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The ECJ Case Law on Cross-Border Aspects of Health Services

(IP/A/IMCO/FWC/2006-167/C3/SC1)

Briefing Note
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1 Introduction – Legal basis

The EU has only residual competences in the field of health, by virtue of Article 152 EC, (first introduced, with even more restrictive content, as Art. 129 of the Treaty of Maastricht). This limited legal basis has made possible the adoption of support programmes and the delimitation of the scope of competence of some EU bodies and agencies.

The main text of secondary legislation dealing with cross-border healthcare is Regulation 1408/71, as it now stands1. This Regulation corresponds to an early and, hence, limited attempt by the Community Institutions to comply with their obligations under Article 42 of the Treaty. It falls short of achieving any substantial degree of harmonisation and limits its ambit to the coordination of basic national rules in the field of social and welfare benefits2. The provisions of the Regulation which are more specifically concerned with healthcare services are Articles 22, for workers and 31, for pensioners. The basic mechanism established by the said provisions is that, any person wishing to receive healthcare services in another member state has to obtain an authorisation by the competent fund in his home state, except for emergencies; once this authorisation is given, the beneficiary is entitled to receive in the host state, both benefits in kind and cash benefits.

Against this background the Court, in several occasions, has interpreted the Regulation in an extensive manner, so as to regulate issues not directly covered under the provisions of the Regulation. The activist approach of the Court has led the Council to amend the Regulation on several occasions, proceeding thus, at the reversal, by legislative means, of the Court’s case law. This, in turn, has led the Court, in its more recent case law, to pay lip-service to the provisions of Regulation 1408/71 themselves and base its judgments directly on the Treaty provisions on free movement, which are beyond the reach of the legislator.

While a historic presentation of the relevant case law would bring up its evolutionary character, the maturity already reached after the issuance of almost a dozen cases, makes a thematic approach more appropriate.

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1 Council Regulation (EEC) No 1408/71 of 14 June 1971 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community. This Regulation has been modified at least thirty times, the last important modification extending its personal scope to cover nationals of non member states legally residing within the EU, see Council Regulation (EC) 859/2003 of 14 May 2003, OJ L 124/1. It has recently been codified and repealed by Regulation (EC) 883/2004 of 29 April 2004, OJ L 166/1. Since all the legislative and judicial developments of the present contribution refers to Regulation 1408/71, references will be made to this legislative instrument.

2 On the qualification of this regulation as an instrument of coordination rather than as a means of harmonisation see the first recitals of the Regulation. See on this issue, the ECJ judgment of 6 March 1979 in case 100/78 Rossi [1979] ECR 831, Rec. 13, where the Court expressly acknowledges that ‘the regulations did not set up a common scheme of social security, but allowed different schemes to exist, creating different claims on different institutions…’
2 Is healthcare a service under Article 49 EC?

2.1 General

For the first time in *Luisi & Carbone* and then again in *SPUC v Grogan* the Court acknowledged that health services are deemed to fall within the ambit of the economic ‘fundamental freedoms’ of the EC. However, in these early cases the consequences of this finding had not been fully acknowledged, especially not in relation to social security.

The breakthrough came with case the *Kohll*. Mr. Kohll, a Luxembourg national, was seeking reimbursement for a dental treatment received (by his daughter) in Germany, without having received prior authorisation by his home institution. In this case, the Court made it clear that Articles 49 et seq. do apply to health services, even when they are provided in the context of a social security scheme. Or, as the Court put it: ‘the special nature of certain services does not remove them from the ambit of the fundamental principle of freedom of movement’. Hence, the requirement of prior authorisation did, indeed, constitute a violation of Article 49 (then 59) of the Treaty.

*Kohll* was delivered the same day and based on the same opinion by Advocate General Tesauro as the judgment in *Decker*. In *Decker* the Court affirmed that national security and healthcare schemes should also respect Article 28 EC on free movement of goods. The finding that healthcare is *a priori* subject to the Treaty rules was further explained in the judgments in *Vanbraekel* and *Peerbooms*, as well as in cases *Müller-Fauré* and *Watts*. It has been repeatedly confirmed in other judgments of secondary importance. This finding, however, raises some definitional elements.

2.2 What is remuneration?

The main conceptual difficulty in qualifying healthcare as “service” within the meaning of Article 49 EC lies in the requirement of remuneration, stemming from Article 50 EC. The Court has ruled that “the essential characteristic of remuneration lies in the fact that it constitutes consideration for the service in question and is normally agreed upon between the provider and the recipient of the service”10. This definition, however, has been considerably watered down, though not completely abandoned, in recent cases.

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6 Rec. 20 of the judgment. This passage of the judgment has been repeatedly cited by the Court in its more recent judgments, see the developments further down in this para.
In *Smits & Peerbooms* and the other healthcare cases, the Court has a) confirmed previous case law according to which remuneration may exist in triangular situations, i.e. where a third party (e.g. a fund) is paying to the benefit of the service recipient (patient) and, more importantly b) accepted that remuneration may be found to exist even in situations where the correlation between services received and moneys paid is only indirect (e.g. paid on a flat rate basis irrespective of the nature and cost of the service provided) if economically nonexistent. These two tendencies are also to be found in the “non-healthcare” case law of the Court.\(^{11}\)

**2.3 Which system is taken into consideration, home or host?**

Remuneration (i.e. moneys paid) should exist in the actual situation of trans-border healthcare service for which the application of the Treaty rules is claimed. In other words, in order to assess whether a specific cure offered abroad qualifies as a service, no arguments may be adduced from the nature of the health care systems of the home or the host member states. It does not matter that the healthcare system of the home member state does not normally provide for refund (*Müller-Fauré*) or that the host member state offers (free) benefits-in-kind to its own patients (*Vanbraekel, Smits & Peerbooms, Müller-Fauré*). What matters is that the actual patient who has moved to another member state has had to incur expenses (either directly or through his fund) in order to receive some cure.

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3 Exceptions to the application of Article 49 EC

3.1 Solidarity

Despite the developments above, the principle that ‘Community law does not detract from the powers of the member states to organize their social security systems’ remains. Social security systems account for the principle of solidarity and embody the state’s choices in the field of social policy. This is why in Duphar (in the field of goods), Poucet & Pistre (in the field of services)\(^{12}\) and Sodemare (in the field of establishment)\(^{13}\), the Court has avoided the application of free market and/or competition principles, on issues which obey a completely different logic. In this respect, one should keep in mind that the very aim of social and healthcare policy is, precisely, to balance the extreme inequalities produced by free markets and competition.

However, the Court has subsequently qualified the above general statement. In a series of judgments concerning the applicability of the competition rules, the Court has gradually drawn a dividing line between funds (and other entities involved in social security and health care) which operate within the market and those which are outside (the market) and are governed by solidarity. The former should fully abide by the Treaty rules, subject to Article 86.2, while the latter are altogether exempt.\(^{14}\) There is no hard and fast rule for the above distinction, rather the Court refers to a set of criteria (faisceau d’indices). Elements which would point to a non-market entity, include: a) the social objective pursued, b) the compulsory nature of the scheme, c) contributions paid being related to the income of the insured person, not to the nature of the risk covered, d) benefits accruing to insured persons not being directly linked to contributions paid by them, e) benefits and contributions being determined under the control or the supervision of the state, f) strong overall state control, g) the fact that funds collected are not capitalized and/or invested, but merely redistributed among participants in the scheme, i) cross-subsidization between different schemes and j) the nonexistence of competitive schemes offered by private operators.\(^{15}\) In Freskot\(^{16}\) the Court has made clear that the very same criteria help determine the scope of application not only of the competition rules, but also of Article 49 EC.

3.2 Article 86(2) EC

Article 86(2) on the pursuance of ‘services of general interest’, may be usefully invoked, in order to set aside the application of the treaty rules. This may be the case when the activity in question does not fulfil all the stringent conditions in order to qualify as a ‘core’ solidarity activity, but, still, is crucial to the pursuance of some activity of public interest. This will almost always be true for activities related to the provision of healthcare services.


\(^{15}\) For a more detailed analysis of those criteria, see Hatzopoulos (2005) pp. 123-160.

It would seem, therefore, that Article 86(2) offers yet a second ground, together with the identification of core solidarity activities, for exempting certain activities from the application of the Treaty rules. The two series of exceptions remain, however, distinct, both in respect of the conditions of their application and of their effects. The existence of a core solidarity activity is linked to the exercise of public authority and it is based on a series of economic, social, societal and other criteria.

On the other hand, the application of Article 86(2) is mainly based on a case-by-case identification of a service of general interest and on a purely economic assessment of its viability.

3.3 Financial stability and operational efficiency of healthcare services

From the myriad of justifications put forward by member states in order to set aside the application of the Treaty rules to healthcare, the Court accepts only two.

First, the Court accepts that the need of maintaining the ‘social security system’s balance does constitute an “overriding reason”\(^\text{17}\). Hence the Court declares itself ready to support national efforts not to ‘undermine all the planning and rationalisation carried out in this vital sector in an effort to avoid the phenomena of hospital overcapacity, imbalance in the supply of hospital medical care and logistical and financial wastage’\(^\text{18}\). This concern, however, is valid only in respect of services offered within a hospital infrastructure, not outpatient services, for which mobility is likely to be low\(^\text{19}\).

Second, the Court also accepts the need to ‘maintain a balanced medical and hospital service open to all’, a reason which ultimately is also linked to the question of financing.

However, the pursuance of those two objectives should fulfil the requirement of proportionality\(^\text{20}\) and they should be carried out according to objective and non-discriminatory criteria\(^\text{21}\). At any rate, reimbursement of hospital expenses incurred by a patient in another member state, cannot disturb the aforesaid objectives, when it is calculated in accordance with, and does not exceed, the amount payable under the national system\(^\text{22}\).

\(^{17}\) Kohll Rec. 41, Peerbooms Rec. 73 and Vanbraeckel Rec. 47.
\(^{18}\) Idem Rec. 106. See also Recs. 77-81 of Müller-Fauré.
\(^{19}\) Müller-Fauré.
\(^{20}\) Ibidem Rec. 82.
\(^{21}\) Ibidem Rec. 89.
\(^{22}\) Vanbraekel Rec. 52 and Kohll Rec. 42.
4 Are some health systems more immune than others to the Treaty rules?

Contrary to the arguments consistently put forward by the majority of member states, the nature and specific characteristics of their healthcare systems has no *direct* impact on the application of the Treaty rules. Hence, systems offering mere refund (for Luxembourg, France and Germany, see cases *Kohll, Inizan* and *Bosch*, respectively23) are, in principle, treated in exactly the same way as systems organizing benefits-in-kind through contracted doctors and hospitals (for the Netherlands see cases *Smits & Peerbooms, Vanbraekel and Müller-Faurè*) and like UK-like NHSs (for the UK see case *Watts*).

This general statement needs, however, further qualification.

*First,* in relation to the three grounds for exception/non application of the Treaty rules identified in the previous sub-section, it is clear that the nature of the national health/insurance system may have some implications. Hence, a pure NHS system is more likely to be governed by solidarity than some more market oriented system of health provision. Similarly, a NHS based on central planning and capacity building, may be more easily affected by trans-border movement of patients than a more flexible system based on refund or on contracting in/out health professionals and infrastructures.

*Second,* the case law of the Court suggests that under certain circumstances the rules on competition24 and, occasionally, those on public procurement25 become applicable to the provision of healthcare. These two sets of rules are antagonistic and should not, in principle, apply concomitantly. In this respect, the degree and nature of state control and intervention in the organization of healthcare is a decisive factor. Hence, again, entities involved in a pure NHS are more likely to be subject to the public procurement rules, while those involved in a system based on contractual relationships are more likely to fall within the scope of Articles 81, 82 and 86 of the Treaty.

*Third,* and this requires a strictly casuistic approach, every specific set of arrangements may/may not trigger the application of the Treaty rules on state aids.

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24 See cases above n. 14.

5 Authorisation under Regulation 1408/71 and under the Treaty provisions

5.1 When is it necessary?

In all the recent cases the Court interpreted Article 49 EC extensively in order to circumscribe the discretion given to Member States by Article 22 of Regulation 1408/71, concerning the delivery of a prior authorisation to patients wishing to obtain treatment abroad. In this respect, the Court held that for non-hospital treatment, patients can move to other Member States without applying for prior authorisation, pay for the treatment received and then claim a refund from their home institution at the rates at which they would be covered had they not moved (and not at those actually paid in the other Member State). Further, in the cases where the patient did seek prior authorisation, it a) should be delivered following a transparent and timely procedure, subject to judicial or quasi-judicial control, b) could not result to patients receiving less money from what they would have received had they stayed in their state of origin (Vanbraekel), c) could not be refused for specific treatment excluded according to purely national criteria (Smits & Peerbooms) and d) should always be given if the necessary treatment could not be offered in the Member State of affiliation within a reasonable time period, taking into consideration the specific situation of each patient. This last requirement was further qualified in Müller-Fauré and more recently in Watts, which concerned the waiting lists practice under the UK NHS (see below 6.4). Further, in Inizan the Court held that national funds may require their affiliates to obtain a prior authorisation for hospital treatment in another Member State irrespective of whether they intend to move under Regulation 1408/71 (and thus claim full refund according to the tariffs applicable in the host state) or under Article 49 EC (and only claim entitlement under national law). The latter authorisation could be delivered in cases where the conditions for the application of Regulation 1408/71 are not met, or when refund under their national system is higher than in the host state, thus avoiding extra claims under the Vanbraekel case law.

In Bosch the Court held that Member States may decide to do away altogether with the prior authorisation requirement, thus ignoring the possibility offered by Article 22 of Regulation 1408/71. Finally, in Keller the Court held that a patient having the authorisation to move from Member State A to Member State B, is entitled to recover expenses incurred in a third country, provided that he has been referred there by the doctors of Member State B26.

5.2 What are the ensuing rights?

The “Article 22 Regulation 1408/71” authorisation, may virtually lead to the assimilation of its holder to patients of the host state, while the Article 49 EC authorisation, only allows for refund at the rates and tariffs applicable at the home state of the holder. Both authorisations are delivered under similar conditions and subject to the same kind of review under the principle of proportionality. Further points in common and of difference are shown in the table in the annex.

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26 Judgment of 12 April 2005 in case C-145/03, Keller, [2005] ECR I-2529. In this case the patient had the authorisation of Article 22 of Regulation 1408/71, but presumably (in view of the parallelism established by the Court in Inizan and Watts) the same solution would apply if she had the authorisation which may be given under Article 49 EC.
5.3 The case of pensioners

Article 31 of Regulation 1408/71 specifically deals with pensioners and is much more generous than Article 22. Contrary to Article 22 of the Regulation, Article 31 recognizes rights to pensioners (and members of their families) ‘staying in the territory of a member state other than the one in which they reside’ contains no reference to any urgency requirement and makes no mention of any authorisation procedure (benefits are offered upon presentation of Form E 111). This stark difference of treatment was put into perspective in the *IKA v Ioannidis* case. Article 31 and the *Ioannidis* case law, however, only apply where the need for medical treatment arises during the stay of the patient in another member state. If, on the contrary, the patient plans to move there specifically for the purpose of receiving a specific cure, then Article 22 becomes relevant (*Pierik* and *Van Der Duin*).

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6 Various technical questions

6.1 Hospital infrastructure

Most member states, several Advocates General and the Court itself in Müller-Fauré have acknowledged that, in view of the differing practices followed in the member states, it is not easy to tell when a hospital infrastructure becomes necessary. In Leichtle\textsuperscript{29}, however, the Court made it clear that the term “hospital infrastructure” is to be understood restrictively. This case concerned a German who received rehabilitation treatment in a thermal cure centre in Italy. The Court, discarding the fact that such treatment necessitated organized facilities and set infrastructures, held Article 49 EC to be fully applicable and did not leave any room for a prior authorisation requirement to be imposed.

6.2 Expenses covered

In the very Leichtle case the refund asked for by the applicant did not concern expenses incurred for the treatment itself nor for the hotel facilities (both had been already paid for), but money necessary for the payment of a local tax and other accessory expenses. The Court, nonetheless, did not rule out that such expenses could be covered, if such is the practice followed by the home state institution. This was confirmed in Acereda Herrera\textsuperscript{30}, where the Court held that travel expenses of the patient and of a member of his family are not covered under Article 22 of the Regulation, but may, nonetheless, qualify for reimbursement (under Art. 49 EC) if such accessory expenses are generally taken in charge by the institution of affiliation of the patient. The same rule is also to be found in Watts.

6.3 Cost of treatment

It has been explained above that patients moving to another member state without the prior authorisation of article 22 Regulation 1408/71, should be able to claim refund at the rates applicable at their home country. This, however, may prove difficult in practice for patients coming from a pure NHS system, where services are offered “for free” and bear no specific price. In this respect, member states should be encouraged to establish (and to communicate to the Commission?) tariffs – or at least cost determining factors – for all healthcare services offered by public institutions in their territory.

6.4 Waiting lists

Waiting lists, as a means of management of a three-tier health system based on devolution, do not violate the principles of free movement. However, if the use of waiting lists causes “undue” delay, then patients should have the right to move to another member state which may offer an equivalent cure in a more timely way and then receive refund. As already stated, account should be taken ‘not only of the patient’s medical condition … and, where appropriate, of the degree of pain or the nature of the patient’s disability which might, for example, make it impossible or extremely difficult for him to carry out a professional activity, but also of his medical history.’\textsuperscript{31}

\textsuperscript{31} Müller-Fauré, Rec. 90.
7 Conclusion - Is further harmonisation necessary in order to ensure free movement?

The Court, through means of negative integration, has gone a long way in liberalizing the provision of health services. The question, then, arises, whether further coordination/harmonisation (through positive measures) is necessary.

7.1 Health professionals

The Court is unwilling to follow the Member States in considering that receiving healthcare services (or goods) in another Member State may entail dangers for public health. It considers that where the medical professions have been harmonized professionals “established in other Member States must be afforded all guarantees equivalent to those accorded to [professionals] established on national territory”.32 It becomes, therefore, apparent that the harmonisation Directives, aimed to achieving the free movement and establishment of professionals, also serve the free provision of cross-border services.33 If further harmonisation were needed in this respect it should cover specific medical specialties, which correspond to cures for which mobility tends to be high.

7.2 Medical practices

Commission v. France, health laboratories 34 concerned the French legislation which made reimbursement of medical analyses subject to the double condition that medical laboratories be a) established on national territory and b) appointed by a public authority. The Court found the establishment requirement unacceptable under Article 49 EC. It held, however, that laboratories from other Member States, wishing to offer services to French patients, could be required to comply with the French rules in order to obtain the authorisation required by the French authorities, subject to the proviso that “the conditions to be satisfied in order to obtain such authorisation may not duplicate the equivalent statutory conditions which have already been satisfied in the State of establishment”.35 As the Court plainly put it: “[i]n the absence of harmonisation measures, Community law […] does not preclude the French Republic from imposing, in the context of an authorisation scheme, its level of public health protection on laboratories established in another Member State which wish to offer services to members of one of the French sickness insurance schemes”.36 This is a surprising judgment whereby, for reasons related to public health, a member state is allowed to ‘export’ its own restrictive practices to undertakings established in other member states.37 Hence, some harmonisation in this field may be required in order to do away with any authorisation requirement.

32 Kohll para. 48.
33 This point is quite controversial; see for some criticisms Jorens, Y., “European Integration and health-care systems...” op.cit., para. IV(C)1a, where he doubts that it is correct, for the Court, to assume that the harmonisation of the requirements for access to some activities necessarily guarantees equally satisfactory practice in all Member States.
34 Case C-496/01, Commission v. France, Medical Laboratories, [2004] I-2351.
35 Id., para 71.
36 Ibid., para 93.
37 The leading case in this field being Case C-384/93 Alpine Investments [1995] ECR I-1141, annotated by Hatzopoulos in (1995) CMLRev, 1427-1445, where the ‘export’ of restrictions to other member states was held to violate Article 49.
7.3 Hospital / outpatient treatments

It has been explained, above, that the Court has progressively drawn a fundamental distinction between outpatient health services and those requiring a hospital infrastructure. For the former there is, in principle, full freedom to move to other member states, while for the latter a prior authorisation (under Art. 22 Reg 1408/71 or under Art. 49 EC) may be required. However, as practices vary among countries and even within any single health system, it is not easy for patients to know their rights in advance. Hence, it may be useful to establish a system of lists, either at the national or at the EU level, with cures which prima facie qualify as hospital / outpatient. If the national level were adopted, then one could envisage a system of white/black lists. If harmonisation were to take place at the EU level, then also a “grey” list could prove necessary.

7.4 The organization of hospital capacity

The maintenance of curing capacity within the territory of any member state is one of the (two) “overriding reasons” justifying restrictions to Article 49 EC. One way to curb such an “overriding reason” would be, especially in respect of highly specialized cures, to encourage the organisation of common treatment facilities, at the supranational level.

7.5 Collaboration between the competent authorities of member states

High mobility of patients also entails closer cooperation between the competent authorities of member states. In many of the cases decided by the Court and especially so in IKA v. Ioannidis, it becomes plain that the system of cooperation established by Regulation 1408/71 may have important lacunae, which may only be overcome by reference to general principles, such as that of good faith, mutual trust and the loyal cooperation (Art. 10 EC). Recourse to general principles, however, often pays lip service to legal certainty. Hence, some more detailed and compelling rules of cooperation between the national authorities dealing with the provision of healthcare services could prove helpful.
## Annex

The Authorisation procedures under Regulation 1408/71 and under Article 49 EC

<table>
<thead>
<tr>
<th>Points of difference</th>
<th>Reg 1408/71 Art. 21</th>
<th>Art. 49 EC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal Scope</strong></td>
<td>Workers &amp; Pensioners</td>
<td>All legally residing within the EU</td>
</tr>
<tr>
<td>+ Reg. 859/2003</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Material Scope</strong></td>
<td>All treatments (including hospital)</td>
<td>Non-hospital treatment (essentially)</td>
</tr>
<tr>
<td><strong>Level of refund</strong></td>
<td>Host State (if &gt; from home State)</td>
<td>Home State</td>
</tr>
<tr>
<td><strong>Out of pocket – refund</strong></td>
<td>Depending on system of host State</td>
<td>Always</td>
</tr>
<tr>
<td><strong>Possible reasons justifying the authorisation requirement</strong></td>
<td>Financial equilibrium of SS system</td>
<td>Maintenance of treatment capacity</td>
</tr>
<tr>
<td></td>
<td>Maintenance of treatment capacity</td>
<td></td>
</tr>
</tbody>
</table>

### Points in Common

- Host MS may not discriminate or refuse access to patient (*Pierik II*)
- Host MS may not charge different tariffs depending on the status of the patient (C-411/98 *Ferlini* [2000] ECR I-8081)
- The Home State determines which treatments it will reimburse
- The same principles apply to all kinds of health systems, irrespective of whether they operate on a benefits-in-kind, reimbursement or NHS basis

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