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# Europeanizing Healthcare: Cross-border Patient Mobility and Its Consequences for the German and Danish Healthcare Systems

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By Thomas Kostera

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## Abstract

Member States have been trying to shield their welfare systems from European integration. Yet, as the recent European Court of Justice's ruling on the Watts case has shown, Member States' healthcare systems have to comply with the fundamental principles of the European Single Market. The obstacles to undergo non-emergency medical treatment in other Member States have been significantly reduced for European citizens. This paper analyzes how Member States' healthcare systems have been affected by the development of European cross-border patient mobility using the concept of Europeanization. Drawing on Historical Institutionalism, it is argued that a process of institutional adaptation will occur in which the pace and the scale of the transposition of European legislation to domestic legislation depend on its fit with existing domestic institutions. Depending on their institutional set-ups, Germany's social insurance system will show a lower degree of institutional misfit than Denmark's national health system. Therefore Germany will try to upload different policy preferences to the European level than Denmark in order to lower the costs of their institutional adaptation to European obligations. It turns out that national health systems show a higher institutional misfit than social insurance systems: the costs of institutional adaptation are much higher for Denmark than for Germany. Hence, Denmark has been slower in transposing European legislation into national law than Germany. Conversely, Germany tries to upload different policy preferences to the European level than Denmark in order to lower the costs of their institutional adaptation to European obligations. The political preferences and interests that the Member States are trying to upload differ as much as their adaptive pressures. A restrictive interpretation of the Court's jurisprudence is of much more importance to Denmark than to Germany, as Germany just tries to avoid further adaptive pressures.

The paper is based on the Master's thesis *Unwelcome Europeanization – the development of European cross-border patient mobility*, College of Europe, Department of European Political and Administrative Studies Bruges, 2007, available at <http://www.efpia.org/content/Default.asp?PageID=543>. Please consult this document for an elaboration of the analysis below.

*“The health of the people is really the foundation upon which  
all their happiness and all their powers as a state depend.”  
Benjamin Disraeli*

The virus of cross-border patient mobility has infected the sovereignty of the European Union’s Member States, and healthcare has become an issue on Brussels’ political agenda. The European Commission has evaluated recently different stakeholders’ responses to the latest consultation procedure on Community action in the field of healthcare. Regardless of Member States’ interests, cross-border patient mobility has thwarted their efforts to keep the organization of healthcare services an exclusively national policy-domain: European citizens turned the simple virus into a heavy flu as they sought reimbursement from their national health insurances for treatment undergone in another Member State. As the latter refused the reimbursement, patients took legal action. As a consequence the European Court of Justice reduced Member States’ room of maneuver in organizing their healthcare services autonomously in a series of several landmark decisions. This paper analyzes how Member States’ healthcare systems have been affected by the development of European cross-border patient mobility using the concept of Europeanization. The paper is structured in four parts: the first part outlines the different institutional set-ups of national healthcare systems and EU competences in health policy. The second part deals with the phenomenon of cross-border patient mobility, the subsequent rulings, as well as with the problems that arise from these rulings for Member States. The third part on Europeanization analyzes the domestic impact of cross-border patient mobility on Germany and Denmark. Drawing on Historical Institutionalism, it is argued that a process of institutional adaptation will occur. Due to their institutional set-ups, Germany’s social insurance system will show a lower degree of institutional misfit than Denmark’s national health system. Therefore Germany has tried to upload

different policy preferences to the European level than Denmark in order to lower the costs of their institutional adaptation to European obligations. The conclusion forms the final part of the paper.

## **1. National Healthcare Systems and EU Competences in Health Policy**

Health policy as a part of the state's social policy is a core element of national welfare regimes<sup>1</sup>. The citizens' health has always been an important concern of national governments as health policies are considered to be an instrument of shaping a country's society: A healthy population increases the economic productivity and tends to be more socially cohesive. Furthermore an extensive public healthcare service enhances the citizen's confidence in the state. Unsurprisingly, citizens expect national governments to protect them from diseases and to guarantee a high standard of healthcare<sup>2</sup>.

The institutional features of the national healthcare systems affect the welfare regime as a whole. The most important fact is that healthcare is provided and financed in different ways. Whereas liberal and social-democratic welfare regimes have created *national health systems* that are funded by taxes, the conservative-corporatist welfare states have created *social insurance systems*, funded by payroll contributions:

“Tax-based finance tends to imply universal coverage, the public ownership of health care facilities and a salaried medical profession. Insurance contributions, meanwhile, are paid into funds organized by occupation or region. Funds contract with what is usually a greater mixture of public and private providers of inpatient care, and with independent physicians paid according to the service they provide.”<sup>3</sup>

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<sup>1</sup> Esping-Andersen distinguishes three different welfare regimes that exist in Europe: A liberal one as found in Anglo-Saxon states, a social-democratic one as found in Scandinavia and a conservative-corporatist one as found in many countries of continental Europe. Cf. Gøsta Esping-Andersen, *The Three Worlds of Welfare Capitalism*, Cambridge: Polity Press, 1990

<sup>2</sup> Monika Steffen, Wolfram Lamping and Juhani Lehto, “Introduction: The Europeanization of Health Policies” in Monika Steffen (ed.), *Health Governance in Europe: Issues, Challenges and Theories*, Oxon: Routledge, 2005, p. 1

<sup>3</sup> Richard Freeman, *The Politics of Health in Europe*, Manchester and New York: Manchester University Press, 2000, p. 5f

Countries such as Germany, France, Austria and the Benelux countries have social insurance systems. Denmark, Sweden, the United Kingdom, Greece and Italy provide national health services<sup>4</sup>. The countries selected for this paper therefore cover the two types of healthcare systems that exist in Europe.

The difference between tax-funded systems and those funded by contributions becomes even clearer when looking at the reforms that these systems adopted after the economic recession of the 1970s and 1980s. In order to lower the costs, national healthcare systems introduced measures such as reducing the number of medical treatments covered by the system, abolishing fee-for-service payments, and using physicians as gatekeepers who have to decide if a patient's treatment with a specialist is necessary or not. With regard to hospital treatments, waiting lists have been established to lower the costs of inpatient care. Looking at the comprehensive control that is exercised by the state over providers such as physicians and hospitals, which have to regulate the access to treatment, we can also speak of *managed care*<sup>5</sup>. Social insurance systems, on the other hand, have limited the possibility of patients to choose freely their physicians for treatment and introduced or increased cost sharing between sickness funds and patients with regard to pharmaceuticals and inpatient care<sup>6</sup>.

Given these reforms, and approached from a rather economic perspective, it seems that health policy is more a technical problem than a political one: the different ways of organizing and providing health services just seem to be related to the costs and the efficiency that such a health system creates. Yet, as Freeman points out, "the health system is coterminous with public (state) intervention: health policy problems

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<sup>4</sup> Ibid., p. 6

<sup>5</sup> François-Xavier Merrien, Raphaël Parchet and Antoine Kernén, *L'État social: Une perspective internationale*, Paris: Armand Colin, 2005, p. 310

<sup>6</sup> Ibid., p. 318

are problems of and for the state”<sup>7</sup>. This is the case as health systems do not only regulate the access to healthcare and its financing, but they also regulate the interests of the pharmaceutical industry, the development of medical technologies, and regulate at the same time struggles between different interest groups such as physicians’ associations, patients’ associations and the pharmaceutical industry’s associations<sup>8</sup>. Keeping in mind the important role that the state plays in regulating healthcare, it is not surprising that EU Member States consider healthcare policies as a genuinely national competence:

“There is no such thing as a European healthcare system, and as long as decisions on financing, organization and service delivery are taken at a national level, there is little chance of one existing”<sup>9</sup>.

Yet, whereas healthcare, which is defined as the treatment of illnesses essentially, stays a national competence, Member States have ceded competences to the EU in public health, which means the management of collective health risks<sup>10</sup>. According to article 3 TEC, the European Community shall contribute to a “high level of health protection”<sup>11</sup>. This aim and the relevant competences are specified by article 152 TEC. Even though the EC has been developing different activities in health policy since the 1970s, article 152 was only introduced in the Treaty of Maastricht<sup>12</sup>. Before the introduction of article 152 TEC, it was mostly secondary legislation that regulated issues relating to health policy on the basis of other Treaty articles. Their aim was to facilitate the free movement of workers throughout the Community and

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<sup>7</sup> Richard Freeman, op. cit. p. 8

<sup>8</sup> Ibid.

<sup>9</sup> Monika Steffen, Wolfram Lamping and Juhani Lehto, op. cit. p. 3

<sup>10</sup> For the definitions of healthcare and public health, Ibid., p. 6

<sup>11</sup> Consolidated version of the *Treaty Establishing the European Community*, [http://europa.eu.int/eur-lex/en/treaties/dat/EC\\_consol.html](http://europa.eu.int/eur-lex/en/treaties/dat/EC_consol.html), 23 April 2007

<sup>12</sup> Tamara K. Hervey and Jean V. McHale, *Health Law and the European Union*, Cambridge: Cambridge University Press, 2004, p. 73



therefore tried to ensure that a worker moving to another Member State would receive healthcare benefits<sup>13</sup>.

The main legislation relevant to the topic is Regulation 1408/71 EC, adopted under article 42 TEC. The Regulation, based on the principle of non-discrimination on the ground of nationality, ensures that EU citizens staying in another Member State have access to the other Member State's healthcare systems: firstly workers, students and tourists are covered in cases of *emergency medical treatment*, using the so called E111 form to get medical treatment. This form has since been replaced by the European Health Insurance Card (EHIC). Secondly the Regulation permitted medical treatment in another Member State if the national healthcare system *could not provide* a specific treatment. Yet, in order to be treated abroad, *prior authorization* of the national health authorities or the relevant sickness funds is necessary (E112 form)<sup>14</sup>. In 1981, the Regulation was amended in order to prevent patients from claiming financial support from their national health insurance for a treatment in another Member State that is not *covered* at home. Furthermore the amendment wanted to make sure that patients could not circumvent waiting lists by claiming to have a 'right to be treated' in another Member State. Hence patients did not have the *right* to receive a treatment that was not covered by the health insurance of the home Member State<sup>15</sup>.

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<sup>13</sup> Vassilis G. Hatzopoulos, "Do the Rules on Internal Market Affect National Health Care Systems?" in Martin McKee, Elias Mossialos and Rita Baeten, (eds.), *The Impact of EU Law on Health Care Systems*, Brussels, P.I.E Peter Lang, 2002, p. 124

<sup>14</sup> Tamara K. Hervey and Jean V. McHale, op. cit. p. 115

<sup>15</sup> Ibid., p. 116

The introduction of article 152 TEC, finally, created a legal basis concerning health policy. The article set a limit to any creeping EU competence in the field of health policy that might occur due to the legislation already adopted under other treaty articles<sup>16</sup>. It limits the EU's activities concerning health policy to coordination between the Member States, who in turn are obliged to coordinate public health policies with the Commission. Yet, the article only covers illnesses and disease prevention, which led the Commission to set up action plans for health. The aims of article 152 TEC are "thus essentially concerned with public health, in the sense of health protection and promotion of good health carried out on a collective basis, rather than individual-health related entitlements"<sup>17</sup>. Hence, Member States made sure in paragraph 5 of art. 152 that "Community action in the field of public health shall fully respect the responsibilities of the Member States for the organization and delivery of health services and medical care"<sup>18</sup>. On the basis of the different provisions regarding public health on one side and healthcare on the other side, one could argue that EU health policy is a "divided policy field"<sup>19</sup>. However, with regard to the complexity of national health systems where public health and healthcare intertwine, it seems questionable if this legal dichotomy established by article 152 TEC reflects reality<sup>20</sup>. It remains even more a question when looking at the phenomenon of cross-border patient-mobility that entailed several European Court of Justice (ECJ) rulings to the disadvantage of Member States' intentions stipulated in the article.

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<sup>16</sup> Tamara K. Hervey and Jean V. McHale, op. cit. p. 74

<sup>17</sup> Cf. Ibid.

<sup>18</sup> Consolidated version of the *Treaty Establishing the European Community*, op. cit.

<sup>19</sup> Monika Steffen, Wolfram Lamping and Juhani Lehto, op. cit. p. 5

<sup>20</sup> Tamara K. Hervey and Jean V. McHale, op. cit., p. 80

## 2. Cross-Border Patient Mobility and the European Court of Justice Rulings

Cross-border patient mobility can be defined as any “movement which involves patients going from one country to another”<sup>21</sup>. Patients can have different incentives for getting *non-emergency treatment* in other Member States. Even if the average patient still likes to be treated locally in a familiar environment, there are several factors that motivate patients to leave their country and seek medical treatment in another EU Member State. These factors include the availability of certain medical treatments, high costs of medical treatments, and a low perceived quality of the healthcare services in the home country. Especially the first factor is important for cross-border patient mobility: Firstly, it might be the case that a special kind of treatment exists in a Member State but cannot be available within a given time limit. This relates, for example, to waiting lists in national health systems for inpatient care. Secondly, in some Member States a special medical treatment requiring hi-tech equipment might not exist at all, and thus patients are usually allowed to go abroad for treatment<sup>22</sup>. Medical services in border regions constitute another important factor: in cases where a patient shares the same linguistic or cultural background with the people living in the other Member State, the individual might decide to get a treatment there instead of traveling inside the home country.<sup>23</sup>

Taking all these factors into account, the number of people seeking treatment abroad still seems to be rather low. The estimated figure for patients crossing borders is about 1% of all patients treated by national healthcare systems. Yet, in border-regions this percentage may rise to about 7 to 9% of patients, and there seems to be

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<sup>21</sup> Irene A. Glinos and Rita Baeten, *A Literature Review of Cross-Border Patient Mobility in the European Union*, Brussels: Europe for Patients Project, 2006, p. 18

<sup>22</sup> *Ibid.*, p. 6

<sup>23</sup> *Ibid.*

potential for this number to grow due to the aforementioned factors<sup>24</sup>. Some of these patients use a commercial middleman who arranges treatments in other Member States, usually if a treatment at home is not covered or for which waiting lists exist<sup>25</sup>. Some of these patients that have crossed the border for treatment for different reasons have claimed reimbursement for their medical treatments by national sickness funds or by the national health service. After having been refused to receive reimbursement, some of these patients went as far as to take legal action. The ECJ subsequently delivered several rulings that have put the “multi-faceted phenomenon”<sup>26</sup> of cross-border patient mobility on the European political agenda and, as a result, have worried Member State governments.

The ECJ rulings on cross-border patient mobility and the delivery of healthcare services left Member States the prerogative to organize their healthcare services and to determine the scope and the content of entitlement to inpatient and a physician’s care. However, the ECJ ruled that healthcare services are no exception to the Treaty regulations on services in general. The national provision of healthcare can only restrict the free movement of patients if these restrictions are objective, non-discriminatory and subjected to possible judicial review:

The ECJ ruled in the Kohll/ Decker case that if a healthcare system allows seeing any physician in the home country, this would now mean that patients could have the permission to see any physician in the EU<sup>27</sup>. Furthermore, treatment by a physician in another Member State would not be subject to prior authorization

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<sup>24</sup> Figures mentioned in a speech given by Robert Madelin, European Commission, Director General of DG SANCO, EHMA conference on health services, Brussels, 30 March 2007

<sup>25</sup> Irene A. Glinos and Rita Baeten, op. cit., p.6

<sup>26</sup> Ibid., p. 5

<sup>27</sup> Cf. European Court of Justice, Preliminary Ruling, *Raymond Kohll vs. Union des Caisses de Maladie*, case C-158/96, 28 April 1998, point 55

anymore, though only the amount that would have been reimbursed at home will be granted for treatment abroad as ruled in the Müller-Fauré / Van Riet cases<sup>28</sup>.

Besides the already existing right for EU patients to receive emergency treatment and authorized planned hospital treatment in another Member State, the ECJ ruled in the Geraets-Smits/Peerbooms cases that patients can obtain an authorization and reimbursement in another member state if a waiting list for an operation leads to an “undue delay”, without however defining exactly what this term implies in practice<sup>29</sup>. The ECJ’s legal (not medical) experts also intervened with the same ruling in medical standard-setting. As the national medical opinion will not be accepted anymore for the decision on prior authorization on hospital treatment abroad, the ECJ translated medical standards into “Euro-Speak”<sup>30</sup> by demanding that national authorities would have to take international medical standards into consideration. Finally, in the last ruling of 2006 on the Watts case, the ECJ decided that the prior rulings would also apply to national health systems and not only to social insurance systems<sup>31</sup>. Inpatient care remains, however, subject to prior authorization. This has to depend on objective criteria, and a refusal cannot merely be based on the existence of waiting lists in the national healthcare system. Member States’ room of maneuver to organize their healthcare systems thus has been affected and the free movement of patients has been facilitated<sup>32</sup>. This leads to a fundamental problem for member states:

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<sup>28</sup> European Court of Justice, Preliminary Ruling, *V.G. Müller-Fauré vs. Onderlinge Waarborgmaatschappij OZ Zorgverzekeringen UA, and E.E.M. van Riet vs. Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen*, case C-385/99, 13 May 2003

<sup>29</sup> European Court of Justice, Preliminary Ruling, *B.S.M. Geraets-Smits vs. Stichting Ziekenfonds VGZ and H.T.M. Peerbooms vs. Stichting CZ Groep Zorgverzekeringen*, case C-157/99, 12 July 2001, point 108

<sup>30</sup> Cf. L. Scott Greer, “Uninvited Europeanization: Neofunctionalism and the EU in Health Policy”, *Journal of European Public Policy*, Vol. 13:1, January 2006, p. 142

<sup>31</sup> European Court of Justice, Primary Ruling; *The Queen, on the application of Yvonne Watts vs. Bedford Primary Care Trust, Secretary of State for Health*, case C-372/04, 16 May 2006

<sup>32</sup> Tamara K. Hervey and Jean V. McHale, op. cit. p. 133f

“By facilitating the free movement of patients, the ECJ subjects the national/insurance health systems to indirect competition amongst them, hence pushing them to rationalize and promote efficiency. At a time where all the systems of social insurance in Europe go through a profound crisis – for economic, demographic, political and other reasons – this choice of the ECJ may prove particularly burdensome, at least in the short-term”<sup>33</sup>.

Given the above development EU Member States did not have much of a choice than asking the Commission to explore what problems arise from the rulings and which actions could possibly be taken to solve them. Furthermore, the Commission is ready to take action against Member States that do not comply with the Court’s rulings: in 2007, there were about 20 pending infringement procedures against 10 Member States according to article 226 TEC with regard to cross-border patient mobility<sup>34</sup>.

The possible competition of healthcare systems implies wider issues such as a EU wide medical standard setting, in which the Commission has taken account of Member States’ reticence to cede sovereignty in its 2007 consultation for a directive on health services<sup>35</sup>. It suggests measures such as shaping a framework for centers of reference for rare diseases, and it wants to apply the Open Method of Coordination (OMC) in order to exchange views on health innovation and the assessment of health systems. The OMC seems to be an adequate proposal, as regulatory measures by the Commission would be rejected by national governments. Member States can participate voluntarily in the OMC, but it also has – to stick to medical terms – some ‘side effects’: they would have to evaluate their healthcare systems, and their respective strengths and weaknesses could become apparent. The Commission also avoids any reference to ‘harmonization’, and the OMC thus usually satisfies all actors

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<sup>33</sup> Vassilis Hatzopoulos, “Current Problems of Social Europe,” *Research Papers in Law*, Bruges: College of Europe, 2007, retrieved from [www.coleurop.be](http://www.coleurop.be), 21 January 2008, p. 13

<sup>34</sup> Presentation given by Geraldine Fages, European Commission, DG Internal Market and Services, EHMA conference on health services, Brussels, 30 March 2007

<sup>35</sup> Commission of the European Communities, Communication: *Consultation regarding Community action on health services*, SEC(2006) 1195/4, Brussels, 26 September 2006, p. 5f

involved in the political process when sensitive issues such as healthcare are at stake. Nevertheless Lamping claims that, “the OMC could be both an effective functional equivalent for the lack of EU competences in social policy core areas, and an effective catalyst for the smooth institutional harmonization of the harder cores of national social security systems”<sup>36</sup>. Given this potential for domestic changes due to the ECJ’s rulings, the next part of the paper will analyze the domestic impact of cross-border patient mobility by using the concept of Europeanization.

### **3. Europeanization and Healthcare Systems**

Since the middle of the 1990s, the concept of Europeanization has become popular amongst political scientists in order to assess the EU’s impact on Member States’ policies, politics and polities. The concept is used to analyze the impact’s scope as well as the final outcomes<sup>37</sup>. Concentrating on the EU’s impact on Member States therefore means trying to explain domestic processes and outcomes due to European integration rather than trying to categorize the EU itself.<sup>38</sup> Most of the early studies on Europeanization expected to find a convergence between Member States that would lead to an enhanced decentralization, cooperation or even centralization among domestic political actors. Yet, empirical studies could not confirm that a general convergence occurred between Member States<sup>39</sup>.

During the last years scholars have developed different approaches to assess the EU’s domestic impact using a variety of analytical tools stemming mostly from

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<sup>36</sup> Wolfram Lamping, *op. cit.*, p. 27

<sup>37</sup> Tanja A. Börzel and Thomas Risse, “Europeanization: The Domestic Impact of European Union Politics” in Jørgensen Knud, Mark A. Pollack and Ben Rosamond (eds.), *Handbook of European Union Politics*, London: Sage Publications Ltd, 2006, p. 483f

<sup>38</sup> Kevin Featherstone and Claudio M. Radaelli (eds.), *The Politics of Europeanization* Oxford: Oxford University Press, 2003, p. 4

<sup>39</sup> Tanja A. Börzel, “Europeanization: How the EU Interacts with Its Member States” in Simon Bulmer and Christian Lesquesne (eds.), *The Member States of the European Union*, Oxford: Oxford University Press, 2005, p. 48

comparative politics. Two of the most prominent approaches analyze processes of *institutional adaptation* and the *adaptation of policies and policy processes*. The first of these both approaches draws on historical institutionalism and analyzes how national administrative institutions adapt to demands and obligations that EU membership implies<sup>40</sup>. But administrative institutions themselves might not only adapt to obligations, they also could shape political interests:

“Historical institutionalism lends itself to studies in which domestic (and/or EU) institutions haven an intervening effect on actor preferences and interests in the short term, and a sufficiently stronger impact over the longer term, to establish distinct paths of development in policies and institutions”<sup>41</sup>.

Studies of the latter category of Europeanization analyze the EU’s impact on national policies, such as the possible restrictions that European law can entail for national policies. The following analysis will aim at assessing the EU’s impact on national healthcare services being part of welfare systems that are “built on strong historical and institutional legacies”<sup>42</sup>. The focus of the analysis will be on the *institutional adaptation* that can occur in Member States due to the described process of unintended integration. Several alternative definitions of Europeanization have been suggested, depending on the focus of the different research categories. Consequentially, the definition that will be employed here defines Europeanization as “a process of change in national institutional and policy practices that can be attributed to European integration,”<sup>43</sup> which has been developed by Hix and Goetz.

Referring to this *top-down dimension* of EU-Member State relations, previous research has identified the causal mechanisms that can determine the EU’s domestic impact. The impact’s character and strength can vary across the different countries

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<sup>40</sup> Kevin Featherstone and Claudio M. Radaelli, op. cit., p. 7

<sup>41</sup> Cf. Ibid.

<sup>42</sup> Cf. Dorte Sindbjerg Martinsen, “The Europeanization of Welfare – The Domestic Impact of Intra-European Social Security”, *Journal of Common Market Studies*, Vol. 43, No. 5, 2005, p. 1031

<sup>43</sup> Cf. Hix and Goetz cited in Ibid., p. 1033



and policies. Such a variation is best to be explained by the ‘goodness of fit’ of national institutions and policies with European rules, as well as by intervening variables or ‘mediating factors’ that filter the impact on Member States. If European policies or institutions differ from the domestic ones (‘misfit’), Member States will feel a need for change. There are two different types of misfits that can entail national changes: the first one is the so called ‘policy misfit’ designating a situation in which national policies are incongruent with European law<sup>44</sup>. As regards the impacts on national healthcare systems the second type, namely ‘institutional misfit’, is likely to occur as Member States have developed a distinct institutional set-up of national healthcare services according to their respective welfare system. Generally speaking, European law can challenge in this case national procedures and rules as well as the collective understandings that are attached to them in Member States. It is not only European law that can cause an institutional misfit. Also soft forms of integration such as the OMC can represent a challenge to national institutions<sup>45</sup>. However, both differ in their coerciveness,

“and thus whether national actors are obliged to implement them, the ability to sanction non-compliance, as well as the extent to which they leave space for national actors to translate their meaning. The *coerciveness* of European rules and norms provides us with a sense of the impact and a formal picture how constrained Member States are”<sup>46</sup>.

The coerciveness of European institutionalized rules regarding healthcare services provided by the national systems is high due to two factors: The first one consists of the ECJ’s several binding rulings on cross-border patient mobility as well as of the ECJ’s interpretation of Regulation 1408/71 EC. The second factor is the Commission’s intention to initiate infringement procedures against Member States if they do not comply with European law.

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<sup>44</sup> Tanja A. Börzel, *op. cit.*, p. 50

<sup>45</sup> *Ibid.*

<sup>46</sup> Cf. Dorte Sindbjerg Martinsen, *op. cit.*, p. 1034

Yet, the *adaptive pressure* that Member States will perceive is “not decided by supranational institutionalization alone; rather, it is equally determined by how that process relates to established national institutions”<sup>47</sup>. Thus, the organizational structure of the two existing types of national healthcare systems is a mediating factor. We can therefore expect that *social insurance systems* will show a different degree of institutional misfit than *national health systems* and therefore cause also different adaptive pressures on Member States.

Due to these differing adaptive pressures, the consequential outcomes of institutional adaptations can vary considerably. The Europeanization literature has distinguished five broad categories of possible outcomes<sup>48</sup>:

(1) Institutional inertia designates a Member State’s resistance against institutional changes and reaffirmation of the existing institutional set-ups. In these cases the Commission usually opens infringement procedures in order to increase the adaptive pressure<sup>49</sup>.

(2) An even more ‘acute’ outcome of resistance is retrenchment. This means a case of national non-compliance by reinforcing the national institutional set-up. As a consequence the already existing misfit increases<sup>50</sup>.

(3) In the case of absorption the European rules are incorporated by Member States into their domestic institutions and policies without modifying the existing structures. Thus, the degree of change will be low<sup>51</sup>.

(4) Member State can also accommodate existing institutions and policies to European rules without changing the core features of the system. For example new

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<sup>47</sup> Cf. Ibid, p. 1035

<sup>48</sup> Tanja A. Börzel, op. cit., p. 58

<sup>49</sup> Ibid.

<sup>50</sup> Ibid.

<sup>51</sup> Ibid., p. 59

institutions or policies are created and simply ‘annexed’. The degree of change is therefore modest<sup>52</sup>.

(5) The most substantial change is transformation. In this case Member States replace the previously existing institutions and policies by new ones. Usually the core features of the system will be fundamentally changed<sup>53</sup>.

Given the different adaptive pressures and the variable consequential outcomes of Europeanization it is quite unlikely that Member States with different healthcare systems will face convergence, at least as far as their core features are concerned. As Börzel states, “we should expect at best some ‘clustered convergence’ among Member States facing similar pressures for adaptation”<sup>54</sup>.

However, the outcomes of Europeanization on national healthcare systems will not depend only on already existing European rules: “Member States are not merely passive receivers of European demands for domestic change”<sup>55</sup>. As a function of the experienced coerciveness of European rules and their perceived institutional misfit, Member States in return may try to find solutions which affect the *bottom-up dimension* between them and the EU: those with a perceived strong misfit will try to influence or shape European policies and institutions in such a way that the domestic misfit is reduced<sup>56</sup>. This attempt to ‘up-load’ their national preferences to the European level can reduce the need and the costs of institutional adaptation.

In order to analyze the impact of the development that has taken place in healthcare policy Germany carrying a social insurance system has been selected. It will be juxtaposed to Denmark’s national health system. Both systems show distinct *institutional features*: the German healthcare system is governed more or less

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<sup>52</sup> Ibid.

<sup>53</sup> Ibid.

<sup>54</sup> Cf. Ibid., p. 61

<sup>55</sup> Cf. Ibid., p. 62

<sup>56</sup> Tanja A. Börzel, op. cit., p. 51

independently from the federal government through sickness funds and physician's associations. Therefore healthcare is financed by private institutions, and providers (such as hospitals) are either public or private. Yet, they work in a highly regulated framework of legal provisions<sup>57</sup>.

The compulsory insurance system consists of a vast number of sickness funds. These sickness funds can be divided in two large categories: regular funds and substitute funds. Both kinds of funds are subject to social insurance legislation, as laid down in the Fifth German Social Code (*fünftes Sozialgesetzbuch* or SGB V). Regular sickness funds usually include the public sickness funds of companies, regional sickness funds, and those of special occupational groups. Substitute funds are usually organized nationwide and mainly insure white-collar workers. Together, regular and substitute funds insure about 88% of the German population. The remaining citizens are usually insured with private sickness funds who are mainly state officials or high earners.

The benefits of German sickness funds cover physician and specialist treatment as well as inpatient care and income maintenance for ill workers. Patients are also free to choose their physician, although they have to pay a fee of 10€ if they are not referred to a specialist by their General Practitioner. Physicians who are contracted with the sickness funds are paid on a fee-for-service system but may not exceed a global budget assigned to them (benefits-in-kind system). 51% of the hospitals are owned by the German states (*Länder*) or by local authorities (*Kommunen*) whereas non-profit organizations run about 35% of hospitals. The remainders are run as business. Hospital physicians are mainly salaried employees<sup>58</sup>.

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<sup>57</sup> Richard Freeman, op. cit. p. 53

<sup>58</sup> Ibid.

In contrast to Germany, Denmark carries a national health system. The system is mainly financed by taxes and most of the services provided are run by the state. Physicians and nurses are civil servants receiving fixed salaries. Hospitals are run and owned by the counties who also regulate physician's activities. They have wide-ranging powers in organizing the supply of healthcare services according to the counties' needs. The Ministry of the Interior and Health sets the broad guidelines for the healthcare system.

General Practitioners have the function of gatekeepers by deciding if medical treatment of a specialist is necessary (so called "family doctor"). They also decide if a patient has to be referred to a hospital, except for cases where emergency treatment is necessary. In order to plan the development of capacities, hospitals operate waiting lists. Denmark has two categories of healthcare insurance: People insured under Group 1, which covers about 97 percent of the population, are obliged to register with a General Practitioner, but are fully reimbursed for medical treatment. People insured under Group 2 can choose freely their General Practitioner, but costs of medical treatment are only reimbursed partially<sup>59</sup>.

Given these institutional differences, we can expect that European law will challenge national procedures and rules as well as the collective understandings that are attached to the German and Danish healthcare system in different ways, as Sindbjerg Martinsen states:

"Free movement and the right to cross-border social security are first and foremost compatible with an individualistic insurance principle, where there is a direct relationship between social entitlements and contributions. On the other hand, the European imperatives contradict the principles of the Danish welfare model, since it grants universal social protection on the basis of residence, with no contributory demands"<sup>60</sup>.

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<sup>59</sup> Danish Ministry of the Interior and Health, *Health Care in Denmark*, Copenhagen: 2002, p. 9-29

<sup>60</sup> Cf. Dorte Sindbjerg Martinsen, *op. cit.*, p. 1033

As a consequence of the above reasoning on Europeanization, the following hypothesis will be tested:

*The integration process of healthcare policy will result in a subsequent Europeanization of national healthcare services. Germany's social insurance system will show a lower degree of institutional misfit than Denmark's national health system. Therefore Germany will try to upload different policy preferences to the European level than Denmark.*

Several different questions arise from this hypothesis: how does cross-border patient mobility affect these countries? Which institutional features are affected? What are their reactions and what are their resulting political preferences in the political process at the European level? Therefore the following part will have a corresponding structure to these questions.

### **3.1 Germany: A Social Insurance System**

#### *Cross-border patient mobility*

Data on cross-border patient mobility is not coherent and there is no standard for measuring patient's movements throughout the EU. Most information is fragmented, too. Therefore the examples that will follow are taken from interviews and case studies.

In Germany most patients going abroad for medical treatment live in border regions. Another group consists of tourists, workers and pensioners. The latter often seek treatment in Southern European countries such as Spain, where they reside for at least some months per year. Patients who intentionally seek treatment often go abroad to Poland or Hungary for dental treatment<sup>61</sup>. An example for this movement of patients is the Polish city Szczecin near the German border. German patients usually seek dental treatment there, as it is about 50% cheaper than back home. The Polish

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<sup>61</sup> Interview with Irene Wittman-Stahl, Senior Health Policy Advisor, German Permanent Representation to the EU, Brussels, 6 March 2007

clinics offer package arrangements for foreign patients, including accommodation and travel. These clinics are especially important for Germans, as dental prosthetics are not paid anymore by German sickness funds. Even before the healthcare reform of 2004, when dental prosthetics were still paid, patients had to bear a co-payment of about 50%<sup>62</sup>. Apart from this case study concerning dental treatment, German authorities could not identify large numbers of patients seeking treatment abroad:

“According to the data available so far, the possibility of cross-border healthcare has not led to a sizable take-up of these services by the insured in Germany. The amounts spent by statutory health insurance funds on outpatient and inpatient services abroad are clearly below 0.5% whereby this number does not even distinguish between EU countries and non-EU countries”<sup>63</sup>.

As far as patients in border regions are concerned, they mostly profit from cross-border regional cooperation in the Euregios. Some local hospitals cooperate with their counterparts in other Member States, and some regions also cooperate in the mutual supply of blood products. Furthermore, some regions have initiated projects on specific diseases<sup>64</sup>.

According to the German government the number of European patients coming to Germany for inpatient care is negligible, too. However, some healthcare providers seem to be interested in offering medical treatment to non-nationals. An example of this willingness was a temporary agreement between Norway and the State of Schleswig-Holstein to treat Norwegian patients in local hospitals. But a general trend of increasing numbers of patients coming to Germany is not identifiable. Despite this fact, some German states see the intended creation of medical centers of reference for rare diseases as a chance to attract foreign patients and to use their

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<sup>62</sup> Irene A. Glinos, Rita Baeten, op.cit., p. 69f

<sup>63</sup> German Federal Government in Co-operation with the Länder, *Answer on the Commission Communication on Community Action on Health Services*, Brussels, 31 January 2007, p. 2

<sup>64</sup> Ibid., p. 3

hospitals to full capacity<sup>65</sup>. Hospitals themselves have also been active in trying to attract non-national patients: a group of about 110 German hospitals has founded the ‘GerMedic’ group that tries to promote German inpatient care abroad<sup>66</sup>.

#### *Institutional adaptations*

In 2004, Germany codified the provisions of the ECJ’s rulings in its SGB V. Therefore citizens insured by a German sickness fund can consume healthcare services in other Member States without referring specifically to the Court’s jurisdiction. Sickness funds have been allowed to conclude contracts with healthcare providers in other EU Member States. Besides a growing use of these contracts with non-national providers, German border regions have been active, too:

“In the border regions, numerous framework agreements have already been concluded in order to avoid, *inter alia*, problems with the billing of inpatient services. Co-operation contracts concluded locally by health insurance funds with foreign service providers that are tailored to the specific demand and situation in a certain region, are usually a suitable means of allowing people living near the border freedom of choice without jeopardizing the steering capacity and affordability of the national health care system”<sup>67</sup>.

Furthermore, a framework agreement has been concluded with France, which became effective in the spring of 2007. This framework agreement comprises not only cross-border cooperation for medical treatment but also emergency medical services<sup>68</sup>. However, national courts also have played an important role for adapting Germany’s healthcare system to European obligations: in the period from 1972 to 2002, an average of about 5 cases per year was referred by national courts to the ECJ for infringements of Regulation 1408/71 EC by German sickness funds<sup>69</sup>.

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<sup>65</sup> Interview with Irene Wittman-Stahl, Senior Health Policy Advisor, German Permanent Representation to the EU, Brussels, 6 March 2007

<sup>66</sup> Irene A. Glinos, Rita Baeten, *op.cit.*, p. 61

<sup>67</sup> German Federal Government in Co-operation with the Länder, *op. cit.*, p. 3

<sup>68</sup> *Ibid.*

<sup>69</sup> Dorte Sindbjerg Martinsen, *op. cit.*, p. 1046



### *Political preferences*

For Germany, as for all Member States, safeguarding its sovereignty and national competence for the organization of its healthcare service is of utmost importance. Therefore Germany has a positive attitude towards legal instruments such as Regulations, as far as they establish legal certainty for patients but also for Member States. The German government would like to clarify the definition of health services in a way that ensures that Member States' competences regarding healthcare services are not impaired. Even though the German healthcare system does not operate waiting lists for hospital treatment, a definition of "undue delay" should be provided by a European legal act, too. As far as the control of the quality of medical treatments abroad is concerned, it should remain with the respective national healthcare system<sup>70</sup>. Interestingly enough, Germany is also in favor of better information for patients, but with a certain number of limits:

"The insured must have easy access to information on the conditions under which they are entitled to receive treatment abroad. The information can be limited to only the conditions under which treatment abroad is covered. Information on which facility in which Member State can provide the necessary treatment, should the need arise, may not be demanded. It is up to the patients themselves to obtain this information with the assistance of their attending physician or the facilities in the Member State in which they are seeking treatment. No Member State can be expected to have information available on service providers in all other Member States"<sup>71</sup>.

This indicates that Germany wants to create legal certainty, but certainly does not want to encourage patients unnecessarily to go abroad. As far as the other issues related to cross-border patient mobility are concerned, Germany welcomes the suggested measures by the Commission such as the creation of a network that should ensure patient safety. In summary, Germany does not see that its supply of healthcare services could be compromised by the treatment of other EU nationals, but does not

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<sup>70</sup> German Federal Government in Co-operation with the Länder, op. cit., p. 4

<sup>71</sup> Cf. Ibid., p. 5

wish that European action regarding healthcare is expanded noticeably: “Measures that go beyond cross-border cooperation and task-sharing cooperation among care facilities including reciprocal supplementation of services provided by the care facilities are not necessary”<sup>72</sup>.

Germany has adapted institutionally to the obligations that the ECJ’s rulings implied: it has simply codified the ruling’s provisions in its *SGB V*. Furthermore Germany has allowed its sickness funds to contract with healthcare providers from other Member States. This indicates that Germany has incorporated European rules into its domestic institutions without modifying the existing structures of its healthcare system. Therefore the Europeanization of the German healthcare system is low as absorption is the result of the institutional adaptation. This low degree of adaptation therefore also implies a previously low institutional misfit of social insurance systems.

Given its political preferences for Community action on health services, Germany tries to avoid any further unwelcome Europeanization by pointing out that any Community action which touches upon Member States’ competences in healthcare policy would be unacceptable. Hence, Germany does not only try to avoid any further loss of sovereignty but also tries to avoid more costs of institutional adaptation by uploading its preferences. The German position also mentioned the beneficial effects of cross-border cooperation in Europe. Cross-border patient mobility therefore does not only imply problems but might bring about economic benefits.

As a German interviewee explained, Germany could react to the ECJ’s rulings in a quite relaxed way, as its healthcare system is comparatively well equipped. There

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<sup>72</sup> Cf. *Ibid.*, p. 6

seems to be no pressure for patients to go abroad, as for example no waiting lists for inpatient care exist. Moreover Germany would not be afraid of implementing the Court's jurisprudence as long as the national healthcare system's fundamental principles would be respected<sup>73</sup>. This seems to be a good summary of a Member State reaction with a social insurance system to the EU's domestic impact.

### **3.2 Denmark: A National Health Service**

#### *Cross-border patient mobility*

About 500 Danish patients per year seek medical treatment abroad, and citizens living in border regions might seek medical treatment in either Germany or Sweden<sup>74</sup>. Even though this number seems to be quite small, it is a significant increase in comparison to the 70 patients<sup>75</sup> that claimed reimbursement of medical treatment in another EU Member State in 2000. An example for a middleman organizing treatment for Danish patients abroad is PatientLink. The organization represents 8 German hospitals that have treated about 265 Danish patients between 2002 and 2005. The latter usually need hip- or knee replacements. Since 2003, Danish cancer patients have the possibility ask for authorization to go to another Member State for experimental treatment. This authorization is granted if all possible treatment options have been already tried. About 310 patients made use of this option<sup>76</sup>.

#### *Institutional adaptations*

Following the Kohll/Decker rulings of the Court, the Danish government created an interministerial working group that had to analyze the possible impacts on

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<sup>73</sup> Interview with Irene Wittman-Stahl, Senior Health Policy Advisor, German Permanent Representation to the EU, Brussels, 6 March 2007

<sup>74</sup> Telephone-interview with official from Danish Ministry of the Interior and Health, Copenhagen, 26 March 2007

<sup>75</sup> Commission of the European Communities, High Level Group on Health Services and Medical Care, *Summary paper on Common principles of Care, from the Mapping Exercise of the High level Group on Health Care Services 2006*, Brussels, 3 November 2006, p. 47

<sup>76</sup> Irene A. Glinos and Rita Baeten, op.cit., p. 61f

the Danish healthcare system. In 1998, Denmark's interpretation of the case law was that it only applied to Luxemburg, and that hospital treatment would not fall under the Treaty definitions of 'services' as hospital treatment was free of charge. The working group's final report followed that opinion as far as hospital treatment is concerned, but admitted that the principles of the internal market were under certain conditions applicable to healthcare services. A reform followed the report in 2000, which allowed patients to purchase certain medical services in other Member States with reimbursement from the Danish health insurance. Patients of Group 2 could seek dental, chiropractic and physiotherapeutic treatment abroad. In 2002, after the Geraets-Smits/Peerbooms ruling, which clarified that hospital care constitutes a service, Denmark was not obliged to change its legislation. Nonetheless it had an impact on the Danish government. In the same year, a reform stipulated the right of Danish patients to seek treatment elsewhere if a public hospital could not provide medical treatment within the delay of two months<sup>77</sup>. Between 2002 and 2003, about 26,000 patients used that scheme. Of these, 1, 3 percent were treated in other Member States, mainly Sweden and Germany. One year later, almost 42,000 patients benefited from the right to choose freely a hospital in Denmark or abroad. Thus, the Danish healthcare system does not meet certain needs of patients. However, most of the demand has been absorbed by the private sector<sup>78</sup>.

The subsequent Müller-Fauré/Van Riet and Watts judgments have clarified that the principles of the internal market apply to all healthcare systems. Therefore, the restrictive application of the Kohll/Decker judgment in Denmark since 2002 is not in line anymore with European legal obligations<sup>79</sup>. Concerning these last two rulings,

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<sup>77</sup> Dorte Sindbjerg Martinsen, op. cit., p. 1043

<sup>78</sup> Irene A. Glinos, Rita Baeten, op.cit., p. 60

<sup>79</sup> Dorte Sindbjerg Martinsen, op. cit., p. 1045

Denmark has not changed its legislation yet, as it wanted to wait for the adoption of a European Directive<sup>80</sup>.

### *Political preferences*

Denmark would want to stipulate in a future Directive that medical treatment abroad could be reimbursed only if the healthcare system of the home country allows for the reimbursement of the respective medical treatment. Furthermore, it should be made clear that medical treatment in another Member State would not undermine Member States' healthcare systems as far as they provide benefits-in-kind healthcare services<sup>81</sup>. Especially the distinction that the ECJ made between hospital and non-hospital care seems to be unsatisfactory to Denmark:

“In Denmark's opinion, this distinction is based on the fact that hospital care is particularly costly and requires planning [...] The requirement for prior approval is therefore accepted with regard to hospital care. However, non-hospital care can in some cases also be very costly and demanding, necessitating a high level of investment [...] The Danish government therefore feels that there can be objective reasons also in the case of non-hospital care which can justify a restriction on the free exchange of healthcare services – in other words it should be possible to impose prior authorization”<sup>82</sup>.

The criteria for prior authorization should also be quite detailed. According to Denmark, prerequisites for prior authorization for hospital treatment should be that the hospital in the other Member State has an agreement with the competent public authorities in the home Member State of the patient. Moreover this Member State should be able to require information on the medical treatments offered by the foreign healthcare providers as well as on the waiting time for medical treatment<sup>83</sup>.

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<sup>80</sup> Telephone interview with official from Danish Ministry of the Interior and Health, Copenhagen, 26 March 2007

<sup>81</sup> Danish Permanent Representation, *Reply to the Commission's "Consultation regarding Community action on health services"*, Brussels, 12 February 2007, p. 2f

<sup>82</sup> Cf. *Ibid.*, p. 3

<sup>83</sup> *Ibid.*, p. 4

As far as the supervision and quality of healthcare services is concerned, the responsibility for that oversight should remain with national authorities. Otherwise, Denmark welcomes further voluntary cooperation between Member States to better use free capacities and to reduce waiting time for medical treatment in hospitals<sup>84</sup>.

Denmark shows a very low degree of institutional adaptation. Even though it has partly transposed the ECJ's rulings into national law, complete transposition has not occurred yet. This is due to the fact that Denmark shows a higher degree of institutional misfit than Germany with a social insurance system. The reason for this misfit is that national health systems provide universal healthcare on the basis of citizenship, thereby attaching much importance to the equity of access to healthcare. The ECJ's rulings stipulating an individual's right to get medical treatment if the home healthcare system does not meet a patient's needs therefore touches upon the fundamental collective understanding attached to the Danish healthcare system. This can be illustrated by Denmark's concern of discrimination against its own citizens that might occur due to cross-border patient mobility: if a Danish patient seeks medical treatment in another Member State, he is free to choose the physician who will carry out medical treatment. However, a patient insured under Group 1 and staying in Denmark cannot choose freely the physician. Only if he changed to Group 2 such a free choice would be possible, but it would also imply a lower reimbursement for medical treatment. A patient having crossed the border would not only get the full reimbursement, but also the free choice of a physician<sup>85</sup>.

The ECJ's rulings also touch upon a key feature of political control over the financing of healthcare services: the control mechanism of waiting lists for the planning of capacities becomes less effective, as it has become easier for Danish

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<sup>84</sup> Ibid., p. 7

<sup>85</sup> Telephone interview with official from Danish Ministry of the Interior and Health, Copenhagen, 26 March 2007

patients to circumvent waiting lists. Unsurprisingly, Denmark thus puts an emphasis on the cost control of medical treatment. According to its point-of-view, a Directive should not erode the political control of financing public healthcare and therefore not touch upon the core institutions of a national health system. The slow transposition of the rulings can be thus explained with the relatively high costs that will occur for institutional adaptation. Denmark cannot simply absorb the European requirements but will have to accommodate its healthcare system's institutions to them.

#### **4. Conclusion**

Irrespective of the difference between social insurance and national health systems, both Member States presented here have an interest in safeguarding their sovereignty. A European Directive should prevent any further case law that has impacts on their prerogatives to organize the national healthcare services as they see fit. The Member States also have a common interest in clarifying the vague definitions of healthcare services and 'undue delay' in order to create legal certainty for them and for patients alike. Yet national health services show a higher degree of institutional misfit to European obligations than social insurance systems: A simple absorption of European obligations is for national health systems not possible as it was the case for Germany's insurance system. Even though Denmark will not have to transform its core institutions, the adaptive pressures are higher and therefore the costs for institutional adaptation as well. Denmark has been thus slower in transposing the ECJ's rulings into national law and waited for the negotiations on a European Directive. Consequentially, the political preferences and interests that the Member States are trying to upload are differing as much as their adaptive pressures. A restrictive interpretation of the ECJ's jurisprudence is of much more importance to

Denmark than to Germany that just tries to avoid further adaptive pressures. Given these results, the hypothesis that has been tested can be confirmed: Member States have shown a different degree of institutional misfit according to the distinct institutional set-up of their respective healthcare systems. As a consequence they also try to upload different preferences for a European Directive. If a convergence between Member States' healthcare systems will occur, is nevertheless questionable. But given their preferences for further voluntary cooperation concerning quality indicators, one could ask if this will not entail new adaptive pressures in the long run, which in turn could lead to a creeping convergence. Another factor could also be the accession of the new Member States. These usually offer standard surgeries at a much lower price than the old Member States. This could enhance cross-border patient mobility as the price of a hip replacement for example is about 50 percent lower than in the EU 15 countries. Hence patients could reduce their co-payments by receiving medical treatment abroad. It therefore seems, as pop artist *Shakira* beautifully sings, that "hips don't lie".



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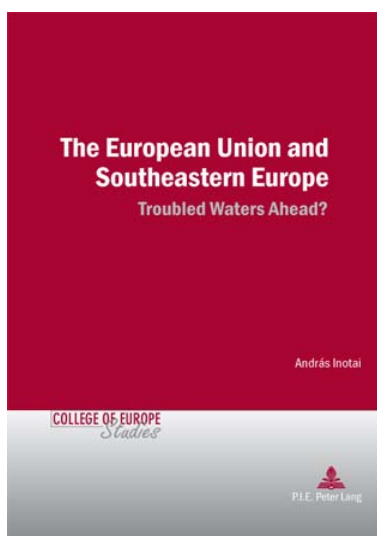
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