

CROSSING STATE BORDERS AND LOOKING FOR HEALTH CARE: THE EU  
AND THE U.S.

John G. Francis, Political Science  
Leslie P. Francis, Law and Philosophy  
University of Utah

On both sides of the Atlantic, the provision of health care is a source of major political debate, principally with respect to equitable access, quality and cost. The availability of health care outside of a home jurisdiction has an impact on these debates: it can both enable access and affect the ability of a home jurisdiction to regulate access, quality, and cost. Efforts by residents to access out of area care may also serve to stimulate change about what is available at home. In the United States, creation of a more robust inter-state market for health care financing was proposed by Senator McCain during the Presidential campaign as a way to generate competitive pressures to reduce health care costs,<sup>1</sup> but cross border access has not been seen more generally as a driver of health care reform. The question of free movement in search of health care is a source of ongoing discussion within the European Union; an aspect of this discussion is the extent to which open cross-border access might affect national efforts to constrain health care

---

<sup>1</sup> John C. Goodman, “The John McCain Health Plan,” National Center for Policy Analysis, Sept. 5, 2008, available at <http://www.ncpa.org/pub/ba629> (accessed April 16, 2009).

costs or to limit available services—but might also stimulate improvements in the quality and range of care that is available locally.

Free movement and a longstanding commitment to universal coverage frame current discussions of health policy in the EU.<sup>2</sup> In contrast, the discussions of access and affordability that dominate American policy formation are largely independent of state borders, even when states matter in the regulation and provision of American health care. This paper explores the significance of this difference. Our conclusion is that with the background of the EU commitment to access, the commitment to free movement has served as a positive spur to improved quality and availability of care. In the U.S., however, the possibility of mobility has had very little influence on the development of health policy.<sup>3</sup>

#### HEALTH CARE AT HOME IN THE EU AND THE U.S.

---

<sup>2</sup> Klaus Sieveking, “ECJ Rulings on Health Care Services and Their Effects on the Freedom of Cross-Border Patient Mobility in the EU,” *European Journal of Migration and Law* 9: 25-51 (2007).

<sup>3</sup> For an argument that the rights to travel in the U.S. and the EU are only superficially similar, and an exploration of differences in the underlying understanding of citizenship, see Francesca Strumia, “Citizenship and Free Movement: European and American Features of a Judicial Formula for Increased Comity,” *Columbia Journal of European Law* 12: 713-749 (2006).

In all European Union states, access to health care is understood as a commitment to inclusion. There is considerable variation in how such systems are organized but it is a widely shared norm that virtually all residents should be enrolled in some form of system of care.<sup>4</sup> Indeed, the right to preventive care and treatment under the rules of respective national systems is recognized as a fundamental right under Article 35 of the Charter of Fundamental Rights of the European Union.<sup>5</sup>

Despite this general commitment to universal access, there are significant variations within the EU in the scope, timeliness, and quality of care that residents receive. Quality may be understood in a number of ways, from input measures such as hospital capacity: equipment, staffing levels, and available beds. It may be the length and nature of training and education for health care practitioners. Contemporary expectations concerning the deployment of health care technologies both diagnostically and in treatment can be measured. Outcome measures may include general indicators of morbidity and mortality as well as frequency rates of visits to practitioners for the population at large.

A challenge to measuring satisfaction with the providers of health care consumed locally is that patient is unlikely to have used health care providers in other areas, let

---

<sup>4</sup> We leave aside discussion of the quite considerable issues involving access to care for those without legal residency in the EU.

<sup>5</sup> Available at [http://www.europarl.europa.eu/charter/pdf/text\\_en.pdf](http://www.europarl.europa.eu/charter/pdf/text_en.pdf) (accessed April 20, 2009).

alone other countries. Yet there does seem to be some conception of relative deprivation that operates in a patient judging health care. An OECD survey that includes member states of the European community indicates greater dissatisfaction with the health care provided in less well off European countries than is the case in wealthier European countries.<sup>6</sup> This may suggest that a country's wealth and more to the point the resources it devotes to the provision of health care matters as to how patients judge the quality of their care. There is also greater variation in perceived satisfaction with health care between the better off and the less well off in wealthier European countries than in less well off countries.

The political significance of the intersection of the issues of access and quality lies in whether health care that meets conventionally understood quality standards is available to the population at large. If there are wide disparities in the quality of care provided to the citizenry, is this evidence of inequity? This is not an easy intersection to map out, for health status is sensitive to how well educated or how well off a patient is. The OECD study suggests that people who have higher incomes live longer--whether they are living in France or in the United States or in many other countries. In many countries, higher education also correlates with increased visits to health professionals.<sup>7</sup>

---

<sup>6</sup> OECD, "Public's satisfaction with health care system, EU countries, 2002,"

<http://www.ecosante.fr/index2.php?base=OCDE&langh=ENG&langs=ENG> (accessed April 16, 2009).

<sup>7</sup> OECD Health Data (2006).

In the past two decades, steady concern has risen on both sides of the Atlantic to constrain the costs of health care. Health care costs in many countries have regularly exceeded growth in the GDP. Explanations of the steady rise range from the demographics of aging populations and their increased use of health care to the increasing use of expensive technological medical interventions. The interplay between the introduction of new medical procedures and heightened patient expectations has generated demands for a greater range of specialized care. Practitioners themselves are an organized and articulate sector capable of formulating and expressing their resource concerns.

European state responses to constrain the rising cost of health care have included expanding funding sources by the introduction of co-payments for many services. General fund revenues have been tapped in greater amounts and have been increasingly used to supplement employer-employee contributions in systems that were dependent on these contributions but now find them dwindling sources of revenue. There has also been a strategic encouragement of selective private insurance options to reduce some pressure on state funding. An ongoing source of debate is the way in which efforts to seek care elsewhere may impact these domestic efforts to constrain costs.

## HEALTH CARE AWAY FROM HOME

Why go to another state for medical care? There may be no choice. A Californian may break an arm skiing in Utah or a Londoner may have a heart attack in Paris—in either case ending up in the local emergency room. In both the EU and in the U.S.,

emergency care is provided to those who require it—in the U.S. without regard to immigrant status.<sup>8</sup> Access to emergency care is governed neither by residency rules nor by enrollment in locally available private or state health care insurance systems. There may be many strategic reasons to cross borders for care as well, and these reasons will be the primary topic of our discussion below.

The way we have framed this question—why would you cross a state border to receive health care?—draws an important distinction between the United States and the EU. The EU usually understands a new policy initiative as a commitment that crosses borders. The debate over a new initiative usually turns on questions of mutual recognition of existing member state regimes as meeting union-wide goals, the development of a set of common standards that will come to serve as a regime that applies to all member states, or an agreement to allow a strategic exception to the development of a largely shared cross border policy regime. Maas, writing about EU educational policy, argues that the free movement of persons is both a cause and effect of policy. “Mobility of students and staff leads to policies favorable to mobility, which increases the number of

---

<sup>8</sup>Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2009) (for the United States). In the EU, there is a commitment to access to emergency care but it is complicated by the fact that illegal immigrants do not have the right to tax funded health care. See, e.g., Román Romero-Ortuño, “Access to health care for illegal immigrants in the EU: should we be concerned?” *European Journal of Health Law* 11: 245-272 (2004).

students and educators making use of the opportunities for free movement, which in turn leads to calls for policy fostering even more mobility.<sup>9</sup>

In contrast, in the U.S., a large number of federal initiatives appear to confine cross border issues to the margins of public policy debate. This is particularly striking in debates of over health care reform. Americans would not understand access to health care as having much to do with crossing state borders, while in Europe an important question for past two decades has been and continues to be what sort of access does a citizen have to medical treatment when she or he is visiting or sojourning in another member state? We suggest that the clarity with which the cross border question in health care has been pressed has helped to drive the move to universal access in the EU, regardless of place of residence. In comparison, in the United States the very diversity of health care financing systems and the ambiguity that shrouds state and federal engagement in the provision of health care may make change politically harder to realize.

In general, mobility within the EU across borders has been described as increasing “exponentially” within recent years.<sup>10</sup> Leaving aside emergency care, Europeans may choose to seek health care outside their respective home states for a

---

<sup>9</sup> Willem Maas, *Creating European Citizens*. Lanham, Md.: Rowman & Littlefield, 2007.

<sup>10</sup> Martin McKee and Paul Belcher, “Cross border health care in Europe: European Commission Provides legal clarity and more information,” *British Medical Journal* 337: 124-125 (2008).

number of importantly different reasons. They may do so because of convenience: they live in another state for a part of the year, for example, Germans who may live in Spain for a part of the year or the British who own second homes in France. Others may conclude that care abroad, particularly in specialized areas of medicine, is superior to care in their own home states. Health care costs may be contained at home by waiting lists for specific procedures; treatment in another state without a waiting list is thus an attractive alternative for those seeking immediate treatment. Treatment abroad may also be cheaper, as it is for example for Germans receiving dental care in Poland. A recent study indicates that over half of EU residents are willing to travel elsewhere for health care, and 4% have done so within the past 12 months. The primary driver is unavailability of the care locally, especially because of wait times, followed by cost. The primary deterrent in the older member states is the perception of high quality care at home; in the new member states, the primary deterrent is the likely cost elsewhere and the primary driver is the likelihood of better quality care.<sup>11</sup> Prospective patients also may

---

<sup>11</sup> The Gallup Organization, Flash Eurobarometer 210, “Cross-border health services in the EU (June 2007), p. 5. A survey by one of the major German insurers, Techniker Krankenkasse, estimates a similar level of care abroad (approximately 5% of the German population) with an increasing percentage involving pre-planned treatmentg. KIEchniker Krankenkasse, “TK in Europe: TK Analysis of EU Cross-Border Healthcare in 2007), available at [www.tk-online.de/centaurus/servlet/contentblob/48308/Datei/1777](http://www.tk-online.de/centaurus/servlet/contentblob/48308/Datei/1777) (accessed April 19, 2009).

discover that their home state does not provide certain treatments on moral grounds: euthanasia, abortion, or in vitro fertilization, for example. As a consequence, people seeking these services must travel to another state to receive them. Finally, the home state may encourage going to another state for specialized health care, concluding that that it is cheaper to reimburse for services abroad than to provide them at home. This last sort of interstate approach to health care delivery and consumption is notable in adjacent border areas.

## MOBILITY IN THE UNITED STATES

Although traditionally in the United States the regulation of health care quality and health insurance has been a matter for the states,<sup>12</sup> the provision of health care itself has not been regarded primarily as a matter of state responsibility. Only the Medicaid program, a federal-state partnership financed from current tax revenues, has drawn states into the provision of health care in a major way. Several states, most notably Massachusetts, have undertaken initiatives towards universal access, and Hawaii has a longstanding commitment to that effect. United States constitutional jurisprudence forbids states from favoring their longstanding residents over new arrivals in state-funded health care programs. But the commitment in the US to the right to interstate travel has

---

<sup>12</sup> The federal Employee Retirement Income Security Act (ERISA), however, preempts state regulation of employer-provided health insurance, albeit saving state regulation of insurance from the federal umbrella.

not been a driver in pressure for health care reform. Nor has the ability to access health care been conceptualized as a cross-border problem. Indeed, despite the constitutional commitment to interstate travel, there remain significant and complex barriers to a mobile citizenry seeking to access health care.

In the United States, employer-provided insurance through the private market has played the primary role in providing funding for health care for working adults and their families. ERISA, the federal Employee Retirement Income Security Act, governs all employer-provided welfare plans (including health benefits). ERISA requires that welfare plans meet certain disclosure and fiduciary standards but apart from certain limited requirements (governing childbirth and mastectomy standards, as well as mental health parity<sup>13</sup>) does not impose any coverage minimums or mandates. Health insurance is regulated by the states, many of which do impose a wide variety of coverage mandates. ERISA's general preemption of state law does not apply to such insurance regulation; however, self-insured employer plans are not "deemed" to be insurance for purposes of ERISA preemption.<sup>14</sup> The result in practice is that approximately 55% of workers (89% of insured workers in firms employing more than 5000 workers) covered by their employers are not subject to state insurance regulation.<sup>15</sup>

---

<sup>13</sup> 29 U.S.C. §§ 1185, 1185a, 1185b

<sup>14</sup> 29 U.S.C. § 1144(b)(2)(B).

<sup>15</sup> See William Pierron, "ERISA Preemption: Implications for Health Reform and Coverage," EBRI Issue Brief (February 2008), available at

Because cost-control has been implemented largely through price negotiation with networks of providers, however, many residents of the United States find it difficult or expensive in practice to obtain non-emergency care away from home. Employer-provided insurance may restrict the receipt of non-emergency care to a network of providers that may be locally-based, or may impose very high co-payments on patients who seek to access out-of network providers.

Similar barriers to mobility exist even in the US Medicare program, the program available to those over 65 who have paid into the Social Security System for 40 quarters, qualifying individuals who have been on disability for 24 months, and persons with end-stage renal disease. Medicare Part A (hospital) and Part B (physician) offer a standard set of benefits and permit open choice among providers who accept Medicare; here, the only barriers to mobility are the practical willingness of providers to accept Medicare and the legal restriction of Medicare payments to services provided within the United States (and Puerto Rico). An elderly parent on Medicare who visits children elsewhere will have no difficulty in obtaining payment for providers' services—at least to the extent that the services are covered by Medicare and that providers are available who are willing to accept Medicare. That Medicare requires coverage of services that are reasonable and

---

[http://www.coalitionbenefits.org/PDF/ERISA/ERISA\\_Pre-emption\\_EBRI\\_Issue\\_Brief\\_No314\\_Feb2008.pdf](http://www.coalitionbenefits.org/PDF/ERISA/ERISA_Pre-emption_EBRI_Issue_Brief_No314_Feb2008.pdf) (accessed October 21, 2008).

necessary in the Medicare population does not, however, mean that coverage is uniform across the United States; absent a national coverage determination, approximately 50 local carriers serve as intermediaries making coverage determinations for their geographical catchment area.<sup>16</sup>

More extensive mobility difficulties with Medicare occur under Part C (“Medicare Advantage”) and Part D, the prescription drug benefit. Part C represents the effort to introduce certain market options into Medicare; however, persons opting for Part C rather than traditional Medicare may find themselves limited to receiving services from specified provider networks, just as are many recipients of employer-provided health insurance. Thus Part C patients visiting where network providers are not available may find themselves without coverage, except for emergency and stabilization services. Part D pharmacy benefit providers may likewise limit coverage to designated providers, provided access is reasonably convenient and emergency access is available out of network.<sup>17</sup>

---

<sup>16</sup> For a discussion of the impact of this structure, see, e.g., Susan Foote, Rachel Halpern, & Douglas Wholey, “Variation in Medicare’s Local Coverage Policies: Content Analysis of Local Medical Review Policies,” *American Journal of Managed Care* 11(3):181-187 (2005)

<sup>17</sup> 42 U.S.C. §1395w-104(b).

Finally, Medicaid is the federal/state partnership that provides health insurance to people falling within certain need-based classifications. Constitutional case-law prohibits states from imposing residency requirements for Medicaid eligibility or from offering differential benefits to recent arrivals.<sup>18</sup> Eligibility is thus uniform within states between the mobile and those who have stayed put. Since the welfare reforms of 1996 (the “Personal Responsibility and Work Opportunity Act”<sup>19</sup>), however, Medicaid has been largely off-limits to non-citizens. Moreover, even those who are eligible for Medicaid may face significant mobility barriers in the care they can access. Federal law permits states to require enrollees to receive care through a managed care organization with a limited provider network. (As with Medicare Part C, however, emergency and stabilization services must be available elsewhere.<sup>20</sup>) Medicaid recipients thus may find themselves unable to receive non-emergency care from providers away from their home region, even within the same state.

Finally, it is worth noting that the role networks play in the negotiation of cost and quality controls in the United States may impact access to care even on visitors from abroad. BUPA (the “British United Provident Association”), for example, negotiates

---

<sup>18</sup> Saenz v. Roe, 526 U.S. 489 (1999).

<sup>19</sup> PRWORA, Pub.L. 104-193, 110 Stat. 2105, enacted August 22, 1996.

<sup>20</sup> 42 U.S.C. § 1396u-2(b) (2009).

with a U.S. care network, UnitedHealth, to provide care for its insured visitors to the United States.<sup>21</sup>

## MOBILITY WITHIN THE EU

The ability of EU residents to receive health care anywhere within the EU is an aspect of the free movement of persons. The development of what this policy means is a very good illustration of the seeming partnership between the activist European Court of Justice and the European Commission. As Cichowski writes: “The degree of power exerted by both the Court and civil society in expanding the scope and meaning of EU policy today is remarkable.”<sup>22</sup> Indeed, Cichowski believes the ECJ is so important that she rejects what she takes to be the dominant theories that integration is a function of the relative bargaining power of member state governments.

Under current policy, EU residents who are employed outside of their home countries or are seeking work, students, pensioners, and trainees are entitled to needed health care when they are away from their country of residence.<sup>23</sup> The scheme currently

---

<sup>21</sup> [http://www.bupa-intl.com/asp/benefits/hospital\\_locations.asp?id=197](http://www.bupa-intl.com/asp/benefits/hospital_locations.asp?id=197) (accessed April 15, 2009).

<sup>22</sup> Rachel A. Cichowski, *The European Court and Civil Society, Litigation, Mobilization, and Governance*. Cambridge: Cambridge University Press, 2007, p. 244.

<sup>23</sup> Regulation 1408/71 of the Council of Europe deals with the application of social security rights to residents of the EU moving from one country to another.

in effect employs the European Health Insurance Card (EHIC), a replacement for the former E-111 form; the card is available free of charge to anyone qualifying under the home country's social insurance scheme.<sup>24</sup> The EHIC allows residents of EU nations to receive certain state-funded health care in other EU countries or countries with reciprocal agreements with the EU (Iceland, Liechtenstein, Norway and Switzerland), although coverage may vary for non-citizen residents depending on the location of care. The EHIC was introduced by decisions in 2004 of the Administrative Commission for Social Security of Migrant Workers (ACSSMW), subsequent to a mandate from the European Commission in 2002.<sup>25</sup>

A trip away from home for “planned treatment,” however, does not come under the EHIC entitlement scheme. Individuals seeking planned hospital treatment outside of their countries of residence must obtain pre-authorization from their home country in order to obtain the care, unless they are paying for it privately. Individuals seeking outpatient treatment hospital may obtain preauthorization or may first receive the treatment and then seek reimbursement—although, without prior authorization, they are at risk that the reimbursement will be denied. Prior authorization is obtained via the E-

---

<sup>24</sup> See, e.g., <https://www.ehic.org.uk/Internet/home.do> (accessed April 20, 2009).

<sup>25</sup> See “Summary of the Decisionmaking Process Which Led to the European Health Insurance Card,” [http://ec.europa.eu/employment\\_social/healthcard/continuum\\_en.htm](http://ec.europa.eu/employment_social/healthcard/continuum_en.htm) (accessed October 22, 2008).

112 form.<sup>26</sup> The interplay between this more restrictive system for planned treatment and the circumstances of non-residents in need of care away from home has not been seamless, however. One source of controversy has been the difficulty in determining when care abroad really was pre-planned, and when the need for the care was genuinely emergent.<sup>27</sup> Another source of controversy has been the treatment of longer-stay visitors who are not working or studying away from home, for example British citizens who own homes in France, live there without working, and seek access to health care while in residence there.

*ECJ Case Law*

The current scheme has been developed along lines established by the considerable ECJ case law interpreting the EU commitment to free movement as applied to decisions about reimbursement for treatment received away from the home state.<sup>28</sup>

---

<sup>26</sup> See <http://ec.europa.eu/social/main.jsp?catId=569&langId=en> (accessed April 16, 2009).

<sup>27</sup> For a case presenting this issue, see *Idryma Koinonikon Asfaliseon v Ioannidis*, [2003] All ER (EC) 548 (holding that under Article 31 of Regulation 1408/71, pensioners entitled to benefits in their home state need not demonstrate in order to receive reimbursement that care was emergently needed during their stay away from home).

<sup>28</sup> See [http://ec.europa.eu/employment\\_social/social\\_security\\_schemes/healthcare/e112/caselaw\\_en.htm](http://ec.europa.eu/employment_social/social_security_schemes/healthcare/e112/caselaw_en.htm). For a general discussion of the case law, see Sieveking (2007). For an

The difficulty is to balance the free movement of persons with the commitment to maintain the various state systems of social security. The home state may wish not to reimburse the treating state for care that would be unavailable or less expensive; the treating state may wish to avoid the burdens of an influx of patients who see their care as more advantageous than the care available at home. Regulation 1408/71 (as amended) governs the receipt of social services away from home. The general approach of the case law interpreting this regulation is that reliance on practices or policies of one country will not justify limitations unless they are objectively necessary to protect the quality of care or the integrity of the state's social security system.

The current leading case on the home state's obligations to reimburse for care received outside of its borders is *Judgement Geraets-Smits and Peerbooms*.<sup>29</sup> In *Geraets-Smits*, a patient from the Netherlands had sought treatment for Parkinson's disease at a clinic in Germany. The patient contended the German clinic offered better quality care for her condition, but her sickness fund in the Netherlands refused reimbursement on the view that, because adequate care was available at home, the German clinic visit was not medically necessary. In *Peerbooms*, a Dutch victim of an accident in Innsbruck, Austria, received special neurostimulation; the Netherlands considered the treatment experimental

---

argument that the ECJ has played a major political role in health policy formation, see Dorte Singbjerg Martinsen, "Towards an Internal Health Market with the European Court," *West European Politics* 28: 1035-1056 (2005).

<sup>29</sup> 12 July 2001, case C-157/99.

and covered it only for people under the age of 25 in two designated medical centers. Each patient sought reimbursement for their care abroad; the question in the case before the ECJ was whether it violated freedom in the provision of services for the Netherlands to limit reimbursement for care received elsewhere by residents of the Netherlands to care regarded as medically appropriate under professional judgment in the Netherlands. The ECJ judged that hospital services are within the scope of the EU guarantee of freedom to provide services and that conditioning reimbursement on professional judgment as understood in the Netherlands restricted that freedom. Such otherwise impermissible restrictions, however, may be justified if they are necessary to preserve the integrity of state social security systems, the objective of maintaining a medical system open fairly to all, or the maintenance of national treatment capacity. The ECJ determined that authorization requirements such as those imposed by the Netherlands are permissible, provided that the authorization decisions are based upon clear, open, and justified criteria. Judgments about coverage must be based on objective medical science, as understood internationally, not on “professional circles” of the state concerned. In addition, judgments about the person’s need for the care must be based on whether effective treatment will be available without undue delay. Concomitantly with *Geraets-Smits*, the ECJ also ruled that when a resident of one country receives care elsewhere, s/he is entitled to reimbursement at the level of the home country.<sup>30</sup>

---

<sup>30</sup> *Judgement Vanbraekel*, 2001, case CI-5363.

More recently, the ECJ has ruled on whether free movement requires reimbursement when residents go elsewhere to avoid waiting times in their home country.<sup>31</sup> A British patient, Watts, had a painful arthritic hip. Initial assessments put her in the “routine” category in Britain, meaning that she faced a waiting time of about a year to receive the procedure. After an assessment in France judged her condition to be deteriorating, she was reclassified in Britain as “intermediate,” meaning a queue of 3-4 months. She was refused E-112 authorization on the view that the delay of 3-4 months was not “undue,” went abroad for the hip replacement, and sought reimbursement. Applying the analysis in *Judgement Geraets-Smits and Peerbooms*, the ECJ reasoned that waiting times may be established provided that they are medically acceptable: “the waiting time, arising from objectives relating to the planning and management of the supply of hospital care pursued by the national authorities on the basis of generally predetermined clinical priorities, within which the hospital treatment required by the patient’s state of health may be obtained in an establishment forming part of the national system in question, does not exceed the period which is acceptable in the light of an objective medical assessment of the clinical needs of the person concerned in the light of his medical condition and the history and probable course of his illness, the degree of pain he is in and/or the nature of his disability at the time when the authorisation is sought.” In the judgment of the ECJ, however, higher costs alone could not justify the refusal to issue the E-112—nor could the structure of the NHS which, in contrast to

---

<sup>31</sup> *Judgement Watts*, 16 May 2006, case C-372/04.

sickness funds, pays the full cost of care (and therefore would be obligated to reimburse the foreign facility in full).

Even more recently, the ECJ applied the reasoning of *Judgement Geraets-Smits and Peerbooms* to the Greek government's refusal to authorize reimbursement for treatment in a private hospital in Britain.<sup>32</sup> Under Greek law, the social security system pays for treatment in Greece in private hospitals with agreements with the state, and for emergency treatment in private hospitals without agreements. Greece, however, prohibits reimbursement for any treatment abroad in private hospitals, except for children under 14. Greece argued that this policy did not disadvantage foreign private facilities, as it consistently applied the rule that reimbursement was only available for private hospitals with agreements. The ECJ disagreed, on the ground that Greek law did not provide for agreements with out-of-state facilities. The ECJ held that this restriction violated EU law with respect to the freedom to provide services. Although the freedom to provide services was the basis of the decision, the Court also noted the increasing importance under EU law of the personal right of access to health care. The first step in the decision was that Greek law did restrict the freedom to provide services. The second step was whether the restriction could be justified by reasons in the general interest: the risk of seriously undermining a social security system's financial balance, the objective of maintaining a high quality balanced medical and hospital service open to all, or the maintenance of treatment capacity or medical competence on national territory.

---

<sup>32</sup> *Judgement Stamatelaki*, 19 April 2007, Case C-444/05.

Narrower restrictions, however, such as the EU-permitted prior authorization scheme or reimbursement scales, are not precluded under the judgment. Thus the *Stamatelaki* decision does not prohibit EU states from reimbursing patients at the lower state level than billings from more expensive private hospitals abroad.

These cases all involve suits for reimbursement brought by patients who have received care away from home. The obverse question is the obligation of the service locale to provide the care. A recent decision of the ECJ is relevant to this question. In 1999, the Flemish Parliament introduced a scheme of insurance for long-term non-medical disability care for residents of their region.<sup>33</sup> The scheme was designed to provide social services to the Flemish-speaking elderly; no similar systems were established by the governments in either the French-speaking or the German-speaking regions of Belgium. The Flemish program was contested by the government of the French Community and the Walloon government within Belgium, along with the French government, on the contention that the restriction to residents of Flanders was a deterrent to the free movement of persons into the region. The Flemish government's response was that this was a program established and financed by the autonomous Flemish community and thus did not fall within the scope of Regulation 1408/71. The practical effect of the scheme would be to discourage a French speaker working in Flemish Belgium from residing in a near-by French-speaking area—thus, the ECJ held, the

---

<sup>33</sup> Government of the French Community v. Flemish Government, Case C-212/06, [2009] All ER (EC) 187.

scheme violated the commitment to free movement of persons. Although about assistive non-medical care rather than health care per se, the decision indicates the extent to which ECJ case law may place upward pressures on regional decisions to establish insurance schemes that take in non-residents.

A recent controversy between France and Britain illustrates what is at stake more generally when a country seeks to protect its social security system from an influx of EU residents from elsewhere. In a number of EU countries, there is a willingness to accept paying patients from other countries to their home medical care facilities, at least in limited numbers. On the other hand, there is concern among policy makers and local citizens about other Europeans receiving medical care at the same minimal cost paid by the domestic population when the foreigners have not contributed to the system over the longer term. The issue is not only fairness but also additional costs. Retirees living away from home can transfer state pensions and health care entitlements under EU form 121, and the home state then contributes to the system providing the care. Approximately 300,000 British citizens live in France, many of whom are “inactive” in the sense that they neither work in France nor are old enough for to qualify for health care as a retired person. Until fairly recently, British inactives in France received health care coverage from the Couverture Maladie Universelle (CMU), a French state-run program designed to furnish health care for categories of less well off citizens who could not obtain care in the traditional programs because they were not employed. Required contributions for participation in the CMU as a percentage of income are much lower than required contributions for participation in the employer-financed sectors of the French health

insurance system, so this represented a considerable French subsidy to the British inactives.

Early in 2007, the French Government informed foreign nationals—largely the “inactive” British—that they would no longer be eligible for CMU coverage unless they met the British retirement age or had lived in France continuously for five years and thus qualified as a French resident. After negotiation involving the British embassy and French officials, an agreement was worked out that British residents settling in France in France before November 23, 2007, would be allowed to continue in the CMU. Arrivals after that date, however, would be required to demonstrate the ability to pay for health care or show proof of insurance.

Similar problems have arisen for the British and other expatriates in Spain. In June, 2008, *The Observer* reported that British inactives living on the Costa Blanca would lose the health care access they had received since 2002 unless they qualified for a British state pension and therefore had access to Spanish health care through an E-121 transfer from the British system. The explanation given was the sharp fall in property values which had reduced revenues for the provincial government.<sup>34</sup> The government of Valencia had extended the health care coverage to the expatriates in 2002, but estimated that by 2008 the costs of caring for the 500,000 British together with other expatriates had reached over 1 billion Euros annually.

---

<sup>34</sup> Jacqueline Stevens, “Costa Blanca Britons to lose free healthcare,” *The Observer* (June 22, 2008), available at <http://www.guardian.co.uk/world/2008/jun/22/spain>.

*The 2008 European Commission Draft Directive*

In July of 2008, the European Commission released a draft directive on how health care can be obtained by citizens of one member state seeking health care in another member state. The result of a process that began in 2003, the directive explicitly seeks to clarify understanding of the ECJ case law<sup>35</sup> and to develop a workable and transparent framework for cross-border reimbursement for care that facilitates free movement while protecting the integrity of state systems.<sup>36</sup> The directive also aims to facilitate cooperation on cross-border care through such mechanisms as accessible electronic health records.

Regarding the receipt of care across borders, the directive both maintains and clarifies the existing EHIC structure, and provides in addition for the home state to reimburse for care received elsewhere that would have been provided at home, up to the limits of home state reimbursement. Under the existing EHIC system, the directive clarifies that prior authorization may not be required for out-of-hospital care received away from home, reasoning that such care will not destabilize social security systems.<sup>37</sup> For hospital care, the directive provides for the European Commission to promulgate and update a definition of hospital care, and then permits home states to introduce a prior

---

<sup>35</sup> [http://ec.europa.eu/health/ph\\_overview/co\\_operation/healthcare/docs/COM\\_en.pdf](http://ec.europa.eu/health/ph_overview/co_operation/healthcare/docs/COM_en.pdf), (accessed April 16, 2009), p. 2.

<sup>36</sup> Communication from the Commission COM(2008), 415 final, p. 9.

<sup>37</sup> Directive, Article 7.

authorization system if they can show the system is proportionate to and justified by the imperative need to protect the home social security system. Such protection may include either financial solvency or planning with respect to issues such as maintaining treatment capacity or competence.<sup>38</sup> As an alternative to this system, the directive also provides that home states must reimburse for care received away from home, if the care would have been provided at home, up to the reimbursement limits of the home state system.<sup>39</sup> The directive does not go beyond the existing structure for the harmonization of social security systems, however, and thus would not expand current requirements for coverage as they apply to long term expatriates who do not otherwise qualify for inclusion in the social security system of the country in which they sojourn.

Thus the draft directive provides for greater transparency in what care will be covered when EU residents move to obtain it. It also places the burden on the home state to defend efforts to restrict its citizens from going abroad for care not immediately available at home. The draft directive thus pushes forward the prior directives that seek to develop standards that transcend borders as people move across them. It also recognizes the central role of the member states who in this case are both policy makers for the EU and the respective managers of the provision of health care within the EU.

---

<sup>38</sup> Directive, Article 8.

<sup>39</sup> Directive, Article 6.

## CONCLUSION

It is useful to recall that the United States does not have a health care system. Rather it has a health care sector that has a strong federal presence in the provision of health care through Medicare, the Veterans Administration, and the Indian Health Service. The U.S. federal government provides resources in conjunction with the states in funding health care for the poor although there is considerable variability in what is provided state by state. In the U.S., private health care and health insurance play a large and influential role. It is ironic that in a country that celebrates both federalism and movement both to and within the nation has only occasionally linked the question of access to the question of movement. We suspect the explanation for the absence of coupling these issues is that the number of players interested in change in the health care debate has been limited, partly because of direct federal underwriting of health insurance for the elderly and various other groups, and partly because the private insurance market until relatively recently made access to insurance relatively easy for the well employed when they changed jobs or moved. The less well off (Medicaid recipients) though unevenly served when they cross state lines, have a limited political voice in the debate.

In contrast, the European debate, driven by an activist court, a sympathetic Commission and the institutional capacity of the EU has for regulatory policy in many social economic spheres been able to frame movement across borders as the basis for moving towards a trans border health care system. Consonant with Cichowski's picture of the powerful role of the ECJ, the Court has succeeded in getting this issue of trans border care on the agenda. This has come at a price, however, for as commentators such

as Schmitt argue the EU has extensive regulatory power but the individual states are key players in determining how policy is implemented.<sup>40</sup> The EU does not have as its disposal the requisite agencies to implement its understanding of health care but must continue to work to induce and to cajole member states to do its bidding in an often convoluted negotiations that takes an extended period of time. As Majone argues, “the Commission’s stubborn opposition to any significant delegation of regulatory powers to independent European Agencies demonstrates the difficulty of introducing significant institutional innovations within the framework of the classical Community method.”<sup>41</sup> In the 1970s, decisions by the ECJ applying the commitment to free movement to expanding the regime of cross border health care were met unfavorably by the European Commission, which continued in place the then-existing system of prior authorization.

The Commission’s current draft directive, as we have seen, largely accepts the commitment to movement in the ECJ case law—but does so subject to maintaining individual state systems of social security. If EU states can demonstrate important fiscal or planning needs to limit authorization for hospital care (and the like, as per Commission

---

<sup>40</sup> Vivien Schmidt. *Democracy in Europe: the EU and National Politics*. Oxford: Oxford University Press, 2006.

<sup>41</sup> Giandomenico Majone, “Federation, Confederation, and Mixed Government: An EU-US Comparison,” in Anand Menon and Martin A. Schain, eds., *Comparative Federalism: The European Union and the United States in Comparative Perspective*. New York: Oxford University Press, 2006, pp.121-148.

definition), they will not be compelled to reimburse for care elsewhere beyond what would have been available at home. Nonetheless, the EU commitment to the health care needs of a mobile population goes well beyond the commitment in the U.S. to mobility in practice, as does the EU commitment to the provision of health care more generally.