Consumer choice of healthcare services across borders

Reinhard BUSSE, Markus DREWS and Matthias WISMAR

Abstract. The chapter first explores access to healthcare services across borders, especially the E111 and attached administrative procedures in the case of Germany, cross-border patient flows and resulting expenditure under E106, E111 and E112, and the ECJ "Kohll" case which established a new procedure for cross-border care. It then analyses the various procedures in regard to consumer choice in four dimensions: range of benefits, degree of restrictions, choice among providers and rate of reimbursement. It demonstrates that E112 is strong on benefits and reimbursement but weak on restrictions while "Kohll/ Decker" is strong on choice but weak on benefits and reimbursement. The chapter concludes by outlining activities to improve access to services across borders, especially in the Euregios.

1. Introduction

Consumer choice for healthcare services across borders is a relatively new research topic. Until 1998, attention focused on the free movement of persons and their potential healthcare needs when on the "other side of the border". This was particular relevant for frontier workers, i.e. persons who live in one country but work in another on a daily basis. But, with the growing movement of workers from southern European countries to those further north, the issue of how to ensure their right to healthcare services while on holidays in their country of origin became an issue. The advent of mass tourism has added a third group of persons to those in need of access to healthcare services in other countries. It was with these groups in mind that, building on previous regulations as well as bi-lateral agreements, Regulation 1408/71 was passed. Regulation 1408/71's original intention was therefore not to facilitate the free movement of services or goods but to facilitate the free movement of persons, more specifically that of workers (for details see previous chapter). The practical consequences of Regulation 1408/71 for people travelling to and from Germany using the E111 process is analysed in Section 2.

From its inception, Regulation 1408/71 also contained, however, an element of the free movement of services, namely the procedure of pre-authorised care with the E112 form. Under this procedure, persons cross borders specifically to receive healthcare services in the other country. In economic terms, services are imported to the country which authorises the patient to go abroad while the country providing the service is exporting it. As the Regulation does not mention that it is based on the free movement of services, this can therefore be considered an unintentional effect. Section 3 will briefly summarise the existing research on the amount of such imported/exported healthcare services.

The famous "Kohll" ruling is dealt with in Section 4. In brief, Raymond Kohll had argued that a restriction of consumer choice for healthcare services across borders – under Regulation 1408/71 and the respective procedures in Luxembourg – would violate Articles 49 and 50 of the TEC. As this conflict was new, the "Cour de cassation" in Luxembourg referred it to the ECJ which agreed with the plaintiff's interpretation of the Treaty, basing

consumer choice of healthcare services across borders directly on the Treaty, and not on secondary legislation (Table 1).

Table 1: Major European sources and interventions analysed and discussed

Legal source	Articles, paragraphs or rulings
TEC	Art. 28-30 (ex-Art. 30, 34, 36), Prohibition of quantitative restrictions between Member States
	Art. 49-50 (ex-Art. 59-60), Free movement of services
Secondary legislation	EEC 1408/71 (Art. 13, 19, 22), modified/ extended by EEC 1390/81 [self-employed], 2791/81 [modification following the Pierik cases] and 1606/98 [civil servants]
	EEC 574/72
ECJ	C-117/77 & C-182/78 Pierik I & II
	C-158/96 Kohll
	C-368/98 Vanbraekel
	C-157/99 Geraets-Smits/ Peerbooms
	currently pending at the ECJ: C-385/99-1 Müller-Fauré/ van Riet

Section 5 analyses the resulting new "Kohll/ Decker" procedure to obtain healthcare services as well as the E111 and E112 procedures in respect of four dimensions relevant to consumer choice – range of benefits, degree of restrictions, choice among providers and reimbursement. Finally, explicit measures to facilitate a higher choice of healthcare services across borders in the "Euregios" will be briefly summarised in Section 6.

The following chapter looks at future scenarios concerning the development of consumer choice in respect of the four dimensions. This chapter also includes a section on the latest rulings, namely "Geraets-Smits/ Peerbooms" and "Vanbraekel".

2. Choice of healthcare services under Regulation 1408/71

2.1 E111 in practice: the case of foreigners coming to Germany

A person coming to Germany from an EEA country who seeks medical help and who produces an E111 is entitled only to healthcare services that are of "immediate necessity" and in accordance with the existing regulations within German statutory health insurance.[1] Apart from the E111 no further document is required, although an identity card or passport may be requested. The patient is accepted as being a member of the health insurance/national health system of the country of origin. The same applies to family members who are included on the E111 form. The foreign health authority decides in accordance with local laws and regulations which family members are insured and includes these persons on the E111. In regard to entitlements and actual treatment, no difference is made between the insured persons and their dependants included on the E111.

Equally, no difference is made with respect to employment status – with one exception. Members of the social insurance scheme of Belgium who are self-employed have only limited access to benefits. They receive the form E111 "B" in Belgium which only entitles them to hospital treatment in Germany (as well as in other countries), while they have to pay privately for ambulatory care services.

There is no specific time span within which holders of an E111 can claim benefits other than the period of validity of the E111 itself as issued by the health authority of the country

[1] Certain groups, such as the unemployed seeking a job, are exempted from the principle of "immediate necessity" and use a different form, i.e. the E119.

of origin (section 3.1 of the form). In some countries, for example the United Kingdom, E111 forms are frequently issued without any expiry date (as possible under section 3.2 of the form). If a long period of time has passed between the day the E111 was issued and the day when it is actually being used, it is likely that the sickness fund will check whether the holder of the document should be insured under the regulations of the German health insurance system. This is the case when anyone taking up work in Germany earns less than the current (2002) threshold of Euro 3375 per month. Students, artists, handicapped living in specialized institutions and others are also compulsory members of one of the legal sickness funds when they start work or enroll at university etc. If there is no reason to believe that the person should be insured in Germany, the form will be accepted as valid.

If a citizen of another Member State wishes to obtain health care services and benefits in Germany, the formal process would be to see an office of one of the approximately 420 statutory sickness funds. The visitor will show his E111 and the official will check formal criteria of the document such as validity, name of patient's insurance company in his country, signature, falsification (handwritten additions possibly made by holder, e.g. adding family members). A frequently occuring problem seems to be that handwritten forms are presented which, depending on the handwriting, seem to be more or less illegible. The foreign visitor with a valid E111 will then receive a document called a "Krankenschein" which substitutes for the German insurance card. This document is essential if a physician in the ambulatory care sector is to claim reimbursement from the sickness fund via the ambulatory physicians' association. The document will carry a note made by the sickness fund official about restrictions of EU regulations to "immediate illness", which by definition excludes health promotion and prevention services. The foreigner will then be able to present this "Krankenschein" to the physician of his/her choice. Should he/she need treatment in a hospital or from a specialist physician he/she will then have to go back to the sickness fund he originally chose with a document from the physician to obtain another such "Krankenschein".

In reality, the experience is that neither the patient nor the physician really knows how to deal with the E111 process, and frequently the patient will not even possess an E111 form. In practice, therefore, the ambulatory care physician will probably telephone one of the legal sickness funds requesting information about the procedure. He will then mail the patient's E111 to the sickness fund, provided the patient is in possession of one. The fund, in turn, will post the "Krankenschein" for this patient. If no E111 is available, the physician has to bear the financial risk of treating the patient. In emergency cases, he is obliged by law to treat the patient. After treatment, the sickness fund will assist both the patient and the doctor to acquire an E111 form from the responsible authority in the patient's country of origin.

If the E111 holder seeks treatment in a hospital directly, he/she will, generally speaking, be in need of very urgent attention, such as in cases of traffic accidents or suspected heart attack (as German hospitals do not regularly have outpatient departments). He/she might even have to be taken to hospital by an ambulance (which is covered by the German SHI benefits catalogue). In practice he/she will not have had time to consult a sickness fund office. If he/she presents an E111, the hospital official will know (or find out) what to do. If the patient is not in possession of an E111, the hospital will give the relevant data to a sickness fund which in turn requests the E111 from the patient's sickness fund or national health service in the country of origin.

German sickness fund officials will not issue any E111 to foreigners, as the form may only be issued by the relevant authority in the country of insurance affiliation (often at the request of the German sickness fund). There are no specific lists of physicians or hospitals for E111 holders – they can receive medical attention for immediate illness at any of the

institutions or practices contracted by the sickness funds. Under the current system of collective contracts of sickness funds and providers, these include about 97 % of all hospitals and practices. As the non-contracted hospitals are specialised and small, it is extremely unlikely that a foreigner will seek treatment by a non-contracted provider.

After treatment has ended (involving possibly more than one consultation) and/or at the end of every quarter, the service provider will claim reimbursement from the German sickness fund, in the case of hospitals directly, in the case of ambulatory care physicians via the regional physicians' association. The fund or the physicians' association will pay the provider and in turn will request reimbursement from the German liaison office for SHI ("Deutsche Verbindungsstelle Krankenversicherung Ausland") by posting all relevant information (name, date of birth, services given, amount of fees) to this institution. The German liaison office will forward the claim and debit the charges to the insurance company or national health service of the patient's country of origin. The United Kingdom and Ireland have, in relation to Germany, bilaterally waived their right for refund concerning E111 cases (except dialysis). This agreement has recently been terminated by Germany as it feels that the waiver is to its disadvantage. A similar waiver agreement exists between Denmark and Germany in respect to unemployed persons using the E119, but not for E111-related cases.

There are two considerations involved in accepting or refusing foreigners' "consumption" of healthcare services. The competent authority – the statutory sickness fund – must first decide on the formal criteria (such as EU regulations and German laws as outlined above). In cases of doubt the German sickness fund will get in contact with the foreign authority. The extent of benefits a foreigner may receive in respect of "immediate illness" and "immediate necessity for treatment" is primarily decided by the provider treating the patient. The sickness fund may, in turn, check whether any "unnecessary" treatment has been given before reimbursing the treatment. In case of doubt, the fund will ask the Medical Review Board to re-evaluate the treatment before withholding reimbursement. Only suspicious cases would be considered for two reasons. First, the sickness fund official is not a physician and will probably not become aware of questionably urgent cases. Second, the additional costs arising from the re-evaluation cannot be claimed from the foreign competent authority. In practice, the sickness fund checks the E111 document, getting into contact with the issuing institution if considered necessary, and the physician in his practice or in the hospital decides about the necessary treatment. Apart from the restriction to immediately necessary treatment, foreign visitors are dealt with in the same way as Germans (appointments etc.). Obviously this depends very much on the individual physician and the special circumstances applying to the foreign visitor through his short stay, the type of illness, and the slightly different formal procedures.

An illness that has existed before the claimant arrives in Germany is an exclusion criterion for obtaining healthcare benefits if a patient presents with such an illness without a need for immediate treatment. A different situation arises if the cause for seeking help is a worsening of a preexisting illness (e.g. onset of pain). The patient will then be able to make use of E111 benefits. It is not possible for the German liaison office to estimate how often patients are not aware or purposely violate this restriction and how often, if at all, their intention to receive treatment for a preexisting illness with the E111 is rejected. In general there is no indication of obvious abuse of the E111 process or fraud on a regular basis. Individual cases cannot be excluded because there is no institutionalized report system of abuse.

Patients needing dialysis receive it with the E111. Dialysis is considered a treatment of immediate necessity, although in conjunction with a preexisting illness. These patients are

well informed about their situation and dependence on treatment. Normally, they will arrange treatment in Germany prior to leaving their home country.

Benefits under the provisions of the E111 for pregnancy depend on the stage of pregnancy. If a woman falls pregnant while in Germany she is able to claim full benefits from the German statutory health insurance scheme. With the exception of Finland, a woman already pregnant at the time when leaving her country of insurance affiliation will normally not receive benefits, unless the pregnancy gives rise for immediate necessity of treatment (incuding birth) while the woman is staying in Germany. In practice, a pregnant woman visiting a foreign country will probably only visit a doctor if she gets worried that something is wrong. Should her situation not fall within the limits set by the regulations for the E111, the German fund contact the foreign authority.

As a general rule visitors presenting an E111 form do not have to pay any fees before being treated especially since there will normally be some element of urgency. The visitor can claim all benefits in kind, including medication, which a German patient would receive. There is the limitation to these benefits in kind for a visitor in that he can claim only what is needed until his intended return to his home country. For example, he will only receive a small pack of a necessary medication. Additionally, the E111 holders are required to pay all co-payments that are applicable in the German SHI system.

2.2 E111 in practice: the case of Germans going abroad[2]

In Germany, E111 forms are issued by the statutory sickness fund with which the person is insured. Some sickness funds have changed their practice and now issue blank E111 forms with instructions on how to complete it. The funds usually also issue information brochures about the the health services and possible pitfalls in country to be visited.

German sickness funds will cover all costs for treatment of immediate necessity which were provided and invoiced by the foreign provider or the statutory health insurance/national health service. If a person insured with one of the German funds has been treated by a private practitioner or a private hospital, only those costs will be reimbursed directly to the patient that the treatment would have costed if the patient had been treated in Germany. Therefore tourists are advised to insure themselves privately in addition to the E111. Costs arising through repatriation will not be reimbursed, a further reason to have additional insurance.

A somewhat unusual institution has been introduced In Mallorca with the opening of an information service by the AOK (Allgemeine Ortskrankenkasse), the General Regional Sickness Fund. About 2.5 million Germans visit Mallorca annually, of whom approximately 2 million are insured with the AOK. It therefore made sense to open a branch since many visitors need help with translation or when choosing a hospital or physician. Many difficulties, initially for the tourist and subsequently for the AOK, can be avoided before they arise, e.g. the problem that apparently many taxi drivers and tour guides bring tourists who become ill only to private physicians and private hospitals.

Problems of a similar kind have been reported about Austria. Physicians and hospitals seem to be unwilling to treat patients according to EU regulations upon presentation of an E111. They advise patients to pay directly and to claim refund from their sickness fund in Germany. As such a private bill is almost always higher, the patient then has to cover that part which the German fund does not reimburse.

---

[2] This section complements the chapter on “The mobility of citizen - a case study and scenario on the health service of the Costa del Sol”.

As only 88 % of the population living in Germany is insured with a statutory sickness fund and is thus entitled to receiving an E111, the question arises of how the others are covered for healthcare services across borders. Nine per cent of the population are covered by private health insurance, 2 % by free governmental health care (i.e. police officers, soldiers and those on welfare who have not been a sickness fund member previously) while only 0.1 % are not insured.

Persons with a private health insurance pay their fees directly to the provider and will be reimbursed by their private insurer. They do not use the E111. The latest Standard Insurance Regulations, which state the minimal set of regulations and which apply to all German private health insurance companies, provide coverage for all EU countries for an unlimited period in respect to length of stay in that country (as long as the place of residence of the insured person remains within Germany). As the insurers also do not limit reimbursement to a certain number of (contracted) providers but allow access to all providers, persons covered by full-cover private health insurance clearly have a larger degree of "consumer choice" than E111 holders. There are, however, some differences depending on the insurance company and the tariff/scheme chosen by the insured person.

About one third of those with private insurance are civil servants who also receive "Beihilfe" (governmental financial support) covering between 50 and 100 % of costs (i.e. they are privately insured only for the remainder). In case of treatment outside Germany, "Beihilfe" only reimburses the types of treatment and up to the value that would paid for in Germany. All costs that are not covered by the "Beihilfe" have to be paid privately or by an additional insurance.

Some people, who are fully dependent on social welfare, are not insured with one of the sickness funds. Their treatment is covered by the community of residence and they receive the same benefits in kind as do members of one of the legal sickness funds. They do not receive an E111, yet should they travel to another EU Member State, become sick and identify themselves as dependent on social welfare, according to the European Convention on Social and Medical Assistance they should receive the same help as citizens of that country.

3. Cross-border patient flows

Knowledge on the actual cross-border movement of persons receiving healthcare services remains rather limited. In quantitative terms, it is mainly based on one study on the amounts and flows of financial transfers for cross-border care within the EU (Hermesse et al. 1997), which has been updated to 1998 (Palm et al. 2000).

According to these figures, the total amount for claims for reimbursement of cross border healthcare rose from 461 million Euro in 1989 to 1103 million Euro in 1993, but then fell to 894 million in 1997 and 758 million in 1998. In relation to public spending on healthcare in the European Union, these values are in the 0.1 %-0.2 % range of overall expenditure. The study carried out research into the flow of the three most important forms for cross-border mobility: E106 (migrant workers), E111 (temporary stay, e.g. tourism and business travel) and E112 (pre-authorised care). Pre-authorised care accounted for nearly 60 % of the total cost of cross border care, while the transfer for temporary stay and migrant workers were financially less important with 25 % and 16 % respectively of the total expenditure. In terms of the number of forms submitted the ranking was in reverse order. With a share of 53 %, the E106 form (migrant workers) was most applied, while E111 (temporary stay) accounted for 33 % and E112 (pre-authorised care) only for 14 %. Only 9 % of the forms referred to hospital care.

Table 2 summarises the expenditure on imported services, i.e. on patients going abroad. Consistently, Luxembourg had the highest per-capita expenditure, but this fell in line with the EU average from 1993. Other countries with above-average expenditures are especially Belgium, Italy and Portugal. Low expenditure figures can be seen particularly in the Nordic countries.

According to the same study, France has been the main exporter of services (= importer of patients) with a share of at least 40 %. It receives its money from the other Member States exclusively through invoiced credits, i.e. does not use lump-sum payments. The latter method is, for example, favoured by Spain.

Table 2: Expenditure on patients receiving healthcare services in other EU Member States in Euro per capita (= volume of imported healthcare services per capita)

	1989	1993	1997	1998
Belgium	3.62	8.93	8.93	4.38
Denmark	-	0.16	0.83	0.63
France	0.79	1.87	1.21	1.05
Germany	1.77	1.83	2.08	2.21
Greece	0.95	2.51	2.68	3.15
Ireland	0.18	0.65	1.68	0.93
Italy	2.99	8.36	3.52	2.89
Luxembourg	58.01	149.55	135.29	116.00
Netherlands	1.95	0.26	1.98	2.85
Portugal	0.82	3.76	6.81	7.00
Spain	0.33	1.48	1.03	1.11
United Kingdom	0.33	1.61	1.92	0.36
Austria	-	-	0.48	1.87
Finland	-	-	0.49	0.52
Sweden	-	-	0.65	0.96
AVERAGE	1.31	2.95	2.37	1.99

Source: Palm et al. 2000

Certain limitations have to kept in mind when interpreting the data, however. First, there are (or have been) waiver agreements between several countries, for example between Germany and the United Kingdom, so that healthcare services provided on that basis do not appear in the expenditure data. Second, France was the claimant for more than half of all money in 1993 (57.6 %) while Italy was the debtor for 43.1% which can either be explained by an extensive cross-border movement of patients from Italy to France or simply by incomplete, and therefore misleading, statistics. Third, expenditure per capita seems to be decreasing, even though public awareness of the issue has increased, especially in 1998 (see below).

The case of Italy has been studied in some depth (France 1997, Mountford 2000). Italian doctors seem to refer patients to specific healthcare providers outside Italy quite often and feel justification for doing so because of the perceived low quality of their own healthcare system. In addition, authorisation by the regional health authorities for care outside Italy did not have any financial consequences for the regional health authorities until 1997 as expenditure was paid directly by the Ministry of Health. Only since 1998 have such expenditures been deducted from the money allocated to the regions.

In regard to the double access eligibility of frontier workers (i.e. access to services both in the country of residence and in the country of work), a survey, conducted at the French-

Belgian border in 1994/95, produced evidence that level of awareness of the arrangements for double access to health care was limited. Approximately one-fifth of both groups of frontier workers were unaware that this option was available. In regard to consumer choice, the results of the survey indicated that 64% of the Belgian and 42 % of the French frontier workers used the option for cross border health care occasionally or usually for goods such as drugs' 38 % and 20 % respectively used it for specialist care, and 27 %, and 23 % respectively for hospital care. Both groups reported problems with reimbursement, of which the most common problem was "expenses not being covered" (Calnan et al. 1998).

4. Unfolding a new dimension of consumer choice: the "Kohll" case[3]

4.1 The issues

In its judgment of 25 April 1996, the Luxembourg Cour de Cassation (Court of Cassation) referred to the Court for a preliminary ruling two questions on the interpretation of Articles 59 and 60 of the TEC in the Maastricht version (now Articles 49 and 50). Those questions arose in proceedings between Mr Kohll, a Luxembourg national, and the Union des Caisses de Maladie (UCM), with which he is insured, concerning a request by a doctor established in Luxembourg for authorisation for Mr. Kohll's daughter, who is a minor, to receive treatment from an orthodontist established in Trier (Germany).

In a decision on 7 February 1994, following a negative opinion of the social security medical supervisors, the request was rejected on the grounds that the proposed treatment was not urgent and that it could be provided in Luxembourg. That decision was confirmed on 27 April 1994 in a decision of the UCM board. Mr Kohll appealed against that decision to the Conseil Arbitral des Assurances Sociales (Social Insurance Arbitration Council), arguing that the provisions relied on were contrary to Article 59 of the Treaty. The appeal was dismissed in a decision dated 6 October 1994.

Mr Kohll appealed against the latter decision to the Conseil Supérieur des Assurances Sociales (Higher Social Insurance Council) which, in its judgment of 17 July 1995, upheld the contested decision on the ground that Article 20 of the Luxembourg Codes des Assurances Sociales (Social Insurance Code) and Articles 25 and 27 of the UCM statutes were consistent with Council Regulation (EEC) No 1408/71.

It appears from Article 20(1) of the Code des Assurances Sociales, that with the exception of emergency treatment received in the event of illness or accident abroad, insured persons may be treated abroad or use a treatment centre or centre providing ancillary facilities abroad only after obtaining the prior authorisation of the competent social security institution. Under Article 27, authorisation will be granted only after a medical assessment and on production of a written request from a doctor established in Luxembourg indicating the doctor or hospital centre recommended and the facts and criteria which make it impossible for the treatment in question to be carried out in Luxembourg.

Mr Kohll appealed against the judgment of the Conseil Supérieur des Assurances Sociales, arguing in particular that it had considered only whether the national rules were consistent with Regulation No 1408/71, and not whether they were consistent with Articles 59 and 60 of the Treaty. Since it considered that this argument raised a question concerning

[3] As there have been numerous articles dealing with the judgement (see the chapter on "The European Union and health services - the context"), this section will concentrate on the facts and follows closely the text provided by the ECJ in its ruling.

the interpretation of Community law, the Cour de Cassation stayed the proceedings and referred the following two questions to the Court for a preliminary ruling:

1. Are Articles 59 and 60 of the Treaty establishing the EEC to be interpreted as precluding rules under which reimbursement of the cost of benefits is subject to authorisation by the insured person's social security institution if the benefits are provided in a Member State other than the State in which that person resides?
2. Is the answer to Question 1 any different if the aim of the rules is to maintain a balanced medical and hospital service accessible to everyone in a given region?

Through these questions, the national court was essentially asking whether Articles 59 and 60 of the Treaty preclude the application of social security rules such as those at issue in the main proceedings. Mr Kohll submitted that Articles 59 and 60 of the Treaty preclude such national rules which make reimbursement of the cost of dental treatment provided by an orthodontist established in another Member State, in accordance with the scale of the Member State of insurance, subject to authorisation by the insured person's social security institution. UCM and the Luxembourg, Greek and United Kingdom Governments contended that those provisions are not applicable or, alternatively, do not preclude the rules in question from being maintained. The German, French and Austrian Governments agreed with the alternative submission.

The questions to be considered concerned first the application of the principle of freedom of movement in the field of social security, then the effect of Regulation No 1408/71, and finally the application of the provisions on freedom to provide services.

In the proceedings before the ECJ, Mr Kohll submitted that he sought reimbursement by UCM of the amount he would have been entitled to if the treatment had been carried out by the only specialist established in Luxembourg. On that point, UCM considered that the principle that a person is subject to one social security tariff only would indeed be complied with if the Luxembourg tariff were applied, but claimed that Regulation No 1408/71 would compel it to reimburse expenditure according to the tariffs in force in the State in which the service was provided.

4.2 The ruling

The European Court of Justice ruled as follows (Kohll ruling, paragraphs 4-6):

> "The fact that national rules fall within the sphere of social security cannot exclude the application of Articles 59 and 60 of the Treaty. While Community law does not detract from the powers of the Member States to organise their social security systems, they must nevertheless comply with Community law when exercising those powers, i.e. the fact that a national measure may be consistent with a provision of secondary legislation, in this case Article 22 of Regulation No 1408/71, does not have the effect of removing that measure from the scope of the provisions of the Treaty.
>
> Article 22 of Regulation No 1408/71 is intended to allow an insured person, authorised by the competent institution to go to another Member State to receive there treatment appropriate to his condition, to receive sickness benefits in kind, on account of the competent institution but in accordance with the provisions of the legislation of the State in which the services are provided, in particular where the need for the transfer arises because of the state of health of the person concerned, without that person incurring additional expenditure. It is

not intended to regulate and hence does not in any way prevent the reimbursement by Member States, at the tariffs in force in the competent State, of costs incurred in connection with treatment provided in another Member State, even without prior authorisation.

Articles 59 and 60 of the Treaty preclude national rules under which reimbursement, in accordance with the scale of the State of insurance, of the cost of dental treatment provided by an orthodontist established in another Member State is subject to authorisation by the insured person's social security institution. 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 freedom to provide services. They are not justified by the risk of seriously undermining the financial balance of the social security system, since reimbursement of the costs of dental treatment provided in other Member States in accordance with the tariff of the State of insurance has no significant effect on the financing of the social security system, nor are they justified on grounds of public health within the meaning of Articles 55 and 66 of the Treaty in order to protect the quality of medical services provided to insured persons in other Member States and to maintain a balanced medical and hospital service open to all. Since the conditions for taking up and pursuing the profession of doctor and dentist have been the subject of several coordinating or harmonising directives, doctors and dentists established in other Member States must be afforded all guarantees equivalent to those accorded to doctors and dentists established on national territory, for the purposes of freedom to provide services. …"

4.3 Impact on national legislation

Following the judgements of the ECJ, only Luxembourg, Belgium and Denmark amended their legislation and established administrative procedures for the unconditional reimbursement of certain out-patient services and health care products purchased in another Member State. In Austria, even before the *Kohll* and *Decker* rulings, socially insured persons were entitled to reimbursement of health care from a non-contracted provider in Austria or abroad at a rate of 80 % of the amount paid for the same treatment from a contracted provider. As explained in the previous chapter, eight months after "Kohll and Decker" Germany abolished the option for all sickness fund members to choose patient reimbursement (instead of the customary benefits-in-kind) which had been introduced shortly before and which facilitated the possibility to receive healthcare services in other EU countries. In summary, impact upon legislation in EU Member States as a whole was negligible.

5. Analysis: degree of consumer choice of cross-border healthcare

The Kohll and Decker rulings of the ECJ (Decker C-120/95; Kohll C-158/96) established, probably unintentionally, a new type of cross-border access to healthcare. European citizens covered by a statutory social protection scheme in one country (CoI = country of insurance affiliation) now have, in principle, three ways to receive healthcare services in another EEA country (CoS = country of service provision), namely

– the procedure outlined in Article 22(1)(a) of Regulation 1408/71, i.e. access to immediately necessary care during short-term stays using the E111 form
– the procedure outlined in Article 22(1)(c) of Regulation 1408/71, i.e. pre-authorisation to receive care in another Member State using the E112 form
– the "Kohll/ Decker" procedure, i.e. "free access" to ambulatory services (and goods) with retrospective reimbursement.

For the purposes of comparison, "consumer choice" is intended to demonstate maximum benefit for the consumer, i.e.

– to have access to the fullest range of medical goods and services ("benefits"),
– to have these benefits with the minimum restrictions (such as necessary referral patterns or prescriptions),
– to have maximum choice between different providers, and
– to have full reimbursement for any amount charged by the provider.

This description does not imply that a maximum of consumer choice is a preferable situation. Table 3 examines the degree of choice for each of the four dimensions mentioned earlier for each of the three cross-border options in comparison to the statutory social protection/ insurance system inside the CoI.

Table 3: Applicability and degrees of consumer choice in accessing health services

	Inside country of insurance (CoI)	Short-term stay (E111)	Preauthorisation (E112)	"Kohll/ Decker" procedure
Countries in which applicable	CoI	Non-CoI EEA countries plus others with E111-agreement	Non-CoI EEA countries plus others with E112-agreement	Non-CoI EU countries if CoI uses patient reimbursement system (incl. Austria)
Benefits available	Benefits catalogue of CoI	Benefits catalogue of CoS, provided the condition necessitates immediate care	Legally benefits catalogue of CoS, de facto often that of CoI	Ambulatory benefits of CoI
Condition to get service	Referral/ prescription/ rationing measures if necessary/ existing in CoI	Referral/ prescription if necessary in CoS (possibly plus further hurdles)	Pre-authorisation for particular service by responsible CoI-payer (but through certain rationing measures in CoI, e.g. waiting lists, patient has right to E112)	Referral/ prescription if necessary in CoI
Service providers available	Those contracted by CoI-payers (all providers in Austria and Belgium)	Those contracted by CoS-payers	Those contracted by CoS-payers	Wide availability as no contracts with CoI- or CoS-payers necessary
Rate of reimbursement	As agreed with CoI-payers, with possible reductions (e.g. 20% for non-contracted providers in Austria)	Usually as agreed with CoS-payers (CoI-rate if no CoS-rate exists or with consent of patient)	As agreed with CoS-payers	Price charged by provider, limited to patient/ provider reimbursement in CoI

CoI = country of insurance (or other social security) affiliation; CoS = country of service provision

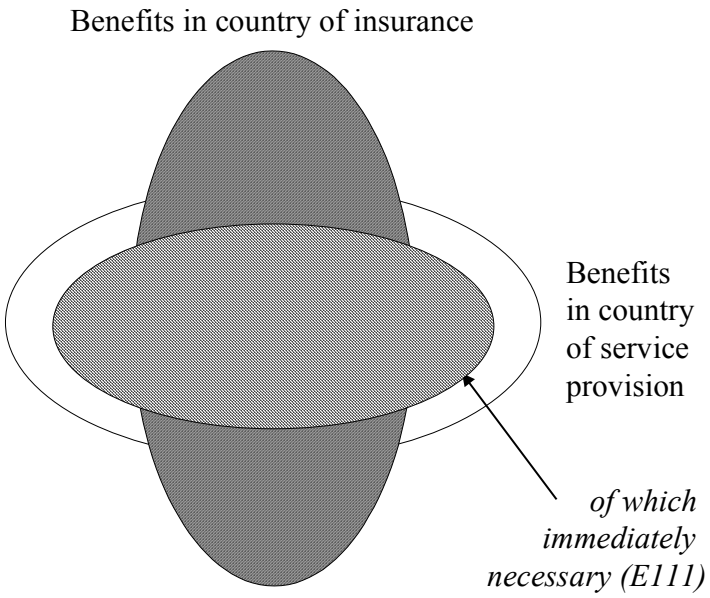


Fig. 1: Extension of available benefits (vs. country of insurance) through E111

None of the options provides the highest degree of choice in all dimensions. Figures 1 to 3 explore the range of benefits available. All figures show two overlapping circles, the vertical one symbolises the benefits available in the country of insurande (CoI) and the horizontal one those in any other EEA country. If the range of benefits is larger than in the CoI, the appropriate area is marked.

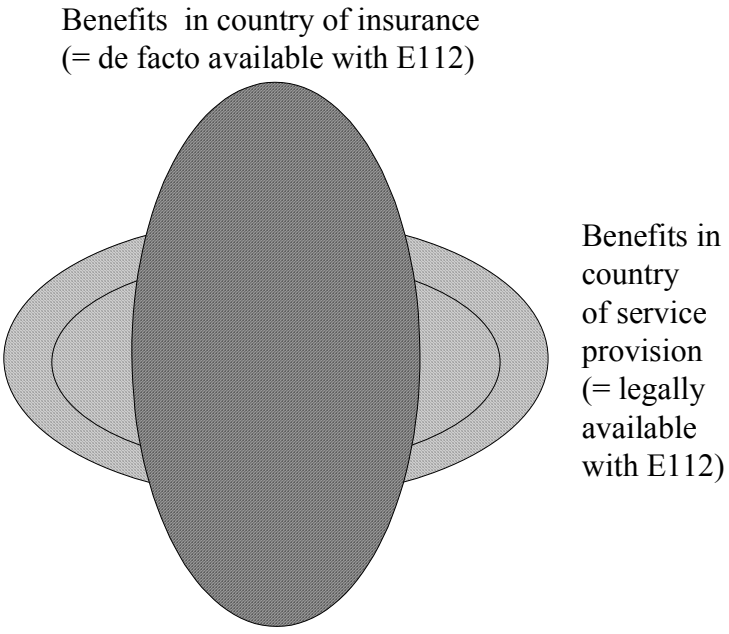
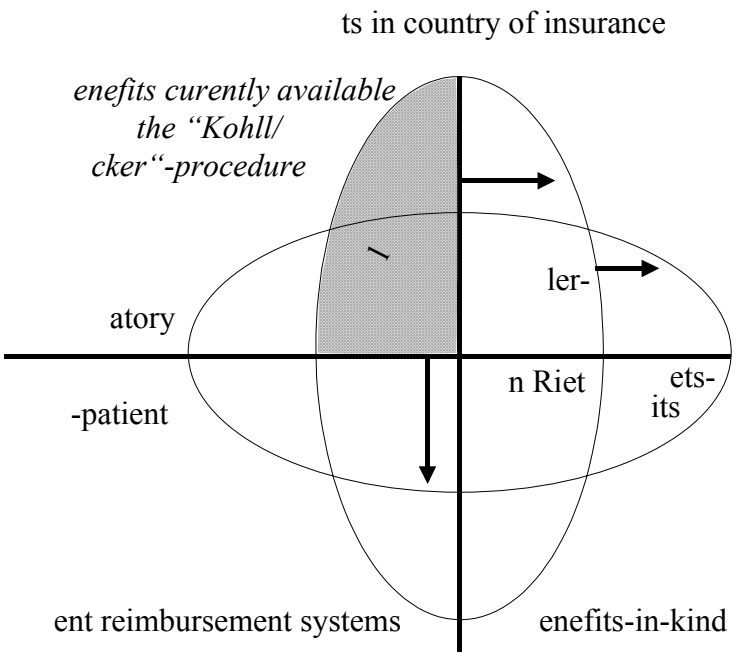


Fig. 2: Extension of available benefits (vs. country of insurance) through E112

If the benefits' catalogue in an EEA country during a short-term stay is larger than in the CoI, than the insured person has, under E111, access to additional benefits as Article 22(1)(a) of Regulation 1408/71 provides that a patient is treated according to the

regulations of the CoS. However, as the availability of services under E111 is generally limited to those that are immediately necessary, the availability of the additional benefits will be restricted. Additionally, benefits included in the catalogue of the CoI will not be available in the CoS (Figure 1).

A good example of increased access to benefits under E111 are Norwegians travelling in Germany. In Norway, in contrast to Germany, dental care is not part of the statutory benefits package, but a Norwegian visitor in Germany will receive dental treatment on presentation with toothache. It is possible that there is some abuse although this is likely to be limited, since travelling from Norway to Germany for the sole purpose of abusing the



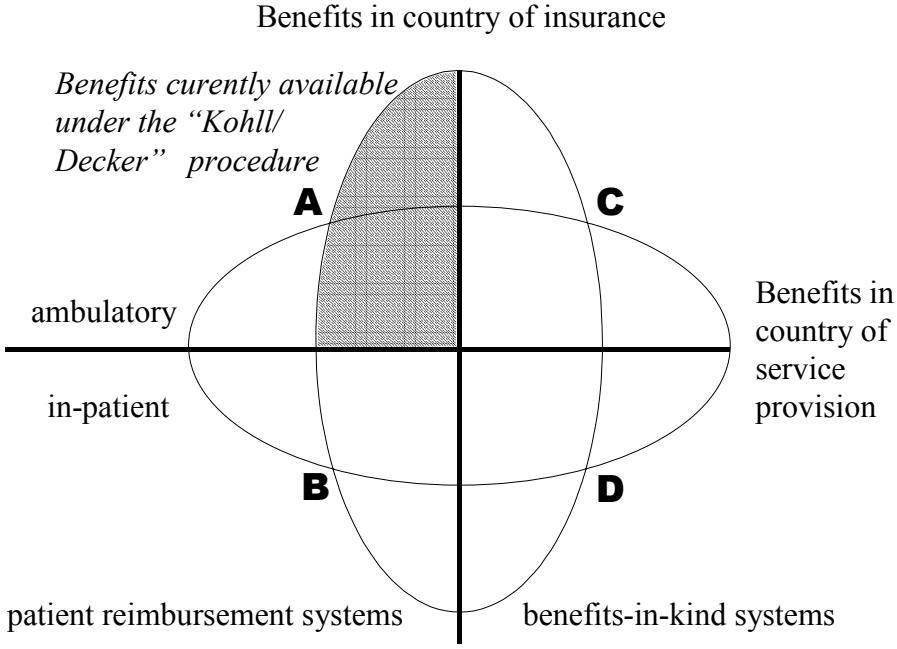


Fig. 3: Benefits available under the "Kohll/ Decker" procedure (early 2001)

In addition, based on the interpretation of the Member States, the benefits are largely limited to countries which routinely use patient reimbursement (Belgium, France, Luxembourg) or as an alternative to the provision of benefits in kind (Austria). In some other countries, it is restricted to certain special groups (group 2 persons in Denmark; voluntarily insured with patient reimbursement agreement in Germany) or certain services (Denmark for group 1 and 2).

Figure 3 tries to capture these double restrictions by dividing the two overlapping circles into four parts, symbolising ambulatory care in patient reimbursement systems ("A") and in benefits-in-kind systems ("C") as well as in-patient services in these two types of systems ("B" and "D" respectively).

In respect to the other dimensions of choice, differences between the various procedures are especially striking in regard to the range of service providers available (Table 3):

- Regarding the conditions to obtain a service, an E111 patient has to conform with the conditions in the CoS which might be better or worse than at home. E112 has mixed effects; on the one hand, it provides another hurdle (i.e. to get the E112 authorisation), on the other hand, it improves the situation in comparison to within the CoI as it provides a way to circumvent waiting lists.
- E111 and E112 procedures limit the choice of providers to those contracted by the responsible third-party payers in the CoS, i.e. systematically it neither decreases nor increases choice. It will, rather, depend on a comparison between the circumstances in the CoI vs. the CoS. Patients coming to Belgium, for example, will find their choice increased while it will be the other way around for Belgian patients who go to, for example, Spain.
- Under the "Kohll/ Decker" procedure, the choice of provider is virtually unlimited. This definite advantage is, however, counterbalanced by a potentially higher patient cost-sharing due to a difference between the price paid in the CoS and the price reimbursed by the responsible third-party payer in the CoI (while there are currently no savings to be made if the price differential is the other way around).

6. Activities to improve access to healthcare services across borders

As shown in the previous sections, consumer choice across borders is quite restricted under the two main options provided by Regulation 1408/71, mainly through administrative hurdles. However, the new "Kohll/ Decker" procedure also has its limitations. A potentially serious limitation is that direct payment is required and that a lower rate of reimbursement in the country of insurance affiliation may lead to a co-payment which would otherwise not arise (and which does not arise under the E111 and E112 procedures due to the benefit in kind principle).

Two promising options to improve access to healthcare services across borders are therefore to ease the administrative procedures and to extent contracts for providing benefits-in-kind across borders. Both options have been and are used in certain border regions within the EU, most notably in the context of the Euregios.

Euregios which have included health services arrangement in their activities include Meuse-Rhine (involving Belgium, Germany and the Netherlands), Rhine-Waal (Germany and the Netherlands), Scheldemond (Belgium and the Netherlands), Hainaut/Nord-Pas-de-Calais (Belgium and France), Schleswig/Südjütland (Denmark and Germany), Eems-Dollart and Rhine-Eems-Ijssel (both Germany and the Netherlands) (Palm et al. 2000).

Long before the term "Euregio" was created or the Euregio Scheldemond established, the Dutch Zeeland-Flanders and West Brabant Sickness Fund (OZ) established contracts with two Belgish hospitals in Ghent and Bruges in 1978. Currently, about 4 % of CZ insurees make use of these contracts. Another example of a contractual arrangement is the one on cross-border ambulance transport from the Belgish municipality of Riemst to the AZ hospital in Maastricht, the Netherlands, as part of the Euregio Meuse-Rhine (see below).

Classical examples of easing the administrative burden for patients can be found in the Euregios Scheldemond and Hainaut/Nord-Pas-de-Calais. In the former, a simplified E112 procedure using a form called E112+ is used. This idea was then adapted in the latter region where an E112TF form can be printed using the French insured person's *Vitale* card or the Belgish insured person's S/S card. Form E112TF is then filled out by the hospital where the insured person seeks treatment and is send directly with the request for payment to a sickness fund in the country of the hospital (which then reimburses the hospital and handles reimbursement by the patient's country of insurance). The project demonstrated that social security cards can be used from one country to another.

Activities in the Euregio Meuse-Rhine started with an analysis of cross-border patient flows in 1991/92 to four large hospitals in the three-country zone. Flows were quite small, ranging from 0.01 % German patients in Liege (Belgium) to 1.7 % Belgish patients in Maastricht (The Netherlands) (Starmans et al. 1997). Since spring 1997, the project has sought to improve cooperation between hospitals and health insurance funds in the three countries. "Zorg op Maat" enabled Dutch patients to access Belgish and German ambulatory care specialists with the E112+ form. This activity was extended to a trilateral project named "Integration Zorg op Maat" from 2000 (Table 4).

Table 4: Cross-border care activities in the Euregio Meuse-Rhine

Name	Features	Period
AOK office in Vaals (The Netherlands)	An office of the German sickness fund AOK provides support to insured living in the Netherlands	Since 1995
Zorg op Maat	Access to Belgish and German ambulatory specialists for Dutch patients using the E112+ form	Ended 1999
Integration Zorg op Maat	Specialist treatment and therapy	Since spring 2000
	Prescription of pharmaceuticals	
	Hospital treatment	
	Therapeutic appliances (requires E112/E114)	
	Centres of excellence (requires E112/E114)	
Rescue and Emergency	Under the Interreg II Programme planning for Interreg III	
Transparency in therapeutic appliances (hearing aids)	Under the Interreg II Programme cost-utility analysis for cross-border service provision	
Co-operation with health insurance funds	Co-operations and co-ordination	

A similarily wide array of activities can be found in the Euregio Rhine-Waal (Table 5), ranging from sickness fund offices in the other country to arrangements enabling patients to access both outpatient and inpatient specialist care across borders (in this case, Germans to access the hospital in Nijmegen).

Table 5: Cross-border care activities in the Euregio Rhine-Waal

Name	Features	Time
Office Service at the Dutch coast for holiday makers	Germans insured with AOK Rheinland receive support in Middleburg and Vlissingen/Zelland from CZ Groep	Since 1996
Patient treatment without borders	Heart surgery	Since 1997
	Radio therapy	
	Renal transplantation	
	Neurosurgery/Traumatology	
Zorg op Maat	See the Zorg op Maat in the Euregio Rhine-Maas	Since 1999
Needs and quality analysis	Needs for cross-border care	
	Quality of service provision	
	Humanitarian aspects	
	Patient/Insuree satisfaction	
	Impact on planning	
	Economic aspects	
Traumatology	Emergency care	Until 1999
HealthCard international	Like Integration Zorg op Maat, but with a Smart card	Since summer 2000

All these activities, with the exception of Scheldemond, involve rather small numbers of patients, usually not exceeding a few hundred. Their evaluation, however, implies some important lessons: First, waiting lists are cited as the major factor contributing to cross-border care (Coheur 2001) which might become an even more relevant factor in the future. Second, proximity of the provider to the place of residence of the patient is another major factor stimulating cross-border care. In the case of Rhine-Waal, for example, the university hospital in Nijmegen is less than 15 km from the German border, whereas comparable hospitals in Germany are up to 100 km away. Using a rather narrow definition of border areas, i.e. all those counties within a 20 km strip along the borders, it becomes clear that the potential for patients seeking access to healthcare services is quite large – but will vary between ambulatory and hospital as well emergency and elective care (Table 6).

The topic of easier access to healthcare services across borders is gaining increasing attention also outside the Euregios: In Germany, the Working Group of Federal Associations of Sickness Funds, which comprises all groups of sickness funds, is urging the government to amend social legislation in order to allow German sickness funds to selectively contract providers in the EEA (Arbeitsgemeinschaft der Spitzenverbände der gesetzlichen Krankenkassen 2000). The reasons for this are threefold. First of all, sickness funds do not appreciate a "Decker/Kohll solution" since this would entail the abolition of the benefit in kind principle. The benefit in kind principle establishes a close link between payers and providers not only on prices and volumes but also on quality. The price issue is not of primary concern since reimbursement would be limited to the domestic level (even though keeping budgets for healthcare sectors will become more difficult). And the volume issue does not matter much, since cross border care still occurs in rather small numbers. The quality issue seems to be more tricky because it assumes that quality abroad is lower than in Germany, an assumption which is difficult to base on evidence. The political reason for the contracting solution is to evade the collective contracts sickness funds hold with providers inside Germany. Provider associations, especially associations of statutory health insurance-affiliated physicians, would loose power if German sickness funds could contract providers abroad.

Table 6: Potential cross-border patients in German *Länder* (population in countries within 20 km of border with EU countries)

Land	Absolute number in million and percentage of population	
	Currently	After accession of Czech Republic and Poland
Baden-Württemberg	1.69 (16 %)	1.69 (16 %)
Bavaria	1.68 (14 %)	2.42 (20 %)
Berlin	0	0
Brandenburg	0	0.93 (36 %)
Bremen	0	0
Hamburg	0	0
Hesse	0	0
Mecklenburg-Western Pomerania	0	0.20 (11 %)
Lower Saxony	0.64 (8 %)	0.64 (8 %)
North Rhine-Westphalia	2.20 (12 %)	2.20 (12 %)
Rhineland-Palatinate	0.67 (17 %)	0.67 (17 %)
Saarland	0.83 (77 %)	0.83 (77 %)
Saxony	0	1.46 (32 %)
Saxony-Anhalt	0	0
Schleswig-Holstein	0.44 (16 %)	0.44 (16 %)
Thuringia	0	0
GERMANY	7.52 (9 %)	11.74 (13 %)

Source: own calculations based on data from Federal Statistical Office

Moreover it is suggested that the opportunities inherent in Article 22(1)(c) of Regulation 1408/71 (E112 procedure) should be used more often and more intensely for healthcare provision in border regions, holiday regions and for specific indications (Arbeits-gemeinschaft der Spitzenverbände der gesetzlichen Krankenkassen 2000). The sickness funds suggest to engage in a debate on the European level to agree on common standards in regard to quality, planning, cross-border contracting and financing, which should facilitate an easier cross-border service provision. The strategy of the sickness funds is to expand European collaboration under the control of the payers. The Working Group of Federal Associations of Sickness Funds suggests to amend Art. 34 par. 4 of Regulation 574/72. The article entitles sickness funds to reimburse costs in exceptional cases to the medical fee schedule of the country of insurance. Currently, the ceiling for this is Euro 500. It is suggested to raise this ceiling. It would make reimbursement procedures easier and quicker since the sickness funds would not need to inquire into the medical fee schedules of other Member States.

The Federal Chamber of Physicians (representing all physicians and not only the SHI-affiliated ones) is also supporting a more liberal approach to cross-border care according to a resolution ratified at the annual congregation in 2000. German physicians (or at least their representatives) do not seem to be afraid of cross-border patient mobility. On the contrary, they rather seem to expect a net-win since Germany has a very comprehensive healthcare basket and no severe capacity problem.

References

Arbeitsgemeinschaft der Spitzenverbände der gesetzlichen Krankenkassen. Strategischer Umgang der GKV mit den aktuellen europarechtlichen Entwicklungen – Herausforderung Europa annehmen und gestalten [Strategy of the statutory health insurance in regard to current European legal developments - tackling the European challenge and shaping the future]. 2000.

Calnan M, Palm W, Sohy F, Quaghebeur D. Implementing a policy for cross-border use of health care: a case study of frontier worker's knowledge, attitudes and use. In: Leidl R, editor. Health care and its financing in the single European market. Amsterdam-Berlin-Oxford-Tokyo-Washington DC: IOS Press; 1998. p. 306-11.

Coheur A. Integrating care in border regions. An analysis of the Euregio projects. eurohealth 2001;7(4):10-2.

France G. Cross-border flows of Italian patients within the European Union. An international trade approach. Eur J Public Health 1997;7(3 Suppl.):18-25.

Hermans HEGM. Patient's rights in the European Union. Eur J Public Health 1997;7(3 Suppl.):11-7.

Hermesse J, Lewalle H, Palm W. Patient mobility within the European Union. Eur J Public Health 1997;7(3 Suppl.):4-10.

Palm W, Nickless J, Lewalle H, Coheur A. Implications of recent jurisprudence on the co-ordination of health care protection systems. General report produced for the Directorate-General for Employment and Social Affairs of the European Commission. Brussels: Association Internationale de la Mutualité (AIM); 2000.

Starmans B, Leidl R, Rhodes G. A comparative study on cross-border hospital care in the Euregio Meuse-Rhine. Eur J Public Health 1997;7(3 Suppl.):33-41.