THE EU AND THE PHENOMENON OF CROSS-BORDER HEALTHCARE – LOOKING FOR THE "WAY"

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Abstract: The presented paper deals with the selected issues of providing healthcare in the EU mainly from the perspective of cross-border healthcare. The author suggests some of the historical milestones of the topic of cross-border healthcare and stresses the relevance of the decisions of the European Court of Justice/Court of the EU to this end. At the same time, the author looks at the topic from the perspective of public administration (administrative law) and introduces the reader to the main substantive elements of the issue (e.g. types of healthcare in the EU law). In the final part of the paper, the author analyses the issue of prior authorisation as set forth by the Directive 2011/24/EU of the European Parliament and of the Council on the application of patients´ rights in cross-border healthcare.

Keywords: healthcare, cross-border, authorisation, compensation, EU, insurance, administrative body

1 General Introduction

One of the key assets of any individual is his/her health as one of the main preconditions of a happy life. Nevertheless, the health "status" of an individual is not a purely individual matter any more. There are no doubts about the fact that the "fitness" of the society has many impacts on the society as a whole – including issues of social benefits, unemployment rates, numbers of healthcare facilities in the country etc. The history is full of cases in which serious diseases have lead to a massive reduction of the society or its sections (e.g. the poor). Healthy individuals form/make up a healthy society. At the same time, a healthy society creates benefits but normally requests much less from public budgets. For this – and a number of other reasons - the protection of the health of human beings has been a central issue of most civilised nations and their governments for a number of decades (or may be even centuries). Member States of the EU do not represent any exception to this rule and the same applies to the EU as a whole. Knowing this, it is not surprising that the EU puts enormous effort into protecting the health of its citizens and into the improvement of healthcare in all Member States. Since health care standards in different Member States may vary greatly, citizens of the EU may be interested in "healthcare motilities" in order to take advantage of cross-border health care. In other cases, it is a matter of necessity, rather than an issue of options or choice.

In reference to the notion of health being one of the most important assets of any society, the Treaty on the Functioning of the EU (TFEU) in **Article 168**[1] **par. 1**[2] stresses, that the EU when defining and implementing EU policies and activities must ensure high level of protection of human health. When looking at the wording of the Article, it is obvious that although the Union wishes to achieve a high level of protection of human health, it does not (legally) strive to achieve the highest one. The next section of the very same Article declares that „Union action, which ***shall complement national policies***, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health...." by which it suggested that EU policies ought to complement the national health policies of Member States. Paragraph 7 of the above Article further stresses the notion of subsidiary especially by stipulating that EU action „***shall respect the responsibilities of the Member States***" for the definition of their health policy and for the organisation and delivery of health services and medical care.

It is worth noting that Article 168 of the TFEU (in comparison to the previous primary provisions on public health) provides for the possibility of introducing incentive measures to be adopted by the European Parliament and the Council (with the ordinary legislative procedure and after consulting the Committee of the Regions). Nevertheless, incentive measures must not be aimed at the harmonisation of the laws of the Member States and must relate to the topic of protection and improvement of human health. At the same time, Article 168 of the TFEU makes it possible for the Council to adopt recommendations on matters of public health (on the proposal from the Commission).

In order to conclude this very general and incomplete introduction into the system of healthcare policy and public health matters in the EU, one must mention **Article 9** of the TFEU and **Article 36** of the TFEU. According to the former, in defining and implementing its policies and activities, the Union shall take into account requirements linked to the promotion of a high level of employment, the guarantee of adequate social protection, the fight against social exclusion, and a high level of education, training and "***protection of human health*".** The latter Article, on the other hand and in reference to the prohibition of quantitative restrictions defines that the provisions of Articles 34 and 35 of the TFEU shall not preclude prohibitions or restrictions on imports, exports or goods in transit justified on grounds of public morality, public policy or public security and ***the protection of health and life of humans, animals or plants***; […] Such prohibitions or restrictions shall not, however, constitute a means of arbitrary discrimination or a disguised restriction on trade between Member States"[3]. Last but not least, one can also mention Article 191 of the TFEU according to which the "Union policy on the environment shall contribute to pursuit of the following objectives: –preserving, protecting and improving the quality of the environment,–***protecting human health***–[...]". In order to continue the list of non-health related Articles having an effect on health issues, the following Articles of the TFEU could be mentioned: **Article 45** (the free movement of persons as guaranteed by EU law may be an issue form the perspective of cross-border healthcare), **Article 114 par. 3** (calls for the protection of human health when establishing internal market policies), **Article 153** (the Union supports Member States in protecting ***workers' health*** and safety) and **Article 169** (states that the Union shall contribute to "protecting the health, safety […] of consumers as well as promoting their right to information systems). Lastly the topic of sustainable development is touched in various Articles of the primary treaties and this, of course, has various links to health care and the protection of health of individuals.

At the same time, some space needs to be devoted to the topic and dimensions of public health as defined by the Charter of Fundamental Rights of the European Union (also referred to as "the Charter" later on). In general, the articles of the Charter (as to the issue of public health) can be categorised into two major groups. The first being the articles which have an **implicit effect** on health care and health issues and the second "group" **(the "explicit" one)** represented by **Article 35** of the Charter. **Article 1** of the Charter deals with human dignity, which indeed may relate to the way healthcare is provided. **Article 2** of the Charter safeguards the right to life, **Article 3** protects the integrity of the person, **and Article 8** focuses on the protection of personal data (which is applicable also in the case of providing healthcare). On the other hand, the rights guaranteed by **Article 10** of the Charter (freedom of conscience, belief and religion) may also interfere or collide with health care issues from the perspective of. **Article 26** of the Charter ensures the proper integration of individuals with disabilities into the society which logically means it has a direct link to the topic of healthcare. If we take the "extreme route" even **Article 4** (prohibiting degrading and inhuman treatment) and **Article 7** (respect for private and family life) may touch the topic of public health. Article 25 (*The rights of the elderly*) could also be categorised into the class of Articles having an implicit connection to the quality of healthcare. Although the above articles do not relate to health care

[1] Public Health was previously dealt with in Article 152 of the EC Treaty.
[2] Article 168 par. 1 TFEU *„A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities."*

[3] Article 34 TFEU: „Quantitative restrictions on imports and all measures having equivalent effect shall be prohibited between Member States.", Article 35 TFEU: "Quantitative restrictions on exports, and all measures having equivalent effect, shall be prohibited between Member States."

specifically, due to their nature, they may be applicable since they have an implicit effect on the issues of public health. On the other hand, **Article 35** of the Charter stipulates that *"Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities"*. Logically, this article has the most immediate effect on public health.
Lastly, we need to mention that **Article 11** par. 1 of the TFEU states that EU institutions should give citizens and representative organisation the opportunity to make their views known on all areas of Union action and that the institutions "shall maintain an open, transparent and regular dialogue with representative associations and civil society.", which can be referred to as the right to discuss opinions with the institutions of the EU. This provision provides a space for health related civil society organisations to get involved.

2 Introduction into the Topic of Cross-border Healthcare

Although cross-border health care within the EU has been in operation for some decades, one must add that at various stages of EC/EU development, cross-border healthcare was based on different pillars and principles.
The original idea of cross-border health care was based on the *freedoms* (freedom of movement of labour, capital, goods and services). However, at the very beginning of its application, Member States and their authorities have been reluctant to accept public health care within the system of cross-border services, since they believed it was not a matter of ***private commerce*** within the free trade community. Member States did not want to accept the application of EC law on the matter of cross-border health care believing that health care issues were governed purely by the national laws and that European law did not apply.
Later on, views on the topic started to change by making health services part of ***services*** **within the meaning of the EC Treaty.** For the first time in *Luisi & Carbone* (1984)[4] and then again in *SPUC v Grogan* (1984)[5] the Court acknowledged that health services are **deemed to fall within the ambit of the economic 'fundamental freedoms' of the EC.** However, the landmark cases often used to illustrate the system of healthcare from the point of law and legal development are the cases of *Kohll* and *Decker*. Mr. Kohll, a Luxembourg national, was seeking reimbursement for a dental treatment received (by his daughter) in Germany, without having received prior authorisation by his home institution. In this case, the Court made it clear that Articles 49 *et seq.* do apply to health services, even when they are provided in the context of a social security scheme. Or, as the Court put it: 'the special nature of certain services does not remove them from the ambit of the fundamental principle of freedom of movement. Hence, the requirement of prior authorisation did, indeed, constitute a violation of Article 49 (then 59) of the Treaty[6]. In this case the court held that the requirement of prior authorisation did, indeed, constitute a violation of Article 49 (then 59) of the Treaty. In the case of *Decker*[7] which was delivered the same day as Kohll the Court came to the conclusion that national security and healthcare schemes should also respect Article 28 of the EC Treaty on free movement of goods[8]. The result that healthcare is *a priori* subject to the Treaty rules was further explained confirmed and explained in the judgments in *Vanbraekel*[9] and *Peerbooms*[10], but also in the cases of *Müller-Fauré*[11] and *Watts*[12].

In the case of **Müller-Fauré / van Riet (1999), 2003**[13] the Court further confirmed that *"A medical service **does not cease** to be a provision of services **because it is paid for by a national health service** or by a system providing benefits in kind..."* The issue of cross-border healthcare is discussed from this perspective in the sections of the paper below.
However, one of the most important elements of the topic that needs to be clarified before proceeding to the next dimension of the topic is the issue of *remuneration* (being one of the key elements of a "service" as it was provided for in Article 49 and Article 50 of the EC Treaty). In the case of the *Belgian State v. Humbel (1988)* the Court held that *"the essential characteristic of remuneration lies in the fact that it constitutes consideration for the service in question and is normally agreed upon between the provider and the recipient of the service"*[14]. Nevertheless, this very concept has been altered by the Court in its later decisions. In *Smits and Perbooms* et al. the Court confirmed that remuneration may exist also in relations involving three parties (i.e. also the national health authorities and their funds – i.e. those relations in which the payment is provided by a third party – not directly by the one who receives the service). To this end, the Court has also confirmed that remuneration may be found to exist even in situations where the correlation between services

[4] Judgment of 31 January 1984 in joined Cases 286/82 and 26/83 *Luisi and Carbone* [1984] ECR 377, Rec. 16.
[5] Judgment of 4 October 1991 in case C-159/90 *Society for the Protection of Unborn Children Ireland* [1991]
ECR I-4685, Rec. 18.
[6] Judgment of 28 April 1998 in case C-158/96 Kohll [1998] ECR I-1931. Rec. 20 of the judgment. The ECJ Case Law on Cross-Border Aspects of Health Services. Briefing Note. IP/A/IMCO/FWC/2006-167/C3/SC1, January 2007. p. 5
[7] Judgment of 28 April 1998 in case C-120/95 Decker [1998] ECR I-1831; see also before that judgment of 7
February 1984 in case 238/82 Duphar [1984] ECR 523.
[8] More facts on the cases will follow in the paper.
[9] *Judgement Vanbraekel (2001)*
Mr Vanbraekel tried to obtain reimbursement for orthopaedic surgery of his late wife Mrs Descamps (a Belgian resident with Belgian health insurance) received in a French hospital, for which she was wrongfully denied authorization, as a Belgian court would conclude after her return to Belgium. The question that faced the Belgian court was whether she should be reimbursed according to the Belgian tariff (as the Kohll ruling would imply for treatment without authorization), or the French tariff (as Council Regulation (EEC) No. 1408/71 implies and which was significantly lower). The ECJ ruled that lower reimbursement rates for treatment delivered abroad can discourage people from applying for authorization. Hence, this would constitute a violation of the free movement rules and, therefore, additional reimbursement covering this difference must be granted to the insured under the social security coordination mechanism.
[10] *Judgements Geraets-Smits/Peerbooms (2001)*
Dutch citizens Mrs Geraets-Smits and Mr Peerbooms were both refused reimbursement by their Dutch sickness funds for the costs of their hospital care abroad for "experimental" treatments for Parkinson's disease in Germany and neurostimulation therapy for coma patients in Austria, respectively. Neither had obtained prior authorization for these treatments (which were unavailable in the Netherlands) and they subsequently attempted to obtain refunds after returning home by using the procedure based on the free movement of services rules established in the Kohll case. The ECJ ruled identically in both cases, drawing on previous case law and reiterating that this hospital treatment is indeed an economic service in the sense of the EC Treaty, which can be obstructed by submitting it to authorization. However, the ECJ accepted in this case that for hospital services – requiring planning in order to guarantee a rationalized, stable, balanced and accessible supply of hospital services – the use of prior authorization was justified as long as it could be considered to be necessary, proportionate and based on objective, non-discriminatory criteria that are known in advance. This would mean, however, that authorization to receive treatment in another Member State could only be refused if the same or equally effective treatment can be obtained without undue delay from an establishment with which the insured person's insurance has an agreement.
[11] The case is analysed in brief in footnote no. 8.
[12] *Judgement Watts (2006)*
Mrs Watts, a 72-year-old British national was put on a waiting list for hip replacement. She was denied authorization by her Primary Care Trust (PCT) to have the surgery carried out in Belgium or France as, according to National Health Service (NHS) plan targets, the standard waiting time is 12 months. She was refused reimbursement for the treatment she finally underwent in France. In its judgement, the Court stated that the obligation to reimburse the cost of hospital treatment provided in another Member State also applies to an NHS which provides such treatment free of charge. In order to be entitled to refuse a patient authorization to receive treatment abroad on the grounds of waiting time for hospital treatment in the country of residence, the NHS must show that that the waiting time does not exceed a medically acceptable period, having due regard to the patient's condition and clinical needs. As to the reimbursement mechanisms, the Court ruled that in the absence of a reimbursement tariff in the United Kingdom, where hospital treatment is provided free of charge by the NHS, any possible user charge the patient would be required to bear in the Member State of treatment should be additionally covered by the competent country up to the difference between the cost (objectively quantified) of the equivalent treatment in the home country and the amount reimbursed pursuant to the legislation of the treatment country, if the latter would be lower – with the total amount invoiced for the treatment received in the host Member State as a maximum.
[13] *Judgement Müller-Fauré and Van Riet (2003)*
In the case of Mrs Müller-Fauré, an insured person under the Dutch health insurance, who preferred to be treated by a dentist in Germany, the Court confirmed that the principle of free movement of services would indeed preclude the use of prior authorisation for the reimbursement of non-hospital care provided in another Member State. This would not be changed by the fact that the Dutch health insurance operates as a benefit-in-kind system (as opposed to the Luxembourg restitution system in the Kohll and Decker cases). In the case of another Dutch insured individual, Mrs Van Riet, who went to Belgium for an arthroscopy because she could get it faster there than in her home country, the ECJ specified the concept of undue delay already raised in the Geraets-Smits/Peerbooms rulings. The Court stated that, in assessing whether waiting times are acceptable, national authorities are required to regard to all the circumstances of each specific case and to take due account not only of the patient's medical condition at the time at which authorization is sought (and, where appropriate, of the degree of pain or the nature of the patient's disability which might, for example, make it impossible or extremely difficult for her/him to carry out a professional activity), but also of her/his medical history.
[14] Judgment of 27 September 1988 in case 263/86, *Belgian State v. Humbel*, [1988] ECR 5365, para 17.

received and money paid is only indirect (e.g. paid on a flat rate basis irrespective of the nature and cost of the service provided) if economically nonexistent[15].

It is obvious, that in its landmark rulings on *Kohll and Decker*[16] and successive jurisprudence, the ECJ emphasized the applicability of the fundamental freedoms, enshrined within the EC Treaty, on statutory health care services. All citizens – service providers as well as recipients – should be able to benefit from the principles of free movement of services (for example, in terms of dental treatment) and goods (such as glasses and pharmaceuticals) in the single European market. Therefore, health care services purchased across the EU should be reimbursed as if they were provided in the country of affiliation. Any measure that would deter or prevent patients from seeking treatment in another Member State (or providers from offering their services) is to be regarded as an obstacle to free movement that only can justified by "overriding reasons of general interest" or the protection of public health. In that sense the Court ruled that submitting the reimbursement of treatment outside the country of affiliation to the condition of prior authorisation could only be upheld for hospital care, as free and unplanned cross-border hospital care could indeed seriously undermine planning and rationalisation efforts, causing imbalances in supply as well as wastage[17] [18].

On the following pages of the paper, we are providing a brief summary of some other case law relating to health care matters in order to provide the reader with additional information on the issues[19]

Judgement Ioannidis (2003)

In this case the ECJ ruled that Greece could not subject payment of the medical expenses of a pensioner incurred during a temporary stay in another Member State either to prior authorization or to the condition that the illness he suffers from has manifested itself suddenly and is not linked to a pre-existent pathology of which he was aware.

Judgement Inizan (2003)

In this ruling the Court explicitly confirmed the consistency of the prior authorization condition provided for in Article 22 of Council Regulation (EEC) No. 1408/71 with Articles 49 and 50 EC on the freedom to provide services. Since recourse to Council Regulation (EEC) No. 1408/71 offers insured individuals certain rights which they would otherwise not enjoy, the Community legislator is free to attach conditions to or determine the limits thereof. However, Regulation 1408/71 is only one way of exercising the right to the freedom to provide health care services. In this ruling the Court also initiatied the cumulative conditions of Article 22(2) under which prior authorization cannot be refused, in line with the earlier judgements in the case Smits-Peerbooms.

Judgement Leichtle (2004)

This ruling targeted German legislation governing the reimbursement of expenditure in respect of a health cure. The condition by which the statutory cover for this care provided outside Germany – namely, that it had to be established in a report drawn up by a medical officer or medical consultant to the effect that the health care was absolutely necessary owing to the greatly increased prospects of success outside of Germany – was held to be contrary to the freedom to provide services. The condition that health spas, in order to be eligible for statutory reimbursement, have to be listed in the Register of Health Spas, was not considered to be an obstacle if the conditions for registration were found to be objective and non-discriminatory.

Judgement Keller (2005)

A German national resident in Spain was authorized by the latter country to be treated in Germany (E112). However, German doctors referred her urgently for specialized treatment in Switzerland, without consulting the Spanish authorities. The ECJ stated that Spain could not require Mrs Keller to return to Spain for medical examination of the need for this referral and that it was bound by the clinical judgement of German doctors. Therefore, the cost of this treatment was required to be borne by the Spanish system.

Judgement Acereda Herrera (2006)

The assumption of the costs of travel, accommodation and meals of the insured person and the person accompanying her/him, in the case of hospital treatment in another Member State, depends on the mechanism by which these costs are met in the country in which they are insured.

Judgement Commission/Spain (2010)

Spain does not restrict the freedom to provide hospital care services (nor related tourist and educational services) by refusing the reimbursement of any user charges imposed on a Spanish insured person treated during a temporary stay in France. In this ruling the ECJ clearly distinguishes the case of an unscheduled treatment from that of a scheduled treatment in another Member State, as in the Vanbraeckel case, in which prior authorization was wrongfully denied.

3 Types of healthcare, the tool of "prior authorisation" and Directive 2011/24/EU

In order to provide the reader with a clear scheme of the general mechanisms of cross-border health care, first of all, we need to look into the issue, whether there are any types of health care at all (from the point of law and the perspective of health care in another Member State). If raising the question so, the answer is positive. Most importantly, there are two major types of healthcare as covered by EU legislation. The first type is usually referred to as **unforeseen medical treatment** (or unplanned medical treatment) and the other one is referred to us as **planned medical treatment** (or planned medical care). The difference between the two must be clear purely from their general description. Unplanned or unforeseen medical treatment involves usually an unexpected treatment that is provided to a person e.g. due to an accident he/she was involved in etc. on the territory of a Member State or other applicable state - other than his/her state of residence (or state where his/her social security system directly applies). On contrary to that, planned medical treatment is a treatment which is *the very reason* of the travel of the person. To simplify the whole difference: while in the first case the purpose of the travel is not the medical treatment itself but some other reason (e.g. tourism), in the latter case, the treatment is the very reason for the travel (the person travels abroad to get medical treatment). In case of unplanned medical treatment, such treatment may be provided to the person through the European Health Insurance Card which covers the cost of medical care during temporary visits abroad (this could include not only

[15] The ECJ Case Law on Cross-Border Aspects of Health Services. Briefing Note. IP/A/IMCO/FWC/2006-167/C3/SC1, January 2007. p. 5

[16] *Kohll and Decker judgements (1998)*
Mr Kohll and Mr Decker, both Luxembourg nationals, were refused reimbursement by their sickness fund. Mr Decker requested reimbursement for spectacles (goods) that he had bought in Belgium using a prescription from a Luxembourg ophthalmologist, whereas Mr Kohll requested reimbursement for a dental treatment (services) his daughter had received in Germany. Neither had obtained a pre-authorization from their home institution, as required. In both rulings, the ECJ affirmed that national social security schemes should also respect the fundamental principles of free movement of goods and services and concluded that submitting reimbursement to the condition of prior authorization constituted a hindrance of those freedoms. Such a hindrance could only be justified if it proved to be necessary for maintaining a balanced medical and hospital service accessible to all, a treatment capacity or medical competence on national territory which is essential for public health – and even the survival of the population – or for preserving the financial balance of the social security system. The ECJ found that in this case no overriding reason in the general interest was applicable, as reimbursement at the level of the home country would in no way threaten the financial balance or the quality of the health services in the home country. The rulings in the Kohll and Decker cases sparked intense political and scientific debate on their ambit and implications. As many open questions remained, for example on the scope (that is, whether it includes hospital care) as well as the implications for national health systems, it was evident that there was a need for further clarification, which was soon to be provided by the ECJ in its rulings in the cases Geraets-Smits/Peerbooms and Vanbraekel, all concerning the reimbursement of hospital costs incurred in another Member State than the home country.

[17] Case C 157/99 Geraerts-Smits and Peerbooms [2001] ECR 5473, para. 106.

[18] *Willy Palm, Matthias Wismar, Ewout van Ginneken, Reinhard Busse, Kelly Ernst and Josep Figueras :* Towards a renewed Community framework for safe, high-quality and efficient cross-border health care within the European Union, pp 24 – 25, In Cross-border Health Care in the European Union : ISBN 978 92 890 0221 9, UK : World Health Organization, 2011

[19] *Willy Palm, Matthias Wismar, Ewout van Ginneken, Reinhard Busse, Kelly Ernst and Josep Figueras :* Towards a renewed Community framework for safe, high-quality and efficient cross-border health care within the European Union, pp 26 – 29, In Cross-border Health Care in the European Union : ISBN 978 92 890 0221 9, UK : World Health Organization, 2011

holidays but also other types of short breaks and even some types of business trips etc.). The European Health Insurance Card is available to all citizens of any Member State and it is issued by the national healthcare (social) authority at which the person is insured.

In line with the sections above, by now it must be clear that along with the unplanned medical treatment, EU legislation deals also with issues of planned medical treatment. Under EU law, the person is entitled to a planned medical treatment in another Member State (or other applicable state) if:

a) the specific treatment the patient **needs is not available in his/her home country**, however, such treatment **would be covered by the national (statutory) health insurance**

b) the patient's situation **requires an early treatment**, however, in the country of origin the patient **might not receive the treatment in time**. The fact whether this situation exists is determined mainly by the patient's medical record. In most cases, the medical history of the patient, the degree of pain he/she suffers and the nature of disability are inspected.

If one of the above conditions applies, the person is entitled to medical care in another Member State subject to authorisation by a national healthcare (social security) authority.

From this perspective, the subcategories of planned medical care can be identified as follows:

A) **Hospital care (hospital treatment)** - sought by patients either to avoid long waiting lists in their countries or to receive specific treatment or a better quality health treatment

B) **Clinical (ambulant) treatment (non-hospital treatment)** – refers to receiving ambulant health care or buying health goods.

Such distinguishing is important, because the legal regime of the health care depends on the type of healthcare sought. As suggested above, the ECJ held that **prior authorisation is only justified for hospital care** but **not for non-hospital care, while hospital service is usually used in reference to those situations, in which the patient stays at the hospital for at least one night.** The importance of differentiating between the two categories of healthcare is relevant, since in the case of hospital care in another Member State than in the Member State of affiliation; prior authorisation provided by the national health authority is deemed justified.

In order to sum up the facts we know by now, the following facts can be outlined:

There are two types of medical treatment – unplanned and planned medical treatment. The unplanned medical treatment is covered in EU law primarily by the existence and application of the European Health Insurance Card. The planned health care is further subdivided into two major parts: hospital care and non-hospital care. In order to be provided with medical care in another Member State, the patient needs to request a prior authorisation from his/her national insurer. In case of non-hospital medical care such authorisation is not required, but is advisable from the point of reimbursement.

Clarifying the right to be treated elsewhere in the EU is also the underlying principle behind **the EU Directive on the application of patients' rights in cross-border healthcare (Directive 2011/24/EU).** It is important to note, that this Directive does not affect the benefits already offered to citizens through the existing Regulations on social security. Although the existing rules – which focus on social security agreements, not on patients' rights - have been in place since 1971, clarification was still needed on the rights of EU citizens to receive healthcare in another Member State. The European Court of Justice has confirmed[20] that the right to seek cross-border healthcare exists in the Treaty. In the case of Kohll, Decker et al., the ECJ announced (in reference to authorisations) that "*...such rules deter insured persons from approaching providers of medical services established in another Member State and constitute, for them and their patients, a barrier to the freedom to provide services*." This means that the requirement of an "*authorisation*" for the reimbursement of medical costs incurred in another Member State is an obstacle to the free provision of services for both patients and providers of medical services. However, different rules apply to different types of health services.

This inconsistency is to be replaced by the new rules as set forth by the Directive since it provides for a uniform and coherent framework for all citizens in Europe to take advantage of cross-border healthcare. The new (and somewhat clearer) rules relate to the remuneration/reimbursement of the services and to the issue of prior authorisation. According to the Directive, national authorities can introduce a system of "prior authorisation" in three cases:

1) for healthcare which involves **overnight hospital stay of at least one night**;

2) for **highly specialised and cost-intensive healthcare**;

3) in **serious and specific cases relating to the quality or safety the care provided abroad**; if the care provided abroad **would constitute a risk to the patient or the population.**

In the above three cases, patients may need to ask for permission in advance from their national health authority in charge of reimbursement. On the other hand, for reasons of fairness it must be added, that those national health authorities may **refuse authorisation** in the following cases:

a) if the treatment in question, or the healthcare provider in question, could present **a risk** for the patient or population;

b) if appropriate healthcare can **be provided at home in good time**.

If the national health authority refuses to issue an authorisation, it will need to provide its grounds of refusal, i.e. a solid reasoning will be required – in other words: the national health authority will need to explain the applicant the reasons behind its negative decision. In case of refusal, patients have the right to request a review of the administrative decision on cross-border healthcare for their individual case. On the other hand, if a treatment is unavailable in the "home" Member State of the patient or is not available in good time, the national health authorities must not refuse authorisation to a patient seeking healthcare in another EU Member State. However, patients will be reimbursed for such treatment provided it corresponds to the national "health benefits package" and the amount reimbursed is the amount the national health authority would pay for the treatment on its own territory. Transposition of the Directive into national laws will have to be carried out until 25 October 2013.

Summary / Conclusion

In the presented paper, the author has suggested the basic routes cross-border healthcare has taken in the law of the European Union. The starting point of the discussions was the fact whether cross-border healthcare falls under the scope of "*free movements*". The author provides the reader with the historical milestones relating to the issue and shows the turning points the topic has taken until it found its way into the category of "services" as stipulated by the Treaties. Nevertheless, it is clear that the topic has many other dimensions some which are rather sensitive and due to this fact, some space in the paper is devoted to the matter of prior authorisation by national health authorities and also to the applicable perspectives of remuneration. Since types of healthcare as defined by the EU law represent an important element of the topic, the author discusses these matters briefly in the third section of the paper. The third section of the paper deals also with some of the clarifications that the Directive 2011/24/EU will bring around once implemented into the national legal systems. Right now and by bearing in mind that the above Directive still accepts the *tool* of prior authorisation one can conclude that cross-border healthcare is still a question of finding the right balance between the individual interests of the particular patient and the public health interests of the society that are represented by the national health authority. The need for a prior authorisation and the reimbursement of health treatment according to the home standards of the patient may – under some circumstances – demotivate patients from taking advantage of the system of cross-border healthcare. On the other hand, such measures could be relevant when protecting the health system of some Member States (some of which are pretty imbalanced and imperfect).

[20] Kohll and Decker (1998); Ferlini (2000); Geraets-Smits and Peerbooms (2001); Vanbraekel (2001); Inizan (2003); Müller Fauré and Van Riet (2003); Leichtle (2004); Watts (2006); Stamatelaki (2007); Elchinov (2010).

Whatever the definite answer, it can only be presumed that a system with (some) obstacles and imperfections is always better not having a system of cross-border healthcare at all.

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Primary Paper Section: A

Secondary Paper Section: AG, AQ, FQ