

Scenarios on the development of consumer choice for healthcare services

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Abstract. This chapter explores future options for the development of consumer choice for healthcare across borders. It analyses the effects of various verdict options of current ECJ cases (i.e. Geraets-Smits/Peerbooms, Müller-Fauré/van Riet and Vanbraekel) in regard to four dimensions relevant for choice, namely range of benefits, degree of restrictions, choice among providers and reimbursement. It demonstrates that important policy questions arise, no matter whether the decisions will freeze the status-quo, open up new opportunities for consumer choice or lie somewhere in between. Finally, it presents the actual rulings in the Geraets-Smits/Peerbooms and Vanbraekel cases and analyses them in the light of the scenario outcomes.

For the purposes of the scenarios developed in this chapter, “consumer choice” is intended to demonstrate 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 the maximum consumer choice is the preferred situation. It is not the intention of the scenario to direct the discussion in one particular direction nor to find the “one possible solution”. Rather, it is intended to steer a discussion, based on current status as developed under EU law and as interpreted by the ECJ, taking into account the possible outcomes of currently pending ECJ cases. The base line, i.e. how much consumer choice the three procedures E111, E112 and “Kohll/ Decker” allow for each of the four dimensions (range of benefits, degree of restrictions, choice among providers and reimbursement), has been developed in the previous chapter.

As the scenario was originally developed early in 2001 (i.e. before the verdicts on Geraets-Smits/Peerbooms (C-157/99) and Vanbraekel (C-368/98) in July 2001), sections 1 to 3 do not take account of the actual verdicts on these cases. However, these are addressed in section 4.

1. Issues and outcomes forecasted in the scenarios

These scenarios are based on different possible verdicts to current ECJ cases (Geraets-Smits/Peerbooms [C-157/99]; Müller-Fauré/van Riet [C-385/99-1]; Vanbraekel [C-368/98]). These deal primarily – simplified for the sake of the scenario – with the following four issues:

1. Extension of the “Kohll/ Decker” procedure to in-patient services;
2. Application of the “Kohll/ Decker” procedure from patient reimbursement systems to systems of benefits-in-kind;
3. Extension of the “Kohll/ Decker” procedure to goods and services which are not included in the benefits catalogue in the country of insurance affiliation (“CoI”), i.e. the country where the citizen has his/her health insurance;
4. Right to be reimbursed at most favourable rate.

The first three issues relate directly to the available benefits and are therefore dealt with jointly (while issue 4 will be introduced in Section 2).

Issue 1 (extension of “Kohll/ Decker” procedure to in-patient services) relates to the question which was left unresolved in the Kohll and Decker judgements, namely “For which healthcare services (and goods) has the principle of free movement as established in the TEC priority over healthcare values such as the financial sustainability of social protection systems or the health of the population?” Possible outcomes are:

- A. The right to choose in-patient services across borders is denied as it would interfere with national capacity planning (which in this outcome is given high importance).
- B. The right to choose in-patient services across borders is accepted but, at the same time, the necessity for national capacity planning is acknowledged, especially for certain high-technology services, so that Member States may limit the free choice to non-high technology services, i.e. general in-patient services.
- C. The free choice of in-patient services is considered a higher value than national capacity planning.

Issue 2 (application of the “Kohll/ Decker” procedure from patient reimbursement systems to systems of benefits-in-kind) relates to a fundamental question regarding the application of the TEC, namely “Are any methods of organising access to healthcare excluded from the application of the principles governing the free movement of goods and services and, if so, which methods?” Possible outcomes are:

- A. Healthcare services in benefit in kind systems are not considered “services” under the TEC. Therefore, the ECJ denies any freedom of choice to cross-border care for persons covered under social security systems operating on the benefits-in-kind principle.
- B. Healthcare services in benefit in kind systems are considered “services” under the TEC, but the right of Member States to organize their social protection systems is also acknowledged, meaning in effect that they have the right to limit the freedom of choice if it endangers the financial sustainability of the system or the health of the population.
- C. Healthcare services in benefit in kind systems are considered as “services” under the TEC. The freedom of services (and goods) is therefore fully applicable.

Issue 3 (extension of “Kohll/ Decker”-procedure to services which are not included in the benefits catalogue of the CoI) is one which was already dealt with in relation to E112, but which is now more generally at stake as it relates to at least two underlying questions: “What powers do Member States have to make access to services subject to certain conditions (e.g. age as in the Peerbooms case) or processes (gate-keeping or waiting periods as in the Van Riet case)? And, more generally, what powers do they have to limit the benefits covered by their statutory health protection system?” Possible outcomes are:

- A. An extension to the Kohll/ Decker rulings is not made, i.e. the choice of services across borders is limited to those included in the benefits catalogue of the CoI and the necessity of which is certified through a prescription.
- B. Access to services which are not included in the national benefits catalogue is principally accepted, but is made dependent on certification by physicians in the CoI that the benefits available in that country are insufficient and that a different treatment (which is available in another EU country) is indicated – in effect this would mean an extension of E112 principles to the “Kohll/ Decker” procedure.
- C. Choice is extended to services which are not included in the benefits catalogue of the CoI, i.e. implicitly to all services included in one of the Member States’ benefits catalogues.

The arrows in Figure 1 indicate the possible extensions for consumer choice for these three issues.

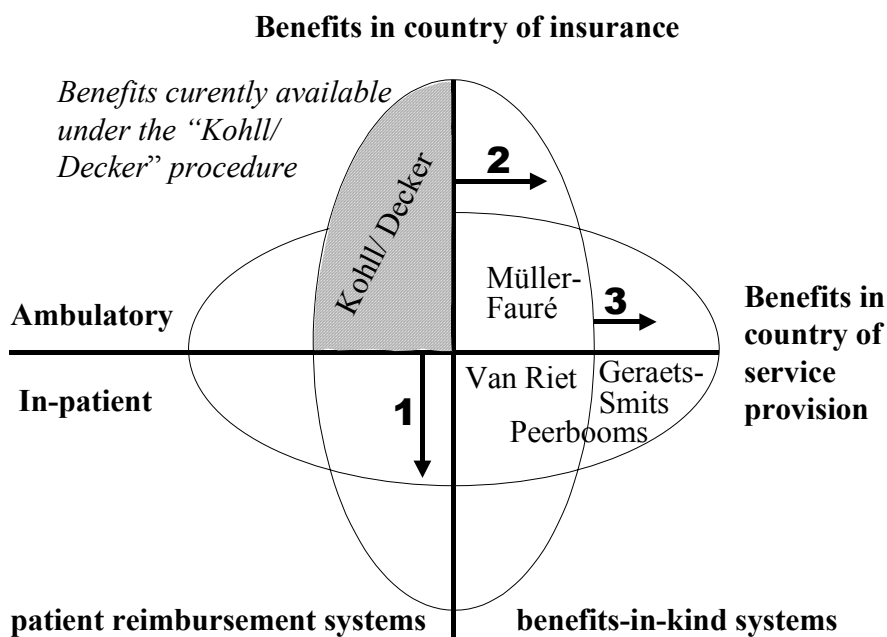


Fig. 1: Benefits available under the “Kohll/ Decker” procedure (early 2001), current ECJ cases and pending extension issues, indicated by arrows for 1. extension to in-patient services, 2. benefits in kind systems and 3. benefits outside the catalogue of the country of insurance

2. Possible general outcomes

Taken together, four general outcomes are possible. Three of them are based on the assumption that the ECJ has a clear line when deciding upon the various cases. These possible general lines – building on the three options A to C above – are “no increase in European patient choice” (Table 1), “more patient choice but also stability for the social protection systems” (Table 2) and “freedom of services and goods is highest value” (Table 3). The result of only “pro-freedom” decisions on the range of services which would then be available under the all-encompassing “Kohll/ Decker” procedure is also demonstrated in Figure 2.

Table 1: General outcome “no increase in European patient choice”

Consumer choice issue	Decision		
	Anti consumer choice	Middle way	Pro consumer choice
In-patient services	A	B	C
Benefits-in-kind systems	A	B	C
Services not included in benefits catalogue	A	B	C

Table 2: General outcome “more patient choice but also stability for the social protection systems”

Consumer choice issue	Decision		
	Anti consumer choice	Middle way	Pro consumer choice
In-patient services	A	B	C
Benefits-in-kind systems	A	B	C
Services not included in benefits catalogue	A	B	C

Table 3: General outcome “freedom of services and goods is highest value”

Consumer choice issue	Decision		
	Anti consumer choice	Middle way	Pro consumer choice
In-patient services	A	B	C
Benefits-in-kind systems	A	B	C
Services not included in benefits catalogue	A	B	C

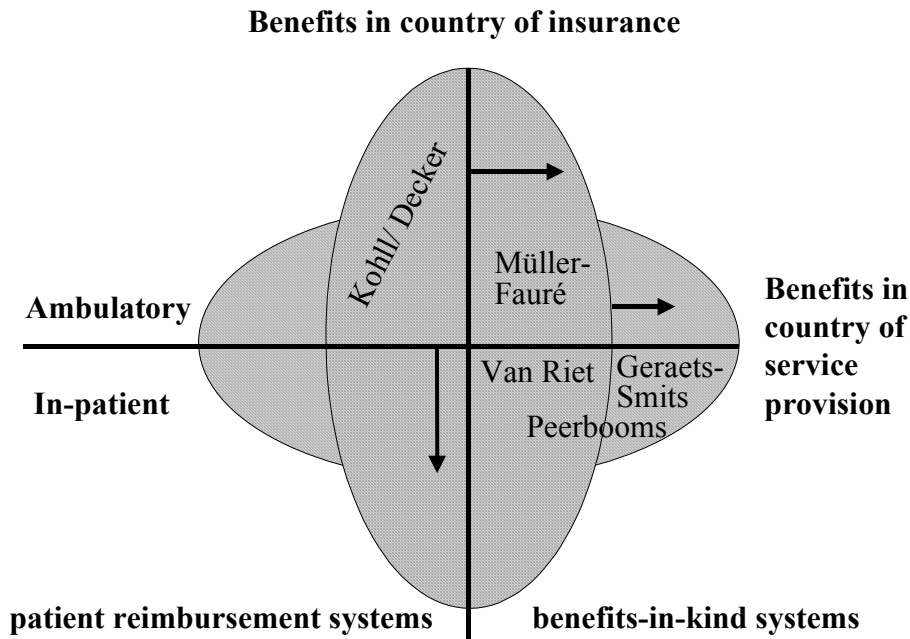


Fig. 2: Benefits available under the “Kohll/ Decker” procedure under the general outcome “freedom of services and goods is highest value”

Taking into consideration that the ECJ has not yet (visibly) found a consistent approach to dealing with these issues, it is possible that such an apparently inconsistent approach will continue. In this case, the various issues could be decided quite differently in regard to their effect on choice, as Table 4 exemplifies. In this example, the “Kohl/ Decker” procedure would be restricted to ambulatory services but be made available to entitled persons in all EEA countries. The availability of benefits not included in the catalogue of the CoI would be made dependant upon certain conditions.

Table 4: General outcome without clear orientation (example)

Consumer choice issue	Decision		
	Contra consumer choice	Middle way	Pro consumer choice
In-patient services	A	B	C
Benefits-in-kind systems	A	B	C
Services not included in benefits catalogue	A	B	C

Issue 4. Clearly, the real effect on patient choice and mobility will also depend to a large degree on the outcome of the ECJ rulings regarding issue 4, i.e. the right to be reimbursed at the most favourable rate. In this respect, possible outcomes are:

- A. The ECJ upholds its view that any reimbursement is limited to the actual bill in the country of service provision (“CoS”) as well the reimbursement used in the CoI (i.e. whatever is lower).
- B. The ECJ considers a limitation of reimbursement to the CoI rate as an impediment to free movement and mandates that the responsible third-party payer has to cover the costs incurred in the CoS if they are higher than in the CoI (limited to the reimbursement which applies to persons insured and treated in that country).
- C. The ECJ comes to the conclusion that for full freedom of services and goods the patient should be reimbursed independently of the place of service (i.e. de facto at the rate used in the CoI).

3. Discussion of scenarios

The most likely outcome of the scenarios is some intermediate form rather than the two extremes of “no increase in European patient choice” or “freedom of services and goods is highest value”. Whether an intermediate outcome will, however, result from a consistent “middle way” approach or from an apparently inconsistent “muddling through” approach is less clear.

These various outcomes will not, however, lead to a stable situation for European health care systems as new problems will have to be tackled – either because of new European health policy initiatives or (possibly more likely) additional cases submitted to the ECJ.

The “freedom of services and goods is highest value” outcome would lead to an almost unrestricted access to services and providers outside the borders of the CoI. This in turn would pose serious questions for national policy making:

- How can Member States deny certain dimensions of choice inside their country (e.g. to restrict access to a limited number of contracted providers) if these limitations do not exist for cross-border care?

- How can equivalence be applied between services belonging to different health care systems where they are integrated and financed according to different rules?
- (and possibly most importantly:) To what extent would the new situation weaken or even cancel out national health policy measures, especially regarding cost containment?

It is important to recognise that one apparently obvious solution – i.e. to restrict access to a defined minimum standard benefits package – is not a real solution if this done individually by each Member State, as access to excluded services which are included in any other Member State would remain (for those patients who are willing/ able to go there). This, in turn, leads to the ultimate question:

- Will Member States need to design a uniform benefits catalogue, to fix uniform reimbursement rates and to develop a uniform system of accrediting/ contracting/paying providers to regain the political power to steer the – then European – health care system?

The most restricted general outcome “No increase in European patient choice” equally generates a set of questions:

- How can it be justified that the alternative methods of accessing healthcare services across borders (E111, E112, “Kohll/ Decker”) enable the European citizen to receive such different options of benefits, service provider and reimbursement, in particular as the third method is available only to those insured under certain healthcare systems?
- If it is regarded as not justified, will this lead to a cut-back of certain freedoms granted in Regulation 1408/71 to reach a status of equality, but at the lowest possible level?

While at first sight the “middle way” outcome (“more patient choice, but restricted”) appears promising, it would also fail to provide a stable situation. Quite to the contrary, many details resulting from the ECJ decisions would be unresolved:

- Will the recognition that certain high-technology services require national planning necessitate an EU-wide list of such technologies? If so, who should decide on such a list?
- Will the recognition that restrictions on access for the sake of financial sustainability necessitate a common understanding of what restrictions are tolerable?
- Is the extension of national contracting systems across borders, which may result in overlapping provider networks, really an effective solution?

4. Developments through the Smits-Geraets/ Peerbooms and Vanbraekel rulings

Before discussing the directions for future development that the rulings point towards, a summary of the cases will be presented. On the Geraets-Smits/Peerbooms case (C-157/99), the ECJ reported the ruling under the heading of “The conditions for obtaining prior authorisation to receive hospital treatment in another Member State must not give rise to an arbitrary refusal” as follows (ECJ Press Release No 32/2001):

“Mrs Geraets-Smits, who is of Netherlands nationality, suffers from Parkinson's disease. She was treated in a specialist clinic in Germany without obtaining prior authorisation from her Netherlands sickness insurance fund. When she

sought reimbursement of the costs incurred, her sickness insurance fund refused to reimburse her on the ground that satisfactory and adequate treatment for that disease was available in the Netherlands and that the treatment provided in Germany conferred no additional advantage.

Mr Peerbooms, who is of Netherlands nationality, fell into a coma following a road accident. He received special intensive therapy in an Austrian clinic, which proved beneficial. Mr Peerbooms did not satisfy the requirements for admission to two Netherlands establishments offering the same medical technique on an experimental basis (as this technique was available in the Netherlands only to persons under the age of 25 years). Mr Peerbooms was also refused reimbursement by his Netherlands sickness insurance fund of the costs incurred, since, according to the authority dealing with his claim, the treatment given to the comatose patient in Austria had no advantage over the treatment available in the Netherlands.

Under the Netherlands social security legislation, a patient can receive medical treatment, either in the Netherlands or abroad, at an establishment which has not entered into agreement with his sickness insurance fund only after obtaining prior authorisation. The Netherlands court hearing the disputes between the persons concerned and their sickness insurance funds has asked the Court of Justice whether legislation of that type is compatible with the principle of freedom to provide services.

The Court observes that Member States are free to organise their social security systems. In the absence of harmonisation at Community level, it is for the legislation of each Member State to determine the conditions concerning the right or duty to be insured with a social security scheme and the conditions for entitlement to benefits. Nevertheless, the Member States must comply with Community law and in particular with the principle of freedom to provide services. Medical activities, even taking into consideration the particular nature of the services concerned (benefits-in-kind, for which the hospital establishment is paid by the fund with which the person concerned is insured), do indeed fall within the scope of freedom to provide services.

The Court then considers whether the effect of the rules in question is to restrict freedom to provide services. By subjecting reimbursement of costs to authorisation, which is granted only where two conditions are satisfied (the treatment must be regarded as normal in the professional circles concerned; and the treatment abroad must be necessary), the rules in question constitute an obstacle to freedom to provide services. Is there any justification for that obstacle? The Court recalls that a risk of seriously undermining a social system's financial balance and the maintenance of a balanced medical and hospital service open to all constitute financial and public-health requirements capable of justifying an obstacle to freedom to provide services.

In the Court's view, the need to have resort to a system of prior authorisation, in the context of a system of agreements to provide health care, makes it possible to ensure that there is sufficient and permanent access to a balanced range of high-quality hospital treatment on the national territory, to ensure that costs are controlled and to prevent any wastage of financial, technical and human resources. None the less, any conditions, such as those applied in the Netherlands, which must be satisfied in order to obtain prior authorisation must be justified and must satisfy the principle of proportionality.

Thus, the condition that the proposed hospital treatment in another Member State must be regarded as normal is acceptable only in so far as it refers to what is sufficiently tried and tested by international medical science.

The second condition, namely the necessity of the proposed treatment, that is to say the requirement that the insured person receive treatment in a foreign establishment owing to his medical state, must mean that authorisation can be refused only if the patient can receive the same or equally effective treatment without undue delay from an establishment with which his sickness insurance fund has contractual arrangements.”

On the Vanbraekel case (C-368/98), the ECJ reported the ruling as follows (ECJ Press Release No 33/2001):

“Mrs Descamps, a Belgian national residing in Belgium, requested authorisation from her sickness insurance fund to undergo orthopaedic surgery in France. That authorisation was initially refused: her request was deemed insufficiently supported in the absence of the opinion of a doctor from a Belgian university. Mrs Descamps none the less went ahead with the operation in April 1990. She brought an action against her sickness insurance fund before the Belgian courts for reimbursement of the costs incurred on the basis of the tariffs applied in Belgium (FRF 49,935.44) and not those applied in France (FRF 38,608.89). In December 1994, a report by a medical expert designated by the Cour du travail de Mons confirmed that the surgery was not currently performed in Belgium and that the restoration of Mrs Descamps’s health did indeed necessitate hospital treatment abroad. As Mrs Descamps had died in the course of the proceedings, her heirs, Mr Vanbraekel and her children, pursued the action.

The Cour du travail de Mons has asked the Court of Justice of the European Communities whether, once it has been established that hospital treatment in another Member State should have been authorised, reimbursement of the costs of hospital treatment must be made in accordance with the scheme of the State of the competent institution (here the Belgian institution) or in accordance with that organised by the State on whose territory the hospital treatment has taken place (in the present case the French scheme). Last, the Court has been asked about the rules on assumption of costs to be followed when the authorisation provided for in the Community rules to obtain hospital treatment in another Member State has been obtained, by declaration of a court where appropriate.

The Court recalls that the Community rules established a system which ensures that a person covered by social insurance who is authorised to receive medical benefits-in-kind in a Member State other than the State in which he is insured enjoys in the Member State in which the treatment is provided conditions as favourable as those enjoyed by insured persons covered by the legislation of that State. The Court therefore considers that the applicable rules on assumption of costs are those applied in the State in which treatment is provided.

The costs of benefits-in-kind are borne, in principle, by the institutions of the State in which the treatment is provided and are subsequently refunded by the institution with which the person concerned is insured. The Court rules that where the costs were not assumed owing to an unjustified refusal to grant authorisation by the institution with which the person concerned is insured, the

latter institution must guarantee directly to the person concerned reimbursement of an amount equivalent to that which it would ordinarily have assumed if authorisation had been properly granted.

Taking the view that medical activities do indeed fall within the scope of the rules on freedom to provide services, the Court also considers that national legislation must guarantee that an insured person who has been authorised to receive hospital treatment abroad receives a level of payment comparable to that which he would have received if he had received hospital treatment in his own Member State.

In those circumstances, the Court considers that the principle of freedom to provide services defined in the Treaty precludes rules which prevent additional reimbursement corresponding to the difference between the lower tariff of reimbursement of the State of stay in which the hospital treatment was carried out and the more favourable tariff laid down in the social insurance scheme of the State of registration.

Although the risk of seriously undermining the financial balance of the social security system may constitute an overriding reason in the general interest capable of justifying a barrier to the principle of freedom to provide services, in the Court's view there is no reason to consider that payment of the additional reimbursement in question would entail an additional financial burden for the sickness insurance scheme of the State in which the person concerned was originally insured capable of preventing the maintenance of treatment capacity or medical competence on national territory.”

When these two rulings are analysed in relation to the four issues explored in section 1 (in-patient services; benefits-in-kind systems; goods and services not included in the benefits catalogue; reimbursement), some clear answers become apparent. Regarding the first two issues, the ECJ decided that both hospital services as well as healthcare services delivered as benefits-in-kind are clearly services under the TEC. This is all the more surprising as the Advocate General in his opinion of 18th May 2000 had originally stated the opposite:

“Overriding reasons for maintaining the financial balance of the compulsory sickness insurance scheme of the Netherlands, which provides only benefits-in-kind, justify restrictions on the freedom to provide hospital care within the Union. In any event, the Advocate General, Mr Ruiz-Jarabo, considers that medical care, provided as a benefit in kind, does not constitute a service and therefore is not subject to the Treaty.”

Regarding the third issue, the Court confirmed, in line with its earlier *Pierik* rulings, the fact that benefits are not covered within a country does not preclude them from being covered if provided in another Member State – though the Court attached certain conditions (see below). The same is true for the generally consumer-friendly *Vanbraekel* verdict on reimbursement which should not be misinterpreted as an invitation to profit financially from accessing healthcare services across borders.

In regard to the four dimensions of consumer choice, the “post-Peerbooms” situation can therefore now be assessed as follows:

- *Access to a range of medical goods and services (“benefits”)*: The range of benefits has definitely increased. While the Court confirms that Member States are free to organise their social security systems (and therefore also to limit the benefits available under

those systems), they cannot restrict cross-border access to healthcare services if they are “sufficiently tried and tested by international medical science”. Clearly, this will have serious implications for national benefits catalogues and may very well be a powerful driver towards a European benefits catalogue (cf. next chapter). Assuming, for example, that the emerging activities in the area of evidence-based dental care will produce favourable results, it will be difficult for countries which have excluded such services from their benefits catalogues to maintain this non-coverage unless all countries agree to exclude these services.

- *Restrictions to access healthcare services:* Restrictions to access healthcare services will be lessened for two principal reasons. First, in the Geraets-Smits/Peerbooms case, the Court stated that authorisation may be refused only if the patient can receive the same or equally effective treatment without “undue delay” from a contracted provider. While the ECJ has not yet defined how an “undue” delay is to be determined (which it will probably do in the pending Müller-Fauré/van Riet case), maximum waiting times as currently accepted for certain specialities in certain countries should definitely qualify. Second, a refusal to authorise a patient to receive cross-border care may prove costly for the competent authority, as the Vanbraekel case has demonstrated. Increasing consumer-friendliness can therefore be expected.
- *Choice among providers:* Two aspects have to be distinguished. On the one hand, choice will certainly increase considerably with the availability of providers in other countries. On the other hand, the Court does not suggest the simple extension of the “Kohll/ Decker” procedure to hospital services (which would have the potentially serious “side-effect” that it would be difficult to withhold payment for non-contracted providers within the country while allowing it for services delivered outside the country) but rather the modification of the pre-authorisation rules. These, however, generally allow access to contracted providers only.
- *Reimbursement:* A further result of the attempt by the ECJ to integrate consumer choice-driven access to cross-border hospital services into the scope of Regulation 1408/71 is that patients will not have to face – potentially high – costs which are not reimbursed. This could have been the case if the “Kohll/ Decker” procedure had simply been copied. Compared to that advantage, the possibility for patients of making a “profit” is of minor importance as it is only possible if two conditions are met – 1. the pre-authorisation has been refused on unjustified grounds and 2. the tariff in the country of insurance is higher than in the country of service provision – and, more importantly, it could also turn out that the refusal was well-founded and the patient has to cover the full costs.

Meanwhile, Peerbooms-induced change is already visible for European citizens, at least in the United Kingdom where the recent rulings had an almost immediate impact on the NHS. On 26th August 2001, The Sunday Times had an article titled “Patients win fight for surgery abroad” on its cover page, stating that “Alain Milburn, the health secretary, [...] would change the law to let health authorities sign contracts with providers of medical care in other European Union countries”, something that “could spark one of the biggest shake-ups of the National Health Service since its inception in 1948.” Milburn also announced that he would review the E112 system to make it “simpler, more transparent and available to everyone.”