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Movement of patients

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Three Rulings that changed our Perception of Health Provision in the EU Memberstates

Decker (C-120/95)

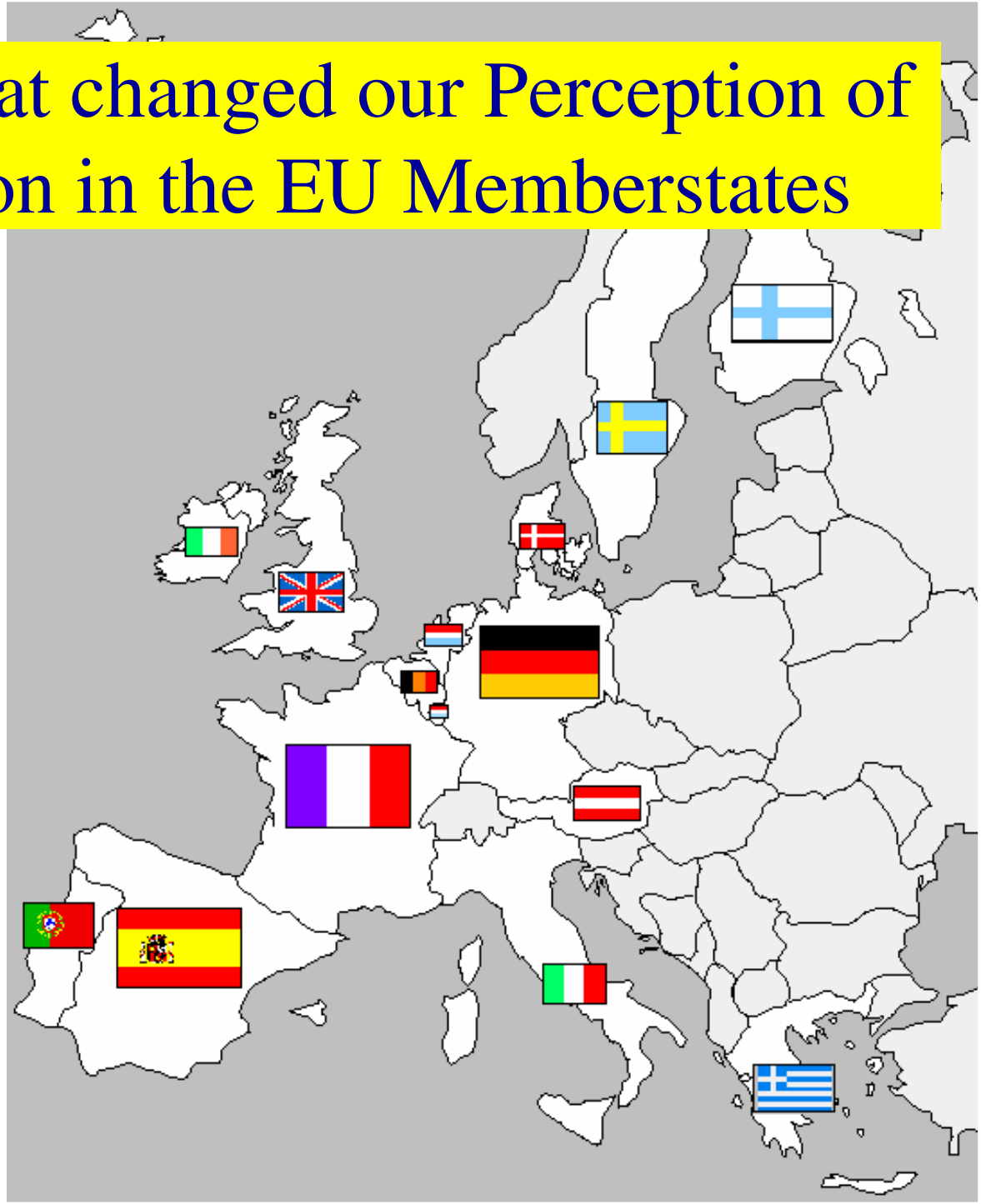
free movement of goods

Kohll (C-158/95)

free movement of services

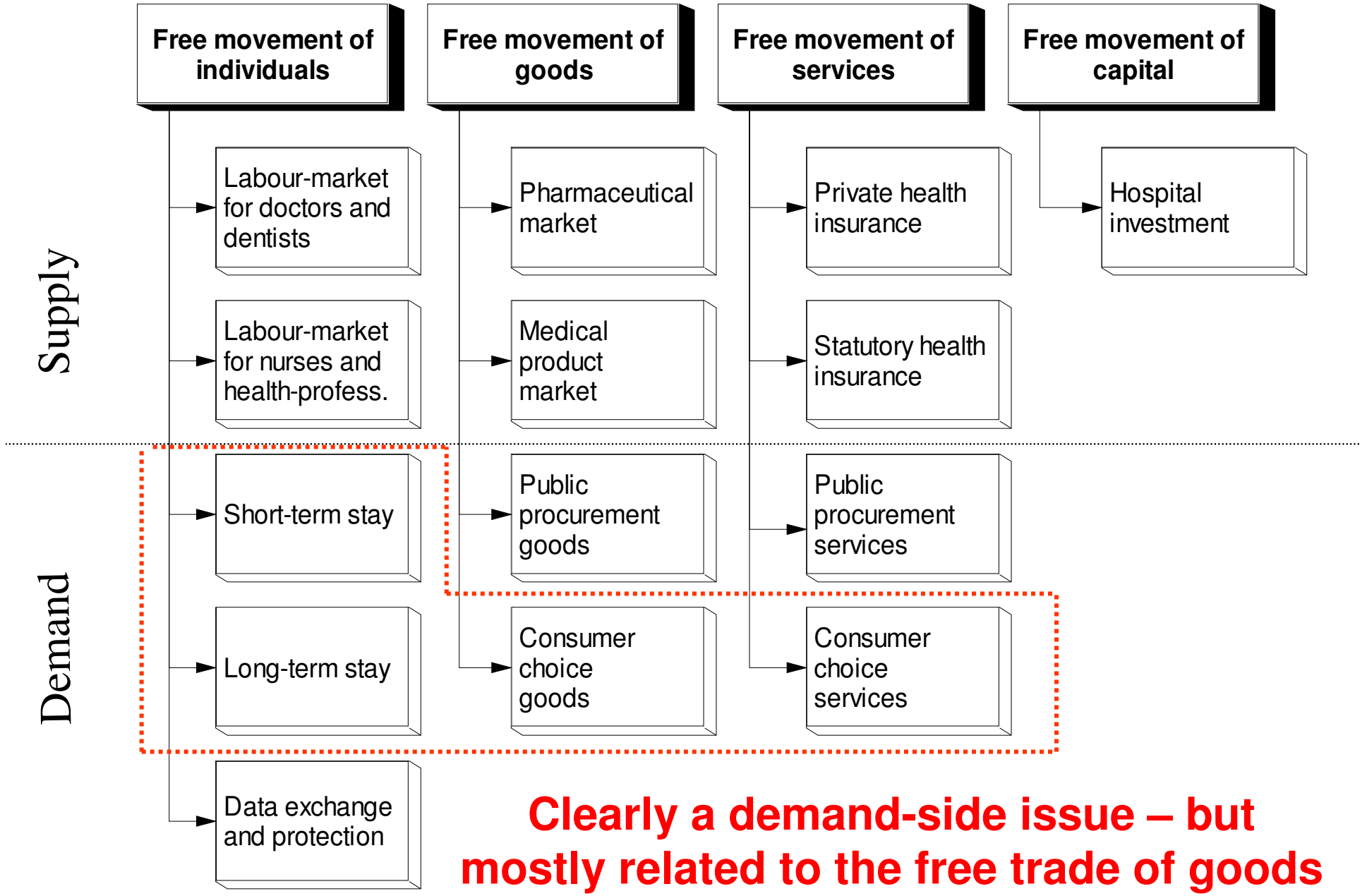
Molenaar (C-160/96)

free movement of service-equivalent cash-benefits; definition of what belongs to health service and what not



Criticism raised

- **Misinterpretation of the Treaty**: the ECJ did not take article 129 (152) into account.
- The ECJ's **decision is not universally** binding: restricted to special Luxembourg circumstances.
- **Exclusion of healthcare from integration is in the interest of the public**: an enforced "social union" will destroy national healthcare systems
- Sovereignty challenged: the **ECJ is not democratically legitimised** and therefore must not interfere with national competence.



Clearly a demand-side issue – but mostly related to the free trade of goods and services (rather than persons)!

Kohll ruling

"The fact that national **rules** fall **within the sphere of social security cannot exclude the application of Art. 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 Art. 22 of **Regulation No 1408/71**, does not have the effect of removing that measure from the scope of the provisions of the Treaty."

Legal source	Articles, paragraphs or rulings of relevance
TEC	• Art. 23 (ex-Art. 9), Free movement of goods • 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-120/95 Decker & C-158/96 Kohll • other cases currently pending at the ECJ: C-368/98 Vanbraekel; C-385/99-1 Müller-Fauré/ van Riet; C-157/99 Geraets-Smits/ Peerbooms

ECJ-code	Parties	Contriy of Insurance	Country of Service	Med. Service /Good
C-117/77; C-182/78	Pierik I & II	NL	D	
C-120/95	Decker	L	B	Glasses
C-158/96	Kohll	L	D	Orthodontic treatment
C-160/96	Molennar	D	F	Long-term care
C-368/98	Vanbraekel	B	F	Orthopaedic hospital treatment
C-411/98	Ferlini	(EC)	L	Discriminating billing
C-157/99	Geraets-Smits	NL	D	Inpatient Parkinson treatment
	Peerbooms	NL	A	Coma therapy
C-385/99-1	*Müller-Fauré*	*NL*	*D*	*denture/implantable*
	van Riet	*NL*	*B*	*Athroscopic treatment*

Economic definitions (and consequence for trade balance)

- If a patient requires/ asks for a health care service in another country, the home country **imports** that service.
- If a country receives foreigners for treatment, it **exports** those services.

Expenditure on patients receiving healthcare services in other EU Member States in Euro per capita

(= volume of imported healthcare services per capita)

Source: Palm et al. 2000

	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

Limitations of the data

- Existence of ***waiver agreements*** between several countries, for example between Germany and the United Kingdom: healthcare services provided on that basis do not appear in the expenditure data.
- ***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.
- ***Expenditure*** per capita seems to be ***decreasing***, even though ***public awareness*** of the issue has ***increased***, especially in 1998.

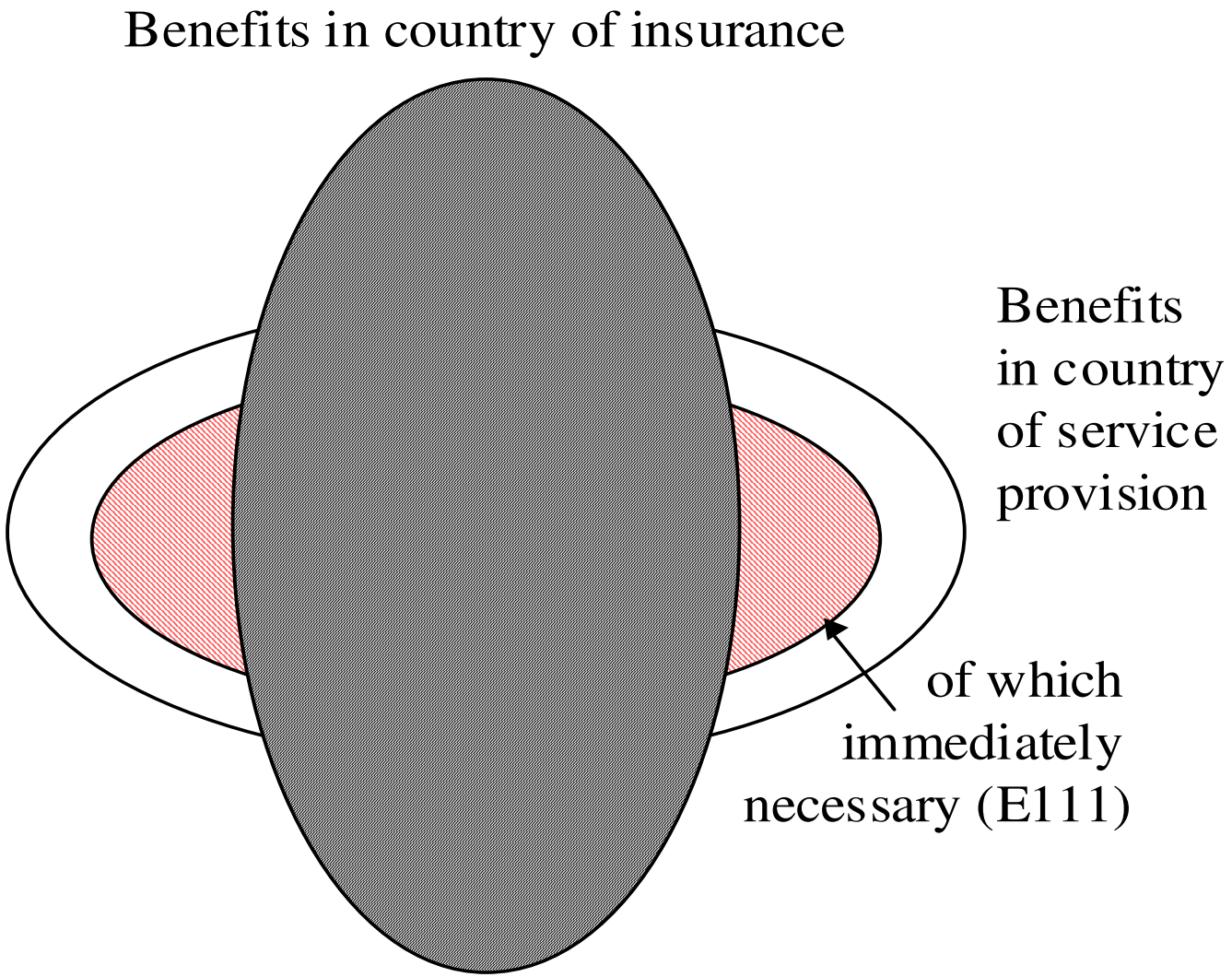
Which dimensions does consumer choice have?

- to have access to a range of services (“benefits”) as encompassing as possible,
- to get them with as few restrictions (such as necessary referrals or prescriptions) as possible,
- to have choice among as many different providers as possible, and
- to get fully reimbursement for any amount charged by the provider

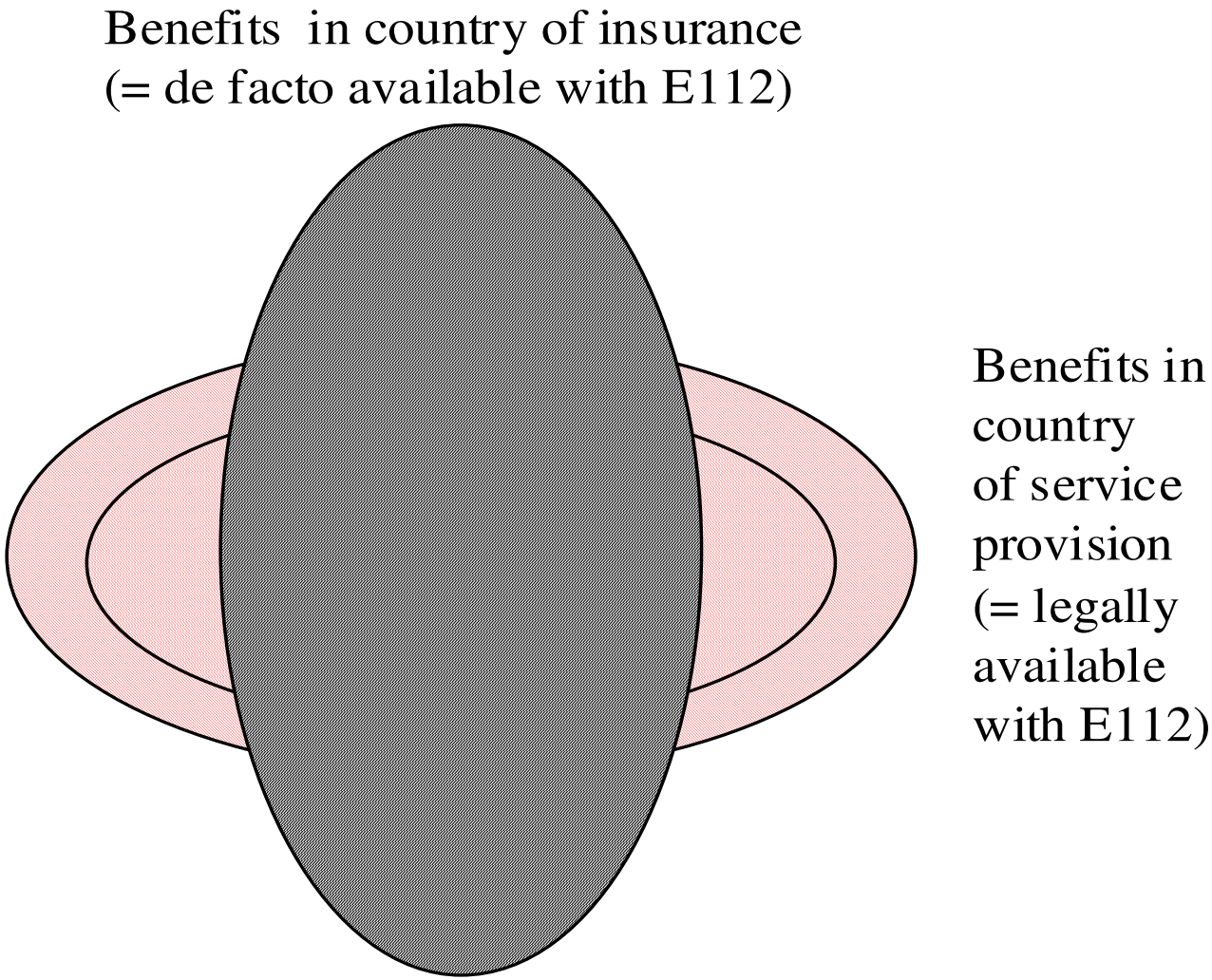
	Inside country of insurance (CoI)	Short-term stay: 1408/71, 22(1)a (E111)	Preauthorisation: 1408/71, 22(1)c (E112)	"Kohll/Decker" procedure
Countries in which applicable	CoI	Non-CoI EEA countries plus others with E111-agreement	Non-CoI EEA countries plus others with E112-agreement	Non-CoI EU countries 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 country of service provision (CoS), de facto often that of CoI	Ambulatory benefits of CoI
Conditions to get service	Referral/ prescription/ rationing measures if necessary/ existing in CoI	Referral/ prescription if necessary in CoS	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 reimburse-ment	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 re-imbursement in CoI

CoI = Country of Insurance; CoS = Country of Service Provision

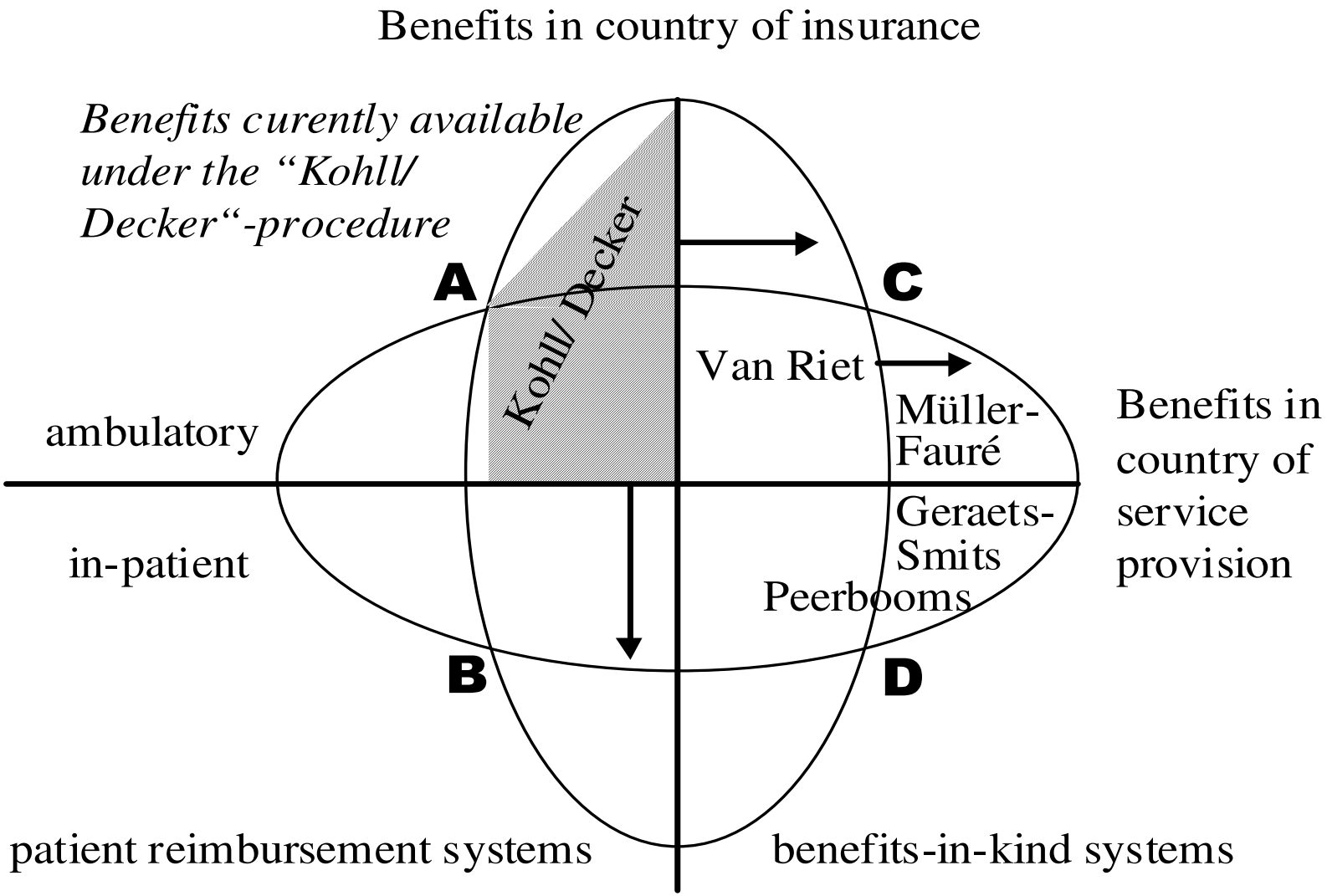
Extension of available benefits (vs. country of insurance) through E111



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



The „Kohll/Decker“-Procedure



Smits-Geraets/ Peerbooms ruling

"... the need to have resort to a **system of prior authorisation**, ..., 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**, ..., which must be satisfied in order to obtain prior authorisation **must be justified** and must satisfy the principle of proportionality. ...

Smits-Geraets/ Peerbooms ruling

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.“

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Contra-consumer choice: What if?

- How can it be justified that the alternative methods of social protection based either on the co-ordination policy (E 111, E 112) or on the principle of free movement of goods and services lead to such different possibilities to receive benefits, choose a provider and be reimbursed?
- If it is regarded as not justified, will this lead to a cut-back of certain freedoms granted in Regulation 1408/71? **(Probably not!)**

Is “yes, but“ (muddling through) the solution? Perhaps, but:

- Will the recognition that certain high-technology services should be nationally planned necessitate an EU-wide list of such technologies? If yes, who should decide on such a list?
- Will the recognition that limits on access for the sake of financial sustainability not require a common understanding of what restrictions are tolerable?
- Is the extension of national contracting systems across borders resulting in overlapping provider networks a solution?

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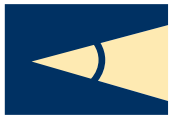


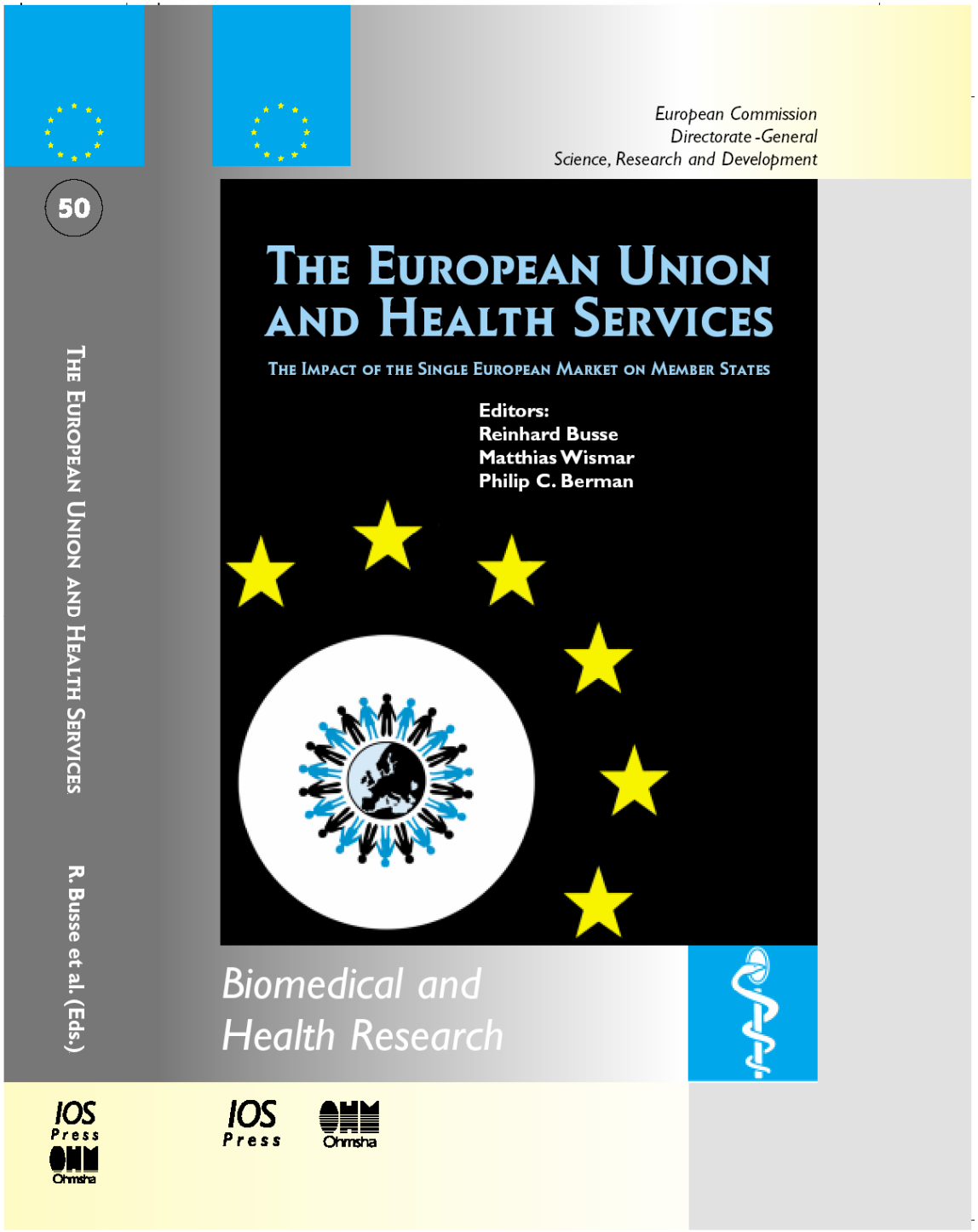
Contracts across borders

- Possible and happening within EUREGIOs, e.g. across the B/NL, B/F, D/NL borders
- Access for patients facilitated by a health insurance card which can be read on both sides of the border
- “Long-distance contracting“ applied by the UK to decrease waiting lists by shipping patients to Germany and France

Pro-consumer choice: What if?

- 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 be-longing to different health care systems where they are integrated and financed according to different rules?
- To what extent would the new situation weaken or even cancel out national health policy measures, especially regarding cost containment?

- CAVE: The easy answer – i.e. to restrict access to a defined minimum standard benefits package – doesn't work! Access to excluded services which are included in any other Member State would remain (for those patients who are willing/ able to go there).
- Will Member States in return 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?



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