. Different aspects of the established *institutional legacy* may make one model or financial method more exposed to European integration than another.

In general research, Europeanization is likely to be rendered more complicated by the fact that both independent and mediating variables are simultaneously in flux, i.e. it involves examining the effect of a dynamic cause transmitted by dynamic national institutions. In this way, Europeaniza-

Figure 1: The Europeanization of Healthcare Policy



tion takes place as a result of multiple influences rather than simply as a top-down EU-imposed or induced process of change.

As Figure 1 illustrates, the scope of EU-induced change is expected to be filtered through a set of mediating variables, which differ for the member states. The time span that the figure addresses is the development and impact up to now (spring 2007). Within this time span, the expected outcome is institutional divergence, based on the argument that the institutionalisation of the EU rules on patient mobility have not yet developed to the extent that they can erode the divergences contained in the mediating factors. However, in the longer run EU regulation is likely to become more detailed and institutionalised; *de facto* patient mobility may increase considerably; the discretionary scope of national administrations will diminish and national institutions will reform gradually due to the EU imperative. Such a future scenario would lead to a gradual convergence – or at least greater similarities between national systems.

1.1.1 European Integration as New Exit Options

European integration can be regarded as a process of new centre formation, which at the same time provides exit options for the citizens of its

member states.[2] This perspective seems fruitful when analysing the developments and impacts of healthcare integration. As will be demonstrated below, internal market principles have gradually come to provide exit options for the European citizen from the national territory.

European integration contains its own process of spatial (re)configuration (Ferrera 2005, p. 7). Hirschman's famous concepts of exit, voice and loyalty operated with exit and voice as alternative individual reactions to the performance of the political centre, where the citizen either left (exited) the polity s/he was dissatisfied with or participated (voiced) in its political interactions (Hirschman 1970). The gradual steps of European welfare integration open up the nation-state boundaries. The welfare state is in this report argued to be structured upon two main organising principles; the principle of social citizenship and the principles of territoriality (Marshall 1950; Cornellissen 1996). The first prescribes that the scope of social sharing covers those who belong to the national community, through citizenship or, possibly, through the status as long term residents. The other principle rules that social benefits can only be consumed within the national territory and thus that the social responsibility of the state goes no further than its territorial boundaries. Both principles are essentially foreclosing exit options through state boundaries. As the principle of territoriality is foremost relevant for the interrelation between EU integration and national healthcare, it is primarily this principle that will be addressed in the subsequent analysis whereas the principle of social citizenship constitutes a fundamental part of the underlying logic. One of the main functions of the principle is to maintain the administrative and political control of national authorities over welfare consumption. The demarcation of public policies thus also relates to the organisation of internal hierarchies (Bartolini 2005) and constructs national means of control, preserved by closure.

The steps of integration encroach on the boundary demarcations behind which the EU member states have structured their public goods and services and it provides new exit options. EU patient mobility is an empirical manifestation of how new exit options develop and at the same time cause national reconfigurations of boundaries and their organising principles. In addition, patient mobility mirrors perhaps a more contemporary form of exit. It is not mobility in a classic sense, meaning settlement on another territory as an individual reaction against the performance of the welfare polity to which one belongs. Instead, it concerns temporary exits from the

[2] For very insightful theoretical and empirical elaborations of the restructuring processes of the European polity based on the classical theories of Hirshman and Rokkan, see among others Bartolini (2005) and Ferrera (2005).

national territory. It goes hand in hand with – and is fortified by – new opportunities of choice and a strengthened focus on patient rights. Fundamentally, it questions traditional understandings of collective loyalty towards public supplies and brings in a more market-oriented logic. Patient mobility addresses a different form of exit option, namely exiting from public supplies and choosing to consume welfare elsewhere.

Analysing the impact and challenges of patient mobility cannot be separated from an examination of patient choice. The analysis must necessarily include an examination of the institutional and individual barriers and incentives to exit. In order to examine impact and challenges, a part of the analysis below questions what motivates patients' choice and examines this at the micro level, i.e. from the actor perspective, at the policy level and at the political level, i.e. surveying how member states react to the current developments and challenges.

Below, the analysis initiates by looking at the developments integrating healthcare in the European Union. In the following section, we turn to the institutionalisation process of EU regulation on patient mobility. How far have developments taken us up to the spring of 2007?

2 DEVELOPMENTS – INTEGRATING PUBLIC HEALTHCARE THROUGH INTERNAL MARKET PRINCIPLES

Until 1998, access to foreign public healthcare providers in the EU was regulated solely through the system coordinating social security rights, i.e. Regulation 1408/71, which originally aimed to secure the free movement of certain types of 'qualified' workers, and was subsequently broadened to promote the free movement of workers in general and gradually came to include more and more categories of persons in its regulatory scope. This piecemeal inclusion of different categories of persons has recently been codified by the Council. Regulation 883/2004 covers all persons who are nationals of a member state, irrespective of economic activity.[3] The member states, the Commission and the ECJ appeared to have found an inter-institutional consensus that European citizens were entitled to *immediate* and necessary healthcare in other member states as well as other kinds of publicly financed health treatment, provided that they had been *authorised* beforehand by the competent national institution. This is how Regulation 1408/71 governs the field today. Should one fall ill during a temporary stay in another member state or should one require treatment while temporarily in another member state due to a chronic illness, one is entitled to this treatment on the basis of the European health insurance card. Launched in March 2004 under the headline "More Europe in Your Pocket"[4] the health card replaced the former Community form E111, which used to verify the holders right to immediate healthcare. Furthermore, the Regulation entitles a person to *planned treatment* in another member state, but only provided that the treatment has been authorised beforehand by the competent national institution and verified in a Community form E112. Due to significant judicial activism back in the late 1970s,[5] where the European Court laid down that member states were obliged to grant authorisation both where treatment in another member state was more effective and where the treatment in question was not provided by the competent member state, the member states had collectively emphasised that the healthcare service must be part of the competent

[3] Although the new Regulation 883/2004 was adopted on 29th April 2004, it does not enter into force before the implementation regulation is adopted by the Council. The proposal on the implementing regulation was adopted by the Commission on 31 January 2006, COM (2006) 16, and is currently being negotiated in the Council working group on social affairs.

[4] See press release http://ec.europa.eu/employment_social/news/2004/mar/healthcard_en.html

[5] See the Pierik cases; Case 117/77, 16 March 1978. *Bestuur van het Algemeen Ziekenfonds Drenthe-Platteland v. G. Pierik.* ECR 1978, page 825 & Case 182/78, 31 May 1979. *Bestuur van het Algemeen Ziekenfonds Drenthe-Platteland v. G. Pierik*. ECR 1979, page 1977.

member state's health care package.[6] At that point, the member states thus managed to overcome 'the joint decision trap' (Scharpf 1988; 2006) and in consensus overruled the interpretations of the Court. From then on, a kind of reconciliation appeared to have been established between the ECJ, the Commission and the member states. Due to the tool of prior authorisation, healthcare supply was very much controlled by the member states and the discretion in deciding whether to grant authorisation or not was left unchallenged. In absolute terms, few authorisations seem to have been granted apart from the case of Luxembourg which seem to rely to some extent to foreign health care provision. However, the few observations where we have data on the ratio between requests and actual authorisations, the national authorities seem not to have been particularly restrictive although the data is too patchy for any definitive conclusions.

Table 1: Number of People Requesting and Obtaining Prior Authorisation for Treatment Abroad in Selected Member States[7]

	Year	No of authorisation requests	No of authorisations granted
Austria	Per year 1996-2002	Not available	850
Belgium	Per year 1996-2000	Not available	2000
Denmark	Per year 1996-2000	40-50	25-35
	2000*	Not available	70
	2001*	Not available	75
Finland	2001	Not available	9
	2002	Not available	4
France	Per year 1996-1999	310	197
Ireland	Per year 2000-2001	600	Not available
Italy	1999	Not available	16280
Luxembourg	1998	7130	7082
	2001	11751	11506
Portugal	2001	260	246
Spain	2001	Not available	651
Sweden	Per year 1996-2000	Not available	20
	2002	6	0
United Kingdom	Per year 1996-1999	800	600
	2000	1100	Not available
	2001	1134	Not available

* Authorisation granted for treatment abroad in general and not only within the EU.

[6] See the amendment of Article 22 (2) of Reg. 1408771, inserted by Regulation 2793/81.
[7] Table from Martinsen 2005, based on Palm et al, 2000: 44-62; Mossialos et al, 2002: 85; Commission Staff Working Paper 2003.

In relation to Table 1, it is important to emphasise that these data only mirrors the part of patient mobility governed through the EU authorisation procedure. In addition hereto, we have to consider the mobility governed through the European health card, mobility governed by bilateral and international agreements as well as privately financed mobility. It has not been possible to update the data contained in Table 1, although there is a great need to get a more complete picture of patient mobility. Future research should address the current state and future evolution of European patient mobility, as the debate on impact and challenges would benefit from comparable, quantitative insights. As for now, data remains scattered and incomplete (Rosenmöller, McKee & Baeten 2006).

Until 1998, regulation 1408/71 was the only regulatory source for cross-border treatment in the EU. The principles of the internal market had not been applied to the health sector and were indeed politically held to be inapplicable. However, ECJ judgements on the relationship between the requirement of prior authorisation and EC law were serious enough to upset the established status quo.

In a series of judgements, the ECJ questioned the justification of 'prior authorisation' and gradually established that the principles of the internal market – and especially Article 49 of the Treaty - also applied to national health policies.[8] The Court first laid down that healthcare was a service within the meaning of the Treaty.[9] The requirement of prior authorisation was, in principle, found to be a barrier to free movement. The immediate impact of the 1998 judgements was, however, modest in that they considered only a limited scope of *non-hospital care* (a pair of spectacles and dental treatment), and concerned the reimbursement-based Luxembourg healthcare system.

In subsequent rulings, the ECJ extended its interpretation across the full range of EU healthcare systems. The *Geraets-Smits* and *Peerbooms* judgements of 2001[10] repeated – this time with regard to the Dutch 'benefit in kind' health insurance system – that prior authorisation constitutes a barrier to the free movement of services. Such a barrier may, however, be justified provided that:

[8] For a more detailed description of the series of judgements, see Martinsen (2005).
[9] In the cases C-120/95, *Decker*, 28 April 1998 and C-158/96, *Kohll*, 28 April 1998.
[10] Case C-157/99, *Geraets-Smits* and *Peerbooms*, 12 July 2001.

- The decision on whether or not to grant treatment abroad is based on "international medical science"; and
- an equivalent course of treatment can be provided in the competent member state without "undue delay" taking into consideration the medical condition of the patient, broadly defined.

The Court further restricted the discretion to grant prior authorisation by emphasising that it can only be a justified barrier to the principle of free movement if it is based on objective, non-discriminatory criteria known in advance so that national authorities cannot control the procedure arbitrarily. Requests for authorisation must furthermore be dealt with within a reasonable time, and refusals to grant authorisation must be open to appeal (para. 90, C-157/99).

The third step towards an internal healthcare market took place two years later with the case of *Müller-Fauré & Van Riet*.[11] In this case, the Court issued yet another expansive interpretation by introducing a distinction between hospital and non-hospital care. In the case of *hospital care*, the Court restated its view that the requirement for prior authorisation is justified on condition that it is exercised proportionately and that the national authority has no scope for acting in an arbitrary manner. The matter was, however, quite different for *non-hospital care*. The Court laid down that national authorisation constitutes an unjustified barrier to the free movement of services for non-hospital care. Given the increasingly blurred distinction between hospital and non-hospital care, the future implications of this judgement are likely to be extensive.

From *Decker/Kohll* via *Smits/Peerbooms* to *Müller-Fauré* it is clear that legal judgements have made a significant contribution to the integration of healthcare. Within a time span of only five years, national health policies have been taken far further into the internal market than politicians ever intended, or could have predicted. That EC law applies regardless of the organising characteristics of national healthcare systems has been made explicit in the recent case of *Watts*, where the Court, for the first time, considered a national health system providing treatment free of charge, funded through general taxation.

[11] Case C-385/99, 13 May 2003. *Müller-Fauré v Onderlinge Waarborgmaatschappij OZ Zorgverzekeringen and Van Riet v Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen*. ECR 2003, p. I-04509.

2.1 The European Patient in Focus

On 16 May 2006, the ECJ's long-awaited decision in the *Watts* case was released. The case is more significant (and controversial) for state-funded national health systems that provide healthcare as a benefit in kind, such as those of the UK, Ireland, the Scandinavian countries and Southern member states than for the insurance-funded systems such as that of the Netherlands or systems based on the reimbursement of costs as in Luxembourg. The *Watts* case considers, for the first time, the implications of the logic of the internal market, for member states that generally separate the provision of healthcare from market considerations.

The case concerned a hip replacement needed by Mrs. Yvonne Watts, a resident in the United Kingdom. Mrs. Watts requested authorisation to receive treatment abroad. In the context of her application, the examining consultant stated that Mrs. Watts was in no more need of a hip replacement than any of the other patients on his waiting list and that the case was in fact routine, and Mrs. Watts was told that she would have to wait approximately one year for her operation. However, upon re-examination, the consultant recommended that she be operated on within three to four months, as her situation had now deteriorated. Despite this reduction in waiting time, Mrs. Watts went to France to have her hip replacement and, on her return, requested reimbursement of her costs of £ 3,900. In October 2003, the High Court in England and Wales rejected her application stating that the reduction in her waiting time would have meant that Mrs. Watts would have been treated without 'undue delay'. Mrs. Watts took her case to the Court of Appeal which, in turn, referred a long list of questions to the ECJ.[12]

In its judgement, the ECJ confirms, and indeed furthers, its previous line of health-related judgements. The conclusions remove the scope for national institutions to exercise administrative discretion and bring the rights of the European patient into sharper focus. In so doing, it intervenes in the national sphere of governance. Furthermore, the Court equips the European patient with institutional structures to claim those rights.

Once again the Court stated that, regardless of individual features, all medical services are 'services' within the meaning of the Treaty:

[12] The Court of Appeal in England and Wales referred no less than 7 questions to the ECJ regarding among other matters whether Article 49 of the Treaty applies to an institution such as the NHS; under what circumstances a refusal to authorise treatment abroad may be justified; and what the proper meaning of undue delay is.

> It should be noted in that regard that, according to settled case-law, medical services provided for consideration fall within the scope of the provisions on the freedom to provide services […] there being no need to distinguish between care provided in a hospital environment and care provided outside such an environment (para 86 of the judgment).

On the basis of this reasoning, the Court clarified that the characteristics of the UK National Health Service do not exempt it from EC law. Article 49 of the Treaty applies regardless of the way the national system is organised (paragraph 90 of the judgement). The last bastion for resisting the general applicability of the Court's previous judgements was rejected by this judgement, since the whole range of European healthcare systems and services now must be interpreted against the requirements of EC law.

Although the Court does not specify when the waiting time for a particular course of treatment might be considered to be 'undue delay' or beyond 'the time normally necessary' – and thus constitute an unjustifiable barrier to the principles of the internal market – it does, however, set out a (reviewable) criterion for determining whether a period of waiting is acceptable in the context of EC law. This is that the waiting time must not:

> exceed the period which is acceptable on the basis of an objective medical assessment of the clinical needs of the person concerned in the light of all of the factors characterising his medical condition at the time when the request for authorisation is made or renewed, as the case may be (paragraph 79 of the judgement).

Furthermore, the decision as to whether the patient faces undue delay in accessing services must be based on:

> 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 (paragraph 119 of the judgement).

Thus, having enhanced the rights of the European patient by setting limits to the time period and the grounds on which the exercise of supranational rights can be put on hold, the Court went on to specify the institutional structures that member states must provide to protect those rights. The Court repeats the conclusions from *Geraets-Smits* and *Peerbooms* as well as *Müller-Fauré* and *van Riet*, stating that the requirement for prior authorisation cannot legitimise discretionary decisions by national authorities, but must be based on objective, non-discriminatory criteria and allow for decisions on authorisation to be challenged in judicial or quasi-judicial proceedings (paragraphs 115-116). Notably, the Court goes beyond a restatement of precedent and extends the obligation of member states to provide transparency and legal certainty to European citizens:

> To that end, refusals to grant authorisation, or the advice on which such refusals may be based, must refer to the specific provisions on which they are based and be properly reasoned in accordance with them. Likewise, courts or tribunals hearing actions against such refusals must be able, if they consider it necessary for the purpose of carrying out the review which it is incumbent on them to make, to seek the advice of wholly objective and impartial independent experts" (paragraph 117 of the judgement).

The *Watts* case thus strengthens the position of the European patient. Not only has s/he been granted rights beyond national borders, but s/he has also been provided with a structure and judicial procedures through which to bypass the national system or challenge its decisions. The response to this judgement by EU citizens, private interests, national courts and member state governments will decide the next steps in the future development of patients' rights and the structures to guarantee them.

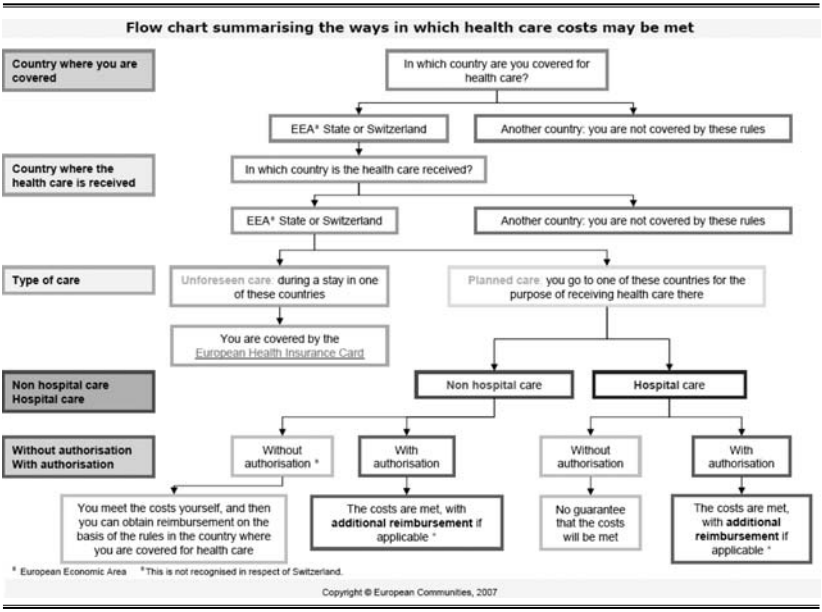
2.2 Current Access to Cross-Border Healthcare

The current situation for those wishing to access cross-border welfare is rather complex in that they have different access points and that a considerable part of the European healthcare rights are based on a series of case-law rulings by the ECJ, but still have to take the restrictions of national legislation into account. In general there is a considerable lack of legal clarity and transparency. However, information on the complex of rights is increasingly becoming available in a more coherent way, communicated from authoritative Community sources. Recently, the European Commission Unit on the Coordination of Social Security Schemes within DG Employment, Social Affairs and Equal Opportunities has launched a new webpage providing an accessible and good overview of the different rights and requirements when seeking healthcare treatment in another member state.[13]

From a citizen's perspective an advantage of the webpage is that it provides an overview of the different routes for unforeseen as well as planned treatment. Besides giving the overview, it makes it possible for the individual patient to question the objective grounds of a refusal to have the costs of treatment in another member state reimbursed or the refusal to be granted prior authorisation to have a planned course of treatment carried out abroad. It also gives an overview of different rules of reimbursement.

[13] The webpage is available at:
http://ec.europa.eu/employment_social/social_security_schemes/healthcare/index_en.htm

Figure 2: Meeting Cross-Border Health Care Costs[14]



It should be expected that the webpage provided by the Commission will in itself lead to more questions and complaints from citizens to the European Commission and to national authorities. It should also be expected that transnational and different national, public or private, agencies will be established to intermediate patients' cross border rights. So far, this type of intermediation seems scarce. However, it is evident that the development opens up for patient organisations, welfare groups and, indeed, private agencies to collate reliable information and carry out the preparatory work to find suitable cross-border treatment. Such agencies could provide the necessary and comparable information on the efficiency, quality and costs of the foreign supply as well as information on the obligations of the competent national institutions. This kind of intermediation would be likely to give new and considerable dynamics to the current development. Such European healthcare intermediation agencies may be the key missing link today. Their absence hinders the spread of information.

[14] Source: European Commission, Unit on Coordination of Social Security Schemes http://ec.europa.eu/employment_social/social_security_schemes/healthcare/e112/pdf/schema_en.pdf

2.3 Future Supranational Healthcare Steps

When the European Court of Justice issued its *Decker* and *Kohll* rulings, politicians reacted forcefully. The German Government, for example, initially spoke out very strongly against the judgements. The former German Minister of Health, Seehofer, argued quite impetuously in the wake of the judgements, saying that the member states had to overturn the rulings through a Treaty amendment and that Germany would not comply with the premises of the judgements (Langer 1999c, p. 54; Børsen, 7. May 1998; Politiken 9 June 1998). The former Minister found the *Decker/Kohll* case-law revolutionary and argued that if Germany adopted its premises, it would be a long-term threat to the sustainability of the German health system (Spiegel 17/98, Fokus from 4 May 1998; Schaaf 1999, p. 274; Eichenhofer 1999a, p. 114; Eichenhofer 1999b, p. 2; Interview, Deutsche Verbindungsstelle, 18 September 2001).

This initial outburst is in sharp contrast to the subsequent political response as nothing further happened. The member states evidently waited for the Commission to take the lead and point out some kind of direction between political opposition and the different positions.

A first step came when the Commission, rather unsuccessfully, attempted to integrate the healthcare area in the proposal for a Directive on services in the internal market.[15] As a precise reproduction of the Court's decisions, Article 23 of the new directive proposed 1) an *internal market for non-hospital care,* where the patient has a right to seek treatment in another member state without prior authorisation and subsequently have the costs reimbursed by the competent national institution, 2) a right to *hospitalisation* in another member state, provided that the member state of affiliation offers the same treatment and that *authorisation* has been granted beforehand. The health ministers, however, refused to have their policy area regulated as part of a general Directive on services, placed under the responsibility of DG Internal Market. Article 23, and thus the healthcare area, was taken out of the Directive.

Consequently it appeared clear that European healthcare could not be regulated from an overall internal market perspective, but the judicial integration still called for political codification and more transparency. In September 2006, DG Health (SANCO) communicated a consultation procedure on health services.[16] The Communication called for stakeholders'

[15] COM (2004) 2, 5 March 2004. Proposal for a Directive of the European Parliament and of the Council on Services in the Internal Market.
[16] The Communication is SEC (2006) 1195/4, 26 September 2006.

contributions to state their opinions on a set of questions related to the free movement of health services. The deadline for submitting the contributions was 31 January 2007 and from here onwards it will be for DG SANCO together with DG Employment, Social Affairs and Equal Opportunities, DG Internal Market and, possibly, DG Competition to formulate a Commission proposal (Interview, European Commission, February 2007). Currently, it is difficult to state more exactly the timeframe for formulating the proposal, but it may be submitted late summer or autumn 2007, or it may take longer, depending on how the Commission evaluates the many contributions and the extent to which the involved DGs are able to establish a consensus between them (interview, ibid).

The Communication begins by giving a kind of status on healthcare integration so far and the need to clarify developments to the public and national administrations. It is interesting to note that the Communication emphasises that previous case-law has developed two guiding principles (SEC (2006) 1195/4, p. 4):

– "Any non-hospital care to which a person is entitled in their own Member State they may also seek in any other Member State without prior authorisation, and be reimbursed up to the level of reimbursement provided by their own system
– Any hospital care to which they are entitled in their own Member State they may also seek in any other Member State provided they first have authorisation of their own system. This authorisation must be given if their system cannot provide them care within a medically acceptable time limit considering their condition. They will be reimbursed up to at least the level of reimbursement provided by their own system"

It seems clear that according to the Commission, the prevoius series of case-law constitutes the binding state of art within the field. The Communication states that "The Court's rulings on these individual cases are clear in themselves, and no precondition may be required for the exercise of the rights of patients recognised by the Court. However, it is necessary to improve clarity to ensure a more general and effective application of freedoms to receive and provide health services" (SEC (2006) 1195/4, p. 4).

Aiming at establishing such transparency, as well as a more general and effective application, the Commission poses a set of questions for stakeholders to respond to. These are:

Questions posed to stakeholders by the European Commission in SEC (2006) 1195/4

Question 1: what is the current impact (local, regional, national) of cross-border health care on accessibility, quality and financial sustainability of healthcare systems, and how might this evolve?

Question 2: what specific legal clarification and what practical information is required by whom (eg; authorities, purchasers, providers, patients) to enable safe, high-quality and efficient cross-border healthcare?

Question 3: which issues (eg: clinical oversight, financial responsibility) should be the responsibility of the authorities of which country? Are these different for the different kinds of cross-border healthcare?

Question 4: who should be responsible for ensuring safety in the case of cross-border healthcare? If patients suffer harm, how should redress for patients be ensured?

Question 5: what action is needed to ensure that treating patients from other Member States is compatible with the provision of a balanced medical and hospital services accessible to all (for example, by means of financial compensation for their treatment in 'receiving' countries?

Question 6: are there further issues to be addressed in the specific context of health services regarding movement of health professionals or establishment of healthcare providers not already addressed by Community legislation?

Question 7: are there other issues where legal certainty should also be improved in the context of each specific health or social protection system? In particular, what improvements do stakeholders directly involved in receiving patients from other Member States – such as healthcare providers and social security institutions – suggest in order to facilitate cross-border healthcare?

Question 8: in what ways should European action help support the health systems of the Member States and the different actors within them? Are these areas not identified above?

Question 9: what tools would be appropriate to tackle the different issues related to health services at EU level? What issues should be addressed through Community legislation and what through non-legislative means?

As many and vast as the questions are, as manifold and vast are the stakeholders' contributions.[17] No less than 266 contributions were submitted. Among the contributors are member states and EEA states, regional authorities, national parliaments, national organisations, international organisations, citizens, universities, and commercial organisations and companies. The member states France, Bulgaria and Portugal did not submit contributions. The different member states' opinions and preferences will be compared and analysed in section 4 below.

What is clear for the time being is that the different DGs involved in formulating the proposal now have an immense task in analysing the different viewpoints and deciding what to take into account and what to leave out – and which precise balance to strike between internal market principles and the protection of the individual characteristics of the national health systems. By having initiated an open hearing process on broad questions, the task of combining and selecting the many different opinions and preferences will be anything but straightforward.

[17] The stakeholders' contributions can be found at: http://ec.europa.eu/health/ph_overview/co_operation/mobility/results_open_consultation_en.htm

3 EUROPEAN HEALTHCARE FAMILIES

European healthcare families mirror the different welfare models that individual states have institutionalised over time. Models or typologies have for a long time been used as comparative tools in welfare research. Back in the 1950s, Wilensky developed the distinction between the residual and the institutional welfare state. In 1971, the distinction was extended by Titmuss, when he added the performance-oriented scheme as a third model. In 1990, Esping-Andersen emphasised the ideological link of the three welfare ideal types, and placed them in their broader political-economic contexts. The residual welfare state referred to the liberal ideology, represented by the US and United Kingdom among others. The institutional welfare state was mainly formed by social democracy, and was represented in the Scandinavian states. The performance-oriented model was found in countries where conservative ideology had dominated such as in Germany, Austria, France and Italy. The criteria for Esping-Andersen's distinction between welfare models was the extent of 'de-commodification' that each state granted its citizens, meaning the degree to which the social security of the individual is independent of market performance.

In the mid-1990s Ferrera pointed out that there was a Southern welfare model in Europe, characterised by 'corporatist' income maintenance, a low degree of state involvement and persisting clientelism. However, for the field of healthcare policy, the corporatist, income-reflecting path was departed and replaced by the establishment of a National Health Service based on universalistic principles (Ferrera 1996). Also the UK made a healthcare departure from its residual welfare model, and established a National Health Service on universalistic principles.

Since then the EU has been enlarged from 15 to 25 to 27 member states. The 10 new member states which were included in 2004 in general chose a different healthcare path. Contrary to Southern Europe, the new member states from Eastern Europe seem to have chosen the performance-oriented or income maintenance model when it comes to healthcare. Slovakia, the Czech Republic, Hungary, Slovenia, Estonia, Poland, Lithuania and Latvia now cover the main part of healthcare expenditure by using social insurance contributions. However, the total funding of healthcare in most of the countries relies on a mix of financing models, which besides contributions also includes general taxation, voluntary insurance premiums and user charges (Dubois & McKee 2004, p. 55). On the other hand, Cyprus and Malta were historically subject to British influences. Here, general taxation is the greatest financial source, but still amounts to less than 50% of health expenditure. The tendency here is that out-of-pocket payments are the

second most important financial source, supplemented by voluntary premiums (Dubois & McKee Ibid.). Also informal payments/under the table payments seem to constitute a significant part of healthcare financing in some of the new member states. It is clear that such informal payments have severe consequences on the effectiveness of the systems and public policies, because the flow of resources into the system depend on the willingness and need of patients to make informal payments (Dubois & McKee 2004, pp. 49-50). Budgetary transparency, capacity planning and equity are difficult to uphold in a system that in part relies on informal payments.

Officially the healthcare policy of the new member states provides universal cover, but in some member states the population is covered to a varying extent. Malta, Slovenia, Slovakia and the Czech Republic have systems that cover all permanent residents. Hungary, Lithuania and Poland differ since entitlements are based on contributions. Cyprus is a third case, making public healthcare restricted to government employees, families with four or more children and low-income households. Higher income groups are charged for access to public healthcare (Dubois & McKee 2004, p. 59).

EU healthcare families can analytically be divided into two typologies/ basic institutional designs (Ferrera 2005, p. 124). A model organised as a *National Health Service* covering the residing population universally and another organised as a *social insurance/Bismarkian* model, around performance or income-reflecting criteria. A main characteristic of the *National Health Service* system is that healthcare rights are granted on the basis of residence (Cornelissen 1997, p. 32). A person is entitled to healthcare because s/he is a citizen or a habitual resident, and not qua individual contributions paid to a specific scheme. Healthcare expenditure is generally financed by taxes. Yet, tax payment is not a requirement to receive a specific social benefit (Ketcher 1998, pp. 254-255). On the other hand, a main characteristic of the *social insurance model* is generally that market participation gives access to a social security scheme, including healthcare and the degree of this participation decides the level of entitlements.

Although dividing European health models into typologies/healthcare families hardly does justice to the many nuances of each individual model, it is a useful way of emphasising how national health institutions diverge across Europe and places the individual models respectively in comparison with their European counterparts. The table below divides the families primarily according to financial models, as this is held to be decisive when discussing impacts from internal market principles:

Table 2: Health Care Supply in EU-25[18]

Social Insurance		National Health Service
Reimbursement	*Benefits in Kind*	*Benefits in Kind*[19]
• Luxembourg	• Germany	• United Kingdom,
• Belgium	• Austria	• Ireland
• France	• Netherlands[20]	• Denmark
	• Czech Republic	• Denmark
	• Slovakia	• Finland
	• Hungary	• Spain
	• Poland	• Portugal
	• Slovenia	• Italy
	• Estonia	• Greece
	• Lithuania	• Latvia
		• Cyprus
		• Malta

3.1 The Principle of Territoriality

Across the different families, healthcare is built on the principle of territoriality. The territorial closure serves to ensure compulsory inclusion and broad risk-sharing (Ferrera 2005, p. 126). The justification of the principle as an instrument of governance is to be found in the long history of the welfare state. The formation and consolidation of modern social policies took place within the territorial boundaries of the nation-state. Welfare policy was, and remains, closely related to the concept of the nation-state (Eichenhofer 2001, p. 55). The welfare state inherited the nation-state way of defining entitlement with its strong emphasis on territoriality. The welfare state has traditionally been in a sovereign position to require that social benefits and services are distributed and consumed within its terri-

[18] The table for EU-15 draws on Langer 1999, p. 358; Palm 2000, p. 17; Martinsen 2004, p. 290 & Ferrera 2005, p. 125. The 10 new member states have been placed in the typology on the basis of the MISSOC Info 02/2004 "Social Protection in the 10 New Member States" http://ec.europa.eu/employment_social/social_protection/missoc_info_en.htm#01/2006

[19] 'The national health, benefits in kind systems' may have reimbursement for certain services and the instrument of reimbursement may have increased over the last year, but reimbursement is not a general characteristic.

[20] The new health insurance act which entered into force in 2006 in the Netherlands has introduced a significant reimbursement policy. However, it still does not appear as a general characteristic and hence the Netherlands is still included in the category 'Social insurance, benefit in kind system'.

tory (Leibfried & Pierson 1995). Alongside that of social citizenship,[21] the principle of territoriality has defined the scope and reach of European welfare.

Social legislation in the EU member states remains largely based on the principle of territoriality. (Haverkate & Huster 1999, p. 115). Even in a 'globalised' world, the principle finds political justification, although, as will be demonstrated below, the principle has recently been modified in some member states. Social benefits and services are designed to address domestic policy aims and correspond to domestic living conditions and costs (Tegtmeier 1990, p. 29; Clever 1992, p. 300). Above all, the principle of territoriality provides an effective means of national control:

- It ensures budgetary control, by restricting benefits and services to people who reside and/or are present within the national borders.
- It ensures that the policy objective is pursued in practice by, for example, monitoring that long-term care benefits are in fact used to purchase care and that family benefits meet policy intentions.
- It serves as a means of controlling the quality of services through nationally defined standards.
- It facilitates capacity planning, ruling out the need to take account of foreign provision.

The principle of territoriality is one of the basic organising features on which modern welfare has been established but it is increasingly challenged by European integration and the enforcement of internal market principles.

[21] Social citizens were traditionally those who were members of the nation. Concepts such as equality and solidarity were not unlimited, but restricted to members of the nation. T. H. Marshall's depiction of 'social citizenship' stands to date as the one that is perhaps most referred to. He wrote: "Citizenship is a status bestowed on those who are full members of a community. All who possess the status are equal with respect to the rights and duties with which the status is endowed" (Marshall 1950, p. 18).

4 ON IMPACTS AND CHALLENGES – EUROPEAN HEALTHCARE MODELS FACING CHANGE?

It is clear that the healthcare systems of EU-25 face a set of common challenges, such as demographic ageing which will severely challenge the balance of public health expenditure. Another common challenge is constituted in the improvements and innovations of new medical technology which demands more advanced and possibly more expensive forms of treatments.

This set of common challenges has inarguably nothing directly to do with the European Union. However, as the European Union gradually, but increasingly, has become involved in an internal market of healthcare demands and supplies, the polity also guides and interferes in the future developments of the sector.

Furthermore, the European Union may in its own right challenge and motivate change in the healthcare sectors of its member states. In its initial phase, the development introduces market logics into the healthcare sector and thus introduces different means of allocating resources more efficiently across borders. In this way, the internal market development challenges those member states which do not provide sufficiently high levels of healthcare quality or do not have sufficiently effective healthcare supply. By inviting patients to choose by exit rather than solely through traditional democratic voice, quality standards or ineffective supply are no longer pure national choices. By interpreting and applying internal market principles, the European Union has granted the Union citizens an opt-out possibility or an exit option from the national system. Until the judicial activism in the late 1990s, this option did not exist, superseded as it was by the national principles of territoriality as a way for the national authorities to steer and control their healthcare sector.

4.1 What Motivates Patients' Choice – Micro level

The case-law development has directly compromised the organising principle of territoriality. The territorial restriction of healthcare consumption has been severely questioned by the constitutionalised principles of free movement in the Union. However, examining the financial impact on the healthcare budgets of this development and the substantive impact on the contents of the different healthcare packages requires a different set of questions.

In the their contributions to the open consultation regarding Community action on health services, the member states' response to question no. 1,

which concerns impact, is quite similar.[22] They note that the current impact in terms of actual patient mobility across member state borders is rather limited. Some member states note that there is no comparable or exhaustive statistics for patient mobility, but that it is 'relatively small'. The member states, however, also emphasise that they expect patient mobility to increase in the future, most notably in the border regions.

One part of the analytical work for this report has been to consider different set of factors that might motivate patient mobility and thus influence the future scope of cross border healthcare. However, the relevant factors depend on which *type of healthcare* we are discussing. In terms of the motivation behind patients' choice, there appear to be two overall types of healthcare benefits and services; 1) Public benefits where the patients *co-finance* a part, 2) Public benefits *provided for free*, i.e. paid fully by the public budget or public health insurance. Patients are likely to be motivated differently in relation to the two healthcare benefit types when they decide whether to stay in their competent member state for treatment, i.e. where they are insured, or opt for treatment in another member state.

In contemporary healthcare, the two benefit types are not just found in separate sectors, so that the benefits with a share of private co-payment are provided *outside the hospital sector* and the others *inside the hospital sector*. The financing form is more mixed today since, for example, hospitals require co-payment for bed-days and night care in some member states, and other member states provide non-hospital care fully free of charge.

Table 3: Factors Affecting Patient Choice

	Factors motivating patient mobility
Public benefits with privately co-financed part	• Economic motivation • Efficiency of supply (waiting time) • Quality of supply • Accessible and transparent information • Individual risk adversity • EU rules. Content and transparency
Public benefits provided free of charge	• Efficiency of supply (waiting time) • Quality of supply • Accessible and transparent information • Individual risk adversity • EU rules. Content and transparency

[22] For the contributions, see http://ec.europa.eu/health/ph_overview/co_operation/mobility/results_open_consultation_en.htm

Whereas the patient, or the health consumer, may be motivated to seek treatment abroad primarily for *financial reasons* when s/he has to finance a part of the service her/himself, there are likely to be a set of additional reasons behind the choice besides the economic rationale such as if the service can be provided *effectively* and with sufficient *quality*. Furthermore, the *information* factor is likely to play a major role. As a consumer area, healthcare must be held to be highly risk sensitive or *risk averse* since personal health is at stake, and hence choice depends on information to a great extent, but also on individual risk adversity. Information may be largely personal between individuals, creating either negative or positive information chains/spirals on the basis of personal experience. However, information may spur as an internal health market becomes more institutionalised, building up different platforms which spread information at a more institutionalised level. Such 'platforms' are private clinics and hospitals, national social security institutions and Commission DGs, detailing Community rules. The new webpage of the European Commission's Unit on the Coordination of Social Security Schemes, described in section 2 above, provides an example of such an information platform. As also emphasised in section 2, the Community information platform is likely to become increasingly supplemented by privately or publicly established intermediation agencies which offer comparable information to patients on the efficiency, quality and costs of cross-border healthcare supplies as well as information on the Community obligations of the competent national institutions. Finally, the development of EU rules stands out as a factor which influences patient mobility. The specific content but also the transparency of European rules have an impact on the extent to which Union citizens find it reliable and a sufficient basis upon which to make cross-border choices. European rules are unlikely to be a dominant factor motivating cross-border choices as long as there is a lack of legal clarity.

For the other category, i.e. public benefits provided free of charge, the set of factors motivating choice are generally similar except that the economic rationale is irrelevant as an individual motivation. *Supply efficiency*, in terms of waiting time for individual forms of treatment, and *supply quality* are likely to become the main motivating factors instead. Moreover, for this kind of healthcare benefit, the accessibility and transparency of *information* is likely to be decisive since *risk adversity* is assumed to be high. Furthermore, the *content and transparency of EU rules* must be significant to cross-border patient choice. For both categories of benefits, it is in particular the lack of institutionalised and transparent information and the lack of legal clarity concerning EU rules which are the two factors likely to at least partly explain why patient mobility remains relatively low.

By the same token, we must expect that as information and Community rules become more accessible and clear this will in itself spur patient mobility.

4.2 What Motivates Patients' Choice – Policy Level

Health policies differ across EU-25. As illustrated in Table 2 above, there are two general typologies rooted in different welfare models; social insurance versus national health services. Whereas the latter generally provides healthcare as benefits in kind, the former diverges between those social insurance systems providing benefits in kind and those where the social insurance institution subsequently reimburses the costs of care to the insured.

Furthermore, member states differ with regard to their individual healthcare packages. Article 152 (5) of the Treaty lays down that the quality and extent of healthcare services are the competences of the member states. It has been important for member states to emphasise that the content of the national healthcare supply falls beyond the scope of Community competences. This was the political message to the Court and the Commission when the member states overruled the Court's *Pierik* decisions in the late 1970s through Regulation 2793/81 – and this is emphasised by several member states in the contributions to the Commission's open consultation on health services.

Nevertheless, both the scope of the national healthcare packages and the quality thereof may indirectly be challenged by greater healthcare exchange across borders. Patients – and voters – will compare the healthcare system and supply of their neighbour state as well as the quality. With extended cross-border information and experience, voters will increasingly require what they provide 'next door' and it will be difficult for politicians to justify lower national standards.

Such 'bottom-up' demands for best quality and standards may be supported by EU soft law measures to compare the quality and safety between the member states. It is interesting to note that some member states in their contribution to the Commission's open consultation on healthcare find that in order to ensure cross-border healthcare, it is necessary to set up comparable basic standards of quality and patient safety (see the contributions of Luxembourg, the Netherlands and Slovenia). The Netherlands goes as far as noting that it is in favour of exploring how to set up minimum standards for care quality at the European level.

It is evident that ensuring patient mobility is not a matter of a single isolated European policy objective. In the logic of issue linking, it is evident that ensuring patient mobility and overcoming national obstacles implies a long list of interlinked policies. If quality is not comparable using certain similar standards, the Community will not be able to realize patient mobility. It is therefore likely that the Commission initiative will propose how to work out minimum comparable standards across the member states, possibly beginning with soft measures such as the open method of coordination.

The policy level is furthermore decisive to *the economic rationale* behind patient motivation to go abroad. The economic rationale becomes decisive when the patient has to co-finance a part of the healthcare service or benefit. National policies decide the extent to which user charges co-finance which benefits and services. User charges differ across EU-25 and across the two typologies; social insurance and national health services, while in some member states, user charges are currently significant for access to healthcare services. In other member states, co-payments have been introduced but the amount that the user has to pay remains at a more symbolic level and has been introduced primarily to avoid overconsumption. However, we expect that since national healthcare systems will gradually have to adapt to the financial challenges caused by demographic ageing, more advanced technology and increased health demands from voters (voice), user charges will become an increasingly important method for healthcare funding.

On the basis of MISSOC data a table on the different use of healthcare user charges in EU-25 has been compiled and placed in the Appendix. The Appendix illustrates the extent to which user charges co-finance health expenditure and differs across the two typologies of national health service systems and social insurance systems. It is clear that a group of member states; Spain, Malta, Ireland, the UK, the Czech Republic, Lithuania have a minimal use of user charges in public health. On the other hand, for a more numerous group of member states co-payment appears to be a fairly important financial instrument, when for example a stay in hospital is user charged. These countries are France, Austria, Germany, Luxembourg, Slovakia, Slovenia Estonia and Latvia, but also in the national health service systems of Finland and Sweden co-payment has come to play a role. However, measured against the level of total costs, user charges remain at a relatively low level in the latter states and foremost aims at discouraging overconsumption. For member states where co-payment plays a prominent role for certain services, the economic rationale to explore the health supply of other member states is clearly present. Also in the

member states where 'under the table payments' are considerable, the economic rationale to go abroad and have the expenses covered by the public purse is likely to intensify.

Furthermore, as the comparison of user charges in the Appendix makes clear, that although there is co-payment for a stay in hospital, co-payment is foremost characteristic for non-hospital care. If we assume that a patient's motivation to receive cross-border healthcare is greater if s/he can save money, then user charges tell us within which treatment types we should expect the economic rationale to play a role. The earlier *Decker/Kohll* judgements spurred the cross-border exchange of dental services and healthcare goods such as eyeglasses. Similar cross-border specialisation could be expected in other forms of ambulant treatment, which are not provided for free in all member states, or may not even be provided by the state in some member states. Different forms of spa treatments are forms of healthcare in which public systems in some member states are advanced and specialised, but which are not recognised in other member states. Some of the new member states have actively started to attract patients from other member states in specific niches of healthcare supply. One such example is Slovenia, which has developed extra capacity in orthopaedics, spa treatment, plastic and gynaecological surgery to meet specific demands from patients from other member states (McKee, MacLehose & Albreht 2004, p. 172).

Fertilisation is another healthcare area of growing public importance. Fertilisation is more accessible, efficiently carried out, offered using different advanced techniques and perhaps less politically regulated in some member states than in others. Abortion is another treatment area where political regulation differs remarkably across the member states, prohibited in some member states if not carried out for medical reasons, legal in other member states but up to different months of pregnancy. From a *de facto* point of view, patient mobility gives European citizens more equal rights to terminate pregnancy. In practical terms, it will be more difficult for, for example, the Swedish or Danish health systems to reject a Polish citizen – on the basis of her European health insurance card – access to abortion. Concrete medical, ethical questions will increasingly be formulated through practice where European citizens exit their national regulations and opt for the more suitable options in another member state and may therefore also impact on diverse public values. Such moves do not respect the ethical boundaries of individual member states and increasingly call for political clarifications at Community level.

The free movement provisions of the EU means in practice that the former voice of patients as voters have been supplemented by a cross-border exit

opportunity, which increasingly will make it difficult to pursue an isolated national health policy without seriously considering what they provide next door.

4.3 The Position of Member States – Political Level

When analysing the member state responses to the internal market implications on national health systems, responses have been uncoordinated, dispersed and reluctant. Far from all member states have implemented the case-law of the ECJ and those which have done so have based their implementation on their national re-interpretation of the meaning and impact of the Court's rulings.

Denmark was one of the first member states to respond to the *Decker* and *Kohll* interpretations of the Court. In the wake of the rulings, the Danish Government set up an inter-ministerial working group to interpret the substance and scope of the Court's statements. The working group published a report on the consequences of the rulings, which formed the basis on which national policy was subsequently amended. In its report, the working group admitted that the *Decker/Kohll* rulings implied general premises. For this reason, the report accepted that their scope exceeded the individual lawsuits. The Danish report, however, revised its interpretation of 'service'. The Danish viewpoint was that for a service to be a service according to the meaning of Article 50 of the Treaty (ex. Article 60), there must be an element of remuneration:

> It is the view of the working group that if, on the other hand, the treatment had been provided by the *public hospital sector, Article 49 of the Treaty would not have applied*. The reason is that Article 50 defines services as *services normally carried out in return for remuneration [...]What characterises a service is thus that a service provider offers a service in return for remuneration*" (Danish Report on the Decker/Kohll rulings 1999, p. 23. Own translation, emphasis added).

The Danish (re-)interpretation of the 'service' concept meant that the vast majority of Danish healthcare services fell outside the definition, since they are provided as benefits in kind, free of charge and thus with no direct remuneration involved. Denmark conceded the *Decker* and *Kohll* procedure to have a discernible impact, but the national definition of what constituted a service in the meaning of the Treaty allowed the entire public hospital sector, as well as all types of non-hospital care provided free of charge, to be exempt. However, the conclusions in the report led to a policy reform, which came into effect on 1 July 2000 and allowed certain services to be purchased abroad with subsequent fixed reimbursement from the

relevant Danish institutions. The policy reform made it possible to purchase general and specialist medical treatment and dental assistance for persons insured under group 2,[23] physiotherapy, and chiropractic treatments abroad.[24]

The subsequent cases, C-157/99 *Geraets-Smits and Peerbooms*, have also led to changes in national healthcare legislation in Denmark. Since 1 July 2002, Danish patients have had the right to receive treatment outside the contracted public hospitals in the event that these are unable to provide the necessary treatment within two months. The purpose of this policy reform was to shorten waiting lists and give patients a certain freedom of choice where the public health supply was insufficient. This health policy reform represented an institutionalisation of an obligation to refer patients to non-contracted healthcare providers in the event that public care could not be provided within the specified time limit. However, the freedom to reform national health policy had been restricted beforehand by the ECJ judicial ruling in *Geraets-Smits* and *Peerbooms*, where the Court clarified that the principle of non-discrimination means that once treatment cannot be provided by the contracted national provider, the member state is not allowed to favour a nationally established, non-contracted, i.e. private, provider over a provider in another member state. In the remarks proposing the national policy reform, its relation to EC law was clear:

> The European Court of Justice has in a judgement dated 12 July 2001 (C-157/99) taken a stand on certain EU judicial questions regarding hospital treatment. The Court has stated that hospitalisation is a part of the provisions on the free movement of services of the EC Treaty. The need for planning and cost containment may, however, justify certain restrictions in access to treatment paid by the public health service or through health insurance. Such rules shall, however, be objective, proportional and non-discriminatory. Supposedly, that implies that when access to publicly paid treatment is given to 'independent' hospitals outside public control and planning, as is the case in the present legislative proposal, access must be provided on an equal footing with hospitals in other EU member states. The legislative proposal complies with the judgement (Legislative proposal L 64, proposed 29 January 2002. Adopted 19 March 2002. Own translation.).

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[23] Denmark has two categories of health coverage. The insured person chooses if he wants to belong to Group 1, under which he is entitled to free medical care, but only from the assigned doctor or from a specialist assigned by the generalist. If the person wants to belong to Group 2, he chooses doctor and specialist freely, but has to pay a part of the costs himself. Group 1 is the most popular choice. Only about 1.6% of all Danish residents are insured under Group 2 (Interview, the Danish Ministry of Health, 3 April 2001; Danish Report on the Decker/Kohll cases 1999, p. 37).

[24] The policy reform entered into force for law no. 467 of 31 May 2000 and BEK no. 536 of 15 June 2000.

From 1 October 2007, the maximum waiting time for treatment in the Danish health system will be further reduced – from two months to one month. This means that after one month of waiting, the patient is entitled to treatment in another member state. Denmark has thus narrowly defined what it considers 'undue delay' and this further reduction in waiting time must increase (considerably) healthcare treatment carried out outside Denmark. It seems highly unlikely, at least at present, that the Danish health system itself will be able to provide a comprehensive set of treatments within one month.

The German federal government responded somewhat later, namely in 2004, when the national health insurance law was adjusted to the ECJ ruling on patient mobility.[25] The health law reform meant that non-hospital treatment carried out in another member state does not require prior authorisation, but hospital treatment must still be authorised in advance. The same health reform made it possible for health insurance funds to contract Community service providers. Essentially the reform means that health insured persons in Germany now have a greater choice of Community service providers. It compromises the principle of territoriality, but by extending the instrument of contracts beyond borders, the national health insurance funds maintain a certain control over the quality and standards of health supply.

Also the Netherlands has recently adopted a major healthcare reform which implements the patient mobility case-law of the European Court and which has a significant impact on the principle of territoriality.[26] It grants freedom of choice concerning supply and demand, also beyond national borders. Moreover, the reform introduces worldwide cover through a principle of reimbursement. Insured persons are entitled to make use of care services covered by the basic health package anywhere in the world, and will as a maximum be reimbursed the usual amount payable in the Netherlands. The reform thus departs from the principle of territoriality.

The fact that member states such as Germany and the Netherlands have gone ahead and implemented the case-law of the Court may prove important when the Commission negotiates the forthcoming proposal on patient

[25] For the direct link between the reform of the national health insurance law and the ECJ case-law, see the contribution from the German government to the Commission's open consultation regarding Community action on health services.

[26] The Dutch Health Insurance Act entered into force at the beginning of 2006. For the direct link between the reformed Dutch health insurance act and the ECJ case-law, see the Contribution by the Dutch government to the Commission's open consultation regarding Community action on health services.

mobility. These countries are thus likely to support a proposal which lies close to the legal interpretations of the Court.

4.3.1 Different political standpoints

When analysing the contributions made by the governments of the member states to the Commission's open consultation regarding Community action on health services, it becomes evident how varied the political positions are. Since the Commission will not be able to find a consensus among the contributions, it must formulate a proposal built on a compromise on the basis of split preferences. The fact that some member states actually favour the development of extending European patient mobility and advocate stronger patients' rights and clarity will no doubt be important to the likelihood for the Commission to have a successful outcome.

From an overall perspective, where member states differ is whether they believe that the case-law strikes the right balance between patients' rights and protecting the particularities of the national health systems or whether they argue that the case-law is formulated too much in favour of the internal market.

The Commission has a strong ally in the Netherlands when it comes to speaking in favour of transnational healthcare. The Netherlands sees a redistributive bonus in the development of transnational healthcare. Cross-border patient mobility can help to increase the efficient use of health resources and the welfare of patients. The Netherlands is a strong advocate of patients' rights, arguing that the key issue of the initiative is how to ensure patient safety and the quality of care. Clearer rules and better information for patients are required. The Netherlands believes that the European Union should seek to establish a readily accessible information system to help patients make cross-border choices, for example on quality, prices, reimbursement, payment by patients, waiting times etc. The impact of such an EU centralised information platform for patients is in itself likely to unleash healthcare from the national territory.

The Netherlands regrets the current lack of legal certainty, but primarily puts the blame on the member states for not having fulfilled their Community obligations by implementing the case-law of the Court:

> This is because legal uncertainty is present not so much at European level, but at national level where member states do not incorporate case law into national legislation. The Netherlands believes that complying with case law is important because it contributes to striking a balance between the interests of individual patients and those of the healthcare system as a whole. The Netherlands believes that member states should incorporate case law into their national systems. It

> has done this in designing its own new healthcare system. Where other member states incorporate ECJ case law insufficiently, the primary solution seems to be for the Commission to institute infringement proceedings against them …

Other member states' contributions also speak strongly in favour of patients' rights (see for example the contributions of Finland, Belgium, Luxembourg and Spain). In fact, it is striking that the member states' contributions in general focus more on patients' rights and transparency than they speak in favour of status quo and the protection of the national systems. The case for the Commission will be to argue the initiative as necessary to ensure patients' rights and - eventually in the light of the current legitimacy crisis – as an important means to lend substance to the idea of a Europe for the citizens.

However, concerns and opposing views are voiced in the contributions too. On analysing the different member states' positions, it becomes clear that 'older' member states (i.e. EU-15) are foremost concerned about a) the distinction made by the Court between non-hospital and hospital care and b) the definition of 'undue delay', whereas 'newer' member states (i.e. EU-10) especially voice concerns about c) how to ensure the health quality and efficiency of their systems for the national populations if the inflow of foreign patients continues to increase. The contributions mirror the fact that the member states see challenges in different dimensions, which is not due to the healthcare model as such but rather to

a) its way of providing healthcare as outpatient or inpatient care;
b) its way of planning capacity, with or without waiting lists; and
c) the costs of the national systems.

4.3.2 Non-hospital versus hospital care

The member states of Germany, Sweden, Finland, Denmark, the UK, the Czech Republic and Belgium emphasise that the ECJ distinction between hospital and non-hospital care is far from sufficient. It is clear that the member states find that the cost-control of non-hospital healthcare might be severely challenged if outpatient treatment could be provided in other member states and reimbursed nationally without the control mechanism of prior authorisation. Furthermore, it is pointed out that hospital care has different connotations in different member states. There is a need for further clarification regarding when prior authorisation is justified under Community law.

The Danish Government takes quite a defensive stand on this point. It finds it decisive to reconsider the distinction between hospital and non-hospital care. Denmark emphasises that non-hospital care may also in

certain cases be very costly and demanding and require considerable investments. Scanning provides such an example. It is therefore the view of the Danish Government that as regards non-hospital treatment there are objective considerations "that justify limitation of the free exchange of healthcare services – i.e. cases in which a requirement of prior authorisation should be possible".

This concern is also voiced by the UK Government. The UK points out that more forms of treatment are today provided as non-hospital care, since many health systems have restructured so that more care is provided outside the hospital sector:

> We were surprised to see in the Commission's Communication the statement that the ECJ has ruled that people may seek 'non-hospital' care (to which they are entitled to in their own Member State) in another Member State without prior authorisation. We do not agree with what the Communication says on this point. In fact the Court has said that it has yet to see a justification for a prior authorisation system for non-hospital care.

According to the UK, prior authorisation is also justified for non-hospital care as it requires no less planning, funding, or careful management than hospital care. It emphasises that it should be considered that many member states have transferred more services from hospitals to primary care settings.

4.3.3 Undue delay

Fewer member states discuss the definition of 'undue delay'. There seems to be a disagreement in the contributions on the waiting time issue as to whether 'undue delay' should rely on a Community or a national definition. It is essentially a question of which authoritative level has the competence to define when delays in treatment are 'undue'. The German contribution points in the direction of a Community definition as it states that further clarification is needed on "how long a waiting period must the insured observe before being eligible for hospital treatment abroad". On the other hand, Sweden and the UK argue that 'undue delay' has already been sufficiently clarified by the ECJ, which essentially means that it is the medical situation of the patient and thus a national decision that will decide when delay is "undue". The UK refers to the Watts case, paragraph 119, emphasising that this is a sufficient definition of undue delay – and that any attempts to further define the concept of undue delay contradicts the logic of the ECJ case-law, "that it should always be clinically assessed against the needs and circumstances of the individual".

4.3.4 The positions of the newer member states – different challenge perceptions

In the debate on the challenges and impacts of European patient mobility, it has been argued that the new member states may benefit from the development as they might attract patients from other member states by offering price competitive treatment. It is clear that the new member states have a competitive advantage concerning costs. The new member states can provide treatment at a significantly lower cost than most of the older member states. European differences in healthcare costs mirror foremost the different costs of salaries. Salaries represent from 65% to 80% of healthcare expenditure (McKee, MacLehose & Albreht 2004, p. 169). Even when travel costs are taken into account, new member states can offer treatment to patients from other member states at very competitive prices. The significance of price differences is illustrated below in terms of the costs of a hip replacement, provided in private hospitals established in different member states:

Table 4 – Charges for Hip Replacement Service in Private Hospitals in Various European Countries (November 2002)[27]

Country	Cost of hip replacement (specialist fee, stay, surgery, prosthesis)
Belgium	€6587 (European HealthNet)
Czech Republic	€1754
France	€4620 (European HealthNet)
Germany	€7000 (through Medibroker)
Hungary	€6600 (Budapest's only private hospital)
Ireland	€5605 (through European HealthNet)
Slovenia	€5675 (results of a survey conducted in Slovenia in 2002)
Spain	€4340 (European HealthNet)
UK	€10640–14840 (BUPA Hospitals – range depends on type of prosthesis)

However, low prices are primarily likely to attract patients if they have to finance a part of the service themselves. Hence this kind of mobility from older to newer member states is most likely to occur in the areas of healthcare where user charges play a role (see the table on user charges in the Appendix and discussed above). Within these treatment sectors patient mobility may have a growing impact. Dental treatment provides such an example, where a certain mobility from Northern and Continental Europe to Eastern member states such as Poland and Hungary is discernable. Some of the new member states have also actively started to attract

[27] McKee, McLehose & Albreht 2004, p. 169.

patients from other member states within other niches of healthcare supply as the case of Slovenia shows (see above).

Despite these competitive advantages, Eastern European member states regard patient mobility from quite a different perspective. Patient mobility also goes the other way; from Eastern Europe to Continental, Southern and Northern Europe. As European citizens, citizens from the newer member states are entitled to a European health card and to apply for authorisation according to the E112 procedure. This type of patient mobility is regulated under Regulation 1408/71 (Regulation 883/2004), and the rules of reimbursement are that the costs of the member state where the treatment is provided are reimbursed. If this member state happens to be Germany, the UK, Denmark or for example Sweden, the price difference for the same healthcare treatment between these states and a competent newer member state is considerable indeed. This has been noted in among others the Estonian contribution to the Commission's open consultation. Estonia notes that in 2005 the average cost per case of person insured and residing in Estonia but receiving treatment in another member state was EEK 11497, whereas the average cost of receiving treatment in Estonia was only EEK 3151. Increased mobility from newer to older member states will therefore have a significant financial impact on the healthcare budgets of the former.

Also Latvia notes that costs are higher in other member states than in Latvia and states that the current impact is that the financial equilibrium is disturbed;

> If the expenses will continue to increase, the budget of Latvian institutions for provision of healthcare services can decrease substantially. This will influence the availability of healthcare services to Latvian residents.

Slovakia has the same point of view, finding that more consideration needs to be given to the financial impact of patient mobility because in some countries healthcare prices are 5-10 times higher than in other countries.

It is interesting to see the different considerations given to question 5 posed by the Commission. Question 5 concerns the action that needs to be taken to ensure that treating patients from other member states is compatible with providing a balanced medical and hospital service accessible to all. Whereas for example Sweden and Germany state that the principle of non-discrimination rules between patients from both home and abroad and that do not entail a negative impact, the newer member states in particular show much greater concern with regard to the longer term impact that patient mobility may have on healthcare accessibility for the national

population. A significant number of newer member states raise concerns about how an inflow of foreign nationals for healthcare treatment may cause imbalances in the national systems, creating longer waiting lists, accessibility problems and a deterioration in service quality. Lithuania argues that the price gap for healthcare services between member states should be reduced in order to maintain the balance in providing equally accessible inpatient and outpatient healthcare. Latvia also raises concerns about that the price differences in services may cause a big inflow of foreign patients. Together with Malta, but also the UK, Latvia argues that member states should be allowed to limit the access of foreign patients, thus allowing national health services to favour the national population. A political position which is in direct conflict with the fundamental principle of non-discrimination embedded in EU law:

> Therefore member states shall have a right to set limitations for planned health care treatment of other EU citizens in institutions providing state financed health care. This measure is necessary to avoid limited access to healthcare of Latvian citizens.

It is thus clear that the newer member states do not share the view that patient mobility gives them a competitive advantage, but rather find themselves severely challenged when it comes to building up, planning and maintaining a national healthcare system within open European borders.

The challenge to the newer member states intensifies when we add the mobility of health professionals. Although the statistics are not available, the newer member states fear an outflow of health professionals, also called 'brain drain'. This emigration of doctors and nurses will have a negative impact on the control of capacity planning as well as the quality and effectiveness of healthcare services. With the active recruitment policies from older member states that lack healthcare professionals and the EU mutual recognition of diplomas, healthcare professionals from the new member states will increasingly emigrate to other member states to get better working conditions and higher salaries. Depending on the extent of this phenomenon in individual states, this must in the medium term be seen as a serious threat to the quality and effectiveness of the healthcare supplies of the new member states. In the longer run, we must, however, expect a levelling out of salaries within the health sector to reduce emigration. This in turn will diminish the price gap between the healthcare services of the member states. It can thus be argued that equilibrium will be established through demand and supply in the longer run. However, in the medium term further patient mobility will be a natural consequence of insufficient health supply, given that European citizens from newer

member states also have a Community-based right to be treated without undue delay. However, their national systems may increasingly become incapable of meeting this right due to the outflow of health professionals and possible inflow of foreign patients to specific healthcare niches. Such cross-border imbalances could give rise to calls for some kind of EU planning capacity.

5 CONCLUDING REMARKS

The institutionalisation of EU rules on patient mobility has been considerably furthered by judicial activism during the last decade. The piecemeal developments have so far succeeded in constructing a significant set of supranational patient mobility rights, which together constitute the contours of an internal market for healthcare. Its future scope and content depends on political responses and/or new judicial clarifications, brought about by citizens, lawyers, intermediation agencies or private interests testing the terrain of intra-European patient rights.

The impacts and challenges of these developments on national healthcare policies are increasingly identifiable. The analysis conducted in this report has pointed out that the adaptive pressure on national healthcare models has not forced them to respond in converging ways. Instead, the impact depends on a set of mediating factors between EU developments and the national outcomes. The impact *de facto* depends on *patient mobility* which remains low at a general level, but is more dynamic within specific healthcare niches. Furthermore, patient mobility must be expected to increase in the future as the transparency and clarity of EU rules improve and as the information on the quality and efficiency of the healthcare system of the neighbouring member state grows. Whereas the *(re)interpretation* of the content and meaning of EU rules by *national administrations* still constitutes a veto point which may hinder full impact, some member states have implemented the case-law of the Court. The discretionary scope that more reluctant member states can hide behind will evidently diminish as others adapt. Furthermore, *national institutions in place* are decisive as carriers of the EU institutionalisation process.

However, the analysis has not confirmed that EU institutionalisation primarily disfavours one healthcare family over another, for example primarily disfavouring national health service systems since they appear to be less compatible with the market logics of the internal market. Instead, challenges and impacts cut across healthcare typologies and put pressure on national institutions for a variety of reasons.

The perhaps most significant impact of developments is that the territorial closure of healthcare policies is compromised. The organising principle of territoriality has been severely questioned by the exit option offered to European citizens. That in turn compromises the steering capacity of national administrations. The principle of territoriality has for long proven to be an effective means through which budgetary control can be maintained. National authorities decide where and at what price healthcare can be provided. In addition, territoriality makes policies more nationally

coherent by establishing a means to control the quality of services through nationally defined standards. Furthermore, it has been a means to facilitate capacity planning as in and outpatient care are only provided nationally. By having to integrate foreign supply, such traditional steering capacity is undermined.

Impacts also depend on the reasons why patients seek treatment in another member state, or why they do not. One crucial barrier to mobility is the lack of information about intra-European healthcare supplies. However, there is no reason to believe that comparable, reliable information will not become increasingly available. Either it will be publicly provided or if not, different intermediation agencies will establish and guide patients through the jungle of different options in accordance with specific needs. Such information mediation can be provided by the insurance industry, other private interests or non commercial welfare organisations, in particular if supranational regulation continues to be absent.

On the other hand, a key motivation for patient mobility is the private economic rationale. When a member state uses user charges as a financial method, it gives the patient an economic motive to consider healthcare where it is provided at a lower cost. Thus public policies are decisive to the motivations behind the healthcare choices of patients. Public policies also determine the quality and efficiency of healthcare supplies. With the exit opportunity provided by EU rules, such policy decisions can no longer be made in isolation without considering the healthcare package and standard of other member states. Patients – and voters – will compare the quality and supply of the healthcare systems of their neighbouring states. In this way, the internal market is primarily a challenge to those member states which do not provide sufficiently high levels of healthcare quality or sufficiently effective healthcare.

When asked themselves, member states see challenges in different dimensions, which do not mirror their specific healthcare model. Instead these challenges depend on a) how they provide healthcare, as inpatient or outpatient care, i.e. as hospital or non-hospital care, b) the way they plan capacity, i.e. for example the use of waiting lists and finally c) the price level of the national system compared to the other member states.

It is mainly the newer member states that point out that the price level is a challenge. They themselves do not regard being able to offer cheaper treatment to patients from older member states – and thus build up a new healthcare industry within specific niches - as a competitive advantage. On the contrary, the challenges for the health systems of the newer member

states are a) the outflow of health professionals to other member states and b) the inflow of foreign patients which obstructs the accessibility to the health systems for the national populations. These two negative impacts may cause an imbalance in their national systems, creating longer waiting lists and a deterioration in service quality. Furthermore, they see the financial equilibrium of their healthcare budgets as threatened since paying for the treatment of one of their citizens in another member state is considerably more expensive than if that treatment had been provided nationally. With insufficient national supplies, also European citizens from the newer member states will increasingly make use of their EU exit opportunity.

For the time being, a great deal will depend on the Commission's forthcoming proposal on patient mobility and the subsequent Council negotiations. New transparent and politically codified EU rules, which clarify and extend Europe for the patients and provide means of redressing supranational rights, will in itself spur patient mobility. However, given the significant disagreements between member states and their very different priorities, a likely outcome might be no political agreement at all or one at the lowest common denominator. Nevertheless, such an outcome is not equal to re-established political or national control, since citizens, national courts and the European Court of Justice will most certainly continue their questions and interpretations. This means that the development will continue to lack political direction and indeed visions on what to do in a EU polity where citizens voice their rights, are not loyal to national provisions and use their exit options from established welfare boundaries. Such European citizen behaviour has a cross-border impact and therefore calls for supranational (political) governance. In essence, the developments, impact and challenges of EU patient mobility demonstrate recent dimensions of European integration, and pinpoint what happens when Union citizens start to practice European rights.

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Appendix – Health Care User Charges (MISSOC)[28]

Member State	User charges for which healthcare benefits
Belgium	– Visit to general practitioner – Visit to medical specialist – Pharmaceuticals – Defined dental treatments
The Netherlands	– Specified dental treatments – Pharmaceuticals – Orthopaedic products – Medically necessary transportation
Germany	– Fee for initial contact with medical or dental service provider – In patient treatment (hospital or rehabilitation) per day of stay – Pharmaceuticals – Orthodontic treatment
Austria	– Stay at hospital per day – Pharmaceuticals – Specified dental treatments – Physiotherapy – Ergotherapy – Medical rehabilitation – Fertilisation
France	– Visits to general practitioners and specialists – Hospitalisation. 20% and daily flat rate for hospitalisation – Pathology lab work – Transport – Pharmaceuticals – Dental treatments – Hearing aids – Orthopaedics
Luxembourg	– Consultation at general practitioner – Home visit – Hospital stay per day – Pharmaceuticals – Dental services – Orthopaedic – Eyeglasses
Spain	– Pharmaceuticals – Orthoprosthetic benefits
Portugal	– Consultation at health centre – Doctor's visit at home – Emergency consultation in hospitals – Pharmaceuticals – Dental care

[28] Data from MISSOC – INFO 02/2005. Health Care User Charges
http://ec.europa.eu/employment_social/social_protection/missoc_info_en.htm#01/2006

Member State	User charges for which healthcare benefits
Italy	– Specialised ambulatory services – Rehabilitations in specialised centres – Health spas – Pharmaceuticals
Greece	– Pharmaceuticals – Hearing aids – Spectacles – Wheelchairs – The regions can furthermore pose costs for non-hospital emergency care
Cyprus	Government medical services are provided free of charge or at reduced rates, depending on category of persons. Paying patients pay for: – Medical visits – Accommodation and nursing – Medical attendance – Pharmaceuticals
Malta	– No considerable co-payment in the public sector
Denmark	– Pharmaceuticals – Defined dental treatments – Physiotherapies – Chiropractic treatment – Hearing aids
Finland	– Visit to doctor – Stay in hospital per day. Day care and night care – Day surgery in hospital – Long-term institutional care. Fees according to solvency – Home help service and home nursing – Dental healthcare – Pharmaceuticals – Transport – The municipalities can determine the amount of client fees for healthcare
Sweden	– Outpatient care – Home visits – Emergency care – Referral to specialist treatment – Specialist treatment – Chiropractor – Gynaecologist – Inpatient care (hospital) per day – Pharmaceuticals – Dental treatment – Eyeglasses – Transportation – The different counties can apply different amounts of co-payments
Ireland	No considerable co-payments

Member State	User charges for which healthcare benefits
United Kingdom	– Dental care – Eye glasses for specific groups
Czech Republic	– Pharmaceuticals – Defined dental treatments
Slovakia	– Transport – Per stay in hospital, accommodation and meals – Spa treatments – Defined dental treatments – Fertilisation – Abortion – Sterilisation
Hungary	– Pharmaceuticals – Defined dental treatment – Extra services in hospitals (better room, meal conditions) – Prosthesis – Spectacles – Hearing aids
Poland	– Spa treatments – Specified dental treatments – Pharmaceuticals – Ambulance service
Latvia	– Outpatient visits to general practitioners and specialists – Doctor home visit – Hospital stay per day – Pharmaceuticals
Lithuania	– Pharmaceuticals – Orthopaedic equipment
Estonia	– Flat fee for services – Patient visits – Stay in hospital as bed day fee – Pharmaceuticals – Defined dental treatment
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