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The Europeanisation of National Health Care Systems: Creative Adaptation in the Shadow of Patient Mobility Case Law, OSE Paper Series, Research paper No. 3 (July 2010), Observatoire social européen: Brussels, 30p.

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Abstract

This paper ⁽¹⁾ examines the actual (as opposed to potential) impact of European Integration on national health care systems as a result of rulings of the European Court of Justice (ECJ) with regard to patient mobility ⁽²⁾. These rulings provoked a number of similar but far from identical responses across the Member States. Adaptation processes are indeed not straightforward. Member States, confronted with the deregulatory dynamic of the applications of the free movement rules, try to uphold their steering instruments as much as they can, whilst allowing patients to be treated abroad. This empirically driven paper provides a detailed assessment of how the Europeanisation of health care systems through ECJ cases sets off a dynamic process of creative adaptation at the national level. Through leverage (and some learning) actors alter the policies and politics of domestic health care systems. Factors that may explain the considerable differences between the reactions of Member States - also between Member States with similar health systems - include the likelihood of an exodus of patients, the compatibility between the European Union Law (EU) and national health care systems as well as the presence of reforms in the domestic system. The process of creative responses to EU law includes - for Member States confronted with long waiting lists - attempts to reduce the demand for exit, for example through contracting the domestic commercial sector. The study furthermore shows the agency by domestic actors who draw legitimacy from the EU setting to reinforce their position (or acquire one) at the national level. It thereby confirms the assertion that the effects of these ECJ rulings regarding patient mobility go beyond the narrow issue of patient mobility itself and that it can have an important impact on the domestic health care systems.

¹ The legal material in section 2 of this paper, especially regarding Belgium, France, Luxemburg and the Netherlands, draws extensively on Coucheir and Jorens (2006), which was written in the context of the Europe for Patients research project carried out under the DG Research 6th framework programme (Ghent University partner). The usual disclaimer applies.

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1. Setting the scene

The impact of European Integration on national health care systems is increasingly analysed, and teaches us a lot about the potential effects of the different branches of EU law on domestic health care systems (see Mossialos et al., 2010 for a recent state of the art assessment). And yet surprisingly little is known about how European legislation resonates with Member States' day-to-day policies and politics in this area (but see some of the studies we refer to below). This paper aims at filling that gap empirically, by analysing the *actual* (as opposed to *potential*) impact of European integration on national health care systems. We try to do so by examining how the European Union interacts with national health care systems as a result of rulings of the European Court of Justice (ECJ) with regard to patient mobility. Our empirical assessment - covering 13 Member States belonging to different families of health care systems - looks into the factors that determine the mechanisms and timing of ECJ case law as it finds its way into national arenas. Furthermore we will try to understand whether and how this case law impacts on the interaction between the stakeholders in the domestic arena.

Our analysis illustrates as such how Member States deal with the deregulatory dynamics of the application of the free movement rules to health care (see Box 1). Steering instruments of health care systems such as collective and selective contracting or limiting the prices that providers can charge cannot be upheld abroad, and thus also come under pressure domestically.

Our findings show some similarities, but also a wide diversity in the reactions of Member States, also of those with similar health care systems. We will see how several enabling and constraining factors determine the timing and mechanisms through which the Court rulings are taken into account (to varying degrees) in national policies.

Member States make a trade off between the compliance costs on the one hand and the costs of non-compliance on the other. Non-compliance costs relate to the risk of being sanctioned by the EU institutions or national courts. These include infringement procedures by the European Commission and court cases introduced by domestic patients (or providers from abroad). Member States confronted with more court cases seem to do more efforts to adapt their health system. The chance of sanctions occurring is however often perceived as a long-term risk. This reduces their weight in the trade off for policymakers, whose perspective is in principle rather short-term.

Calculating compliance costs on the other hand, is a rather complex exercise in this domain. A *first* type of compliance cost, similar for all Member States, is the loss of control in organising and managing the domestic health care system. Nearly all Member States initially took a very reserved attitude, arguing that their system was "different" from the specific system under scrutiny by the Court. Member States thus exploited as much as possible their powers to interpret the scope of application of the Court rulings in a minimalist way. Implementation took place gradually and only when all doubts about the scope of application were removed (through subsequent Court rulings).

Secondly, compliance costs are higher when the free movement of services principles collide with the applicable mechanism in the domestic health care system. Our findings show that principles of the Court rulings are more easily incorporated in health systems that do not need to substantially modify the existing procedures and policies. On the other

hand, when the domestic and EU system are largely incompatible, adaptation is only marginal.

In the *third*, place there is the perceived risk for an exodus of patients. Member States fearing that patients may be willing to make use of the new possibilities to go abroad in large numbers are less likely to fully implement the Court rulings. These include Member States with long waiting lists, small Member States who do not ensure the whole range of specialised care at home, and Member States who fear that their citizens perceive care abroad as being of a higher quality. These Member States develop policies to address factors underlying the demand for exit, in particular waiting lists. Furthermore we will see how health authorities try to channel as much as possible patients to selected providers abroad, integrated in the statutory system of the country of care provision or providers with whom some kind of agreement has been concluded. In that way they try to avoid an uncontrolled 'exodus'.

Fourthly, domestic reform efforts in the health system push Member States to assess whether the proposed changes are 'EU proof'. In other words: European law is likely to be taken into account more seriously when (even small) reforms are undertaken in the national system. At such moments checks and balances incorporated in the domestic system change in any case, new balances have to be found and the compliance costs of taking into account EU law (on top of things) are perceived as being lower. The paper will look into the national strategies developed to reduce compliance costs.

Box 1: Patient mobility in the EU: the rules of the game in a nutshell ⁽³⁾

The classical EU mechanism under which patients are entitled to receive treatment abroad (other than patients paying for such treatment privately) is the Regulation on the coordination of social security schemes (former Regulation 1408/71, currently Regulation 883/2004) (Council of the European Communities, 1971; European Parliament and Council, 2004). This regulation entitles patients whose treatment becomes necessary during a stay in another Member State (for example people travelling, studying or working abroad) to the same benefits as patients insured in the host Member State. It also provides for planned treatment in other Member States which is subject to prior authorisation, based on an authorisation form commonly known as the E112. We will refer to this as the *Regulation based procedure*.

In a series of judgments over the last decade, the European Court of Justice (ECJ) has however made clear that health care provided in another Member State against remuneration, both in and outside a hospital environment, is an economic activity in the meaning of the EC Treaty. As a consequence, the Treaty provisions on the freedom to provide services apply. In successive rulings it was clarified that these principles apply irrespective of how and by whom health care is funded, and irrespective of the way Member States organise and finance their social security systems ⁽⁴⁾. Since 2006 - in the famous *Watts case* ⁽⁵⁾ - it became clear that the free movement of service principles also apply to National Health Service systems based on integrated public funding and provision of health services. We will refer to this procedure to receive care abroad as the *Treaty based procedure*.

³ For more detailed accounts of the application of the legal framework of services applied to patient mobility in the EU see for example (Mossialos, 2010; Jorens, 2005; Hervey, 2004)

⁴ Case C-158/96, *Raymond Kohll v. Union des caisses de maladie*, Judgment of 28 April 1998; Case C-120/95, *Nicolas Decker v. Caisse de maladie des employés privés*, Judgment of 28 April 1998; Case C-157/99, *B.S.M. Geraets-Smits v. Stichting Ziekenfonds VGZ and H.T.M. Peerbooms v. Stichting CZ Groep Zorgverzekeringen*, Judgment of 12 July 2001; Case C-385/99, *V.G. Müller-Fauré c/ Onderlinge Waarborgmaatschappij O.Z. Zorgverzekeringen UA and E.E.M. Van Riet c/ Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen*, Judgment of 13 May 2003, Case C-444/05 *Stamatelaki*, Judgment of 19 April 2007.

⁵ Case C-372/04 *Watts*, Judgment of 16 May 2006

Box 1: Patient mobility in the EU: the rules of the game in a nutshell (continued from page 5)

The Court also clarified that making the reimbursement for care received abroad subject to the requirement that the patient must first receive authorisation from his domestic social protection system is an obstacle to freedom to provide services. However this barrier may be justified for intramural care by the need to ensure the provision of a balanced medical and hospital service accessible to all, and the maintenance of a treatment facility or medical service on national territory.

As a consequence, statutory social protection systems have to reimburse their affiliates for health care provided in another Member State up to the level of reimbursement provided by their own system, if this care is included in the domestic benefit package. If the costs actually incurred are lower than that amount, reimbursement can be limited to the actual costs.

For hospital care Member States may require that this reimbursement is subject to prior authorisation. This authorisation *must* be given if the domestic system cannot provide the same or equally effective treatment within a medically acceptable time limit, considering the patient's medical conditions, course of illness, nature of disability, as well as the degree of pain.

The conditions on which benefits are granted pursuant to the legislation of the State of affiliation remain enforceable where treatment is received abroad, provided that these conditions are necessary to protect a general interest objective and are proportional to this objective. The Court accepted in this respect for instance the requirement that a general practitioner should be consulted prior to consulting a specialist.

However not all national conditions and formalities, even though they apply in a non-discriminatory manner, can be upheld in a cross-border situation. The most notable exception is the requirement to only be treated by a contracted provider. The Court ruled in the *Geraets-Smits and Peerbooms* case that if the assumption of the costs of treatment given by (both domestic and foreign) providers who are *not* contracted by the sickness fund or health system, is made conditional on the granting of prior authorisation, then this is liable to affect foreign providers more than providers established in the State of insurance. This condition is therefore seen as an obstacle to the free movement principles⁽⁶⁾. This applies even if foreign providers have the same possibility to enter into contracts. Foreign providers are thus in principle entitled to be placed on the same footing as domestic contracted providers, even if they do not have to comply with the requirements included in the contracts with which domestic providers have to comply, in particular with regard to price setting.

In the *Vanbraekel* ruling, the Court stipulated that the provisions on the free movement of services act as a complement to the rights of E112-holders. If, for a holder of a form E112 the amount reimbursable under the legislation of the State where treatment is received is lower than the amount payable under the legislation of the State of affiliation, the patient should receive a complement in order to guarantee him a level of coverage which is at least equivalent to the level of cover provided by the legislation of the State of affiliation⁽⁷⁾. This is relevant when the insured person was required to make a financial contribution to the cost of treatment abroad.

In an attempt to codify the complex Court rulings, the European Commission presented a legislative proposal on patients' rights in cross border care in July 2008 (CEC, 2008).

⁶ Case C-157/99, *Geraets-Smits and Peerbooms*, above n. 4, at 66-68.

⁷ Case C-368/98, *Vanbraekel*, Judgment of 12 July 2001, at 45.

2. National policies and politics in the wake of the ECJ rulings

This section analyses how Member States reacted to the judgements of the European Court of Justice (and national court rulings) with regard to reimbursement of care provided in another Member State. Furthermore, it provides some examples on how actors involved in the national health care systems tried to take advantage of the newly created opportunities. The analysis is based on 13 case studies. Systematic information has been collected France, the Netherlands, Belgium and Luxemburg. This has been complemented with desk research for Germany, Denmark, Ireland, Hungary, Poland, Spain, the UK, Sweden and Slovenia.

For analysing the case studies, we grouped them according to the characteristics of the health care systems of the respective countries. This is based on the typology presented in Table 1 below.

Table 1: Typology of public health care systems: case studies

Category (funding)	Social Insurance		National Health Service
Type (payment)	Reimbursement	Benefits in Kind	Benefits in Kind
Case studies	Belgium France Luxembourg	Germany Hungary Netherlands ⁽⁸⁾ Poland Slovenia	Denmark Ireland Spain Sweden United Kingdom

Source: own adaptation from Sindbjerg Martinsen (2007) and Palm e.a. (2000).

European health care systems can broadly speaking be divided into two categories: social health insurance systems and National Health Services (NHS) systems.

Social health insurance systems are mainly funded by means of earmarked social contributions from employers and employees. Private, often not for profit actors such as sickness funds and hospitals- have an important role in funding and provision of care. A further distinction can be made within this category between reimbursement systems and benefit in kind systems. Care can be paid for through a fee for service, in which case the patient or provider is reimbursed for the costs. Providers can also be remunerated at a flat rate, a lump sum based on the population size they serve. In the latter case the patient has -often free of charge- access to the providers with whom the scheme concluded agreements for service delivery. Patients have thus the right to benefits in kind.

NHS systems are mainly funded through general taxation. Delivery and funding of health care are typically integrated into one single, public body. Hospitals are state owned and general practitioners (GPs) have contracts with the NHS. Patients do have free of charge access to these public or contracted providers. Patients have thus access to benefits in kind.

⁸ After the 2006 reform the Dutch system can no longer be considered as a clear benefit in kind system, and in fact became a stand alone type of system, see below.

The case studies include all three health care systems based on reimbursement (Belgium, France and Luxemburg) and five health insurance systems based on benefits in kind (Germany, Hungary, the Netherlands, Poland and Slovenia) and four National Health Systems (Denmark, Ireland, Sweden and the UK).

This typology should of course be read with the necessary caution. Health care systems are dynamic, change over time and incorporate elements of systems with different characteristics. Reforms can furthermore overrule the basic characteristics of a system. This has become most apparent in the period we study here (1998-2008) in the Netherlands. After the 2006 reform the Dutch system became in fact a stand alone type of system, of which we will highlight some characteristics below.

This wide coverage allows us to analyse on the one hand the similarities and dissimilarities in the reactions of the systems belonging to the same family and on the other hand the divergent or concurrent reactions of countries having a different type of health care system.

In what follows we will analyse the reactions to the ECJ case law on patient mobility per cluster of systems. Within each cluster we will first describe the implementation process and reactions of stakeholders in each country. Next, we will try to explain the similarities and dissimilarities in the reactions.

2.1 Social insurance systems based on reimbursement of care

The social insurance systems based on reimbursement of care were the first ones to come in the legal and political spotlight. The initial *Kohll* ⁽⁹⁾ and *Decker* ⁽¹⁰⁾ rulings concerned a health care system of this type. The next section analyses the reactions in Belgium, France and Luxemburg.

2.1.1 Assessing implementation and politics

Belgium reacted very promptly to the rulings by implementing the most important aspects. The National Institute for Health and Disability Insurance (INAMI) issued already in 1998 a Circular on the application of the *Kohll and Decker* rulings ⁽¹¹⁾, with the aim of giving an interpretation of these rulings. Pursuant to this Circular, insured persons were entitled, subject to certain conditions but without prior authorisation, to be reimbursed for the costs of cross-border non-hospital care not exceeding EUR 500. Subsequent Circulars have progressively broadened this right (for example removing the maximum ceiling), without however changing the approach in any fundamental way ⁽¹²⁾. The currently applicable Circular states that non-hospital treatments in other Member States are reimbursed at the rates of the Belgian sickness insurance, provided that the conditions for assumption which prevail in Belgium (e.g. authorisation) are fulfilled. Pharmaceutical products purchased in another Member State qualify for reimbursement if its characteristics are identical to a pharmaceutical reimbursed in Belgium.

⁹ Case C-158/96, *Raymond Kohll v. Union des caisses de maladie*, above, n. 5.

¹⁰ Case C-120/95, *Nicolas Decker v. Caisse de maladie des employés privés*, above, n. 5

¹¹ INAMI Circular nr. 98/258 of 5 August 1998.

¹² The current Circular is the one of 16 March 2006, VI nr. 2006/117, complemented by one of 7 June 2008, extending the procedure without authorisation to the 3 EER States and Switzerland.

For hospital care prior authorisation is required. Belgian insured persons who go abroad with a E112 form and have to pay user charges, are entitled to an additional reimbursement insofar as the level of cover (the amount publicly funded) under Belgian legislation is higher than the level of cover provided under the legislation of the State of treatment.

Interestingly, in a similar vein of what was done in France (see further down this section), the latest versions of the above mentioned Circular have extended the definition of hospital care. The Circular lists now several treatments that do not involve overnight stay but which require, “a hospital infrastructure with all the equipment which normally can be found in a hospital to provide them” ⁽¹³⁾. The annexed list is broader than its French equivalent.

Whereas Belgium does not face important outflows of patients, the increasing inflow of patients from abroad has been the subject of heavy political debate. There is a concern that treatment of foreign patients could lead to increasing commercial behavior of the (mainly not for profit) domestic providers. The Federation of Enterprises in Belgium (FEB, *Fédération des entreprises de Belgique*) launched the debate on opening up the Belgian health care market to foreign patients, referring to the possibilities created by the ECJ rulings (De Greef and Thomaes, 2006).

This initiative had two consequences. First, a law has been adopted to change the rules for hospital funding, making a legal distinction between patients covered by the Belgian public system and (foreign) patients that are considered as “private” patients and to whom higher tariffs can be charged ⁽¹⁴⁾. That way, hospitals have more incentives to attract foreign patients. “Private” patients were so far not known in the Belgian system, as all care providers in Belgium are integrated in the publicly funded system. The legitimation for the changed legislation is that the Belgian tariffs do not cover real costs. However, due to political disagreement and technical problems, this law has not yet been implemented. Secondly, a series of public and not for profit hospitals, including several major university hospitals, created - at the initiative of the aforementioned FEB - an association called “Healthcare Belgium”, with the aim to promote Belgian health care abroad. This is the first time that hospitals, traditionally organised in umbrella organisations of the not for profit sector, organise themselves at the initiative of the national organisation of Belgian enterprises, which suggests a shift of focus and interests.

As Luxembourg was directly involved in the initial Kohll and Decker cases, the national authorities examined the consequences of the decisions promptly and thoroughly. The Union des Caisses de Maladies (UCM), the social security authority that was a party in these court cases, issued its opinion as early as May 1998. A new procedure was introduced whereby medical devices, pharmaceuticals and out-patient care are reimbursed without prior authorisation (Palm *et al.*, 2000; Kieffer, 2003). Interestingly, this procedure has not been incorporated into national legislation. Patients are informed about the possibility and the procedure in an official note that is attached to the negative reply on a request for a E112 form for ambulatory care ⁽¹⁵⁾.

For assumption of the costs of hospital treatment abroad, prior authorisation remains required. Reimbursement extends to co-payments and co-insurance rates levied in the Member State where treatment is obtained, minus the co-payment charged under

¹³ INAMI Circular VI nr. 2006/117 of 16 March 2006.

¹⁴ Loi du 4 juin 2007 modifiant la législation en vue de promouvoir la mobilité des patients, Moniteur Belge 25/7/07.

¹⁵ Written exchange, legal advisor, Caisse nationale de la santé Luxembourg (d’Gesondheetskeess), 4 August 2009.

Luxembourg legislation (¹⁶). Accommodation expenses and costs of an accompanying person can also be assumed under certain conditions (¹⁷). Hospital care however is to be provided by a provider integrated in the statutory system of the country of care provision. This is a requirement we will come across in different forms in other Member States and which shows that Member States want to keep control over the selection of the providers for which they do reimburse care abroad. Luxembourg justifies this by stating that the Luxembourg health insurance does not dispose of tariffs for hospital care, and that a lot of these treatments are even not available in Luxembourg and do not have a domestic tariff (Kieffer, 2003). Reimbursement is consequently based on the official tariffs of the country of care provision. Only when the authorised treatment cannot be performed by a health care provider operating within the framework of the statutory social security system of the Member State of treatment, reimbursement is guaranteed according to Luxembourg tariffs (¹⁸). Luxembourg argues that hospital treatment in Luxembourg is not a service provided against remuneration and thus implicitly suggests that hospital treatment does not fall under the scope of the free movement rules (Gouvernement Luxembourgeois, 2007).

The main result of the Kohll and Decker judgements for Luxembourg was however a major confrontation with its medical corps. In Luxembourg all health professionals are compulsory submitted to collective agreements between the professional groups and the public health insurance system. The agreement system that is in place since 1930 requires the professionals to comply with imposed tariffs and other conditions. Following the Court rulings, the health insurance system was however obliged to reimburse costs of providers abroad, even though these providers were not bound by the official tariffs, or by any other constraint imposed by the agreement system. The Luxembourg medical profession perceived the opening of borders and the reimbursement of care provided by foreign providers not bound by the agreements as (reverse) discrimination. Consequently, negotiations to adapt the medical agreement were suspended. More in particular the discussions concerning the introduction of profiles of medical activity to trace abuse of the system were blocked. Furthermore, Luxembourg physicians were calling to abandon the compulsory agreement system. This was at stake in a doctors' strike 2000. In response, the government was forced to increase reimbursement fees by on average 6.5%. The Court rulings thus seriously damaged the cooperation between the doctors and the public health insurers (Kieffer, 2003).

In France, there has been a more gradual acceptance of the principles stemming from the Court's health care rulings, in several domains. The initial reaction of the administrative authorities has been one of complete rejection. In a Circular letter dated 28 June 1998, the Director of Social Security asked the Sickness Insurance Fund not to take account of the Kohll and Decker judgments, as long as their possible implementation has not been the object of discussion among Member States. Fears were expressed that a unilateral opening would jeopardise the relations between sickness insurance and the health care professionals, notably as regards cost containment.

An infringement proceeding initiated by the European Commission in October 1999 as well as some national court cases brought about the revision of the initially obstructive governmental position (Obermaier, 2008). A first breach was created by a Circular of the social security administration in 2001 (¹⁹), which instructed the Health insurance funds to

¹⁶ *Code des Assurances Sociales*, Article 26 § 1

¹⁷ *Ibid.*, Article 28.

¹⁸ *Ibid.*, Article 26.

¹⁹ DSS/DACI nr. 2001-120, Circular of 1 March 2001.

reimburse the costs of optical devices purchased in another Member State without prior authorisation, subject to the condition that the relevant provisions of French legislation were complied with. This opening, deemed “not liable to put at risk the national social security system”, corresponded to a strict application of the Decker ruling. According to another Circular in 2003 sickness funds should proceed to the assumption of the costs of pharmaceuticals purchased in another Member State, if these products are included in the list of reimbursable products in France ⁽²⁰⁾ or if their composition and form are identical to a pharmaceutical included in the French list ⁽²¹⁾.

As to medical services, the 2003 Circular drew attention to the French system of national agreements, within the framework of which nearly all French self-employed doctors practise. These agreements, which are signed between doctors’ representatives and the national sickness insurance funds, include a number of provisions regarding conditions of practice and list the tariffs doctors are allowed to charge (*les tarifs conventionnels*). These tariffs also serve as a basis for reimbursement of the patient (Sandier *et al.*, 2004). The Circular provided that the national agreements could not produce effects outside the French territory, and thus could not be extended as such to health care professionals established in another Member State. It went on to state that, in order not to favour these foreign health care professionals in relation to their French colleagues who expressly adhered to the national agreement - and, hence, accepted to act in accordance with its terms - it is appropriate to treat the former as if they were French professionals who opted not to take part to that agreement. Accordingly, the costs of cross-border extramural treatment were assumed on the basis of the *tarifs d'autorité* (the amounts of which did not exceed EUR 1 per visit). However, according to the Circular, the systematic application of the almost insignificant *tarifs d'autorité* is likely to constitute a new restriction to the free provision of services as interpreted by the ECJ. As a consequence, French legislation was modified again soon after. A Decree (*décret*) of 2005 ⁽²²⁾ stipulates that the sickness insurance funds proceed to the reimbursement of the costs of treatment provided in a Member State of the European Union/EEA, under the same conditions as if the treatment were received in France ⁽²³⁾. The applied tariffs are henceforth the ones that apply for French contracted providers.

For ambulatory care, no prior authorisation is required ⁽²⁴⁾. Prior authorisation is nevertheless required for the assumption of the costs of hospital treatment and of treatment necessitating the use of heavy medical equipment ⁽²⁵⁾. In regions in which some specific treatments are permanently unavailable, an authorisation must be delivered automatically ⁽²⁶⁾. The Commission referred France in 2008 however to the European Court of Justice for having extended the requirement for prior authorisation to certain types of non-hospital treatment ⁽²⁷⁾.

²⁰ DSS/DACI nr. 2003-286, Circular of 16 June 2003.

²¹ DSS/DACI nr. 2004-134, Circular of 23 March 2004.

²² Decree nr. 2005-386 of 19 April 2005

²³ In order for their costs to be assumed, the provision of certain treatments, such as physiotherapist treatment, requires prior consent (*entente préalable*) of the fund. This requirement, which applies to certain care provided in France, must also be fulfilled by insured persons who intend to receive the concerned treatment in another EU/EEA Member State. On referral by a general practitioner, see *below*.

²⁴ *Code de la sécurité sociale*, Article R. 332-3.

²⁵ *Code de la sécurité sociale*, Article R. 332-4.

²⁶ DSS/DACI nr 2005/235, Circular of 19 May 2005 (LHERNOULD, 2009).

²⁷ Case C-512/08, *Commission of the European Communities v French Republic*.

Furthermore, following an ECJ court case in 2004 ⁽²⁸⁾, reimbursement of analysis by foreign biomedical laboratories is since 2007 no longer subject to an administrative authorisation of the laboratory ⁽²⁹⁾.

Until that year the French legislation did not specify in which situations patients receiving treatment abroad (following the Regulation based procedure) were entitled to reimbursement up to the reimbursement level applicable in France (*the Vanbraekel ruling*). This led to diverging decisions of different competent funding institutions. Following an infringement procedure launched by the European Commission in 2007, the French administration specified that the supplement should apply to both occasional and planned care and for any kind of medical services (Lhernould, 2009) ⁽³⁰⁾. This however did not withhold the Commission from referring the case to the European Court of Justice ⁽³¹⁾.

A final illustration of how Member States incorporate EU law while introducing new elements in their domestic system is the implementation of a mild gate-keeping procedure which was adopted in mid 2004 as part of the reorganisation of the French sickness insurance scheme. People can register with an attending doctor of their choice (GP or specialist) who will be responsible for coordinating the patient's treatment pathway ⁽³²⁾. If a patient chooses not to register or to see another doctor without prior referral, the reimbursement level for medical treatment will be lower. With a view to ensuring that the new attending doctor policy is EU proof, insured persons can choose a doctor established in another Member State of the EU/EEA ⁽³³⁾. However, in order to be recognised as a doctor the foreign health care professional has to conclude an agreement with the French sickness insurance funds, specifying the obligations which he has to fulfil.

2.1.2 Social insurance systems based on reimbursement: (dis-)similarities

A comparison of the reactions of this first cluster of countries to the Court rulings allows drawing some initial conclusions. In principle, this group of countries should be the most "fit" to comply with the Court rulings. They have an explicit catalogue of benefits, defining the tariffs of individual treatments, including reimbursement levels. This should allow them to apply the same tariffs to care provided abroad, which makes it in principle quite easy for them to adapt their systems. Nevertheless, there seem to be great reluctance to implement the court rulings and, besides some similarities in their approach, important dissimilarities have been traced. To understand the differences in the approaches, we need to take a closer look at the different characteristics of the respective health care systems.

A first important characteristic distinguishes Belgium on the one hand from Luxemburg and France on the other hand. In all three countries a system of collective agreements applies between the health professionals and the health insurers/sickness funds, defining the prices and reimbursement tariffs for care. However, all health professionals are obliged to adhere to these agreements in Luxemburg, while professionals not having adhered to the agreements in France can only have their care services reimbursed at a marginal level (*tarifs d'autorité*). In Belgium by contrast all care is reimbursed at the same level, whether or not providers adhere to the agreements. Providers who do not adhere have freedom of price setting. This makes the Belgian system the most "fit" to the rulings with

²⁸ Case C-496/01, *Commission v. France*, Judgment of 11 March 2004

²⁹ Decree n° 2007-1494

³⁰ DSS/DACI/2008/242, Circular of 21 July 2008

³¹ Case C-512/08, *Commission of the European Communities v French Republic*.

³² Act nr. 2004-810.

³³ DSS/DACI nr. 2005-275, Circular of 27 May 2005

regard to the reimbursement of care provided in another Member State, at least for ambulatory care, and probably explains the promptness of the Belgian reaction and the great - at least initial - reluctance in France, that indeed explicitly justified its initial response stating that it did not want to favour foreign health care professionals in relation to their French colleagues who expressly adhere to the national agreements⁽³⁴⁾. Similarly, in Luxemburg the medical corps reacted heavily to the Court rulings and the discrimination they could provoke. Luxemburg is in this respect more vulnerable than France: given the size of the country, patients can easily cross the border for care.

This brings us to the second difference between the three countries. Contrary to Belgium and France, Luxemburg does not, due to its small size, provide the whole range of specialised treatments at home and has a long tradition of authorising patients to go abroad for care, based on former Regulation 1408/71 (see Palm e.a., 2000). The lack of domestic availability of certain treatments, combined with the fact that all patients live close to a border, make Luxemburg a country where the likelihood that patients will try to use the newly created possibilities for care abroad is very high. It is not a coincidence that Mr Decker and Mr Kohll, who were the first voicing their willingness to exit the domestic system through the ECJ, were both Luxemburg citizens. This explains why Luxemburg, even if it did implement the Court rulings to a large extent, tries to make the "Treaty" based procedure (see Box 1) less attractive than the procedure it traditionally applies based on Regulation 1408/71, now Regulation 883/2004. Luxemburg basically makes the "Regulation" based procedure as attractive as possible financially, by providing reimbursement of additional costs. Also the administrative handling of the Treaty based procedure is less attractive. As stated by the president of the Union des Caisses de Maladies during a hearing in European Parliament "there is the risk also, and a real risk, that such doctor's bills will not be given favourable treatment when presented in Luxembourg to the insurance organisations. That is why we recommend that patients should (...) use their E112 form" (Kieffer, 2005). Similarly, the Luxemburg authorities seem to somewhat "hide" the existing Treaty based system. Patients are only informed about its possibilities when their application based on the Regulation based procedure failed.

The final implementation of the EC rules in France and Belgium is quite similar. In both countries ambulatory care received without prior authorisation in another Member State is reimbursed at the rates of the domestic sickness insurance, provided that the conditions for assumption which prevail at home are fulfilled. Both tried to identify pharmaceuticals that have the same active ingredient as those reimbursed at home, even if they are sold under a different (brand) name. Finally, the definition of hospital care has in both countries been widened, as compared to the narrow definition of care for which an overnight stay is necessary: it also includes care for which planning is necessary (in essence relating to heavy medical equipment). It is interesting to see that the widening of the Belgian definition was inspired by the French policy practice⁽³⁵⁾.

2.2 Social insurance systems based on benefits in kind

Prevailing doubts about the applicability of the Treaty provisions to health insurance systems based on benefits in kind were fully removed with the *Geraets-Smits and Peerbooms* as well as the *Müller-Fauré and Van Riet* ECJ rulings. We analysed the developments in two "old" Member States, the Netherlands and Germany, and three

³⁴ DSS/DACI nr. 2003-286, Circular of 16 June 2003.

³⁵ Oral discussion, Advisor international healthcare conventions, INAMI, spring 2008.

“new” Member States, Hungary, Poland and Slovenia. These are discussed in the next sections.

2.2.1 Assessing implementation and politics

The case of the Netherlands is an interesting one for more than one reason. First, two landmark ECJ rulings (*Geraets-Smits and Peerbooms* and *Müller-Fauré and Van Riet*) have their origin in this Member State, which, as will be demonstrated below, went to great effort to comply with the principles stemming from these judgments. Second, the country has (had) a problem with waiting lists, which, being a major push factor for the cross-border movements of patients, might help to explain the abundance of national court cases addressing the right to seek health care outside the national territory⁽³⁶⁾. Thirdly, the Netherlands held a unique position among other Member States in that about 30 % of the population were not compulsorily insured for health care and were expected to take out private health insurance. As a result, this category of persons did not fall within the ambit of former Regulation 1408/71. This situation has come to an end on 1 January 2006, with the entry into force of the new Health Insurance Act⁽³⁷⁾, pursuant to which the entire population is obliged to take out sickness insurance with one of the competing private health insurance companies. The distinction between the compulsorily insured with a sickness fund and privately insured was thus abandoned. From the outset of the legislative process leading to the 2006 reform, due attention has been paid to the compatibility of the future scheme with Community internal market requirements.

According to the Dutch interpretation of the initial Kohll and Decker rulings in 1998, the Dutch system of contracting was in conformity with EU law. Health insurers can conclude contracts with foreign providers if there is a need for it, while they may not refuse to contract with a provider solely on the grounds that the provider is located in another Member State. In addition, no distinction could be made between domestic and foreign non-contracted providers in those cases where patients had the right to go to non-contracted providers with prior authorisation from their insurer⁽³⁸⁾. In 2002 sickness funds were advised to conclude contracts with foreign providers if they planned to systematically offer their members access to cross-border health care⁽³⁹⁾.

The Dutch practice to contract with foreign providers is not only - and arguably *not even in the first place* - inspired by the Court rulings. The domestic political pressure to address the waiting times certainly pushed the Netherlands to look for appropriate answers by offering its citizens treatment abroad (Baeten, 2002; Glinos *et al.*, 2005).

After the *Geraets-Smits and Peerbooms* and *Müller-Fauré and Van Riet* Court rulings it became clear that this approach of contracting abroad had to be complemented by a second approach of pure reimbursement of care. The traditional Dutch approach already embraced a dual system with benefits in kind for sickness fund patients and reimbursement system for privately insured patients. Reimbursing care abroad was thus not completely alien to the system.

The possibility has been created from 2005 onwards to obtain care from a provider which is not contracted by the sickness fund, at home or abroad, under certain conditions. Based

³⁶ The situation with regard to the Netherlands has been updated until 2007.

³⁷ *Zorgverzekeringswet* Act of 16 June 2005, *Staatsblad* 2005, 358.

³⁸ Ziekenfondsraad, Grensoverschrijdende zorg: arresten Decker en Kohll, Aan de uitvoeringsorganen ZFW en AWBZ, Circulairenummer ZFW/38/98, AWBZ/31/98, of 15 July 1998.

³⁹ CVZ, Circulaire 02/021 met betrekking tot grensoverschrijdende zorg, 2 May 2002.

on this provision, an arrangement provided for the assumption of the costs of extramural care received in an EU Member State without prior authorisation⁽⁴⁰⁾. For intramural care from a non-contracted care provider, prior authorisation remained necessary⁽⁴¹⁾. Following several national court rulings, it became clear that hospital treatment abroad could not be refused if the patient could not be treated in a contracted hospital within waiting times corresponding to the Dutch norms defining acceptable waiting times (Treek norms)⁽⁴²⁾.

Based on the health care reform sickness funds were furthermore no longer obliged to engage contracts with all domestic care institutions, such as hospitals. This new law provided the legal basis for Dutch sickness funds to agreements with foreign hospitals, in a reaction to the *Geraets-Smits and Peerbooms* ruling. It had been pointed out by the ECJ that this possibility, although applied in practice, was not included in law. The concerned foreign hospitals must provide care within the framework of the social security system applicable in the country of care provision⁽⁴³⁾. The justification given for this requirement is to ensure at least the quality level deemed in the state of treatment is acceptable⁽⁴⁴⁾.

The reimbursement of the costs of the (extra- and intramural) care amounts to the expenses actually incurred and can not be higher than the costs which can reasonably be deemed to be in conformity with the market circumstances⁽⁴⁵⁾. The latter provision aims to avoid having to assume medical costs incurred abroad, without being able to control the tariffs⁽⁴⁶⁾. To determine the tariff, it has to be assessed to which Diagnosis Treatment Combination (DBC, the Dutch version of DRG's⁴⁷) the medical interventions abroad resemble most⁽⁴⁸⁾.

As from 1 January 2006 a new sickness insurance system has been introduced. The entire population is now obliged to take out sickness insurance with one of the competing private health insurance companies and contains a uniform arrangement of insured persons' entitlements. All insured persons have henceforth a choice between a so-called restitution policy, a benefits in kind policy or a combination of both. If the insured person has opted for a restitution policy, she can turn to any provider of health care anywhere in the world and is entitled to the reimbursement of the costs incurred⁽⁴⁹⁾. However, here too, the health insurer is not obliged to reimburse costs which are higher than what can be deemed reasonably appropriate in the Dutch market circumstances⁽⁵⁰⁾.

In principle, the insured person who has opted for benefits in kind policy has to turn to those providers of care - either domestic or foreign - who are contracted by the health insurer. He has however the right to go to a provider - either domestic or foreign - who is not contracted by the health insurer and be reimbursed an amount which is determined by

⁴⁰ Arrangement of 16 August 2005 on the implementation of Article 9 ZFW and Article 10 AWBZ, Article 2 § 1.

⁴¹ Ziekenfondswet, Article 3 § 1 and 9, §3 as amended by the Law of 9 December 2004.

⁴² CVZ, Tweede aanvullende circulaire inzake arrest Müller-Fauré en Van riet n.a.v. uitspraken Centrale Raad van Beroep d.d. 18 juni 2004, Circulaire 04/45, College voor zorgverzekeringen, Diemen, 1 september 2004 (http://www.cvz.nl/resources/circ0445_tcm13-9078.pdf).

⁴³ Ziekenfondswet, Article 1 as amended by the Law of 9 December 2004.

⁴⁴ Zorgverzekeringswet, *Kamerstukken II*, 2003-04, nr. 29.763, 3, 80.

⁴⁵ In Dutch: "Niet meer dan de kosten die in de Nederlandse marktomstandigheden in redelijkheid passend zijn te achten".

⁴⁶ A national court ruling in 2004 had held that, in view of the absence of an assumption arrangement, the costs of extramural care abroad should in principle be reimbursed in its entirety. CRvB, in its judgment of 18 June 2004 (nr. 02/1641 ZFW).

⁴⁷ DBC: Diagnose-Behandel Combinatie (Diagnosis Treatment Combination), DRG: Diagnoses Related Groups.

⁴⁸ CVZ, *Commissie adviezen, Verkorte weergave van de in de commissie verstrekkingenschillen besproken adviezen van de laatste zes maanden*, Diemen, nr. 25112505, meeting of 16 March 2006.

⁴⁹ Zorgverzekeringswet, Article 11.

⁵⁰ Besluit zorgverzekering, Article 2.2 § 2.

the insurer in its policy (full or partial) ⁽⁵¹⁾. Noticeably, this right has been incorporated in order to comply with the Court rulings and create new rights not only for patients searching for treatment abroad, but also for patients that are treated in the domestic system ⁽⁵²⁾. Interesting furthermore is that the law does not stipulate a minimum level of assumption: the explanatory statement to the health insurance law (ZVW) confines itself to stating that the level of assumption should not be such as to create a *de facto* obstacle to the provision of care in another Member State ⁽⁵³⁾. It does however not really seem to aim to encourage patients to make use of this procedure.

It follows from the above that under the new Dutch scheme, according to which the authorisation requirement is abolished altogether, the distinction between intramural and extramural care is no longer relevant. Furthermore, there is no longer a need to interpret the concept of undue delay.

In its immediate reaction to the initial Court rulings the **German government** denied that the Decker/Kohll case law had any consequence for the German system of statutory health insurance (SHI) or national authorisation policies on the grounds that the decisions applied only to health care systems reimbursing the costs of treatment (Sindbjerg Martinsen, 2005). A Joint Working Group, consisting of the German states (Länder), the federal associations of sickness funds and the Ministry of Health concluded in 1999 that the economic freedoms of the EU did not apply to in-kind German-style benefit systems (Obermaier, 2008). It should be noted, however that the federal associations of sickness funds pleaded in their own assessment in 1999 to handle Kohll and Decker strategically, and recommended to analyse whether and when the sickness funds should be allowed to conclude contracts with foreign care providers, analogous to the Netherlands (Obermaier, 2008).

The judgment in *Müller-Fauré and Van Riet* in 2003, in which it was made clear that social security systems based on benefits in kind also had to conform to the *Kohll and Decker* jurisprudence, sparked a process of amending social security legislation.

The legislation was changed accordingly as one aspect in a comprehensive act that fundamentally reformed German statutory health insurance. The legal change, which took effect from 1 January 2004, provides that insured persons are entitled to reimbursement of the costs of care provided by health care providers established in EU/EEA Member States ⁽⁵⁴⁾. The costs of hospital treatment are covered only after prior authorisation by the insured person's sickness fund ⁽⁵⁵⁾. Crucially, the possibility to choose for reimbursement of health care costs was not limited to foreign care. The implementation of the case law thus breached a central principle of the German social security system: delivering in-kind health care benefits. However, several restrictions characterised the new regulation: the insured cannot limit their choice of reimbursement to ambulatory care only; they have to stick to reimbursement for at least one year; before reimbursing, the insurance fund has to deduct administrative and other costs (Obermaier, 2008). Obermaier (2008) argues however that this measure was more in continuity with German health policies than appears at first sight. Attempts to introduce the possibility for cash benefits had been made several times, also before the ECJ rulings and the category of voluntarily insured persons had since long the possibility to opt out of the in-kind benefits system.

⁵¹ Zorgverzekeringswet, Article 13.

⁵² Tweede Kamer, 2002-2003, URL: <http://www.st-ab.nl/wetzvwmvt.htm> (accessed 28 June 2010).

⁵³ *Kamerstukken II*, 2003-04, nr. 29.763, 3, 31 and 110.

⁵⁴ Fifth Social Security Code (SSC V), amended § 13, subsection 4

⁵⁵ *Ibid*, Subsection 5.

The same reform of the health insurance system allows the sickness funds to enter from this time forward into agreements with foreign health care providers. These agreements should incorporate the requirements of German law. Only health care providers integrated in the public system of their country of establishment qualify⁽⁵⁶⁾ (Nebling and Schemken, 2006: 139). The patient receives the medical treatment free of charge and the German sickness fund pays the care provider (Sylvest e.a. 2007). It is noticeable that individual German sickness funds anticipated this change in the law and already concluded agreements with foreign health care providers before the law was changed. This was in breach with the domestic system, in which the responsibility for concluding such agreements fell at that moment exclusively within the remit of the regional associations of sickness funds (Nebling and Schemken, 2006). Since 2004 individual sickness funds have also domestically gradually been able to contract with individual care providers. The ECJ case law thus seems to have been used by the sickness funds as an element in a strategy to obtain instruments for positioning themselves in an increasingly competitive domestic environment.

In spite of increasing pressure by the European Commission, **Slovenia** has only marginally implemented the ECJ case law (Földes, 2009). The Slovenian health authorities argue that more clarification on the EU rules are required before they can be implemented (Földes, 2009). Slovenia allows for the reimbursement of the costs of certain medical devices⁽⁵⁷⁾ purchased abroad without authorisation, on the basis of the costs actually incurred, which should not exceed the average cost in Slovenia⁽⁵⁸⁾. As a general rule, long waiting time does not constitute a justification to authorise treatment abroad. Nevertheless, the Slovenian Health Insurance Institute approved, by a special decision, *in vitro* fertilisation procedures abroad in cases of excessively long waiting time⁽⁵⁹⁾. Costs were reimbursement up to the amount of these services in Slovenia (Földes 2008). Interestingly, Slovenia did *de facto* also reimburse treatment obtained abroad without prior authorisation after an assessment of the individual cases. Two out of thirteen applications were approved for reimbursement in 2005⁽⁶⁰⁾. This suggests that Slovenia tries to avoid that patients would go into litigation, by reimbursing them without a legal basis to do so.

Upon accession in 2004, **Hungary** amended its legislation on mandatory health insurance, guaranteeing reimbursement of the expenses of treatment abroad up to the level reimbursed for the same treatment in Hungary. Nearly all non-hospital treatments were covered by this provision⁽⁶¹⁾. A health insurance system reform in 2008 introduced a private-public mixed insurance system, with multiple insurers. The legal act of this reform⁽⁶²⁾ kept on board the procedure for reimbursement of treatment expenses for care received abroad. However, the rule is vaguely formulated and did not specify, for example, whether this reimbursement procedure applies to ambulatory care only or also to hospital care, and under which conditions. Implementing legal norms that would regulate access to planned health care abroad were envisaged, but not yet issued. (Földes, 2009). This suggests that Hungary tried to anticipate the adoption of the Directive on patients'

⁵⁶ Ibid, New § 140e.

⁵⁷ Spectacles, incontinence aids, contact lenses, ultrasound sticks, walking sticks for the visually impaired, aids for stoma care and cassette players with Braille typewriters. Articles 136 of the bylaws of the National Health Insurance Institute (HIIS).

⁵⁸ Information obtained from the Slovenian partner to the Europe for Patients (E4P) project.

⁵⁹ Fourteen treatments in 2006

⁶⁰ Information obtained from the Slovenian partner to the E4P-project.

⁶¹ Parliamentary Act on Mandatory Health Insurance, LXXXIII/1997, Art. 27(6)

⁶² Parliamentary Act on Health Insurance Funds, 2008, Art 72(4)

rights in cross border care when reforming its system. However, since the adoption of the Directive is delayed, Hungary is not able to adopt implementing measures ⁽⁶³⁾.

So far, Hungarian patients have not made much use of this procedure for treatment abroad, which is explained by the high co-payments associated to this mechanism, the tariffs for care being significantly higher in the Western EU countries (Földes, 2009).

Poland did not yet implement the ECJ case law. Poland fears that by reimbursing care provided by non contracted care providers abroad, its citizens would also demand to be reimbursed for care by non-contracted domestic health care providers (Machalska, 2009).

2.2.2 Social insurance systems based on benefits in kind: (dis-)similarities

If we have a look at *the social insurance systems based on benefits in kind*, a first conclusion is that the process of implementation of the Court rulings in the older Member States is much more advanced than in the newer Member States, the notable example being Hungary. This finding seems to concur with the 'world of dead letters' that Treib and Falkner describe as regards the transposition, enforcement and application of EU legislation in Member States from Central and Eastern Europe (Treib, 2007). This has certainly partially to do with the fact that the newer Member States have to catch up with an ongoing process (a "moving target"), for which the guidelines are far from clear and remain controversial. At a time where conforming to clearly established "*acquis communautaire*" absorbs a lot of energy, they probably prefer to await clear guidelines before engaging in transposition of these additional rules. Since the new Member States only became subordinated to the ECJ instructions since 2004 (EU accession), their reactions can in fact be compared to the initial reactions of the older Member States. As discussed above, initial reactions in the EU 15 were equally rejecting. The more advanced implementation in Hungary might have to do with the positive attitude of Hungarian authorities, especially with regard to treatment of patients coming from abroad ⁽⁶⁴⁾.

On the other side of the spectre we have The Netherlands, which undoubtedly invested the most energy in making its system EU proof. The planned overhaul of its health care system ensured that the marginal costs of implementing the case law - and of making its system "fit" - were considerably lower. The country is also sparked by a relatively high number of national and European judgments, originating often from citizens dissatisfied with the domestic waiting lists and therefore in search for exit options. Strikingly, the risk for an exodus of patients due to waiting lists did not keep the Netherlands from implementing the Court rulings. Contrary to other countries confronted with long waiting lists and political pressure to address them -especially NHS systems, there was no domestic parallel sector in the Netherlands of care providers not integrated in the publicly funded system, and which could have absorbed the waiting list patients (Glinos *et al.*, 2009). Therefore, the Netherlands had to turn to foreign countries for extra capacity. Furthermore, the Netherlands needed a larger pool of providers in order to be able to create more competition as an important element of the general reform of the system. The Court rulings were supportive for the domestic policy options: the EU internal market approach fitted well with the rationale of the health care reform in the Netherlands, aiming to create more competition in the system.

⁶³ At the moment of writing this paper, the Council and European Parliament issued their position in first reading and will now have to negotiate in view of the final adoption of this proposal.

⁶⁴ See e.g. Hungarian reply to the Commission consultation in 2006 http://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/health_services_co153_en.pdf (accessed 28 June 2010).

There are striking parallels between the implementation of the Court rulings in Germany and the Netherlands. Both countries created the right for patients in the benefit in kind system to opt for reimbursement of care. This right was created not only for patients searching for treatment abroad, but also for patients that are treated in the domestic system. This measure was however less alien to the respective health systems than might appear at first sight: part of the population had always been privately insured, based on reimbursement of care. Finally, the newly created possibilities have not really been made attractive, in order not to encourage patients to make use of them.

Many member States, especially those with a benefit in kind system, consistently voiced concerns that the implementation of the case law would in the longer run oblige them to also domestically reimburse care of non contracted providers or of providers that are not integrated in the publicly funded health care system. (see e.g. Palm et al. 2000). This concern was one of the main reasons for the slow progress in the negotiations on the European Commission's proposal for a Directive on patients' rights in cross border care in the Council. The examples of Germany and the Netherlands illustrate how member states with a benefit in kind system try, in a creative way, to deal with this concern.

Both the Netherlands and Germany also allowed for cross-border contracting. Health insurers can only conclude contracts with foreign hospitals that are integrated in the social security system of their country. Health insurers thus try to keep an eye on the quality and tariffs of the care provided abroad. It is the approach that fits most with these benefit in kind systems. Interestingly, German sickness funds referred to the possibilities in the Netherlands for cross-border contracting, when assessing the opportunities offered by the initial court rulings. Some years later, German law made this indeed possible. Sickness funds had however not awaited this change in legislation for actually concluding contracts with foreign health care providers. Similarly, Dutch sickness funds selectively concluded contracts with hospitals abroad at a moment they could not yet selectively contract hospitals domestically. Although these practices and developments are not exclusively attributable to the ECJ patient mobility rulings, the latter clearly played a role in this policy change. Sickness funds thus successfully used the case law to push through their own aspirations: they learned from each other's experiences while public authorities found additional legitimacy in the Court rulings for domestic reforms.

The most important difference between Germany and most of the other countries with social insurance systems based on benefits in kind is that Germany does not have supply problems; as a result, the willingness to travel abroad for treatment is in principle low. This explains why Germany, after a first rejection in principle of the Court rulings, did implement them quite smoothly.

2.3 National Health Service systems

The landmark ruling for this cluster of health systems was the *Watts case* in 2006. We analyse the reactions from Denmark, the UK, Sweden, Spain and Ireland in the next sections.

2.3.1 *Assessing implementation and politics*

In Denmark already in 1999 an interministerial working group issued a report in which it was conceded that the Decker/Kohll procedure had a discernable impact. However, its

interpretation of the 'service' concept allowed for the exception of the entire public hospital sector, as well as all types of non-hospital care provided free of charge. Nevertheless, health services for which the insured personally paid one part and the competent institution the other were judged to fall under the "service" concept of the EC Treaty. This led to a policy reform, which allowed from the 1st of July 2000 onwards dental assistance, physiotherapy and chiropractic treatment to be purchased abroad, without prior authorisation, with subsequent fixed reimbursement from the Danish institutions⁽⁶⁵⁾. For a limited group of people, namely those who opted for a health protection scheme with more free choice of provider whilst paying an out of pocket payment for treatments, it also includes general and specialist medical treatment (Sindbjerg Martinsen, 2005)⁽⁶⁶⁾.

A health care reform in 2002 aimed at bringing down waiting times for care (which were perceived as a major political problem) and to ensure patients a certain freedom of choice if the public health supply was inadequate. A waiting time guarantee offered patients a general right to hospital treatment outside the Danish public hospitals sector, either in Denmark or abroad, in the event these hospitals are unable to provide the necessary treatment within two months⁽⁶⁷⁾. As of October 2007, the waiting time guarantee has been further reduced to one month (Sindbjerg Martinsen and Vrangbaeck, 2008), although this measure was suspended again until June 2009, due to a strike among nurses in the spring of 2008 (Christiansen, 2009).

The explanatory memorandum of the reforming law introducing the waiting time guarantee refers to the Court rulings as a reason for extending the right to treatment from non-contracted providers established abroad (Sindbjerg Martinsen, 2005). De facto however, the choice for patients has been restricted to those private and foreign hospitals with which the competent Danish institution has concluded an agreement (Sindbjerg Martinsen and Vrangbaeck, 2008). While agreements have been concluded for 2009 with more than 150 private hospitals or clinics in Denmark, only six foreign hospitals or clinics are contracted⁽⁶⁸⁾. The central argument for restricting treatment to contracted foreign providers only is that this allows the Danish authorities to exercise control over the quality of provision through prior assessment of overseas facilities (Sindbjerg Martinsen and Vrangbaeck 2008).

In the wake of the *Watts case* in 2006, Denmark's compliance with Community law has been readdressed. The day after the *Watts judgment* was delivered, the Danish Minister of Interior and Health took the view that due to the waiting time limit, scheduled to be lowered to one month in 2007, the judgment would not have any practical effect⁽⁶⁹⁾. The restrictive Danish definition of the concept of service is maintained: a service within the meaning of the EC Treaty is a service provided with the intention to make a profit and where the insured person pays more than half of the costs⁽⁷⁰⁾ (Sindbjerg Martinsen and Vrangbaeck, 2008). Nevertheless, the Danish interpretation of the notion of "service" was challenged in 2006 by the Social Appeals Board, stating that this definition was too narrow since it did not cover the right of all persons, including those who have right to free medical care, to purchase specialist health care in another Member State (Jorens and Hajdu, 2008). Denmark is awaiting the adoption of a European Directive before taking further action (Kostera, 2008).

⁶⁵ Amendment on the Act on public health insurance, and a new executive order taking effect from 1 July 2000.

⁶⁶ Act nr. 467 of 31 May 2000 and consolidation act (*Jovbekendtgørelse*) nr. 536 of 15 June 2000.

⁶⁷ Consolidation act nr. 143 of 25 March 2002.

⁶⁸ In Germany, Sweden and Spain. See <http://www.sygehusvalg.dk/geoomraade.aspx> (accessed 03/02/10).

⁶⁹ Answers to parliamentary questions no. 4965, 4967 and 4969 of 17 May 2006.

⁷⁰ Answer to parliamentary question nr. 4967 of 17 May 2006.

In Ireland there is no specific legislation addressing the circumstances under which insured persons are entitled to treatment abroad. Prior to the ECJ ruling in *Watts*, the Department of Health and Children (DOHC) took the view that due to the different nature of the Irish health care system from those insurance-based systems on which the health care rulings have been developed, this case law was not applicable to the Irish health system. Nevertheless, since the *Watts* case, the competent Department is more prudent, stating that this judgement “may mean that the rules can be applied more extensively but this is not yet fully clear” (71).

There are however some benefits which can be purchased abroad. The Irish system provides for limited insurance based dental, aural and optical care. Previously the provision of such care was confined to providers in Ireland, but from 2005 persons are allowed to avail of services abroad and to receive the standard payment or the actual cost (whichever is lower) (Cousins, 2006).

Furthermore, since 2002 patients who have been waiting longest for procedures in public hospitals, the National Treatment Purchase Fund was set up. Almost 150.000 patients have been treated through this fund until 2009 (72). It purchases mainly domestic care in private hospitals. Only two hospitals in Northern Ireland are included in the scheme (73).

The initial position of the authorities in the **United Kingdom** was that the principles on which the Kohll and Decker rulings are based do not apply to the National Health Service. Nevertheless, in practice regional authorities reimbursed patients in cases which could potentially have ended up before the ECJ, in order to avoid possible precedents (Palm et al., 2000).

After the *Geraets-Smits and Peerbooms* rulings of 2001, defining that in-kind benefit systems fell within the scope of the free movement of services, and that if a Member State could not provide a treatment “without undue delay”, patients had the right to seek treatment abroad, the then secretary of State, Alan Milburn declared that the decision was of great importance and required the NHS to re-examine its practice on the funding of overseas treatment. This was done after initial suggestions that the *Peerbooms* ruling was of limited significance (Montgomery, 2005). Montgomery suggests that the Court rulings and political pressure to address waiting lists were used by the government and reinforced its determination to shorten waiting times, make the NHS more businesslike and increase patient choice (Montgomery, 2005). As a consequence, since 2002, the UK allows local health commissioners in England to commission treatments from hospitals within the EU for the treatment of NHS patients. Since 2004 however, patients were no longer sent through this procedure. It is argued that the procedure was actually set up mainly to put pressure on domestic private providers to lower their prices when contracting with the NHS, which was also part of the NHS reform (Glinos et al., 2006).

Following the *Watts* case, which concerned a UK citizen, the Department of Health issued an advice to local health care commissioners on handling requests for care in other European countries, with detailed guidance (Department of Health, 2007). This advice can be seen as a reaction to the Court criticism that the NHS lacked clear criteria for managing its prior authorisation procedures. It allows for the funding of planned hospital care abroad

⁷¹ http://www.dohc.ie/public/information/hospital_services/hospital_treatment_abroad.html?lang=en, (accessed 09.02.10)

⁷² See http://www.citizensinformation.ie/categories/health/hospital-services/national_patient_treatment_register (accessed 06.10.10); <http://www.ntpf.ie/home> (accessed 2/8/09)

⁷³ <http://www.ntpf.ie/where> (accessed 2/8/09)

after prior authorisation, when care cannot be provided without undue delay in the NHS, either through the Regulation based procedure or the Treaty based procedure. It suggests that the Treaty based procedure is in the interest of the patient only when the treating hospital is not integrated in the public system of the country of treatment.

For ambulatory care the advice distinguishes between services for which it is not necessary for local health care commissioners to put in place prior authorisation processes such as GP consultations, optometry, pharmacy and some dental treatments. By contrast for services whose complexity and cost make them more similar to services provided in hospitals the requirement for prior authorisation may be justified. The latter might include services subject to referral or which are parts of complex patient pathways. The advice warns that particular care is needed for handling requests for dental care abroad since it is difficult to establish after the event whether any treatment undertaken abroad was clinically necessary and therefore of a sort that would have been provided by the NHS. It is suggested to limit reimbursement to the average cost paid by commissioners for the equivalent NHS course of treatment.

In October 2009, the Department of Health circulated draft regulations and a draft update of the 2007 advice, aiming to create a legal base in UK domestic legislation for decisions on prior authorisation and reimbursement of costs for treatment abroad (⁷⁴). It applies to England and Wales only. These proposals were drafted in the light of the publication of the proposal for an EU Directive on patients' rights in cross border care; but they are also in line with plans to turn some NHS targets, including increasing patient choice, into enforceable patient entitlements.

Compared to the 2007 advice, these documents narrow the definition of health services that can be assimilated to hospital care and for which prior authorisation thus will be required. They include surgery, services which require the use of specialised and cost-intensive medical infrastructure and equipment, and specialised services which require high levels of finance or planning.

With regard to reimbursement levels the documents suggest that, where there is no tariff, a price will need to be calculated, and average costs which can be shown to have been reasonably calculated may be used. If commissioners are however unable to work out an objective cost, or appropriately decode EU receipts for health care, they may face the prospect of reimbursing the full costs of treatment.

The documents also provide guidance for the treatment of patients coming from abroad. Lack of service capacity is likely to be the strongest ground for rejecting a request for treatment of a non-UK patient. Providers who receive requests from EEA patients under the Treaty based route should assume that the patients wish to be treated in the same way as an NHS patient, unless they specifically state that they wish to be treated privately. If they wish to be treated privately, they can be charged at the equivalent cost to UK private patients.

When they were handed down, the Swedish Government believed that the *Kohll and Decker* rulings did not apply to its health system, and that treatments received under a benefits in kind system do not constitute an economic activity (Palm et. al, 2000). However, following two national court rulings based on the ECJ case law in 2004, things began to change.

⁷⁴ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107296 (accessed 06.07.10)

Since 2004 some de facto criteria for decisions on reimbursement of care received abroad are established, according to the principles established by the ECJ. No system for prior authorisation applies. Applications for reimbursement can only be made after treatment abroad. These criteria do not refer to the waiting period for treatment in Sweden (Sylvest et al., 2007). In the year following the ruling, applications for reimbursement for care abroad rose dramatically and the overwhelming majority (⁷⁵) were approved (Blomqvist and Larsson, 2009). In a reaction, a proposal for a law was presented by an expert committee in 2006. According to the proposal, prior authorisation would be required for hospital care abroad. The adoption of the proposal was however blocked by the new center-right government later in 2006 (Blomqvist and Larsson, 2009).

Furthermore, in a response to domestic controversy over waiting times, a national waiting time guarantee was established in 2005, ensuring that no patient in Sweden should have to wait longer than 90 days. This measure was however also considered as a measure addressing the threats the ECJ case law with regard to “undue delay” could represent for the Swedish system. According to Blomqvist and Larsson, the Court rulings may have helped the Ministry in persuading the county councils to agree with the waiting time guarantee (Blomqvist and Larsson, 2009).

In **Spain**, no changes to the legal system to incorporate the ECJ rulings have been made so far. It is perceived that more legislative guidance at an EU level is required (Sylvest e.a., 2007).

2.3.2 National Health Service systems: *(dis-)similarities*

In this cluster of case studies, we see again some important parallelism.

First, all these countries took initiatives to reduce waiting lists and to offer patients more choice of provider when they could not be treated with undue delay in the public health system. Although these measures were in the first place a response to domestic political pressure, there was in most countries also an interaction with the EU level developments. In each of these cases patients were given, primarily the right to be treated domestically, outside the public sector. In addition, possibilities were provided to be treated in contracted hospitals abroad. However, only very few hospitals abroad were included in the schemes. Furthermore, the ECJ Court rulings were used by policymakers aiming to introduce the treatment guarantees as arguments to get their policy accepted. And the other way round, the existence of treatment guarantees was used to argue that no further adaptation to the domestic health systems was needed in order to comply with further ECJ rulings. Domestic political efforts to enact formal patient rights to care are thus supported (see e.g. Blomqvist and Larsson, 2009).

These countries thus took measures that reduced the demand to exit the system, by addressing the problem of waiting times. The marginal number of providers contracted abroad suggests that they are rather a side effect of contracting the domestic private sector and aim to make the domestic contracting system EU compatible. This contrasts with the Dutch system, where contracting abroad was the only option to increase capacity in the short term.

⁷⁵ 945 out of 1101

Secondly, the process of institutional adaptation to the ECJ Court rulings is clearly slower and started clearly later in the NHS cluster. It is only after the 2006 Watts case - when it became indisputable that the free movement of services principles also apply to care provided abroad to patients affiliated to a National Health Service system - that these systems are seriously considering to implement the principles of the Court. In Sweden, which was confronted with national court rulings, the process started earlier. When the *Watts* case was issued, it was already clear that the European Commission would bring forward a specific legislative proposal on patient mobility. Therefore, several of these countries seem to be awaiting the adoption of this Directive before taking further action. It is interesting to see how the NHS is already anticipating on the adoption of this Directive.

Finally, the UK advice to local health care commissioners and the recent draft proposals illustrate how complex cost calculations and the definition of the benefit package can be in NHS systems, where care provision is mainly public; where there is often neither money transfer nor a price for the provided treatments.

Conclusions

This paper aimed at opening the black box regarding the actual (as opposed potential) impact of European Integration on national health care systems. We tried to do so by examining how the European Union interacts with national health care policies as a result of rulings of the European Court of Justice (ECJ) with regard to patient mobility.

We tried to find out how Member States deal with the deregulatory dynamic of the applications of the free movement rules to health care.

Our empirical assessment - covering thirteen Member States which belong to different families of health care systems - looked into the factors that determine the mechanisms and timing of ECJ case law finding its way into national arenas. Furthermore we tried to understand whether and how this case law impacts on the interactions between the stakeholders in the domestic arena.

A first finding of this analysis is that the ECJ rulings regarding patient mobility provoke a number of similar but far from identical responses across the Member States when they initiate processes of adaptation to the Court ruling by reducing the misfit between EU and domestic legal provisions. These adaptation processes are not straightforward and represent creative responses in a context of legal uncertainty:

- initially *most* Member States opt for limited interpretation of the scope of application of the rulings. In other words: they reject the scenario that the Court rulings would be applicable to their system ("our system is different from the system in question in the Court case");
- services that are provided on a fee for service basis (often including dental care) and medical products are typically the first to which the principles established by the ECJ are applied;
- Member States require that the treatment abroad complies with the conditions for funding care domestically;
- Member States try to channel patient mobility through procedures that are 'fit' to their own system and discourage procedures that are less fit. For example, where

the domestic system is based on benefits in kind, the attempt is to channel patients abroad through contracted providers;

- nearly all Member States try to keep some grip on the selection of providers abroad, e.g. by requiring that they are integrated in the statutory system of the Member State of care provision.

Member States thus try to uphold their steering instruments while allowing patients to be treated abroad. They try to copy as much as they can the requirements for funding care at home to care delivered abroad. Progressively, however, they realise that doing so is not EU proof, as a result of which some of the requirements applicable at home are dropped for care provided abroad.

Secondly, our research enables to identify some of the factors that may explain the considerable differences between the reactions of Member States - also between Member States with similar health systems - to the ECJ rulings regarding patient mobility. The most important factors which determine the pattern of adaptation to EU pressure are:

- the degree in which Member governments have been faced with national and European Court Cases.
- the likelihood that patients will effectively use the new mobility option (e.g. because of domestic waiting lists);
- the degree of institutional fit/misfit between the domestic and EU setting (e.g. existence of reimbursement tariffs);
- the presence of reforms of the domestic health care system, certainly if these domestic reforms aim to create more competition in the system.

Thirdly, the empirical material confirms the assertion - which has been voiced for some time now (see e.g. Palm *et al.*, 2000) - that these ECJ rulings regarding patient mobility have potentially an important impact on the domestic care systems. The possibilities created in the reformed Dutch and German system to allow patients to exit from the contracting system - also for care provided at home - is an example thereof. The impact thereof so far must however not be overestimated. The discussed examples were more in continuity with the domestic health policies than appeared at first sight.

The described domestic strategies make it clear that the process of 'adaptation' to the Court rulings is not a simple command-and-control process, but rather a process of creative response to EU law. Strategies include - for Member States confronted with long waiting lists - attempts to reduce the demand for exit, e.g. through contracting the domestic commercial sector. Policies addressing waiting times, although rarely explicitly justified by the case law, might in reality well be one of the most important results of the Court rulings.

Furthermore, we provided evidence of agency by domestic actors who draw legitimacy from the EU setting to reinforce their position (or acquire one) at the national level. Examples include:

- threats to question the domestic contracting system, with as a result that compliance has been assured by a strong (and effective) increase of doctor's fees (Luxemburg);
- setting up of a broad coalition pushing for commercialisation of hospital services (Belgium);

- selective contracting by sickness funds in Germany and the Netherlands.

These examples illustrate how the jurisprudence can encourage more competitive behaviour of insurers, and more commercial behaviour and price increases from providers.

Also public authorities make use of the jurisprudence to support domestic reform agendas, such as the enactment of formal patients' rights (Sweden), addressing waiting times, make the health care system more businesslike and increase patient choice (UK) or the introduction of more competition in the system (the Netherlands).

Finally, the case studies also provide examples illustrating the interaction between national policies implementing the Court rulings and EU level policies and jurisprudence. Several Member States interpreted the concept of hospital care -for which prior authorisation is required- as extending to certain forms of care that do not involve overnight stay. This can be considered as a creative interpretation of the ECJ concept of intramural care. The possibility to extend the definition of hospital care to certain forms of out patient care has next been incorporated by the Commission in its proposal for a Directive on patients' rights in cross border care. Furthermore, the European Court of Justice, referred in more recent case law explicitly to this wider definition as stipulated in the Commissions' proposal (⁷⁶).

More research on this topic is needed to assess the extent to which the 'effect' of the Europeanisation of health care systems is influenced by the degree in which Member States are involved in 'shaping' the EU policy space on this topic. This 'uploading' dimension, which would acknowledge the Europeanisation of health care policies and politics as a two-way-street (Hamel and Vanhercke, 2009), has so far only marginally been taken on board in the literature (nor has it in this paper). The policy process with regard to the adoption of the Directive on patients' rights in cross border care certainly provides ample opportunities to analyse this uploading dimension. In turn, the expected entry into force of this Directive will again set in motion important dynamics at domestic level which might well go beyond what we found in this analysis.

⁷⁶ Case C-169/07 Hartlauer Handelsgesellschaft mbH v Wiener Landesregierung, Oberösterreichische Landesregierung, Opinion of the AG of 9 September 2008, note 44

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