

Everyone's Right to Health Care in Europe: The Way Forward

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1. The Right to Health Care in Europe

We are currently witnessing the emergence of a EU-based health policy, in some sense one could even speak of a Europeanization process. This development has been initiated by the European Court of Justice, which in several rulings has interpreted health care as an area subject to the principles of free movement of services within the internal market.¹ The practical application of the right to health care in other parts of the Union is primarily the fruit of the independent and somewhat integrationist interpretation of the provisions of the EC Treaty by the Court. Without prior authorization, EU citizens are now entitled to seek non-institutional care, including out-patient care and dental care, both on an emergency and non-emergency basis, in all Member States and thereafter claim reimbursement for health care expenses from their home country. The exception to this rule is so-called unnecessary care, e.g. beauty operations.

¹ Please see the following cases in particular: Case C-120/95 (Decker v Caisse de Maladie des Employes Prives), Case C-158/96 (Kohll v Union des Caisses de Maladie), Case C-157/99 (Smits and Peerboms), Case C-385/99 (Müller- Fauré and van Riet), Case C-372/04 (Watts).

When it comes to treatment of patients admitted to hospital, the issue is somewhat more complicated. Generally speaking, patients must obtain prior authorisation from their insurance scheme to be entitled to reimbursement for hospital treatment in other Member States. However, according to the case law of the European Court of Justice, treatment in another Member State may only be refused if the same or equally effective treatment can be obtained in the patient's own country without undue delay. The concept "undue delay" is a legal concept interpreted by the Court, as has been done in, e.g., the Watts case. The concept is related to the seriousness of the illness and the urgency of the treatment, i.e., as underlined by the European Court in the Watts case, it is interpreted in the light of the needs of the individual patient, not timetables or waiting lists drawn up by national health authorities.

This development has been opposed by the U.K. and some other Member States, among them, until recently, Sweden. They have argued before the European Court that cross-national health care (particularly hospital care) would make financial control impossible and lead to an impairment of national control, planning and organisation, which in turn could cause a threat to the basis of universal health care access. The UK Government has argued that the NHS would not be covered by the EC Treaty provisions on services at all, since the NHS is a non-profit-making body (i.a., in the Müller-Fauré case, decided in 2003 and the Watts case, decided in 2006). However, according to the Court's understanding of European law, medical care is a service by definition and a right for the individual. Exemptions from the fundamental EU principle of free movement should be admitted only if objectively necessary and only to the extent the same result cannot be achieved by less restrictive rules. The European Court has not accepted broadly formulated arguments brought forward by the British Government about detrimental effects on the management of the NHS and, in particular, the risk that payment for medical treatment in other Member States would threaten the financial balance of the NHS system. The decision by the European Court in the Watts case should have put an end to this line of reasoning.

2. Sweden and Cross-National Health Care

Sweden has recently experienced a dramatic legal evolution in the field, driven by three ground-breaking cases in its Supreme Administrative Court, decided in 2004. As a result of the outcome of these cases, the country now faces important challenges to its past health policy approach. In Sweden medical care is managed primarily by regional health authorities (the politically elected county councils, the *landsting*) on a non-profit bases, financed by taxes. The private health sector is growing but still very small by comparison with many other Member States.

Until 2004, health care was commonly believed in Sweden to be an area mainly excluded from EU-cooperation. Sweden adopted a “wait-and-see policy”. Few patients and health professionals knew about the individual’s right to seek health care in another EU-country. This drastically changed when the Swedish Supreme Administrative Court decided to hear three important health care cases regarding reimbursement from the national health insurance system for non-emergency utilisation of health care in other Member States (dental care in Germany,² hospital treatment of rectal cancer in France³ and long-time, mostly hospital based treatment of SLE⁴ in Germany⁵).

In January 2004, the Court announced its judgments. The Court found against the National Social Insurance Board, representing the Swedish state, in all three cases and interpreted health care as a service subject to free movement in the internal market in accordance with previous rulings of the European Court of Justice. In the SLE case, the Court ordered the full cost of the treatment in Germany, 70 000 US dollar, to be paid by the national health insurance system to the patient. Also in the two other cases, refund from the national health insurance system was ordered by the Court. In the cases, the National Social Insurance Board argued before the Court that Sweden had a prior-

² Stigell against National Social Insurance Board, case nr. 6790-01

³ Wistrand against National Social Insurance Board, case nr. 6396-01

⁴ Systemic lupus erythematosus

⁵ Jelinek against National Social Insurance Board, case nr. 5595-99

authorisation system in place, which the Court found had no support in Swedish law or practice. Other legal hurdles were set aside by the overriding EU law.

This development was unexpected by Swedish politicians, and there were no preparations in place to adjust existing system structures to the rulings of the Supreme Administrative Court. Sweden is currently adjusting its health care system to these new policy challenges, e.g., there is at present no prior-authorisation or clearly formulated reimbursement structure in place but such legislation is in preparation. There is a remaining question mark about the interpretation of “undue delay” which the regional health authorities, most likely wrongly, try to relate to the length of their own waiting lists.

On request, the national health insurance system (the *Försäkringskassan*) is providing information about patients’ rights to healthcare in other Member States. However, little seems to have been done by way of publicity to make the general public aware of their rights to public health service abroad. Also among the medical profession, there seems to be a great lack of knowledge.

3. The Way Forward

Currently, the number of EU citizens seeking health care in another EU country is very limited. It is estimated that cross-national health care account for no more than around 0.5%, possibly up to 1 %, of the Member States’ total health care costs. In Sweden, the amounts paid by the national insurance system for health care abroad has only been marginal. Today, cross-national health care utilisation seems to be concentrated in areas where the Europeanization process has gone far, the so-called Euro regions (primarily the Benelux countries, Northern France and Western Germany). But as the European integration process further deepens in the wider EU regions, a similar intensification of cross-national health care is most likely to be observed in other EU countries. For

example, in years to come British and Scandinavian citizens are likely to discover their rights as EU-citizens when it comes to health care in other Member States.

So far, there seems to have been too much focus on the particular issue of reimbursement of costs and we have seen different efforts and proposals to curtail the right to health care in other Member States as laid down by the European Court. It should be underlined that the right to health care in other Member States is based directly on the EC Treaty, thus it is primary law. *It cannot be legally restricted either by secondary EC legislation (regulations or directives) or by national legislation in the Member States.* On this point, there seems to exist much misunderstanding of the legal position under Community law. If further clarification of the application of the law in borderline cases is considered needed, the best way to get such clarification would be to refer additional cases from the national courts to the European Court for preliminary ruling. However, what seems important is not primarily detailed legislation but clarifying and easily accessible information about patients' rights to health care in other Member States.

There has been a tendency to focus on costs and other administrative issues related to health care in other Member States. This seems to be the wrong approach. The right to health care in other Member states is not primarily a cost; it contributes to the opening up of a cross-boarder European health care market. Thus, it is promoting growth and greater efficiency. Increased health care mobility within Europe will be beneficial for the individuals, the further development of medical care and the economy in general. In front of us, we have a development which will hopefully lead to increased cross-boarder cooperation in the medical field, a better environment for further improvement of medical treatment and increased efficiency by better possibilities to pool resources and develop specialisation. In short, the positive aspects and consequences arising from patients seeking health care abroad within Europe are greater than potential negative consequences.

4. Key Issues for Future Action

Time seems due to start implementing on EU level structural schemes in order to be able to respond appropriately to cross-national health care. Let me end by pointing at a few key issues which need to be observed and solved.

- There is a need for clarifying, easily accessible information about the possibilities and surrounding conditions for health care in other Member States – addressed to patients as well as to the medical profession.
- Consumer protection issues related to risks of malpractice and the liability of health providers have to be clarified in such a way that good European consumer protection standards in the field are secured.
- Remaining barriers restraining cross boarder medical practice and mobility within the medical profession should be removed, unless appropriate and necessary in the particular case.
- Increased cross-boarder cooperation in the area of health care services should be encouraged by Community measures. Such initiatives should include, i.a., E-health issues, collection and dissemination of data, increased use of cross-boarder public procurement, establishment of cross-boarder medical centres for advanced research and treatment of rare diseases. Primarily, most of these initiatives do not require European legislation (at least not in the first place) but would rather have the shape of European projects or initiatives in cooperation with national and private health providers.

The right to cross-boarder health care opens up what should become a very promising way forward with the potential of creating a particularly important new area of intense cooperation within the EU.

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