PATIENT MOBILITY IN THE EU – A PLAYGROUND FOR ALL OF US?

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1. INTRODUCTION[1]

In November 2010, the European Commission launched an extensive media campaign the slogan of which was "*Europe is your playground*". One of the main messages of the Commission was that people can preserve their right to social security benefits when moving to a different Member State. This is clearly among the biggest achievements of the social security coordination legislation. However, when looking more closely at certain groups and certain situations, it becomes visible that the above-mentioned playground is more like an obstacle course – with booby traps, hidden or less hidden barriers to tackle. Mobile patients belong to one of these groups as well as receiving healthcare abroad constitutes one of these situations.

Remarkably, during the recent Brexit negotiations, the questions of accessing healthcare both for citizens of the United Kingdom (UK) in the European Union (EU) and for EU citizens in the UK have received prominent attention. The media[2] as well as scientific circles[3] engaged in a lively discussion on the topic and sought feasible answers. This debate provided a vivid example for those who stigmatised cross-border healthcare and patient mobility to be marginal. It is true that the overall effect of cross-border patient movements on the healthcare budgets is not striking,[4] but patient mobility is very important for certain pathologies (e.g. rare and complex diseases), for certain geographical areas (e.g. small countries, touristic areas) and for certain groups (e.g. highly mobile workers, mobile pensioners).[5]

(1) More details on the topic can be found in Berki, G., *Free movement of patients in the EU – A patient's perspective*, Cambridge, Antwerp, Portland, Intersentia, 2018.

(2) See for example https://www.theguardian.com/politics/2019/jan/29/british-pensioners-in-eu-will-lose-nhs-covered-health-care-under-no-deal-brexit (date of access: 30 May 2019), https://www.bbc.com/news/business-47214093 (date of access: 30 May 2019), and https://www.thelocal.fr/20190321/anger-among-britons-in-europe-over-uk-governments-brexit-healthcare-offer (date of access: 30 May 2019).

(3) See for example Cayon-De Las Cuevas, J. and Hervey, T., A place in the sun? Healthcare rights of retired UK citizens in Spain post-Brexit, *Health Economics, Policy and Law*, Volume 12, Issue 3, July, pp. 297-307, 2017; Strban, G., Brexit and social security of mobile persons, *ERA Forum*, Volume 18, Issue 2, June, pp 165-185, 2017 and Hervey, T., Reciprocal healthcare arrangements after Brexit, *BMJ*, p. 363, 2018.

(4) Recent statistical data show that "*the budgetary impact of cross-border healthcare on total healthcare spending in kind is rather marginal as it amounts to only 0.4% of total healthcare spending in kind. Nonetheless, in absolute terms annual cross-border healthcare spending amounts to more than EUR 4 billion.*" De Wispelaere, F. and Pacolet, J., *Coordination of social security systems at a glance: 2016 Statistical Report*, Network Statistics FMSSFE, Leuven, p. 23, 2016.

(5) France, G., Cross-border flows of Italian patients within the European Union – An international trade approach, *European Journal of Public Health,* Volume 7, Supplement 3, p. 18, 1997.

Upon the celebration of the 60th anniversary of the coordination of social security schemes in the European Union, it seems both necessary and desirable to account for what we have gained and what we are still lacking in this domain, which – without any doubts – went through an enormous development throughout the decades. In this paper, I approach this progress from the perspective of European (mobile) patients.

2. CHALLENGES

According to the Eurobarometer survey on patients' rights in cross-border healthcare in the European Union, 49 per cent of EU citizens would be willing to travel to another EU country to receive medical treatment.[6] Nevertheless, practice shows that only as much as five per cent did actually receive medical treatment in another EU country.[7] Might this huge gap be – at least partly – explained by the difficulties insured people face when receiving healthcare abroad?

In my view, free movement of patients in the EU would mean a borderless Europe where insured persons can travel and receive healthcare in any Member State without any difficulties, by simply proving their healthcare entitlement with a universalised EU document, just like we can travel across borders simply by carrying our ID cards. In practice, this requires – first of all – a clear and consistent legal framework which ensures that patients can benefit from the rights conferred on them by the European legislation.

I find that one of the main reasons why it is difficult to tackle the problems of cross-border patient mobility is that the field of healthcare is a multi-player arena where many different interests (of the patients, healthcare providers, healthcare funds, national governments, Union institutions etc.), different competences (basically of the Member States and various EU institutions, but also within the Member States competences are often allocated among different levels, e.g. federal, regional, local) and different ideologies collide. This creates a tense political atmosphere in which the patients' well-being, which is supposed to be the starting point and the main aim of any health-related arguments, runs the risk of evaporating in the process. Thus, after sixty years of healthcare coordination and two decades since the ground-breaking judgements[8] of the Court of Justice of the European Union (CJEU), European patients are still left with restricted cross-border mobility rights and impediments of free movement both from legal and non-legal points of view.

(6) Special Eurobarometer 425, Patients' rights in cross-border healthcare in the European Union, http://ec.europa.eu/commfrontoffice/publicopinion/archives/ebs/ebs_425_sum_en.pdf (date of access: 29 May 2019), p. 6.

(7) Special Eurobarometer 425, Patients' rights in cross-border healthcare in the European Union, http://ec.europa.eu/commfrontoffice/publicopinion/archives/ebs/ebs_425_sum_en.pdf (date of access: 29 May 2019), p. 4.

(8) The (in)famous Kohll and Decker judgements opened a new path of patient mobility directly based on the Treaty provisions on free movement of services. C-158/96 Raymond Kohll v Union des caisses de maladie [ECR 1998 Page I-01931]; C-120/95 Nicolas Decker v Caisse de maladie des employés privés [ECR 1998 Page I-01831].

2.1. LEGAL OBSTACLES

2.1.1. Legal complexity

The European legislation governing intra-EU patient movements across the Member States is in itself very complex. At least two dimensions of legal complexity can be identified. On the one hand, access to healthcare abroad includes three different situations to which different rules apply: access to healthcare in the competent Member State (where the person is insured) when residing outside this State; access to necessary healthcare during a temporary stay outside the Member State of residence; and access to planned healthcare outside the Member State of residence. On the other hand, these situations are currently regulated by two (if counting the case-law of the CJEU as well, three) separate sets of rules: the social security coordination mechanism[9] and the case-law based Patient Mobility Directive,[10] which partly overlap and partly conflict with each other, creating doubts and legal uncertainty.

So how do these pieces of the legislative puzzle fit together? The Directive unambiguously states in its Preamble that for patients the two systems should be coherent.[11] Article 2 (m) of the Directive indicates that the Directive should apply without prejudice to the Coordination Regulations, which implies that they are applicable in parallel and that there is no priority between them.

2.1.2. Administrative burden

The administration related to patient movements is not less complex than the legislation. Patients might easily find it discouraging to learn that both the Regulations and the Directive have their separate procedures, with their own set of administrative requirements, documents to fill in and attach, and administrative steps to follow. It is very crucial for patients to be aware of all the relevant information on the procedures, their entitlements under the two legal tools and the implications of the outcomes of these procedures. For instance, it is of utmost importance to inform the patient what the difference is between being granted prior authorisation under the Regulations or under the Directive.

Moreover, in the different scenarios, different administrative paths are to be followed. For instance, under the coordination regime, insured persons residing outside the competent Member State have to register themselves at the institution of the place of residence and have to provide proof of insurance under the sickness scheme of the competent Member State[12] by using portable document (PD) S1. In order to obtain

(9) Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems, OJ L 166 of 30 April 2004 (hereinafter also referred to as Basic Regulation or BR) and Regulation (EC) No 987/2009 of the European Parliament and of the Council of 16 September 2009 laying down the procedure for implementing Regulation (EC) No 883/2004 on the coordination of social security systems, OJ L 284 of 30 October 2009 (hereinafter also referred to as Implementing Regulation or IR).

(10) Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, OJ L 88 of 4 April 2011 (hereinafter also referred to as Patient Mobility Directive or PMD).

(11) Recital 30 of the Preamble of PMD.

(12) Article 24 (1) IR.

necessary healthcare abroad during a temporary stay on the account of the patient's health insurance in the competent Member State, the healthcare entitlement is to be proved by a valid European Health Insurance Card.[13] Lastly, when travelling to another Member State with the purpose of receiving benefits in kind during the stay, the insured person shall seek authorisation from the competent institution.[14] For this purpose, PD S2 is used.

Furthermore, as a result of the transposition of the Directive, in terms of administrative procedure and requirements attached to the right to reimbursement, numerous patterns can be identified among the Member States. On the one hand, most of the Member States which apply a prior authorisation requirement created a uniform procedure where the authorisation process under the Regulation and under the Directive are merged and go through the same steps. On the other hand, some Member States decided to keep the procedures under the two different legal tools entirely separated. In some of these states, the separate authorisation procedures belong to the competence of different divisions of the same institution, or even to different institutions.[15] Finding the competent institution might prove to be challenging for some patients, especially if the lack of information is added to the picture.

2.1.3. Discretionary power

It is evident that the Member States transpose directives as best fits their aims, tools and circumstances within the given legal framework, thus there are differences between the entitlements and practical opportunities of patients insured in different Member States. However, the Regulations, which are to be applied in a universal manner, also leave considerable space for Member States' discretion. For instance, the outcome of the evaluation related to a request for prior authorisation highly depends – despite the efforts of the CJEU to define procedural minimum requirements and limit the discretionary power of the competent institutions – on the national administrative guidelines and practices.

The minimum requirements intend to guarantee an impartial and objective evaluation of the requests and to ensure transparency of the procedures in order to strengthen the patients' feeling that they are not exposed to an uncontrollable, untraceable bureaucratic mechanism. Nevertheless, some of the requirements are rather vaguely phrased and may thus not have the desired effect. For instance, the criterion which says that the factors assessed in the authorisation procedure are to be known in advance does not concretise how or by means of what platform and where this information must be published or how much in advance this has to be communicated towards the insured persons.

(13) Article 25 (A) (1) IR.

(14) Article 20 (1) BR.

(15) Strban, G. (ed.), Berki, G., Carrascosa, D. and Van Overmeiren, F., *Access to healthcare in cross-border situations*, FreSsco Network, Ghent, 2017.

2.2. NON-LEGAL OBSTACLES

2.2.1. Language gap

Communication is a key element of healthcare provision, in the course of which it is of essential importance that each party involved expresses him/herself clearly and exactly. If the mutual communication works properly, it "*ultimately leads to an enhanced doctor-patient relationship resulting in satisfaction with the encounter by both parties and thus improved health care outcomes*",[16] whereas the lack of or inappropriate information exchange might result in incomplete medical assessment, distrust between the parties and inadequate medical treatment. The language gap constitutes a serious obstacle in cross-border healthcare situations: if the patient and the healthcare professional do not speak the same language, the risk of misunderstanding and – as a consequence – of misdiagnosis increases significantly, and "*extensive physical examinations and diagnostic tests [are] sometimes required to compensate for the inability to communicate verbally*."[17] Interestingly enough, this problem has not been addressed at the EU level so far.

2.2.2. Lack of information

The European citizens' awareness of their cross-border healthcare rights is rather low: the above-mentioned EU-wide survey demonstrated in 2014,[18] and a cross-border healthcare simulation also confirmed,[19] that a large share of the European population has no or very little information about the possibility to receive medical treatment in another EU country and to be reimbursed for that treatment by their national health authority or healthcare insurer.

The Patient Mobility Directive clearly articulates the patients' need for information on cross-border healthcare.[20] It acknowledges that appropriate information on all essential aspects of cross-border healthcare is necessary in order to enable patients to exercise their rights on cross-border healthcare in practice.[21] Both the Directive[22] and the Coordination Regulations[23] provide rules on the Member States' information duties.

Although the codification of information duties in the current set of Regulations is an applaudable improvement in the coordination mechanism, it suffers from several

(16) Fowler, J.D., *Cultural and Structural Barriers that Affect the Doctor-Patient Relationship: A Bolivian perspective*, http://ir.library.oregonstate.edu/xmlui/bitstream/handle/1957/9896/Fowler.pdf?sequence=1 (date of access: 9 June 2019), p. 5.

(17) Priebe, S., Sandhu, S. et al., Good practice in health care for migrants: views and experiences of care professionals in 16 European countries, *BMC Public Health*, vol 11, issue 187, p. 4, 2011.

(18) Special Eurobarometer 425, Patients' rights in cross-border healthcare in the European Union, http://ec.europa.eu/commfrontoffice/publicopinion/archives/ebs/ebs_425_sum_en.pdf (date of access: 29 May 2019), p. 6.

(19) Jelfs, E. and Baeten, R., *Simulation on the EU Cross-Border Care Directive. Final Report*, http://www.ose.be/files/publication/2012/CrossBorderHealthcareSimulation_FinalRep_09052012.pdf (date of access: 9 June 2019, p. 20.

(20) Recital 19 of the Preamble of the PMD.

(21) Recital 48 of the Preamble of the PMD.

(22) Article 4 and 5 PMD.

(23) Article 76 (4) BR, Article 3 (1) IR.

weaknesses. It should therefore be made more exact and patient-friendly in order to ensure quick, reliable and understandable cross-border healthcare information for free. Compared to the rules of the Regulations, the rules of the Directive are more specific and detailed and guarantee access to a broader scale of information. However, they do not offer a solution to the problem that if a patient wants to collect all relevant information concerning a certain treatment abroad, this involves at least three sources he/she needs to contact in (at least) two different Member States. So even if a patient possesses the necessary language skills to acquire the essential information, the multi-source investigation puts a considerable burden on him/her.

2.2.3. Financial affordability

One of the most outstanding differences between the Coordination Regulations and the Patient Mobility Directive is the financing of cross-border medical treatments: the most relevant discrepancies between the two routes of patient mobility concern the level of reimbursement and the mechanism of reimbursement.

The level of reimbursement is basically dependent on which tariffs are applied when calculating the reimbursement. According to the coordination rules – on the ground of the full integration principle, namely that foreign patients must be treated as if they were insured in the Member State of treatment – the rules of the Member State of treatment apply, including the rules on the calculation of medical fees. Hence, in principle, the healthcare costs incurred abroad are fully covered.[24] However, the Directive's financing mechanism is based on the idea that the reimbursement of cross-border healthcare costs may not affect the financial balance of the Member State of affiliation. Patients can thus claim reimbursement up to the level of domestic tariffs in that country. If the actual costs exceed this amount, the Member States cannot be obliged to bear the difference, which therefore remains at the expense of the patient.[25]

Concerning the mechanism of reimbursement, whereas the Regulations primarily require the institutions involved to settle the claim for reimbursement between each other without the patient needing to advance the costs of the treatment, under the Directive, the patient is invited by the healthcare provider to pay the invoice upfront, after which he/she can claim posterior reimbursement from the Member State of affiliation.

From the patients' point of view, both characteristics are more beneficial under the Regulations, and the less favourable financial scheme of the Directive has the potential to prevent patients from using their rights conferred on them by the Directive. The risk indeed exists that the Patient Mobility Directive exacerbates pro-rich inequality, because it is "*likely to disproportionately benefit wealthy and well-informed patients*."[26]

(24) Article 35 (1) BR.

(25) Article 7 (4) PMD.

(26) Legido-Quigley, H., Passarani, I. et al.; Cross-border healthcare in Europe: clarifying patients' rights, *British Medical Journal* 2011, vol 342, p. 366.

3. TOOLS

There are numerous weak points in the current European legislation on cross-border patient mobility. The legislative body is complex, the relation between the different legal tools is unclear, the administrative procedures are often lengthy and burdensome, the monitoring and enforcing mechanism is poor, the information is scattered, the discretion of the national healthcare authorities and the financing schemes of healthcare abroad restricts cross-border patient movements.

The European patient mobility legislation has two basic tasks, namely providing patients with clear provisions on their entitlements and serving European patients. Thus, it seems necessary to create a legal framework which takes the interests of the (border-crossing) patients into due account.

These challenges give a brief glimpse of the difficulties European border-crossing patients face when (intending to) obtain(ing) healthcare in a Member State other than their Member State of residence. Einstein warns that we cannot solve our problems with the same level of thinking that created them. Thus, we should – at least slightly – change our mindset and question what we hold solid and unchangeable in the current patient mobility legislation. I suggest considering two groups of ideas, namely rewriting the existing playbook of patient movements and bringing new tools into play.

3.1. REWRITING THE PLAYBOOK

I found that the above-mentioned defects could be overcome by a consistent, integrated legal system which builds on the legacy of sixty years of healthcare coordination and which is complemented by the innovations of case law and the Patient Mobility Directive. Such a scheme could synthesise the high level of protection provided by the Regulations and the more liberal approach of the Directive. The establishment of the integrated system in the framework of the Regulations would solve the problem of diverse transposition in the various Member States and enable the European institutions to monitor the application of the rules more easily. Last, but not least, a mono-track system – especially if combined with an accessible and patient-friendly network of national contact points (NCPs) – would significantly decrease the legal uncertainty and administrative burden on the patients' side.

As I see it, the complexity of the issues related to cross-border patient mobility excludes the possibility to unite all the relevant rules in one single legal tool and requires a fine-tuned, contradiction-free multi-level legislation instead. To design the integrated legislation of free movement of patients, the structure of the free movement legislation could be used by analogy. In the field of free movement of workers, the

basic entitlements are incorporated into a Regulation,[27] and a Directive was adopted in order to facilitate the exercise of rights conferred on the workers.[28]

The proposed integrated legal scheme is based on equal cross-border healthcare entitlements for each insured person without a distinction between planned and unplanned care, with as little administrative burden as possible and with access to any legally functioning healthcare provider who meets the universalised European standards.

3.1.1. Prior authorisation

As to prior authorisation required for planned treatment abroad, the baseline of the patient mobility case-law was that the Treaty precludes national rules which have the effect of making the provision of services (and the consumption of services) between Member States more difficult than the provision of services purely within one Member State.[29] Nevertheless, after refusing a series of possible grounds for justification of restrictions, the Court acknowledged that planning objectives can justify the maintenance of prior authorisation schemes.[30] Opening up the possibility for the Member States to make reimbursement of medical costs incurred abroad subject to prior authorisation substantially eroded the patients' rights to cross-border treatments. Moreover, the Patient Mobility Directive took it a step further and introduced grounds for justification – based on the protection of public health – which were not even verified by the Court.[31] As a consequence, the cross-border mobility of European patients is more restricted today than it was at the end of the 1990s.

It is clear that the great majority of European patients prefer to use healthcare facilities which are close to their home and which they are familiar with. Hence, no indicators suggest that cross-border patient movements can be expected to grow into a mass phenomenon in Europe: as it seems now, patient mobility will remain limited, although very important in certain areas and certain cases. Thus, the Member States' vehemence with which they guard their national healthcare (authorisation) schemes against border-crossing patients hardly correlates with the figures on the current

(27) Regulation (EU) No 492/2011 of the European Parliament and of the Council of 5 April 2011 on freedom of movement for workers within the Union.

(28) Directive 2014/54/EU of the European Parliament and of the Council of 16 April 2014 on measures facilitating the exercise of rights conferred on workers in the context of freedom of movement for workers, OJ L 128 of 30 April 2014.

(29) C-381/93 *Commission v France*, 17; C-158/96 *Kohll*, 33; C-368/98 *Vanbraekel*, 44; C-157/99 *Geraets-Smits and Peerbooms*, 61; C-8/02 *Leichtle*, 37; C-372/04 *Watts*, 94; C-444/05 *Stamatelaki*, 25; C-211/08 *Commission v Spain*, 55; C-490/09 *Commission v Luxemburg*, 16, 33.

(30) This argument first occurred in the *Geraets-Smits and Peerbooms* judgement and was then confirmed on several occasions. C-157/99 *Geraets-Smits and Peerbooms*, 76, 78-80; C-385/99 *Müller-Fauré and Van Riet,* 77-81; C-56/01 *Inizan*, 56; C-145/03 *Keller*, 62; C-372/04 *Watts*, 108-110; C-173/09 *Elchinov*, 43; C-512/08 *Commission v France*, 33-42.

(31) Article 8 (2) (b)-(c) PMD.

volume of cross-border patient movements.[32] It is high time to raise the question: is the authorisation mechanism still necessary and proportionate? What would the implications be of the removal of the prior authorisation requirement?

Since factual evidence does not support the Member States' argument that the current volume of patient movements would constitute a major risk to their healthcare systems, the justification that prior authorisation should be maintained in meeting the desire to control costs and to prevent as far as possible, any wastage of financial, technical and human resources[33] is hardly valid in today's circumstances. It can thus be argued that the prior authorisation requirement should be erased from the Regulations. Nevertheless, upon the occasion of abolition of prior authorisation schemes, a practical counterbalance could be introduced into the protection of national healthcare systems against any possible extreme change in patient mobility trends. An 'in case of emergency' (ICE) clause could be inserted into the Regulations – similar to the one which has been applied to the free movement of workers in the newly accessed Member States – indicating that when a Member State undergoes or foresees disturbances in its national healthcare system which could seriously threaten the standard of healthcare provision or the national healthcare scheme in the given Member State, that Member State shall inform the Commission and other Member States thereof and shall supply them with all relevant particulars. On the basis of this information, the Member State may request the Commission to permit certain restrictions in order to restore to normal the situation in the healthcare system concerned.[34]

This way, the burden of proof would be shifted: instead of the patient being required to request an authorisation from the competent institution in advance and meet the conditions laid down in the legislation in order to receive an authorisation, the Member State has to provide evidence that patient movements put its system at a considerable risk. If such evidence cannot be given, patients are free to access healthcare in any other Member State.

3.1.2. Distinction between planned and unplanned healthcare

The distinction between planned and unplanned care has occupied a place on the list of difficulties of healthcare coordination. From a conceptual point of view, the

(32) The Commission's report on the operation of the Directive underlines that *"[t]he data returns made by the Member States, in general, do not suggest that extensive systems of prior authorisation are justified"*, because "*some Member States with prior authorisation systems have received no requests for authorisation at all (and many others have received very few)"*, European Commission, Report from the Commission to the European Parliament and the Council, Commission report on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, COM (2015) 421 final, 04.09.2015., p. 4 and 16.

(33) C-157/99 *Geraets-Smits and Peerbooms*, 76, 78-80. On this issue see also C-385/99 *Müller-Fauré and Van Riet,* 77-81; C-56/01 *Inizan*, 56; C-145/03 *Keller*, 62; C-372/04 *Watts*, 108-110; C-173/09 *Elchinov*, 43; C-512/08 *Commission v France*, 33-42.

(34) See by analogy for instance the Act concerning the conditions of accession of the Czech Republic, the Republic of Estonia, the Republic of Cyprus, the Republic of Latvia, the Republic of Lithuania, the Republic of Hungary, the Republic of Malta, the Republic of Poland, the Republic of Slovenia and the Slovak Republic and the adjustments to the Treaties on which the European Union is founded – Annexes to the Act of Accession – 1. Freedom of movement for persons, Article 7.

difference lies in the (prior) intention of the person concerned, namely whether or not he/she willingly travelled abroad in search of medical treatment. However, a genuine problem is how the intention of the person – when not obvious from the circumstances – can be unfolded.

From an administrative point of view, the different nature of the health risks explains the different administrative procedures. Whereas necessary care, which may occasionally occur during a temporary stay abroad, can be obtained simply by presenting a valid European Health Insurance Card to the healthcare provider, in case of planned care, where the aim of the travel is to receive healthcare in another Member State, a prior authorisation from the competent institution must be requested. However, in a system in which no prior authorisation is required, as proposed above, the legal distinction between occasional and planned care becomes outdated. The removal of the distinction is in line with the Patient Mobility Directive. With such a change, instead of investigating the person's intention, which is problematic, only the patient's entitlement should be examined.

3.1.3. Exclusion of private providers

Another long-lasting teething problem of European social security coordination is that only national statutory systems are coordinated. This limitation of the Regulations might have been appropriate at the end of the 1950s, but in today's social security systems the exclusion of the voluntary and supplementary elements of social security coverage is no longer acceptable. The consequence of this characteristic in the field of healthcare is that under the scope of the Regulations, patients can – in principle – obtain treatments only from providers affiliated to the statutory healthcare system of the Member States. This not only causes uncertainty and misunderstandings concerning the recognition of which providers do belong to the system and which do not, but more importantly, it considerably limits the patients' freedom to choose which provider they wish to turn to.

It is a great merit of the Patient Mobility Directive that it covers both public and private providers, thus offering the patients significantly more options. This development should be built into the proposed integrated legislation of European patient mobility, which requires the Regulations to open up for private providers.

3.2. NEW TOOLS

3.2.1. Financing mechanism

It is equally true for healthcare systems that money makes the world go round: healthcare budgets constitute a fundamental unit of national budgets, so anything which has the potential to genuinely affect healthcare expenditures, is a politically sensitive area. The currently existing reimbursement regimes of medical treatments abroad greatly differ, and their interaction is not always clear. It is beyond dispute that the Regulation rules on financing are more favourable for the patients, since – in principle – they do not need to advance the medical costs and the full cost of medical intervention abroad is covered except for the co-payments. The single asset of the Directive in this regard is that it offers reimbursement if the treatment was

provided by non-contracted healthcare providers, who are excluded from the scope of the Regulations.

In my opinion, once again the starting point of the integrated system must be the financing mechanism of the Regulations, since it ensures higher protection for the patients. However, if the applicability of the tariff of the Member State of treatment is maintained while no prior authorisation is in place, unpredictable patient movements might produce high medical invoices and feed the Member States' budgetary fears. This might impact especially those Member States in which tariffs are considerably lower than in others. Thus, this scenario has the potential to deepen the division between western and northern Europe as patient exporters, where patients can easily access healthcare systems with lower tariffs, and eastern and southern Europe as patient importers, where patients have less chance of heading towards countries with higher tariffs. A compensation mechanism is needed to tackle this defect.

As an ambitious solution, a European Healthcare Fund could be set up, which compensates the Member States for the difference between their domestic tariffs and the foreign tariffs invoiced for them. Hence, cross-border patient movements would leave national healthcare spending basically intact. This European healthcare budget would ensure that patients of worse off Member States have the same opportunities in terms of cross-border healthcare as those with better financial conditions. It would thus be a manifestation of European supranational social solidarity.[35] However, an unavoidable question is where the revenues of this solidaristic fund should come from. In this respect also multiple options can be suggested: I hereby outline three of them.

A possible alternative, which implies higher Union involvement, is that transfers are made from other European funds, such as the European Social Fund, for this special purpose. The advantage of this option is that it is based on a long-existing European fund. Transfers could thus be made rather promptly. Still, a huge disadvantage is that it takes away money from other (similarly important) social purposes.

Another solution – by analogy to what was proposed by Commissioner Andor in relation to the supranational unemployment scheme – is that the Fund functions as a supranational healthcare insurance scheme; hence, all Member States pay a part of their revenues to the Fund. To this end, a universal contribution could be introduced to each insured person in Europe. I find this option fair and promising, because it embraces solidarity and unity, values which I think are supposed to be the leading stars of an enhanced social Union. However, it puts the financial burden directly on the citizens. Nevertheless, I think this burden – since shared by all insured persons in all the Member States – is far less per capita than the burden a patient might face in a cross-border situation without an appropriate financing mechanism.

(35) The idea of creating a common European fund for specific social purposes received a new stimulus in recent years. In Berlin on 13 June 2014, Commissioner László Andor outlined a scheme where the eurozone states would share the costs of a European short-term unemployment insurance, http://europa.eu/rapid/press-release_SPEECH-14-455_en.htm (date of access: 10 June 2019).

Whereas countries with lower tariffs need to rely on the Fund to be able to pay medical invoices from other Member States, Member States with higher tariffs save money if their insured persons receive healthcare in a country with lower costs. Another element of cross-national solidarity would be, if a part of these savings would also be paid into the European healthcare fund. This is all the more reasonable, since otherwise Member States might be motivated to 'outsource' their patients to countries with good quality care but much cheaper treatments to save money. The aim of the patient mobility legislation is certainly not to push patients – against their will – to receive healthcare services far from where they live, but to guarantee that in case they need or prefer to undergo a medical treatment in another Member State, they have both the right and the real possibility to do so on an equal basis without facing significant hurdles. Therefore, this option seems to deserve more attention in the future.

With a well-functioning compensation mechanism in place the financing of cross-border patient movements would not significantly affect the financial balance of the national social security budgets. Hence, the Member States cannot use this argument to restrict the free movement of patients.

3.2.2. Supranational central unit for NCPs

In order to ensure the smooth functioning of European cross-border healthcare legislation in practice, a solid institutional background needs to be created. The Patient Mobility Directive already took the first, important step forward by imposing the obligation on the Member States to designate one or more national contact points for cross-border healthcare.[36] However, I find the provisions on the network of national contact points rather vague and I hold the firm opinion that for now, the Union is far from using the full potential of such a network.

According to my ideas, a network of national contact points coordinated by a supranational central unit could be the right advocate for European (border-crossing) patients. This system could ensure that patients engaged in cross-border healthcare provision can exercise their rights simply by turning to a single institution on national level. Seeking to guarantee that these institutions work in the best interests of the patients and towards the enforcement of Union legislation without external influence, it is desirable that they function independently, separately from national healthcare funds and ministries.

There are a number of tasks in relation to cross-border patient mobility which could be delegated to these institutions. The national contact points could provide interpretation and translation services for patients in order to bridge potential language gaps. Modern information and communication technologies can significantly simplify this exercise. They could also serve as a knowledge base and information centre for cross-border healthcare. They should both provide information on request and carry out information campaigns aimed at patients and providers. If the request for information concerns another Member State, they should contact the national contact point in

(36) Article 6 PMD.

that state at the shortest notice.[37] They could easily do so by means of a common online platform. In this sense, I think they could function similarly to the SOLVIT network but specialised in cross-border healthcare issues. Yet, differences are that whereas SOLVIT is a service provided by the national administration of each Member State, NCPs must be independent institutions functioning on a national level; whereas SOLVIT mostly deals with cases when public authorities breach Union law, NCPs must have a broader competence and deal with any issues related to cross-border healthcare and also; whereas SOLVIT is mainly approached online, NCPs should offer various means by which they can be contacted by patients. Nevertheless, the rules on the establishment and functioning of the SOLVIT network can provide some ideas.[38]

The national contact points should establish a one-stop shop system for patients by connecting each party involved in cross-border healthcare, and cooperate and frequently consult with patient organisations, healthcare providers and healthcare insurers. The point of a "*one-stop shop for cross-border problems*" is very well summarised by the Commission: "*[d]ifferent mechanisms to assist citizens […] must also be better co-ordinated. The world looks different through the eyes of a citizen […] than through the eyes of the public sector. When citizens have a problem in the Internal Market, whether it relates to a bad experience when buying goods across borders or when trying to exercise their civil liberties, they do not wish to wander around looking for a helping hand. They want one door to knock on: A one-stop access to clear information about their rights, advice and a remedy.*"[39]

As to the central unit at the EU level, its main mission is to enhance the cooperation between national contact points, monitor their functioning and deal with the tasks which go beyond borders, such as training and research on European cross-border healthcare, organising multilateral seminars and consultations where experts can share their experience, working on methods to develop cross-border mechanisms and operating the proposed European Healthcare Fund.

3.2.3. European Reference Networks

In 2017, 24 European Reference Networks (ERNs) were set up based on the Patient Mobility Directive.[40] Each ERN is a virtual expert network involving healthcare specialists all over Europe and focusing on a rare or complex disease or group of

(37) Article 6 (2) PMD.

(38) See European Commission, Communication from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions - Effective Problem Solving in the Internal Market ("SOLVIT"), COM (2001) 0702 final, 27.11.2001; European Commission, Commission Recommendation of 7 December 2001 on principles for using 'SOLVIT' – the Internal Market Problem Solving Network, C (2001) 3901, OJ L 331 of 15 December 2001 and European Commission, Commission Recommendation of 17 September 2013 on the principles governing SOLVIT, C (2013) 5869 final, 17.9.2013.

(39) European Commission, *Communication from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions – Effective Problem Solving in the Internal Market ("SOLVIT")*, COM (2001) 0702 final, 27.11.2001.

(40) Article 12 PMD.

diseases.[41] ERNs offer the potential to give patients and doctors across the EU access to the best expertise and timely exchange of life-saving knowledge, without having to travel to another country.[42]

This innovation can be a viable alternative of patient mobility, eliminating some of the difficulties described above. However, ERNs are yet in an early phase of functioning and much has to be done in relation to both their clinical and research practices. Nevertheless, they hold a great potential for European patients, mobile or otherwise.

4. CLOSING THOUGHTS

Although the achievements of the social security coordination mechanism have benefitted the citizens of the EU immensely in the last 60 years, we cannot sit still, but must constantly review the current legislation to meet the requirements of today.

The controversial issues of cross-border healthcare are just a few of the many examples of the dilemma that are rooted in the Member States' fear to give up (more pieces of) their national sovereignty as opposed to the Union's steady intention to develop the internal market and deepen integration. It seems clear that without further measures, the questions surrounding cross-border healthcare entitlements will remain unanswered for a long time. I firmly believe that the European institutions and the Member States must join forces and work towards a more integrated, solidarity-based, socially sensitive European Union, providing equal rights and opportunities for all. Hopefully, we do not need to wait another 60 years to see this happen.

(41) The list of ERNs can be found here: https://ec.europa.eu/health/ern/networks_en (date of access: 12 June 2019).

(42) https://ec.europa.eu/health/sites/health/files/ern/docs/2017_brochure_en.pdf (date of access: 12 June 2019).

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