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**The Impact of the European Court of Justice
Case Law on National Systems for Cross-Border
Health Service Provision**

(IP/A/ALL /FWC/2006-105/LOT 3/C1/SC1)

Briefing Note

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Executive summary

Cross-border health care is an issue of growing importance in the European Union. This briefing note provides information on the structure of health care systems with respect to cross-border health care in selected Member States. It examines to what extent rulings from the European Court of Justice (ECJ) have caused Member States to make legislative or administrative changes, and the challenges that have been experienced in this regard.

Although patient mobility has increased, the current volume of patient mobility seems to be relatively low (around 1% of overall public expenditure on healthcare). Cross-border challenges predominantly concern planned healthcare as opposed to other forms of care. For planned care, the key challenge is the nature of the authorisation procedures which remain in place as a way of protecting national systems. The terms and application of the authorisation scheme are the central subject matter for the ECJ judgments.

As a result of the ECJ rulings, patients' rights to treatment have been extended and secured and the awareness of these rights and what opportunities and threats they provide has increased. Member States seem to be aware of the ECJ rulings and the necessity of considering their impact on healthcare. Some Member States have made legislative changes as a result of the rulings, while others have accepted them 'wholesale' as part of entering the EU. Some have yet to make any legislative changes. In addition, a number of administrative changes were reported.

ECJ rulings have increasingly challenged the national instruments to retain health supply within their own borders and altered the health care resource atlas available for consumers. However, despite these advances, the ECJ can only develop its law on the basis of the cases brought before it. The lack of legal certainty and the perception that legal standards are vague, coupled with issues of legitimacy of the treatment (what should be paid for and what should not) have contributed to the call for greater clarity on a number of issues. Nonetheless, access to cross-border healthcare will continue to improve as ECJ rulings are transposed into national legislation.

The true nature of the impact of the ECJ rulings might be seen once more information for consumers (as well as health care professionals and providers) becomes more readily available.

The Member States appear, in the main, to be operating largely in accordance with the case-law decisions emerging from the ECJ. However, it is also clear that a balancing act is occurring between addressing ECJ rulings and the perceived needs of national systems: in effect, attempting to balance patients' rights and State interests. This presents a range of challenges for all concerned, not least for those MS who use waiting lists as a device for managing scarce resources, and it may help explain why some MS appear to have made more progress than others. Increasing rights to cross-border healthcare may not, in some cases, be universally perceived as a positive development. Yet the opportunities these rights convey, not least amidst rising health care costs, already appear to be significant.

1 Introduction

Cross-border health care is an issue of growing importance in the European Union. Yet cross-border health services have often encountered problems due to incompatible rules between Member States and the lack of a clear framework and European structure for co-operation. In the absence of a comprehensive EU legal framework for health care, the European Court of Justice (ECJ) has shaped an emergent EU health care policy through applying the rules of internal market law. In essence, the rulings of the ECJ have demonstrated a tension between EU Member States' autonomy in the control of their health social service provision and the Union's basic task of creating a European internal market in goods and services.

The health care systems of the EU Member States (MS) were originally designed as territorially closed systems which serve both economic efficiency and social justice objectives¹. All are predicated on a widely developed system of collective responsibility, universal coverage and social solidarity, and endorse the fundamental goal of access to necessary health care for the whole population irrespective of individual and financial status. They are also characterised by a high degree of government intervention.

Health care systems are usually said to fall into two main categories (although the distinction between the two types is minor in practice):

- National Health Systems (NHS) which are funded by taxation. Entitlement to healthcare is straightforward (free at the point of delivery) and provided to the whole of the resident population. This model exists, e.g. in the UK, Italy, Spain, Denmark, and Sweden.
- Social Insurance Systems (SIS) The system is financed by payment of premiums and the administration is entrusted to various bodies to administer the funds. This model (which can be sub-divided into 'reimbursement systems' and 'benefits in kind' systems) exists, e.g. in Austria, Belgium, the Czech Republic, Luxemburg, France, Germany, the Netherlands, Poland, and Slovenia.

The ECJ decisions influence access to cross-border care and reimbursement schemes for both hospital and non-hospital care to which one is entitled in one's own Member State.

This briefing note provides information on the structure of health care systems with respect to cross-border health care in the Czech Republic, France, Germany, Poland, Sweden, Spain, and the UK. It examines to what extent the ECJ rulings have caused Member States to make legislative or administrative changes to the conditions under which health care can be accessed across borders, and the challenges that have been experienced in this regard.

Information from each of the selected MS has been provided by local experts in response to a uniform set of questions (cf. appendix 1). Variation in responses may be attributed to Member States' varying level of experience in cross-border healthcare, the length of their EU membership and also internal policy challenges.

¹ Rosenmöller M *et al.* - forthcoming (2007)

2 Impact of existing ECJ case law on health service providers and health service recipients

2.1 Current status - Introduction

The management of national social security systems lies within the competence of the MS. In exercising this responsibility, MS must also comply with Community law, in particular, Article 28 of the Treaty on the principle of free movement and Article 49 of the Treaty on the freedom to provide services.

The regime on cross-border health care is governed by interactions between Regulation 1408/71/EEC (to be replaced by Regulation 883/2004/EC) which coordinate national social security systems, and Treaty provisions (Article 49EC) which prohibits restrictions on freedom to provide and receive services in the EU. The principal aim of the legislative framework is the co-ordination of national security systems in the EU, in order to facilitate the free movement of workers.

Data on patient mobility in the EU is limited. However, the extent of cross-border health care is not thought to be huge with the current volume of patient mobility relatively low (around 1% of overall public expenditure on healthcare). Patient mobility has increased, but so far not excessively.²

The dominant drivers for accessing cross-border healthcare appear to be:

- Getting the treatment: Where certain treatments/expertise are available in some countries and not others;
- Getting the quality of treatment: Where the quality of treatment is supposedly superior in some countries as opposed to others; and
- Getting the treatment quicker: Where care can be accessed in another country quicker than the waiting list time of the 'home country' and where accessing capacity quicker in another country could have a marked impact on the effectiveness on the treatment.

We have divided healthcare into four groupings. These are planned care (e.g. a hip replacement or cancer treatment), ambulatory care (e.g. cut hand needing stitching), unplanned care (e.g. tourists having an accident whilst abroad) and privately funded healthcare (e.g. health interventions which are not deemed to be clinically essential). Cross-border challenges associated with access to healthcare predominantly concern planned healthcare as opposed to other forms of care.

Planned care

Citizens have a right to intramural care (care given in hospital that requires a period of stay within that hospital) funded by their health insurance system if they have been authorised and provided with an E112 from their home country. If E112 authorisation is granted the treatment is provided (funded) on the terms of the scheme in the country where treatment is provided (which may include a patient contribution to the costs), and the home state pays the provider directly. In some cases patient may access planned care in MS other than their own and seek authorisation (and reimbursement) retrospectively (see later).

² Rich & Merrick 2006 & Hervey T – forthcoming (2007).

It is in the application of this process which has provided the main body of case law and challenges facing the different countries.

Planned care can also be bought abroad via the purchaser/provider system – a health service purchaser in one MS contracting directly with a health service provider in another MS. This institutionally arranged care usually involves contracting for specific types of planned care and is not governed by Regulation 1408/71.

Ambulatory care

On the whole access to ambulatory care (extramural, ‘walk-in’ care not requiring a hospital stay, provided within or without a hospital setting) is not deemed to be problematic. This is covered by the European Health Insurance Card system (EHIC). All the countries studied in the sample, apart from Germany, appeared to have few issues/challenges associated with accessing this form of care. German law does not differentiate between various treatments undertaken in a hospital setting i.e. it sees all care actually provided in a hospital, *including* ambulatory care as requiring authorisation. This same care would not require authorisation were it to be administered outside of a hospital.

Unplanned care

When it becomes necessary for an individual to receive treatment when abroad, after an accident or unexpected illness, this too is covered in whole or in part by the EHIC. The card gives access to state-provided medical treatment only – treating individuals on the same basis as an ‘insured’ person living in the country being visited. As there is different State coverage in different countries, individuals may be required to contribute to payment under certain circumstances (co-payments). Generally however access to healthcare for individuals requiring treatment under these circumstances does not appear to be a major challenge.

Privately funded healthcare (sometimes termed ‘self-managed’ care)

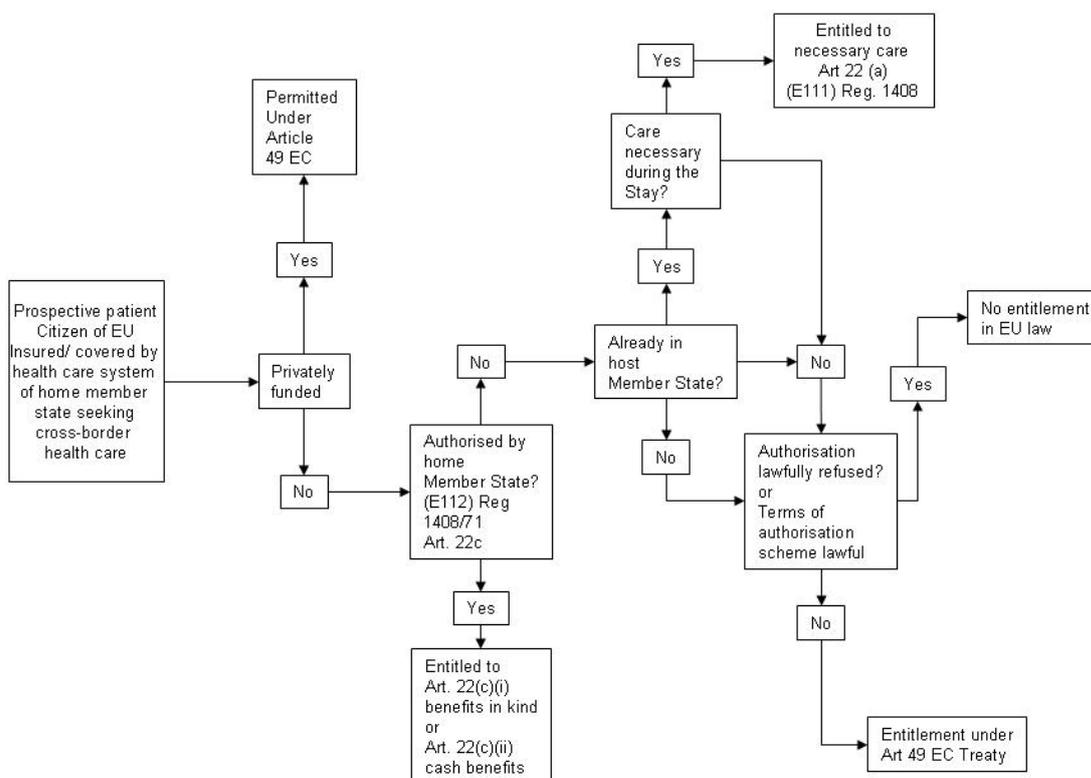
For these interventions there are no access issues and the ECJ case law is not a significant factor here. However, from a regulatory perspective, variation in the regulatory regime within different countries potentially exposes unwitting patients to differing levels of risk. In the UK, whilst health care providers have a regulating body, the Healthcare Commission, it has only been since April 2005 that private providers have also been regulated by this body. It is unclear how extensive regulation of private care is across all other MS, for tariffs and content of care are often not well defined. There are cases where nationals from one country have sought low-cost cosmetic interventions in other countries, and have sometimes needed further remedial (corrective) healthcare interventions in their own country. However, the size of this challenge is unclear.

2.1.1 Focus on planned care

The MS are obligated to follow the recent ECJ rulings, but they are free to decide whether compliance is achieved through national legislation, changes to administrative procedures or other means. Since ECJ rulings are implemented directly by the MS according to their individual administrative structures, the practical application of the standards adopted in the rulings may be subject to different national and local interpretations. Certainly, the impact of the rulings is not uniform across the MS.

A number of MS have made legislative changes in line with the ECJ rulings. Some have welcomed the rulings for their role in clarifying interpretation of certain provisions of the EC regulation 1408/71 (e.g. the Czech Republic), with France commenting that no remaining challenges to accessing cross-border healthcare have been identified. Others, (e.g. Spain) felt the rulings generated more questions than they answered and no changes to their legal system to incorporate ECJ rulings have yet been made. For, despite awareness by both their Ministry of Health and Consumption and the Ministry for Social Affairs that recent case law will require changes in domestic legislation, it is perceived more legislative guidance at an EU level is required and felt that this task falls to the Legal Advisors of the Commission.

The figure below (Hervey 2007) outlines the current process and entitlements of a prospective patient seeking cross-border healthcare. The impact on the various health care systems involved will be different depending on whether the 'foreign' patient enters the system via the E112 route, the institutionally arranged care route (contracts for purchasing planned care) or via private / self-managed care³.



For planned care the key challenge is the nature of the authorisation procedure. Authorisation procedures for non-emergency medical care remain in place as a way of protecting national systems and securing an optimal community size for cross-border services and goods. The terms and application of the authorisation scheme are the central subject matter for the ECJ judgments.

³ Rosenmöller M *et al.* - forthcoming (2007)

Authorisation procedures appear to differ across MS, which causes increased complexity. For example, in addition to the qualification on non-hospital care issue already noted (Germany) there are variations in the time frame that surrounds the process. Sweden appears only to take ECJ rulings fully into regard if application for authorisation is made after treatment, but if the patient applies for authorisation prior to the treatment, this is denied if the expected waiting period is considered normal by Swedish standards under the specific circumstances. At the other extreme, in France a failure to answer a request for authorisation within two weeks implies tacit authorization⁴.

Case study 1: Sweden

Patients may apply to receive prior authorisation, but it is not a requirement for reimbursement of treatment from EU/EES countries. If no prior authorisation has been received, and the patient seeks reimbursement after having received the treatment, the authorities will make a decision according to the following criteria:

- The patient had right to care in Sweden, e.g. had registered domicile in Sweden, when the care was provided for.
- The care shall have been performed in an EU/EEA country.
- It related to a disease or a health condition that is treated within public health care in Sweden.
- The care method that is used abroad shall be identical or in several aspects correspond to a treatment that is used within the public health care in Sweden for the disease or the health condition.
- If the care method is not identical, but corresponds in several aspects, it shall furthermore have been used by the Foreign Service provider during a few years and have been described in scientific medical literature.
- The application must have been filed to the Swedish Social Insurance Administration within two years after the year the care costs were paid or the care bill was due for payment.

When a patient applies for prior authorisation for a treatment abroad, authorisation will be denied if the patient is expected to be able to receive the planned care in Sweden within the waiting period which, taking the patient's health condition and the likely progression of the disease into account, is considered normal for such care in Sweden. However, the patients may still be entitled to reimbursement after the treatment according to the criteria mentioned above.

The Swedish Social Insurance Administration is the body charged with deciding whether the criteria are fulfilled (www.forsakringskassan.se). Its decision may be appealed to the County Administration Court. Recent 2004 rulings from the Swedish Supreme Administrative Court follow the case law of the ECJ.

⁴ The French Social Security Code, Article R 332-4

Case study 2: Spain

Spanish regulations⁵ identify that in order to obtain health care in health centres in other EU countries; an E112 authorisation issued by the Sub-Directorate General of Health Inspection (INSALUD) is required. To obtain the authorisation, the applicant must file a request to the territorial Directorate of the National Institute of Health (INSALUD), attaching a detailed clinical report (issued by a Spanish Social Security hospital) explaining the reason and need to be assisted in another centre and specifying the centre and services to be provided. The applicant will receive a letter, if the request is accepted, which should be delivered to the Agency or Provincial Directorate of the INSS, where they will provide the applicant with the E112 Form. INSALUD's deadline for granting the authorization is 3 months from the date of the relevant request. We are not aware of any specific criteria as yet.

Case study 3: UK

The Department of Health (via local health commissioners in the first instance) is responsible for authorising planned treatment abroad. Three options exist.

- The E112 referral system covers maternity care and referrals for specific (clearly needed) medical treatment with treatment provided on the terms of the 'host country'. The NHS reimburses this cost directly to that country. Travel costs will not be met.
- As a result of ECJ rulings, there are also (now) some *limited* circumstances where patients may pay for hospital treatment abroad and reclaim the costs from their UK health care provider. However this is seen as a complex and evolving area of European legislation and UK practice and the rules for reimbursement differ from those of the E112 scheme.
- It is also possible that treatment abroad may be purchased directly (in a pre-arranged setting) by local health commissioners e.g. a block purchase for cataract surgery. The option of this treatment can then be offered to patients.

Thus, when an individual applies for an E112 there are variations in the authorisation process in terms of the responsiveness (i.e. how quickly a decision is made) and the transparency of the criteria applied by the authorities/states to permission being granted for an E112 (i.e. who is making the decision, based upon what information in different policy contexts). These variations; which may include deliberations on the clinical evidence underpinning the sought-after treatment and contradictory clinical judgements, provide a range of barriers to patients applying to access services in other countries, as the criteria and the evidence against which to judge individual cases is likely to vary substantially.

⁵ Circular 8/1989 of 2nd June adopted by the General Directorate of INSALUD, on the application of the EEC Regulations 1408/71 and 574/72, concerning the provision of health services and Circular 27/1989 of 7th August, from the National Health Institute and Circular 1/1990 of 11 January, from the National Institute of Social Security.

Moreover, when the patient approaches a provider in another country directly, without authorisation, the patient pays, but *may* be entitled to reimbursement *up to the financial limits applied in the home state*. This approach presents a financial risk for patients and can potentially result in drawn out, expensive court cases for both the State and the patient. Currently this is seen to be "a developing area of case law"⁶ and one of a number of areas where increased clarity might be welcomed.

Equally, doubt and ambiguity seem to exist around the interpretation of terms used within Regulation 1408/71 and ECJ rulings such as 'undue delay', 'the time normally necessary for obtaining treatment', and 'taking account of the patients' current state of health and the probable course of the disease'. The focus on waiting times (as a key issue in relation to authorisation) across countries with a variety of funding regimes provides different incentives for States to embrace European healthcare provision. States, insurers and patients have different expectations concerning waiting times and what is deemed to be acceptable. In England a new cross-country target has been set, to be achieved by April 2008, of a maximum 18 week wait from referral to treatment. Such initiatives provide added incentives in some States to increase efficiency within the national system but potentially to look to European capacity if needed.

Data from Spain supports a call for a common glossary of terminology of relevant terms such as medically acceptable time limits, hospital care, comparable costs, as well as a unified social security code at an EU level.

2.1.2 Opportunities and Threats

ECJ rulings provide opportunities and threats for governments, providers and consumers. For governments, the opportunities, (as outlined within the sample data), created by the opening up of cross-border health care include commissioning care in other Member States as a means of managing waiting lists (UK) and as a way of managing health care costs.

The literature suggests that facilitating cross-border care also presents opportunities for maximising resources, sharing best practice, addressing scarcity of supply issues and appears particularly relevant for close border regions, highly specialised treatment centres (centres of excellence / reference centres) and foreign tourist centres.⁷

The issue of utilizing spare capacity also presents opportunities for private providers by way of allowing them to attract additional business, although such 'opening up' of provision requires private providers to keep their costs at a competitive rate.

It appears that Governments have used the advent of a potential European 'healthcare basket' as an additional incentive (within wider health care system reform) to drive efficiency measures in their own country. Both the UK and Sweden reported additional resources (incentives) being made available to increase capacity to speedy clinical care 'at home'.

For individuals (health consumers), the current legal framework appears to have secured their *formal* right to access health care products and services in other MS, with the cost being covered by their own health system (subject to the constraints of the authorisation process).

⁶Department of Health: Going to an EEA Country or Switzerland in order to get treatment.

http://www.dh.gov.uk/PolicyAndGuidance/HealthAdviceForTravellers/GettingTreatmentAroundTheWorld/EEAAndSwitzerland/EEAAndSwitzerlandArticle/fs/en?CONTENT_ID=4114804&chk=%2BQGZ3Q

⁷ See e.g. Hervey (2007 – forthcoming) and Rosenmöller M *et al.* (2007 - forthcoming)

This includes access to care which they may not be able to receive in their own country and opportunities for financial savings. The German data, for example, reports that German patients have the possibility to receive dental treatment in Eastern European countries which costs sometimes 70% below the costs in Germany. In practice however, for the reasons outlined, it may not be easy for a patient to secure the right to access cross border health care within the EU.

From the sample, some MS noted a concern in relation to the ECJ rulings related to the Member States' potentially diminished powers to define how, where and under what conditions taxpayers' money (or social security contributions) will be spent. In addition, the data suggests that were a 'flood of medical tourists' to occur, this could have serious economic and employment implications for the 'host country' and its health care services (UK). Furthermore, substantial migration issues raise further challenges. On this note, Spain identified the high number of foreign nationals of other EU member States who reside in their country, as a significant contextual issue.

Case study 4: Germany: In Germany where a 'benefits in kind' system operates, German care providers are remunerated by lump sum payments based on the population size they serve. Care providers in other Member States are however remunerated according to *actual* costs. This potentially discriminates against German providers i.e. unlike foreign providers they have to pick up the financial differential between the lump sum payment and the actual cost which counteracts stable financial planning. Moreover, German public health insurers feel unable to control the quality of care and the costs of that care in systems outside their own national arrangements. This means that it is difficult to determine the correspondence between the invoice and the actual treatment performed and presents particular difficulties should care 'go wrong'.

However, as stated, it is believed that the number of patients accessing care in another country is relatively small but growing. This is not surprising as, for many patients receiving care locally, within a 'known culture', a familiar system and familiar language is very important. Furthermore, many citizens still do not see themselves as consumers who have choices in relation to their healthcare. The situation is compounded by the dearth of information (for everybody) concerning availability and potential benefits of alternative care providers and the variations in the data related to cost effectiveness and efficacy of different treatments available. There is also little comparative information concerning the quality of medical professionals and providers in different countries. Consequently, informed choices are hard to achieve, which acts as a deterrent to cross-border health care traffic.

2.1.3 Regulation and Quality

Whilst there is evidence that different States regulate their clinical professions and healthcare providers, lack of comprehensive European co-ordination of professions and organisations presents a number of challenges. Currently there are extensive national differences in the way health care professionals are regulated and there is little harmonization between the duration and content of training for different cadres of professionals across the EU. The medical skills and competencies required to exercise each speciality vary greatly from country to country.

Most importantly, the relevant Directives focus on length of initial training, not continuing professional development, practitioner revalidation or quality of treatment and care given. This is why surpluses and deficits have not been addressed by mutual professional recognition.⁸ Whilst the benefits of pan-European regulation of both providers and professionals appear self-evident, it is also clear that the logistics of operationalising this are far from straightforward.

Yet, some health professionals do now work in more than one country. As an example can be mentioned English hospitals contracting with surgical teams from Germany to fly to England for a weekend to operate on large numbers of patients requiring non-urgent surgery⁹. This raises a series of important issues such as systems for clinical governance, professional registration, medical malpractice cover and follow-up. It is understood that whilst work is being undertaken in this area¹⁰, it is uncertain whether this will tackle the assurances that consumers will need to comfortably receive health care from professionals from other MS.

Additional threats to cross-border care include the legal uncertainty for all the different players involved, not least around litigation and compensation issues. There are also concerns about variations in the quality of care across the MS, issues associated with the continuity of care (particularly for those with chronic diseases) and the ‘transferability’ of treatments. For example, drugs often do not have the same name and the same presentation from one country to another. Furthermore, lucrative cross-border institutional arrangements may lead to prioritizing foreign patients over domestic patients¹¹.

2.2 What has changed?

As noted, as a result of the ECJ rulings patients’ rights to treatment have been extended and secured and the awareness of these rights and what opportunities and threats they provide, has increased amongst providers, purchasers and users. Information on these issues (although still very limited) is now available from a number of sources e.g. the European Health Portal¹².

In effect the ECJ rulings have highlighted the existence of an EU based alternative to insufficient national health services¹³. They have also highlighted the notion of patient choice – a concept increasingly at the heart of health care reforms.

All MS contacted were cognisant of the ECJ rulings and the necessity of considering their impact on healthcare. Some Members have made legislative changes as a result of the rulings, e.g. France¹⁴ and Germany¹⁵. Other States had accepted these rulings ‘wholesale’ as part of entering the EU, e.g. the Czech Republic and Poland who both entered the EU in 2004 when the majority of the judgements of the ECJ were already known. Others, e.g. Spain, have yet to make any legislative changes.

⁸ Lethbridge J. (2002).

⁹ Bertinato *et al* (2005)

¹⁰ Grewin B. (2004).

¹¹ Rosenmüller M *et al.* - forthcoming (2007)

¹² <http://ec.europa.eu/health-eu/>

¹³ Martisen DS (2005).

¹⁴ Modification of the French Social Security Code (Decree no 2005-386) to introduce the principle of reimbursement.

¹⁵ ‘Gesundheitssystemmodernisierungsgesetz’ - modernisation of the Public Health System 14.11.2003 which introduced new central provisions in Sec. 13 SGB V and Sec. 140 concerning authorisation and reimbursement.

Variations in the change process may also be explained by the internal political context of some MS. For example, the Swedish government has initiated a report (2005) with the purpose of adopting new regulations on cross-border care, but the report has been delayed due to the advent of a new government. It is now estimated that the report may result in a new Act in 2008. Further changes are likely to follow as the implications of the Watts case from the UK¹⁶ are incorporated into national legislation.

In addition to relevant 'internal' health care reforms already noted (UK and Sweden), a number of administrative changes were reported. For example, a Centre for International Reimbursements has been established in the Czech Republic responsible for implementation of international agreements and EU law. In the UK, the Department of Health has established an overseas commissioner responsible for finding suitable overseas hospitals for the treatment of NHS patients.

¹⁶ Case C-372/04 *Watts* Judgement of 16 May 2006.

3 Conclusions

Health policy-makers will increasingly have to reflect on how EU Community law interacts with the management of national health systems. For without doubt, ECJ rulings have increasingly challenged the national instruments to retain health supply within their own borders and altered the health care resource atlas available for consumers.

However, despite these advances, the ECJ can only develop EU law on the basis of the cases brought before it. Such cases raise significant uncertainties for relevant actors, especially the governments of the MS, and their health care institutions. Moreover, litigation before national courts and the ECJ frames the issue of cross-border health care in terms of a once-off *ex post* adversarial process in which there is one winner and one loser. The opportunities created by the free movement of application of services to healthcare – where the EU can add value to national health care systems – would be better served by a reiterative, deliberative process with which the contours of EU law (and therefore national control over health care), were determined¹⁷. The lack of legal certainty and the perception that legal standards are vague, coupled with issues of legitimacy of the treatment (what should be paid for and what should not) have contributed to the call for greater clarity on a number of issues and certainly contributed to the lack of uniformity of action across MS. Nonetheless, access to cross-border healthcare will continue to improve as ECJ rulings are transposed into national legislation. It may be considered whether support from the European Union may assist a speedy and uniform adoption.

The true nature of the impact of the ECJ rulings might be seen once more information for consumers (as well as health care professionals and providers) becomes more readily available and part of common patient information currency. In addition, building on EU initiatives on cross border care, and the Open Method of Co-ordination in health and long term care, to establish a system which includes robust data collection methods on patient mobility, and best practice in terms of national regulatory standards, within the framework of internal market law, appears to be indicated¹⁸.

Judging from the data obtained, MS are clearly aware of the ECJ rulings and their implications for the provision of cross-border health care and appear, in the main, to be operating largely in accordance with the case-law decisions emerging from the ECJ. However, it is also clear that a balancing act is occurring between addressing ECJ rulings and the perceived needs of national systems: in effect, attempting to balance patients' rights and State interests. This presents a range of challenges for all concerned, not least for those MS who use waiting lists as a device for managing scarce resources, and it may help explain why some MS appear to have made more progress than others. Increasing rights to cross-border healthcare may not, in some cases, be universally perceived as a positive development. Yet the opportunities these rights convey, not least amidst rising health care costs, already appear to be significant.

¹⁷ Hervey. Forthcoming (2007)

¹⁸ Hervey T and L Trubeck. Forthcoming (2007).

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Further information

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The EC has undertaken in its 2007 Annual Policy Strategy to develop a Community framework for safe, high quality and efficient health services, by reinforcing cooperation between Member States and providing certainty over the application of Community Law to health services and healthcare. A public consultation on this was launched in September 2006, due to complete January 2007 with proposals for action to be launched in June 2007.

European Observatory on Health Systems and Policies:

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European Research Programmes (directly relevant):

Europe for Patients. <http://www.europe4patients.org>

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See for example: Grewin B.2005. Cross Border Health Care - Challenges and Perspectives – Patients’ Rights and Liabilities - Access to Information, Quality and Continuity of Care.

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Medicine:

- received in hospital taxes__ public insurance scheme__ other:

- received outside hospital taxes__ public insurance scheme__ other: _____

b) How do the patient receive the health care system's share of the costs for covering medical expenses (inside the country):

(Check more fields if a combination applies. You do not need to indicate voluntary private insurance schemes and specific treatments that are excluded from coverage or only partly covered by the health care system.)

Hospital care:

- emergency care treatment free of charge__ reimbursement__ other:

- ambulatory care treatment free of charge__ reimbursement__ other:

- long-term illnesses treatment free of charge__ reimbursement__ other:

Non-hospital care:

- ambulatory care treatment free of charge__ reimbursement__ other:

- long-term illnesses treatment free of charge__ reimbursement__ other:

Medicine:

- received in hospital treatment free of charge__ reimbursement__ other:

- received outside hospital treatment free of charge__ reimbursement__ other:

You are welcome to also supply very brief examples on how access to and reimbursement for care is applied to the main categories of treatments, such as emergency care (e.g. car accident), ambulatory care (e.g. cut hand need stitching), long-term illnesses (e.g. cancer) – but this is not a requirement.

2) Reaction to the judgments of the European Court of Justice (ECJ) on cross-border health service provision and current status on access to cross-border health services

How has the Member State reacted to the recent case law of the European Court of Justice on cross-border health service provision, and what is the current situation:

- a) Has the Member State identified any areas where the rulings of the ECJ make it necessary to change national legislation and/or practice?

(Focus on the official sources of information (government, parliament, case law etc.). It is not required to mention views of parties separate from the state, such as independent experts).

- b) Has the Member State taken any action to address the issues that have been identified?

(This could be legislation, case law, changes in administrative guidelines and practice, establishment of special bodies to study the issues further, etc.)

- c) Has the Member State identified any barriers or challenges that must be overcome to implement the rulings of the ECJ?

(e.g. does the Member State find the case law too unclear? - difficult to implement directly via national legislation and/or difficult to apply to the specific national cases)

- d) When adopted changes to implement the ECJ rulings, has the Member State adopted any other legal changes which affect the service providers (hospitals, etc) and service recipients (patients)? Will the impact be different for public and private health care provision (public hospitals vs. private hospitals, doctors in private practice, etc.)?,

(Central examples of other changes:

- stricter legal requirements for speedy treatment inside the country(e.g. maximum waiting times)
- increased patient rights to receive treatment at other facilities inside the country (public hospitals in other areas, private hospitals or doctors in private practice)
- changes to the funding of service providers
- changes in taxes, insurance premiums etc. to finance improved treatment rights for patients)

- e) What are the current requirements for accessing hospital and non-hospital care in other Member States, paid by the “home” Member State’s health care system? (this should only be answered for the treatments that the health care system in the “home” Member State would be required to pay for if they had been carried out there). Which public authorities are competent to decide whether the requirements are fulfilled?

(e.g. do the patients need to obtain prior authorisation for the treatment from a public authority? When do the rules say authorisation must be granted?)

- f) Are there any publicised examples on how the above requirements are applied in administrative practice? As far as possible, please supply links or alternatively scanned copies.

(e.g. case law, decisions from the competent administrative authorities)

Appendix 2 – Structure of healthcare systems

National Health System	Comments
United Kingdom	<p>See: http://www.euro.who.int/countryinformation/CtryInfoRes?COUNTRY=UNK&CtryInputSubmit=</p> <p>Tax-financed system, supplemented with private insurance schemes for elective procedures.</p> <p>Currently undergoing considerable reforms designed to improve quality and efficiency by encouraging choice and provider competition and where care is delivered by a diverse range of largely autonomous public and private organisations within a health care market.¹⁹</p>
Sweden	<p>See: http://www.euro.who.int/countryinformation/CtryInfoRes?COUNTRY=SWE&CtryInputSubmit=</p> <p>The Swedish health care is mainly financed by taxes. However, a patient who visits hospital or a doctor must also pay a small fee for each visit.</p> <p>The total fee that a patient needs to pay is limited to SEK 900 per year for medical treatments including emergency care, ambulatory care and long-term illnesses. After the patient has paid SEK 900 all other treatments will be free of charge.</p> <p>The same scheme but with different amounts is used for medicine, technical aids, and sick-travel.</p>
Spain	<p>See: http://www.euro.who.int/countryinformation/CtryInfoRes?COUNTRY=SPA&CtryInputSubmit=</p> <p>The Spanish health care system is financed by taxes which guarantee almost universal coverage. The principal sources of finance of social services of general interest are social security contributions and taxation (both direct and indirect). Other sources do exist (e.g. patient contribution / co-payment, which is particularly relevant in relation to prescribed medication, where it amounts to approx. 40% of the total cost), but the importance and prevalence of such sources is less pronounced.</p> <p>Clinical specialisation is a central feature of the system; a decentralised system made up of a conglomeration of public and private organisations. Private / public partnerships for healthcare provision are becoming more common and the private sector is becoming an increasingly important financer of healthcare services.</p>

¹⁹ Lewis R, Alvarez-Rosete A & Mays N. 2006. *How to regulate Health Care in England? An international perspective*. London: Kings Fund.

Social Insurance System	Comments
a. benefits-in-kind	
Germany	<p>See: <a data-bbox="347 405 1409 479" href="http://www.euro.who.int/countryinformation/CtryInfoRes?COUNTRY=DEU&CountryInputSubmit=">http://www.euro.who.int/countryinformation/CtryInfoRes?COUNTRY=DEU&CountryInputSubmit=</p> <p>A key feature of the German health care service is the clear institutional separation between public health services, primary and secondary ambulatory care and hospital care (traditionally confined to in-patient care).</p> <p>Germany provides for a mandatory public health care system where all employees and workers are insured and the premiums are shared between the policyholders and the employer. The system operates on a “benefits in kind principle”. Therefore the medical treatments that are covered by the health insurance are free of charge.</p> <p>Besides this, a private insurance scheme exists that mainly concerns self-employed persons or likewise employees earning more than 47,250 EUR net per year (at present). These persons can nevertheless voluntarily join the public health care system. The private insurance scheme in contrast establishes a system of remuneration.</p>
b. Reimbursement systems	
Czech Republic	<p>See: <a data-bbox="347 1111 1409 1184" href="http://www.euro.who.int/countryinformation/CtryInfoRes?COUNTRY=CZH&CountryInputSubmit=">http://www.euro.who.int/countryinformation/CtryInfoRes?COUNTRY=CZH&CountryInputSubmit=</p> <p>Health care is provided on the basis of compulsory public insurance scheme, without co-payments. There is universal membership and contributions are made by the individual, the employer and the State.</p> <p>Patients have free choice of health insurance fund, which always has to reimburse the standard level of health care, as stipulated by law.</p> <p>There is a diversity of provision with mainly private ambulatory care and public hospitals.</p> <p>Dental care is reimbursed in accordance with a special price list, while procedures using material above the stipulated standard are paid for by patients.</p> <p>Medicines are classified into 3 categories, one part being fully reimbursed, second one partly reimbursed, and the third one is fully paid for by patients.</p> <p>Spa treatment is reimbursed (fully or party) or not reimbursed according to the patient’s health condition.</p> <p>In all abovementioned categories, the required health care is provided on the basis of insurance card (today issued in form of European Health Insurance Card), usually without co-payments (except the above stated exceptions). The costs are subsequently paid for by their insurance fund to the respective service provider.</p>

Social Insurance System	Comments
a. benefits-in-kind	
France	<p>See: <a data-bbox="347 353 1401 421" href="http://www.euro.who.int/countryinformation/CtryInfoRes?COUNTRY=FRA&CtryInputSubmit=">http://www.euro.who.int/countryinformation/CtryInfoRes?COUNTRY=FRA&CtryInputSubmit=</p> <p>The health care system is mainly funded by a public insurance institution called the Sécurité sociale – branche assurance maladie (the “Sécurité sociale”) which reimburses medical costs incurred by patients. The Sécurité sociale is principally funded by mandatory payroll deductions.</p> <p>General taxes are used to fund in part the health system, e.g., to finance public hospitals. On top of that, some specific taxes are levied to fund the Sécurité sociale – branche assurance maladie (e.g., the Contribution sociale généralisée - CSG), resulting in public insurance schemes being intertwined with tax resources.</p> <p>The patient receiving hospital care need not pay the share of the costs covered by the Sécurité sociale. This is “treatment free of charge” for this share of the costs.</p>
Poland	<p>See: <a data-bbox="347 913 1401 981" href="http://www.euro.who.int/countryinformation/CtryInfoRes?COUNTRY=POL&CtryInputSubmit=">http://www.euro.who.int/countryinformation/CtryInfoRes?COUNTRY=POL&CtryInputSubmit= <a data-bbox="347 1003 957 1037" href="http://www.euro.who.int/document/e67136.pdf">http://www.euro.who.int/document/e67136.pdf</p> <p>Poland has a mixed system of private and public health care financing. Social health insurance contributions represent the major source of health care financing.</p> <p>Health insurance contributions are mandatory.</p> <p>The public insurance system which provides treatments ‘free of charge’ at the point of delivery although some specific treatments are not covered by the public insurance scheme.</p> <p>Prescription medicines can be purchased: a) for a lump-sum price (in case of basic medicines – PLN 3,20 and in case of magistral preparations – PLN 5); b) for 30 or 50% of the price of a medicine (in case of supplementary medicines); c) for a full price - in case of medicines which are not included in the reimbursed drugs list.</p>

Appendix 3 – National regimes on access to cross-border health care

Country	Changes to national legal system regarding cross-border health care, further to the ECJ rulings	Current regime on access to cross-border healthcare	Practical consequences and experiences
United Kingdom	<p>Following European Court of Justice (ECJ) rulings in July 2001, patients in the UK are entitled to receive hospital care in other countries in the European Economic Area. Therefore, healthcare organisations in the UK, for example, health authorities (HA), Primary Care Trusts (PCTs) and Trusts, may commission treatment from other healthcare organisations within the EU.</p> <p>The Department of Health has established an NHS overseas commissioner who is responsible on behalf of the NHS for finding suitable overseas hospitals for the treatment of NHS patients.</p>	<p>The Department of Health, or its equivalent in Northern Ireland, is responsible for authorising the treatment abroad and, if appropriate, for issuing an E112, basing its decision on recommendations made by local health commissioners.</p> <p>E112 are not issued automatically or on a 'just in case' basis. There must be a clear need for treatment.</p> <p>Patients wishing to receive treatment abroad at the expense of the NHS will either need to be referred abroad by their NHS Trust, or need to receive prior authorization to receive treatment under the E112 scheme. Patients who fund their hospital treatment privately will not be separately reimbursed.</p> <p>Authorization does not have to be granted if the treatment in question is available under the NHS and can be given in the time normally necessary, "taking account of the patient's current state of health and the probable course of the disease".</p>	<p>Sending patients for treatment in the EEA has been identified by the UK Department of Health as one of the options open to NHS/PCTs (Primary Care Trusts) wishing to manage their waiting lists and reduce waiting times; the view being that this may offer greater patient choice where this represents good value for money and increased convenience.</p> <p>At the centre of the Government's policy for improving patient services is reducing the time that patients have to wait for hospital appointments and admissions. Additional resources are being made available to increase the NHS's capacity so that more patients can be treated and more quickly.</p>

Country	Changes to national legal system regarding cross-border health care, further to the ECJ rulings	Current regime on access to cross-border healthcare	Practical consequences and experiences
United Kingdom (cont.)		<p>If the treatment is not something available under the NHS, authorization may be granted on discretionary grounds, if there are strong clinical grounds (supported by the patient's specialists in this country) and the patient's Primary Care Trust (PCT) agrees to meet the costs.</p> <p>A patient applying for the Department of Health for authorization of treatment abroad must, with his/her consultant, locate an appropriate hospital abroad, have sufficient financial resources to pay for travel. If the application is approved, the NHS only pays for the treatment.</p> <p>In some circumstances the local health commissioner must recommend that a patient is given an E112. This is in situations where the patient cannot obtain the treatment in the UK without undue delay and where the treatment is of a kind provided by the NHS and is justified. In considering what constitutes undue delay, the local health commissioner will take into account all the circumstances of the patient's case, including, if appropriate, the degree of pain or the nature of the disability and whether this affects, for example, the patient's ability to work.</p> <p>The Department of Health or the NHS will not reimburse patients for treatment where no prior approval has been sought</p>	<p>Since January 2002 almost 600 patients have received treatment in the EEA in France, Belgium and Germany, which has been funded by the NHS.</p>

Country	Changes to national legal system regarding cross-border health care, further to the ECJ rulings	Current regime on access to cross-border healthcare	Practical consequences and experiences
Sweden	<p>The issues have been considered by the Supreme Administrative Court in 2004. These rulings are binding on the Swedish administrative authorities. A brief summary of the rulings is provided below.</p> <p>Case 1</p> <p>In 1994, the patient was diagnosed with a severe inflammatory disease, "SLE". She was offered treatment at a Swedish hospital according to the NIH protocol, which was then used in Sweden and several other countries. After two rounds of treatment (out of the planned 6 to 12), she interrupted this treatment. She had become aware of a treatment method that was available at a university hospital in Kiel, Germany, known as the Kiel protocol. The patient received this treatment from September 1997 until June 1998, and since then she had needed no further medicine or treatments.</p>	<p>The Swedish Social Insurance Administration is competent to decide whether the requirements are fulfilled. Its decision may be appealed to the County Administration Court, and eventually to the Supreme Administrative Court.</p> <p>The current requirements for receiving reimbursement for costs for accessing hospital and non-hospital care in other Member States are the following.</p> <p>Decisions on applications for prior authorization (E112) are made according to the following criteria:</p> <ul style="list-style-type: none"> • The patient has a right to care in Sweden, e.g. has a registered domicile in Sweden without being subject to a social insurance scheme in another EU/EEA country. • The application concerns care that would be provided within the regular Swedish health care system for the particular disease and health condition of the patient. • The planned care must be performed within the regular health care system in an EU/EEA country or Switzerland. 	<p>There has been an increased awareness of the right to receive treatment in other EU countries. However, the number of service recipients using this right is still limited.</p> <p>Between January 2004 and June 2006, the Swedish Social Insurance Administration approved 258 and declined 205 applications for prior authorization.</p> <p>Between February 2004 and June 2006, the Swedish Social Insurance Administration approved 2,028 applications and declined 205 applications for treatment in other EU/EEA countries in cases where no prior authorization had been received. The total costs for the reimbursements were approximately 26 million SEK.</p>

Country	Changes to national legal system regarding cross-border health care, further to the ECJ rulings	Current regime on access to cross-border healthcare	Practical consequences and experiences
<p>Sweden (cont.)</p>	<p>For the treatment in Germany the patient paid 70,000 USD. In December 1997, after having commenced the treatments in Germany, the patient applied for reimbursement from the Swedish authorities. The application was denied, and the patient brought the matter before the Swedish administrative courts.</p> <p>The Supreme Administrative Court ruled in favour of the patient. The court found that SLE was a disease that was treated at Swedish hospitals. The technique used in Sweden at the time was in several regards comparable to the Kiel protocol, though not identical. In 1997, the Kiel protocol had not won common acceptance within international medical science, but it had been used for some years at the Kiel hospital, including for a number of treatments for SLE, and had been described in published medical literature. Therefore, if the treatment had been carried out in Sweden, it would have been subject to the normal Swedish health care payment rules.</p>	<ul style="list-style-type: none"> • The patient cannot receive the planned care in Sweden within the waiting period which, taking the patient's health condition and the likely progression of the disease into account, is considered normal for such care in Sweden <p>Prior authorization for is not a requirement for reimbursement of expenses for treatments in other EU/EEA countries. Applications for reimbursement after the treatment is completed are granted when the following conditions are met:</p> <ul style="list-style-type: none"> • The patient had right to care in Sweden when the care was provided for, e.g. had registered domicile in Sweden. • The care shall have been performed in an EU/EEA country. • It related to a disease or a health condition that is treated within the public health care in Sweden. • The care method that is used abroad shall be identical or in several aspects correspond to a treatment that is used within the public health care in Sweden for the disease or the health condition. 	

Country	Changes to national legal system regarding cross-border health care, further to the ECJ rulings	Current regime on access to cross-border healthcare	Practical consequences and experiences
Sweden (cont.)	<p>Based on these facts, the court found that, in view of the case law of the ECJ, Articles 49 and 50 of the EC Treaty made the patient entitled to reimbursement from Sweden for the expenses paid for the treatment in Germany, less the amount that the patient would have had to pay herself if the treatment had been carried out at a Swedish hospital.</p> <p>Case 2</p> <p>Since the early 1990's, the patient had spent half the year in Sweden and half the year in Germany. During a stay in Germany in 1997, he developed a need for dental care and was treated in Germany. The initial care was considered to be acutely necessary and was therefore paid for by Germany.</p> <p>However, the next step in the treatment (prostheses), which was also carried out in Germany, was not considered acute by the German authorities and was therefore not paid by Germany. Before this treatment, the patient had been informed by the Swedish authorities that he would not be eligible for reimbursement. After the treatment was completed, the patient formally applied for reimbursement from the Swedish authorities. The application was denied, and the patient brought the matter before the Swedish administrative courts.</p>	<ul style="list-style-type: none"> • If the care method is not identical, but correspond in several aspects, it shall furthermore have been used by the foreign service provider during a few years and have been described in scientific medical literature. • The application must have been filed with the Swedish Social Insurance Administration within two years after the year the care costs were paid or the care bill was due for payment. 	

Country	Changes to national legal system regarding cross-border health care, further to the ECJ rulings	Current regime on access to cross-border healthcare	Practical consequences and experiences
Sweden (cont.)	<p>The Supreme Administrative Court ruled in favour of the patient. According to the previous Swedish rules, dental care was only covered by the Swedish health care system when the provider was included on a list maintained by the health care authorities. Only providers established in Sweden were able to be included on the list. The rules also established that for some treatments, advance approval of compensation was mandatory, and compensation was not given if the treatment had been completed before advance approval was given.</p> <p>The court established that the patient had received non-hospital care, and therefore it followed from the case law of the ECJ that advance approval could in no event be demanded. Therefore, a person covered by the Swedish health care system that received dental treatments in other EU countries would in any event be entitled to compensation for the costs from the Swedish health care system. The compensation should be calculated according to Swedish compensation rules, and therefore the patient was entitled to compensation in the amount that the Swedish health care system would have been required to cover if the treatment had been carried out in Sweden.</p>		

Country	Changes to national legal system regarding cross-border health care, further to the ECJ rulings	Current regime on access to cross-border healthcare	Practical consequences and experiences
Spain	<p>No changes have been adopted so far.</p> <p>Both the Ministry of Health and Consumption and the Ministry for Social Affairs are conscious that recent ECJ case law will require a change in domestic legislation, but there is little additional information available at this time.</p>	<p>According to Spanish administrative regulations on the matter, in order to obtain health care in health centres in other EU countries, an authorization issued by the Sub-Directorate General of Health Inspection (INSALUD) is required.</p> <p>The health care services comprise sanitary assistance which the insured person may require immediately, provided that the requested service is included in the general scheme of health insurance in the country where the service is requested.</p> <p>Under Spanish regulations, the persons having the right to obtain cross-border assistance are those covered by the public insurance system in Spain i) who travel to any EU country for a temporary stay or ii) who travel to receive specific treatment.</p> <p>The requirements are different for each case. In relation to i), the applicant may fill in the E111 form, issued by the Spanish Social Security (at the National Institute of Social Security, INSS), together with an Identification Document (DNI, Passport etc) and other documents requested in the form.</p>	

Country	Changes to national legal system regarding cross-border health care, further to the ECJ rulings	Current regime on access to cross-border healthcare	Practical consequences and experiences
Spain (cont.)		<p>In the case of ii), at the centre where the specific treatment is requested the applicant must file the E112 Form issued by the Spanish Social Security, together with ID. To obtain the Form, the applicant must file a request to the territorial Directorate of the National Institute of Health (INSALUD), attaching a detailed clinical report (issued by a Spanish Social Security hospital) explaining the reason and need to be assisted in another centre and specifying the centre and services to be provided. If the request is accepted, the applicant will receive a letter which shall be delivered to the Agency or Provincial Directorate of the INSS, where the E112 Form will be issued.</p> <p>INSALUD's deadline for granting the authorization is 3 months from the date of the relevant request</p>	

Country	Changes to national legal system regarding cross-border health care, further to the ECJ rulings	Current regime on access to cross-border healthcare	Practical consequences and experiences
Germany	<p>Before the ECJ rulings, a medical treatment abroad could only be reimbursed by the public health insurance if the medical treatment was only possible abroad according to the general approved status quo of medical expertise.</p> <p>The German legislator has since introduced the “Gesundheits-systemmodernisierungsgesetz” (Modernisation Act for the Public Health system – “GMG”) dated 14 November 2003, which have led to increased patients’ rights to reimbursement for treatments abroad.</p>	<p>Patients’ rights to treatment abroad have been extended through the new provisions in the SGB. The GMG introduced three new central provisions in Sec. 13 SGB V:</p> <p>1) Sec. 13 para. 4 SGB V: which allows German policyholders to reclaim the costs for medical treatment in the member states of the EC under 2 requirements:</p> <p>a) policyholders may only choose care providers where the requirements for access and exercise of their profession is subject of a EC guideline or who are qualified to take care of public medical insurance policyholders in the respective national system of the member state;</p> <p>b) reimbursement of the costs is capped to the amount that would have been reimbursed by the German public health insurance; except in cases where according to the current status quo of medical expertise the medical treatment is only possible in other EC member states, then the public health insurance may reimburse the entire costs.</p>	<p>German patients have the possibility to receive medical treatments in other EC Member States where the doctor fees are less expensive, e.g. in the eastern European countries. This is especially attractive in the sectors of dental treatments where the costs for treatments are sometimes 70% below the costs in Germany.</p>

Country	Changes to national legal system regarding cross-border health care, further to the ECJ rulings	Current regime on access to cross-border healthcare	Practical consequences and experiences
Germany (cont.)		<p>2) Sec. 13 para. 5 SGB V: the reimbursement of costs in case of a clinical treatment abroad in another EC member state requires the prior consent of the German public health insurance; this consent can only be denied if the same effective treatment can be assured in due time by a contracting party of the public health insurance in Germany.</p> <p>3) Sec. 13 para. 6 SGB V: in cases where medical treatments in other EC member states are reimbursable according to the precedent paragraphs 4 and 5, there exists also a valid claim for sick pay as well as the existing possibility that the health insurance covers additional costs as well as costs for a necessary accompanying person.</p> <p>Travel costs will not be reimbursed. There will be no difference for public and private health care provisions. All doctors and medical institutions are affected that take part in the contractual medical supply with the public health insurances according to Sec. 95 SGB V no matter if publicly or privately organised.</p>	

Country	Changes to national legal system regarding cross-border health care, further to the ECJ rulings	Current regime on access to cross-border healthcare	Practical consequences and experiences
Germany (cont.)		<p>Furthermore, Sec. 140 e has been implemented in the German SGB V, which gives the public health insurances the possibility to conclude contracts with the care providers of other EC member states who fulfil the requirement of Sec. 13 para. 4 sentence 2 SGB V. This way the system of reimbursement of the costs for medical treatments in other EC member states will be replaced by the German “benefit in kind principle”. In these cases the policyholder will receive the medical treatment free of charge and the German public health insurance will reimburse the fees of the care provider.</p>	

Country	Changes to national legal system regarding cross-border health care, further to the ECJ rulings	Current regime on access to cross-border healthcare	Practical consequences and experiences
Czech republic	<p>Czech Republic has entered the EU (and EC) in May 2004. At this time, the judgements of the ECJ concerning cross-border health care were already known, so they were taken into account when applying the EC Regulations 1408/71 and 574/72 from the beginning. The relevant EC Regulations are being interpreted in the light of the judgements from the outset, while there were no special formal regulations adopted or amended.</p> <p>There was a special competent authority established already from January 2002 – Centre for International Reimbursements – as a contact agency for the Czech health insurance system, responsible for implementation of international agreements and EU law. This institution associates and represents all health insurance funds active in the Czech Republic. Its main tasks are:</p> <ul style="list-style-type: none"> - execution of international payments - conceptual, methodical and information service 	<p>Access to health care in other Member States is fully governed by the EC Regulations 1408/71 and 574/72, which are being applied and interpreted with regard to Recommended administrative procedure for application of the Council Recommendations (ECC) 1408/71 and 574/72 (891/15/POJ) and relevant rulings of the ECJ.</p> <p>Generally, a patient has to contact the service providing institution (which is financed from public sources) and submit European Health Insurance Card (EHIC), or Provisional certificate. Costs of the care provided are first being covered by the foreign health insurance (or competent public authority) and subsequently reimbursed by Czech health insurance fund.</p> <p>Patients can also travel to another Member State for purpose of obtaining specific treatment (planned health care) with a prior authorization of their ‘home’ health insurance fund. This authorization cannot be refused if the required treatment cannot be provided in the home country within a medically acceptable time limit, taking into account their condition.</p>	

Country	Changes to national legal system regarding cross-border health care, further to the ECJ rulings	Current regime on access to cross-border healthcare	Practical consequences and experiences
Czech republic (cont.)	<ul style="list-style-type: none"> - agreements with foreign contact agencies dealing with and administration of disputable cases (including legal aid for insured persons, doctors and insurance funds) - cooperation with state administration 	<p>The competent authority for deciding on prior authorization is the respective Czech health insurance fund, while disputable cases are being dealt with by the Centre for International Reimbursements.</p> <p>Non-hospital care can be obtained in another Member State without the need of prior authorization of the Czech health insurance fund, with subsequent reimbursement from the Czech health insurance fund.</p>	

Country	Changes to national legal system regarding cross-border health care, further to the ECJ rulings	Current regime on access to cross-border healthcare	Practical consequences and experiences
France	<p>A decree n° 2005-386 dated April 19, 2005 (the “Decree”) has modified the French Social Security Code (Article R. 332-3 et seq.) and introduced the principle of a reimbursement by the French Sécurité sociale of medical costs incurred in an EU country.</p>	<p>Regarding non-hospital care, no authorization from the Social Security is needed.</p> <p>Regarding hospital care, an authorization is needed but must be granted unless</p> <ul style="list-style-type: none"> (i) the reimbursement is for medical costs not reimbursed in France, or (ii) a “similar treatment or a treatment as efficient as the foreign treatment can be obtained in France within a due delay given the state of the patient and the foreseeable development of his sickness” <p>The person shall file a request for authorization with the local Sécurité sociale (caisse primaire d’assurance maladie), whose medical department shall issue an answer within two weeks. Failure to answer in this two-week period of time implies tacit authorization (Article R. 332-4).</p> <p>Any refusal to grant the authorization may be challenged before the competent court for social security affairs (tribunal des affaires de sécurité sociale).</p> <p>Reimbursement shall not exceed the amount of the sums incurred by the patient.</p>	

Country	Changes to national legal system regarding cross-border health care, further to the ECJ rulings	Current regime on access to cross-border healthcare	Practical consequences and experiences
Poland	<p>Poland as a Member State accessing the European Union in 2004 identified the necessity of adjusting its legal system to the requirements of the European law binding at the time of the accession, also within the scope of the cross-border health service provision.</p> <p>Consequently to the accession of Poland to the European Union the Polish Parliament adopted the following legal acts regarding among others the cross-border health services, and relating in a part to the Regulation No. 1408/71:</p> <ul style="list-style-type: none"> - the Act of 27 August 2004 on Health Care Services Funded from Public Resources (published in the Journal of Laws 2004, No. 210, item 2135, as amended) - the Ordinance of 20 December 2004 by the Minister of Health on directing service receivers to treatment or diagnostic examinations abroad (published in the Journal of Laws 2004, No. 274, item 2729); 	<p>According to art. 25 of the Act of August 27, 2004 on Health Care Services Funded from Public Resources, the National Health Fund generally does not fund costs for treatments and diagnostic examinations costs abroad, when these treatments are also conducted in Poland. However, an exception is made for costs of health care services rendered in compliance with Regulation 1408/71.</p> <p>Prior authorization for treatment in other EU/EEA countries are given upon request if a given treatment or diagnostic examination is conducted in Poland, but, considering the long waiting period for the health care service, the service receiver may not undergo treatment within the usually necessary term.</p> <p>Additionally, pursuant to art. 26 of the Act, the Minister of Health may direct a service receiver, on their request, to treatments or diagnostic examinations abroad, if such treatments are not conducted in Poland, following the necessity of such service for life saving or health improvement of the service receiver, after gaining an opinion of the national consultant competent in a given medicine discipline.</p>	

Country	Changes to national legal system regarding cross-border health care, further to the ECJ rulings	Current regime on access to cross-border healthcare	Practical consequences and experiences
Poland (cont.)	<ul style="list-style-type: none"> - the Ordinance of 22 December 2004 by the Minister of Health on an application to the President of the National Health Fund for conducting treatment or diagnostic examinations abroad (published in the Journal of Laws 2004, No. 279, item 2769) - the Ordinance of 5 October 2005 by the Minister of Health on the manner and criteria of fixing the waiting time for chosen health care services (published in the Journal of Laws 2005, No. 206, item 1724). 	<p>The costs of such treatment or diagnostic examination abroad, together with the costs of the transport to the place of treatment abroad and the place of treatment or residence in Poland, by a cheapest transport mean appropriate for the service receiver's health state, are financed from the budget of the State. The financial resources for coverage of the treatment or diagnostic examination costs are transferred to the medical care institution abroad, under an invoice issued by this institution, and the transport costs are transferred under an invoice issued by the entity conducting the transport.</p> <p>There will be no difference for public and private health care provision, unless a private health care service provider has not entered into a contract with the National Health Fund (NFZ) for rendering health care services within the NFZ. Private service providers which do not cooperate with the NFZ do not render services funded from the public resources, and a service receiver needs to pay for the services personally.</p>	

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