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## **Political territoriality in the European Union : the changing boundaries of security and healthcare**

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## Chapter 8

# The territorial closure and the European opening of the Dutch healthcare state

*A key issue is how to reconcile the existence of an EU without borders, with the principle of territoriality that continues to exist in the field of social security.*  
Paul Belcher<sup>1</sup>

### 8.1 Introduction

According to Frits Bolkestein, the former European Commissioner for the Internal Market, a European citizen does not understand that he or she cannot enjoy free access to health services across national borders within an internal market.<sup>2</sup> That may be rather unfortunate since some EU Member States are confronted with long waiting lists, while others have overcapacity. The territorial closure of healthcare systems has been considered, however, essential to the evolution of national states in Europe, and national solidarity in particular.<sup>3</sup> The opening of the territorial healthcare state within a European market may therefore have severe implications for core themes in political science like the state and citizenship. Surprisingly, healthcare has been a relatively under-explored issue in political science.<sup>4</sup> In addition, the spatial dimension of welfare politics has been often neglected in the literature on welfare states, and

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<sup>1</sup> Belcher, P. (1999). *The Role of the European Union in Healthcare: An Overview*. Zoetermeer: RVZ. p. 69.

<sup>2</sup> European Commission (3 February 2003), *Meeting of the High Level Process of Reflection on Patient Mobility and Healthcare Developments in the EU: Minutes of the Meeting*. HLP/2003/ REV1.

<sup>3</sup> Offe, C. (1998), 'Demokratie und Wohlfahrtsstaat: eine Europäische Regimeform unter dem Streß der Europäischen Integration', in W. Streeck (ed.), *Internationale Wirtschaft, Nationale Demokratie: Herausforderungen für die Demokratietheorie*. Frankfurt/ New York: Campus Verlag. pp. 99-136; Ferrera, M. (2005), *The Boundaries of Welfare: European Integration and the New Spatial Politics of Social Protection*. Oxford: Oxford University Press.

<sup>4</sup> Moran, M. (1999), *Death or Transfiguration? The Changing Government of the Health Care State* (EUI Working paper 99/15). Florence: EUI.

scholars' attention concerning the impact of European integration on healthcare states is only of a recent date.<sup>5</sup> The impact of European integration *within* healthcare states is in particular need of more in-depth research.<sup>6</sup> Europe without frontiers offers health consumers exit options to access healthcare outside their healthcare state. Ensuing cross-border patient mobility may unsettle the (territorial) organisation and financing of healthcare within the EU Member States. Chapters 8 and 9 trace the effects of European integration on the territorial underpinnings of healthcare states from the angle of cross-border patient mobility. The aim is not only to give an empirical impression of how European integration impacts on the territorial set-up of healthcare states, but also to explore the usefulness and plausibility of the analytical instruments presented in the previous chapters.

Chapter 8 first presents the history of the territorial closure of healthcare states in the European Union and of the Dutch healthcare state in particular. Subsequently, it explains how the internal market has undermined the territorial basis of healthcare states in the EU. Following the propositions discussed in Chapter 5, this chapter sketches in the final section the implications of the European openings for the previously territorially closed healthcare states in the EU. The focus of this chapter is only on people moving to consume healthcare, which is defined here as the prevention, treatment and management of illness and the preservation of mental and physical well-being through services offered by health professionals. Health involves much more than healthcare; from public health, mobility of health professionals, hospital financing to pharmaceutical products and medical devices. This chapter on the closure and opening of healthcare states is therefore necessarily offering a limited view on the impact of European integration on domestic health policy.

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<sup>5</sup> Ferrera, M. (2005), *supra* note 3; see, e.g., Steffen, M. (eds.) (2005), *Health Governance in Europe: Issues, Challenges and Theories*. London: Routledge; Martinsen, D.S. (2005), 'Towards an Internal Health Market with the European Court', in *West European Politics*. Vol. 28, no. 5, pp. 1035-1056; Greer, S.L. (2006), 'Uninvited Europeanization: Neofunctionalism and the EU in Health Policy', *Journal of European Public Policy*. Vol. 13, no. 1, pp. 134-152.

<sup>6</sup> Lamping, W. & Steffen, M. (2005), 'Conclusion: The New Politics of European Health Policy: Moving beyond the Nation-State', M. Steffen (ed.), *Health Governance in Europe: Issues, Challenges and Theories*. London: Routledge. pp. 188-200.

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The empirical results in this and the following chapter are predominantly drawn from the Netherlands and in particular its border regions, where (European) initiatives of cross-border patient mobility have been in existence since the late 1970s. Since institutional change usually takes some time, a period of thirty years may give an impression as to what extent the logic of territoriality has left its imprint on the healthcare states involved. Legislation and reports from the responsible healthcare authorities, interviews with policy-makers and the insurance companies involved, as well as surveys on cross-border patient mobility provides the empirical basis to map changing political territoriality.<sup>7</sup>

### **8.2 The territorial underpinnings of healthcare states**

#### *8.2.1 Territorial closure*

Until the First World War, welfare arrangements including healthcare were primarily person- or function-based, depending on religion, ideology, social status, or occupation.<sup>8</sup> Stricter border control with passports, checkpoints and visas limited the possibilities to leave or enter national territories after the First World War. These territorial confines have marked the further development of healthcare systems in Europe. Particularly since the Second World War, healthcare systems have been gradually extended towards almost universal, obligatory insurance or service coverage of citizens' basic health needs. Locked in national territories, solidarity has thus been moulded and enforced on an impersonal, geographically exclusive basis, increasingly replacing solidarity according to someone's personal characteristics or functional activities. The introduction of (nearly) universal, compulsory health insurance has strengthened external consolidation by excluding non-residents as well as solidified internal loyalties within the fixed national territories between the healthy and unhealthy, rich and poor, old and young, and manual and non-manual workers.<sup>9</sup> Thus, the territorial healthcare system, the "healthcare state"<sup>10</sup> has been the last phase in the

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<sup>7</sup> A list of interviewees is adopted in the annexes.

<sup>8</sup> Freeman, R. (1999), *The Politics of Health in Europe*. Manchester: Manchester University Press; Ferrera, M. (2005), *supra* note 3, Ch. 2.

<sup>9</sup> Ferrera, M. (2005), *supra* note 3.

<sup>10</sup> Moran, M. (1999), *supra* note 4.

formation of European states and nations; provision of healthcare is now part of the social contract between states and their citizens. Richard Freeman speaks in this context about “health citizenship” in European states.<sup>11</sup> For example, the Dutch constitution says since 1983 the government is responsible for the promotion of the public health of the Dutch population (Article 22.1).

In the past, the principle of territoriality designated the membership of European healthcare states.<sup>12</sup> Health citizenship and the consumption of healthcare were geographically circumscribed. The right of access to health facilities and reimbursement of the costs were in principle delineated by state borders. Only exceptional circumstances justified granting the privilege of reimbursement for cross-border healthcare. Rights and membership obtained in a foreign healthcare system were not valid within the territory of the healthcare state. National health authorities were the only institution to designate membership and regulate the healthcare system; no other healthcare system was allowed to compete on the territory. This was also the case with regard to granting the status of health providers and insurance agency, and the supervision of the quality of health treatments and the legitimacy of insurance policies.

European healthcare authorities had various reasons to organise their systems according to the principle of territoriality.<sup>13</sup> Territorial delineation facilitates control of quality and can help in the protection against contagious diseases. Borders efficiently visualise where healthy and unhealthy elements should be separated. In addition, a territory-based healthcare system prevents patients from shopping around for more and more expensive treatments and medical goods abroad, which would

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<sup>11</sup> Freeman, R. (1999), *supra* note 8.

<sup>12</sup> Leibfried, S. & Pierson, P. (1995), ‘Semisovereign Welfare States: Social Policy in a Multitiered Europe’, in S. Leibfried & P. Pierson (eds.), *European Social Policy: between Fragmentation and Integration*. Washington DC: Brookings. pp. 50ff; Mei, A.P. van der (2001), *Free Movement of Persons within the European Community: Cross-border Access to Public Benefits* (dissertation Maastricht University). Maastricht: Maastricht University. pp. 7-8; Cornelissen, R. (1996), ‘The Principle of Territoriality and the Community Regulations on Social Security (Regulation 1408/71 and 574/72)’, in *Common Market Law Review*. Vol. 33, p. 441; Jorens, Y. (2002), ‘The Right to Health Care across Borders’, in M. McKee, E. Mossialos & R. Baeten (eds.), *The Impact of EU Law on Health Care Systems*. Brussels: PIE-Peter Lang. pp. 83-122.

<sup>13</sup> Mei, A.P. van der (2001), *supra* note 12, pp. 7-9; 264-265.

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otherwise jeopardise the financial balance between investments in healthcare facilities and medical personnel and earnings from treatment fees, premiums and taxes. The territorial containment of patients also facilitates planning of the healthcare infrastructure. Fluctuations in health demand due to patient mobility would severely hamper efficient planning, resulting in overcapacity or under-capacity of healthcare facilities. In addition, territorial containment facilitates the compulsory payment for the healthcare system. The overlap of contributors of healthcare premiums and taxes, on the one hand, and health consumers, on the other hand, also enhances the necessary we-feeling for sharing the burden of health costs. Notwithstanding the functional arguments for a territorial strategy in organising healthcare, healthcare systems have been established within the framework of mutually exclusive national states having socially defined territories. Therefore, territories of healthcare systems have been deeply entrenched in the behaviour of ‘health citizens’ and other actors in the health sector, as well as broadly embedded in politics, society, and the economy. A dysfunctional size of a national healthcare territory is not expected to be re-scaled quickly, because of the heavily institutionalised social, rather than functional, definition of the territory of healthcare states.

#### *8.2.2 Two families of healthcare states*

Although European healthcare systems are all framed within the territorial framework of the state, the organization, financing and delivery of healthcare differ from country to country. Two families can be distinguished among the healthcare states in the European Union.<sup>14</sup> A “command-and-control healthcare state” is characterized by a state-guaranteed universal health insurance covering citizens’ basic health needs, state-led planning and provision of mainly publicly owned national health services, the funding of healthcare through taxation, and decision-making by elected politicians and public administrators at the national, the regional or the local levels. Costs of supplementary health can be covered by private voluntary insurance or direct payments. This model can be found in the United Kingdom and Scandinavia. Southern European healthcare states are incomplete versions of this type. Though

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<sup>14</sup> Moran, M. (1999), *supra* note 4.

the universal coverage of basic health has been legally enshrined there, in practice, many citizens rely upon private insurance companies and care providers or direct payments to obtain more timely and better quality healthcare. Former communist healthcare systems in Central and Eastern Europe have attempted to shift from this model towards the corporatist family (see below). Their citizens like Southern European citizens often rely on private arrangements.

Within the “corporatist healthcare state,” insurance and the provision and purchasing of healthcare is largely in the hands of hospitals and health insurance funds within a public law framework in which the associations of health professionals and health insurance funds as well as social partners (labour unions and employer federations) have a large say in formation and implementation of health policy. This type of healthcare state is largely financed through a social insurance system of income-related social security contributions. Health insurance arrangements may differ according to religion, ideology, region, or occupation. The central government operates as a director of this corporatist amalgam, only showing its hierarchy in times of (financial) urgency. Countries such as France, the Netherlands, Belgium, and Germany belong to the corporatist family of healthcare states.

The distinction between the two families of healthcare states has been predominantly based on their organisation in their founding period (until the 1970s). However, most corporatist healthcare states now also have universal coverage, while command-and-control healthcare states give more space for private healthcare providers. Even before the 1970s, the distinctions between these two families of healthcare states were not rigid. For example, the Netherlands has had an obligatory, income-dependent, social insurance for long-term, privately uninsurable, and high-cost medical treatments since 1968, which has been universal and partly tax-financed. The National Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten*, AWBZ) cover, for example, nursing-homes and mental health providers. In addition to the AWBZ, various arrangements existed for the coverage of basic healthcare needs. In 1941, compulsory health insurance was introduced by the German occupying power for workers below a certain income ceiling. This policy was transposed in Dutch law in 1964 as the Sickness Fund Act

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(*Ziekenfondswet*, ZFW). It gradually extended to the self-employed, retirees, and their family dependants and the elderly over the years. Approximately two thirds of the Dutch population was covered by the ZFW in the 1990s. Sickness funds had to accept ZFW-insured as clients, and provided them benefits-in-kind through contracted healthcare facilities. Comprising approximately 5% of the population, civil servants and teachers could count on special health insurance arrangements for basic healthcare needs. The rest of the Dutch population had to rely on voluntary private insurance to cover basic healthcare needs. The latter paid, however, premiums for the larger share of elderly among the ZFW insured (so-called MOOZ-premium), and for those who were refused by health insurers and who could therefore count on a low-priced standard health insurance policy (WTZ-premium). In 2006, a single, universal, and compulsory health insurance (*Zorgverzekeringswet*, *Zvw*) replaced the ZFW and the voluntary basic health insurance.<sup>15</sup> Health insurers have to accept any client looking for compulsory basic health insurance. Clients can switch annually. Insurers compete at the level of the nominal premiums, and the healthcare offered. Within this new health insurance system, private healthcare insurers reimburse clients' healthcare bills obtained anywhere in the world (maximised by Dutch tariffs), or contract healthcare providers (if necessary abroad) to provide healthcare to their clients (although they can also obtain healthcare from non-contracted providers and receive reimbursement at a certain level). A system in which health providers deliver healthcare to patients, while being paid directly by health insurers is called a benefit-in-kind system. In Germany, most healthcare is provided on a benefit-in-kind basis. In a reimbursement system, such as in Belgium and Luxembourg, patients can freely choose a care provider for treatment and send the bill to their health insurance funds for reimbursement afterwards.

#### *8.2.3 Centralisation in the Dutch healthcare state*

Next to impersonal, geographically inclusive solidarity within fixed territories, healthcare systems have also experienced centralisation.

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<sup>15</sup> Hamilton, G.J.A. (2007), 'Zorgstelsel 2006: De Rollen opnieuw verdeeld', in A.C. Hendriks & H.-M. Ten Napel (eds.), *Volksgezondheid in een Veellagige Rechtsorde: Eenheid en Verscheidenheid van Norm en Praktijk*. Alphen aan den Rijn: Kluwer. pp. 11-32.



Although later than the command-and-control healthcare states, corporatist healthcare states have also centralised<sup>16</sup>, as the Dutch healthcare system exemplifies. As with many other continental healthcare systems, organisational logics based on function or personal characteristics have dominated the history of health governance in the Netherlands. Health insurance funds originated from the guilds' arrangements to mutually cover health costs. Since the late 19<sup>th</sup> century, so-called cross organisations of various religious and ideological backgrounds were involved with home care and health prevention. Local municipalities did exercise some territorial control regarding health, among other things to protect their populations against epidemic diseases. The Dutch government only very gradually enhanced its grip on this patchwork within its territory. Around 1900, its task was largely limited to the supervision and quality control of health providers. When the health of the Dutch population became its increasing concern after the First World War due to urbanisation, industrialisation and warfare, the government started to streamline health provision through subsidies with guidelines attached. Despite elaborate proposals for rearranging health insurance in the 1920s, it was not until the German occupying power decided to introduce a national arrangement in 1941. After the Second World War, Dutch governments set tight budgetary limits on the construction of hospitals and healthcare prices, even though the initiative to build hospitals remained in private hands. After a relaxation of this regime and the expansion of health insurance coverage in the 1960s, healthcare became a considerable financial burden in the eyes of many in government.

Since the early 1970s, Dutch governments have reintroduced budgetary limits on the construction of intramural healthcare facilities. Approval from the Dutch health authorities became necessary for building and exploiting intramural healthcare facilities, as well as for being eligible to be contracted by health insurance funds for ZFW and AWBZ care. This and other attempts by the government to contain health costs entailed a "process of creeping *étatization*,"<sup>17</sup> in other words,

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<sup>16</sup> Cf. Freeman (1999), *supra* note 8, p. 75.

<sup>17</sup> Schut, F.T. (1995), 'Health Care Reform in the Netherlands: Balancing Corporatism, Etatism, and Market Mechanisms', in *Journal of Health Politics, Policy and Law*. Vol. 20, p. 615.

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centralisation within the state territory. The establishment of health facilities previously originated from private activity. Beside university hospitals and some municipal health centres, most health facilities remained in private hands. Nevertheless, the government sought to plan and coordinate health provision more efficiently according to geographical spread and according to function from general to specialist care.<sup>18</sup> For example, referral from the General Practitioner or Regional Indication Organisations gave access to specialist care covered by the ZFW and the AWBZ. The Dutch health authorities set tariffs with the 1979 Health Care Prices Act (*Wet Tarieven Gezondheidszorg, WTG*), after consultation with insurance funds and health providers. Governments also succeeded in introducing geographical planning of expensive healthcare facilities. However, full-scale, detailed planning of the entire health sector failed in the 1980s due to the multi-level complexity of private and public actors.<sup>19</sup>

Successive attempts by Dutch governments to contain health expenditures through the introduction of competition and choice within the health sector demonstrated the tendency to centralisation. As a start in 1986, the centre-right Lubbers-II government appointed a committee led by the former Philips CEO Wisse Dekker. Among the committee members were no representatives from health interest groups. A full-scale reform of the Dutch health system according to the proposals on “managed competition” from the Dekker committee did fail under Hans Simons, junior minister for health in the centre-left Lubbers-III government. Yet free choice for patients among health insurance funds had been introduced, while until 1992 only one health insurance fund could be active per region. A wave of mergers among health insurance funds and healthcare insurance companies followed throughout the 1990s. In addition, maximum tariffs replaced fixed tariffs in the contracts between health insurance funds and health providers. Despite the political sensitivity of healthcare reform, further incremental steps were made in the 1990s and 2000s, such as the introduction of partly flat-rate

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<sup>18</sup> See Boot, J.M. & Knapen, M.H.J.M. (2005), *De Nederlandse Gezondheidszorg* (8th ed.). Houten: Bohn, Stafleu van Loghum. Ch. 5.

<sup>19</sup> Grünwald, C.A. & Kwartel, A.J.J. (1996), ‘Orderingsprocessen in de Gezondheidszorg: De Ongrijpbare Regio’, in *Beleid & Maatschappij*. No. 5, pp. 223-234.

premiums, the expansion of financial risk for health insurers, and a pricing system for health treatments (Diagnosis and Treatment Combinations).

The failure of full-scale healthcare reform has heightened the political significance of healthcare. Since 1994 a minister instead of a junior minister has been made responsible for health again. Its political significance has also risen among voters-consumers. As a majority of citizens in the EU Member States, the majority of Dutch are against the dismantling of their healthcare systems and cuts to their basic health package, adhering to the principle of solidarity and subscribing to the statement that the health rights of the lower incomes should not be diminished.<sup>20</sup> Meanwhile, rising assertiveness and expectations among patients and the ageing population have increased the demand for healthcare, as well as advances in medical technology and an increasing number of chronic patients. Since European governments have decided to curtail budgets in accordance with the EMU-norms and limit the burden of premiums and taxes to remain internationally competitive, the fulfilment of citizens' healthcare demands have come under pressure. The centralisation of authority due to their budget-motivated interventions has increased the accountability of governments to provide timely access to affordable healthcare of high quality.<sup>21</sup>

In 1995, the ministry of health was warned that due to cuts in training positions and annual limits to hospital finance waiting lists may soon become a political problem. Because no parliamentary question on waiting lists had been submitted, the ministry did not consider them a political issue. In 1996, the Sickness Benefits Act (*Ziektewet*) changed, however, to the effect that employers had to cover the first year of sick leave. Due to this privatisation of sick pay, employers launched initiatives to provide priority care for their employees. Medical airlifts to Switzerland encountered fierce criticism from particularly left-wing parties, because they feared that affluent and employed patients would be given priority over non-affluent and unemployed patients, leading to the creation of

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<sup>20</sup> European Commission (1998), *Eurobarometer Survey 49*.

<sup>21</sup> Freeman, R. (1999), *supra* note 8; Grinten, T.E.D. van der & Kasdorp, J. (1999), 25 *Jaar Sturing in de Gezondheidszorg: Van Verstatelijking naar Ondernemerschap*. Den Haag: SCP. p. 46.

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dual systems of healthcare.<sup>22</sup> The government promised to combat waiting lists in exchange for employers stopping preferential treatment for their employees.

After becoming aware of the existence of waiting lists, some health insurance funds started to collect data on waiting lists to find earlier treatment for their patients. According to the rulings of a few court verdicts in the 1990s, health insurance funds have the obligation to provide healthcare to their patients in due time. Health providers and health insurance funds subsequently agreed upon norms in 2000, defining the acceptable waiting times for treatments (known as the Treek norms). Dutch citizens perceive, however, that their government as primarily responsible for affordable and timely access to healthcare.<sup>23</sup> Although the waiting lists were not necessarily shorter in the early 1990s, the issue became politically sensitive once citizens became aware of it. While only 11% to 13% of the respondents in the Dutch Election Studies considered healthcare as one of the main national problems in the 1980s and the 1990s, by 1998 healthcare was considered problem number 3 by 33% of the respondents.<sup>24</sup> In 2000 the government decided to loosen budgetary constraints on the reimbursement of AWBZ-covered services, allowed commercial companies to deliver AWBZ home care, and provided extra funding to hospitals with waiting lists. An explosive rise in public health expenditures ensued from 8.3% of GDP in 2000 to 9.3% of GDP in 2002.<sup>25</sup> Despite the government's efforts to cut waiting lists, they became the most important issue in the turbulent Dutch elections of 2002 and 2003. 57% and 52% of the respondents, respectively, mentioned healthcare as the most important issue in the Dutch Elections Studies.<sup>26</sup> Just after the 2003 elections, the government tightened its budgetary

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<sup>22</sup> Grinten, T.E.D. van der & Kasdorp, J. (1999), *supra* note 21.

<sup>23</sup> Centrum voor Verzekeringsstatistiek (2002). *De Consument aan het Woord: Onderzoek naar de Mening van de Consument over de Gezondheidszorg en de Ziektekostenverzekering* (report at the request of the Verbond van Verzekeraars). Den Haag: Centrum voor Verzekeringsstatistiek.

<sup>24</sup> Aarts, K. (1994), 'Nationale Politieke Problemen, Partijcompetentie en Stemgedrag', in J.J.M. van Holsteyn & B. Niemöller (eds.), *De Nederlandse Kiezer: 1994*. Leiden: DSWO Press. p. 178.

<sup>25</sup> OECD Health data (2005), [www.oecd.org](http://www.oecd.org).

<sup>26</sup> Holsteyn, J.J.M. van (2003), 'Minderheden en de Verkiezingen van 15 mei 2002', in H. Pellikaan & M. Trappenburg (eds.), *Politiek in de Multiculturele Samenleving*. Amsterdam: Boom. pp. 104, 120.

control of health costs again. A major overhaul of the Dutch health insurance system followed in 2006, effectively implementing the main ideas of the Dekker committee on competition and choice. The Dutch health authorities continue to be central in the Dutch healthcare system, for they remain constitutionally responsible for the affordability, quality, and access of healthcare. That requires a comprehensive set of regulatory bodies to oversee and supervise the mainly private health providers and health insurers.

As the Dutch healthcare system shows, the logic of territoriality has left its mark on the organisation of the healthcare system. The territorial basis of the healthcare state has also left its imprint on the behaviour of health users. For example, an airlift from the Netherlands to Houston (Texas), Geneva, and London in 1974 for heart surgery raised a “xenophobic” protest, accompanied with the “shame that we need to use care abroad.”<sup>27</sup> According to ZFW and AWBZ legislation, only if a health insurance fund could not provide (top-clinical) healthcare through its contracted health providers in due time, while the patient is in need of treatment and the treatment is covered by mandatory health insurance, then it should grant the client the privilege to receive care from a non-contracted provider in the Netherlands or abroad. The provided healthcare had to be considered, however, as acceptable among Dutch medical professionals.<sup>28</sup> The other exception to the territorial closure of the Dutch healthcare state existed in the Zeeuws-Vlaanderen region. The rationing of healthcare facilities in the 1970s had reduced hospital capacity in this relatively isolated border region (at least as viewed from the Dutch government’s perspective). The regional health insurance fund OZ closed an informal deal with Belgian hospitals in Ghent, Bruges, and Knokke-Heist for its approximately 100,000 clients to treat them via a simplified E112-procedure.<sup>29</sup> The Dutch health authorities somewhat reluctantly sanctioned this deal in 1978.

Elsewhere in the European Union, only selective patients made use of healthcare across borders because of the dissatisfactory state of healthcare at home (Italy) or the insufficient availability of (top-clinical) healthcare

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<sup>27</sup> Quotations without reference are drawn from interviews.

<sup>28</sup> Most, J.M. van der (2002), ‘Zorg in het Buitenland vanuit Juridisch Perspectief’, in CVZ (2002), *Kwantiteit en Kwaliteit in Evenwicht*. Amstelveen: CVZ. pp. 35-50.

<sup>29</sup> See below for an explanation of the E112-procedure.

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(Luxembourg).<sup>30</sup> The cross-border consumption of healthcare covered by mandatory health insurance took a fairly negligible share of the total public health spending within the EU-area until recently, estimated at 0.17% in 1989 and 0.50% in 1997.<sup>31</sup> In addition, the willingness among EU citizens to share their welfare with others seems to be limited, even if they are coming from other EU member states.<sup>32</sup> Solidarity has thus been locked in the fixed territories of healthcare states. However, European legislation has now offered exit and entry options to those healthcare states.

#### **8.3 European exit options from European healthcare states**

The International Labour Organisation (ILO), the World Health Organisation (WHO), the United Nations, and the Council of Europe have set certain minimum health standards, such as the basic health package to be covered or provisions for sick leave and maternity leave. Moreover, similar to the operation of the Organisation of Economic Co-operation and Development, such organisations have been platforms used to transfer ideas and best practices in healthcare policy among the participating states. Until the early 1970s, only one civil servant at the Dutch ministry of health was responsible for the contacts with these international organisations.

European integration has, however, gradually weakened the borders of the healthcare states. It has not only offered patients opportunities to obtain healthcare abroad, but has also challenged step by step the image of a closed healthcare state among health policy-makers, as the responses of Dutch health policy-makers will show below. Since the Dutch healthcare system is one of the first healthcare systems on the European continent to introduce market elements, as well as experiments with cross-border healthcare in its border regions, its analysis would be most fruitful in helping explore the weakening logic of territoriality.

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<sup>30</sup> France, G. (1997), 'Cross-border Flows of Italian Patients within the European Union: An International Trade Approach', in *European Journal of Public Health*. Vol. 7, no. 3 (supplement), pp. 19-32.

<sup>31</sup> Palm, W., Nickless, J., Lewalle, H. & Coheur, A. (2000), *Implications of Recent Jurisprudence on the Coordination of the Health Care Protection Systems* (report at the request of DG Employment and Social Affairs). Brussels: AIM. p. 37.

<sup>32</sup> Ferrera (2005), *supra* note 3, p. 1.

8.3.1 Regulation 1408/71<sup>33</sup>

In principle, no barriers exist to healthcare access across national borders because of the freedom of movement and residence in Western Europe. The question remains, however, how the costs of cross-border healthcare will be covered. Since the late 19<sup>th</sup> century, a few bilateral agreements have provided frontier workers and transport workers access to and reimbursement of cross-border healthcare in Western Europe. For instance, Belgian family doctors and midwives can provide health to Dutch ZFW clients according to the 1868 Dutch-Belgian Convention and the 1947 Dutch-Belgian Treaty. At the European level, regulations have existed to cover cross-border healthcare costs for all socially insured workers by coordinating the participating social security systems since 1958. These regulations were based on the 1957 Treaty of Rome article to facilitate the freedom of workers. The Regulations 1408/71 and 574/72 provide various procedures to determine the competent healthcare state to cover the costs of cross-border healthcare. The most relevant procedures are arranged through the E-111 and E-112 form, covering cross-border healthcare of socially insured citizens.

Coverage of costs necessary for immediate care during a temporary stay abroad for both professional or private purposes are arranged via an E-111 procedure. In case of acute, unplanned emergency healthcare abroad, the health insurance institution 'at home' will then cover these health costs. Since 2004, emergency care also includes medical treatments necessary during trips abroad. As a consequence, a chronic patient can still receive renal dialysis or oxigenotherapy, even though he or she knows in advance that treatment will be necessary during the stay abroad. Initially, this procedure was foremost aimed at providing Southern-European workers in Northern Europe the possibility of obtaining coverage of healthcare costs while being on holiday in their home country. Since the late 1970s, tourists have increasingly made use of the E-111 procedure. Until recently, the procedure represented, however, quite an administrative burden for all those involved for only a potential chance of treatment abroad. An E-111 form had to be requested from a domestic

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<sup>33</sup> In due time (not expected before 2010), Regulation 1408/71 will be replaced by Regulation 883/2004, which has been in force since May 2004, but not applied pending the approval of the necessary implementation measures.

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health insurance institution before travel. Many tourists were, however, uninformed about the form's existence.<sup>34</sup> In certain countries, some foreign health insurance institutions also wished to approve the E-111 form in advance to obtain reimbursement for yet unforeseen emergency care. In addition, healthcare providers often preferred to arrange payment via travel insurance, since the payment is faster, direct and less bureaucratic. The national healthcare authorities and the special Administration Commission at European level which deal with E-111 administration and finance, take much more time than a travel insurance company. Since June 2004, the bureaucratic E-111 paper procedure has gradually been replaced by the European health insurance card (see below). Next to workers and tourists, an increasing number of retirees use the E-111 form and later the European health insurance card to cover healthcare costs when they stay a couple of months abroad.<sup>35</sup>

When an employee plans to seek treatment in another Member State, he/she should request prior authorization from the competent health insurance institution via a so-called E-112 form indicating the desired medical treatment and the period in which the treatment might be obtained. This authorization cannot be refused if two conditions are fulfilled, 1. the desired treatment is part of the employee's healthcare package, and 2. that the treatment cannot be given within the period that is normally necessary in view of a patient's state of health and the probable course of his or her disease. The first condition has thus been set by the Council of Ministers in 1981, after the European Court of Justice interpreted a previous version of the E-112 procedure too patient-friendly, which would have allowed patients to use any more effective health treatment abroad if it was not available in their home country.<sup>36</sup> For the most part, the authorisation has been applied fairly restrictive; it was considered a privilege only granted in exceptional circumstances.<sup>37</sup> It

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<sup>34</sup> Hermans, H.E.G.M. & Berman, P.C. (1998), 'Access to Health Care and Health Services in the European Union: Regulation 1408/71 and the E111 Process', in R. Leidl (ed.), *Health Care and its Financing in the Single European Market*. Amsterdam: IOS Press. pp. 324-343.

<sup>35</sup> See contributions in Rosenmöller, M., McKee, M. & Baeten, R. (eds.) (2006), *Patient Mobility in the European Union: Learning from Experience*. Copenhagen: WHO.

<sup>36</sup> Jorens, Y. (2002), *supra* note 12, pp. 91-92.

<sup>37</sup> Mei, A.P. van der (2004), 'Cross-border Access to Medical Care: Non-hospital Care and Waiting Lists', in *Legal Issues of European Integration*, Vol. 31, no. 1, pp. 57-67.



was only in Italy and Greece that patients obtained authorisation relatively easily. This was because the health insurance institutions considered the domestic healthcare facilities as underdeveloped in comparison to those in, for example, France.<sup>38</sup> Both the E-111 and E-112 procedure cover costs of treatment according to the tariffs in the country of treatment. Additional costs, such as travelling expenses and accommodation expenses, should also be reimbursed if they are included in the insurance package of patients' country of residence. National healthcare authorities and the EU-level Administrative Commission deal with the financial settlements of cross-border healthcare. Bilateral agreements can specify further cross-border health insurance arrangements within the Regulation framework, such as the 1980 bilateral agreement between the Netherlands and Belgium regarding access to healthcare for relatives of frontier workers.

The European privilege of coverage of healthcare abroad has been gradually extended from employees and their (surviving) relatives to virtually all people with a social health insurance legally residing in the EU, such as, former employees, those being self-employed and their dependants, students and those undertaking professional training and their families, transport workers, pensioners, posted workers, stateless persons, refugees, unemployed persons looking for a job in another Member State, civil servants, and eventually also to all legally resident socially insured third-country nationals (with remaining restrictions on their right of residence).<sup>39</sup> Furthermore, the Regulation method applies in the European Economic Area (EU plus Liechtenstein, Norway and Iceland), and with certain restrictions in Switzerland. In addition, the European Court of Justice decided in 2005 that a *foreign* health provider within the EU/EEA area can refer a patient to a health provider for emergency treatment *outside* the EU/EEA area.<sup>40</sup>

Regulation 1408/71 overrules the principle of territoriality of national healthcare systems, even though European treaties acknowledge Member

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<sup>38</sup> France, G. (1997), *supra* note 30.

<sup>39</sup> In Denmark, only those having the nationality of EEA Member States and Switzerland, as well as stateless persons and refugees are covered by Regulation 1408/71. Anywhere else in the EU, those having a foreign (also non-EEA) nationality are covered if they belong to the national social security systems of a EU Member State. For Switzerland, Norway, Iceland and Liechtenstein similar restrictions hold.

<sup>40</sup> Case C-145/03 *Keller* (2005) ECR I-2529.

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States' prerogatives regarding the organization and financing of their healthcare systems. But health authorities of the EU Member States can no longer freely determine the consumption, purchasing and provision of healthcare within their territories.<sup>41</sup> Therefore Stefan Leibfried and Paul Pierson disagree with the conclusion that "territorial sovereignty in social policy, as conventional wisdom has it, is alive and well."<sup>42</sup> Healthcare systems in the EU-area are no longer territorially "closed shops"<sup>43</sup>, as Van der Mei explains: "the co-ordination system (i.e. Regulation 1408/71, HV) deterritorialises the national systems in order to ensure that migrants are entitled to benefits on the basis of their own insurance record."<sup>44</sup>

Insurance rights follow the worker anywhere in the area of the Member States, meaning a "personalization" of previously territorially restricted rights.<sup>45</sup> While regulation 1408/71 was originally aimed at the freedom of movement of workers, it has been expanded such that "under certain circumstances, the fact that a person has never worked or resided in another Member State is not, as such, an obstacle to entitlement to medical care in another Member State."<sup>46</sup> However, some limits on health tourism exist. Restrictions on the freedom of mobility and residence are justified if public security, public policy, or public health is at stake. A list of disabilities and contagious and infectious diseases drafted by the World Health Organisation (WHO) determines whether a person is considered a threat to public health. In addition, people are required to have health insurance if they want to stay longer than 6 months in another Member State to prevent new residents overburdening the host Member State.

#### *8.3.2 The Single European Act*

In the 1980s, Dutch health authorities feared that patients may seek expensive top-clinical care abroad. They did not want to make the Dutch healthcare system dependent on foreign developments in medical

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<sup>41</sup> Leibfried, S. & Pierson, P. (1995), *supra* note 12, 50ff.

<sup>42</sup> *Idem*, p. 44.

<sup>43</sup> Leibfried, S. & Pierson, P. (2000), 'Social Policy', in H. Wallace & W. Wallace (eds.), *Policy-making in the European Union* (4<sup>th</sup> ed.). Oxford: Oxford University Press. p. 283.

<sup>44</sup> Mei, A.P. van der (2001), *supra* note 12, p. 75.

<sup>45</sup> Watson, Ph. (1980), *Social Security Law of the European Communities*. London: Mansell Publishing.

<sup>46</sup> Cornelissen, R. (1996), *supra* note 12, p. 463.

technology, and changed in 1988 the ZFW and AWBZ accordingly. In principle, a Dutch patient could only enjoy healthcare from the providers contracted by his or her health insurer. A patient could ask permission to be treated by a non-contracted health provider in the Netherlands, if the treatment is covered by the mandatory health insurance and medically necessary. The Dutch minister could decide under which conditions and what cases patients may ask permission for healthcare abroad.<sup>47</sup> Thus, Dutch legislation effectively sealed off the borders of the Dutch healthcare system. The encroachment on territorial sovereignty by Regulation 1408/71 did not draw much attention from the Dutch health authorities. It was not until the creation of a Single European Market and the Schengen area that Dutch health authorities became aware of the potential impact of European integration on their formerly territorially closed system. For instance, the Dutch health authorities changed the health insurance legislation out of fear of health tourism in the newly established Schengen area without internal borders. People were eligible for AWBZ care only after a maximum of 12 months residing on Dutch territory.<sup>48</sup>

Dutch health authorities had already seen impact of European legislation on the organisation, financing and delivery of healthcare in the Netherlands. In the 1970s and 1980s, the European Court of Justice ruled in a few cases on reduction of medicine prices and medicine imports. When the Dutch health authorities tried to conclude a cartel-like medicine price agreement, the European Commission has been consulted several times.<sup>49</sup> Nevertheless, the final rejection of the agreement by the European Commission at the request of a small pharmaceutical company did take many by surprise. Debating the Dekker proposals on healthcare reform for the first time, it struck the conservative-liberal MP Nijhuis (VVD) that the proposals did not refer to the European Single Market.<sup>50</sup> He also expressed his concerns about competition from foreign health

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<sup>47</sup> Staatscourant (30 June 1988), *Besluit van de Staatssecretaris van Welzijn, Volksgezondheid en Cultuur in gevolge art. 9, vierde lid, van de ZFW*. No. 4026859.

<sup>48</sup> Kamerstukken II 1990/91 20596 *Voltooiing van de interne markt*, no. 19 (24 October 1989) p. 19, and no. 36 (11 April 1991) p. 25

<sup>49</sup> De Kruijff, M.I. (1993), 'Neocorporatisme en de Geneesmiddelensector: Het Belang van het Omni Partijen Akkoord', in *Beleid & Maatschappij*. No. 4, pp. 182-193.

<sup>50</sup> Kamerstukken II 1987/88 19945 *Gezondheidszorg: plan-Dekker* (1 June 1988), p. 83-4398; (8 June 1988), p. 86-4678; (9 June 1988), p. 87-4725.

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insurance companies in an already overcrowded Dutch health insurance market. Some parliamentarians were also worried about foreign patients occupying beds in Dutch hospitals or patients with higher income seeking healthcare abroad.<sup>51</sup> Junior minister for health Dick Dees (1986-1989) promised to watch European developments closely, as well as to report on the impact of the internal market on healthcare issues.<sup>52</sup> In response to parliamentary questions, the government later acknowledged that European legislation on health services and goods does exert influence on the Dutch healthcare system.<sup>53</sup> Since 1990 the ministry of health has therefore had a representative at Dutch Permanent Representation in Brussels. The Dutch government managed together with its Irish and German counterparts to exempt substitutive social insurance from the third insurance directive (1992). The Dutch government could therefore still oblige private health insurance companies to offer a standard health insurance policy for the group of privately insured (WTZ), and to levy premiums for them and the overrepresentation of old clients in the group of obligatory socially insured (ZFW). It thus attempted to keep European influence at bay in its health insurance system.

In a parliamentary debate on the Single European Market in April 1991, a MP asked about the implications of cross-border patient mobility. According to Hans Simons, junior minister for health (1989-1994), hospitals particularly in border regions reported problems with their capacity and cross-border payments. He promised an inventory report and mentioned that at local level flows of foreign patients could be taken into account.<sup>54</sup> Meanwhile, law professors warned that European legislation circumscribes the introduction of more competition and choice in the Dutch healthcare system.<sup>55</sup> According to a health official

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<sup>51</sup> Kamerstukken II 1988/89 20620 *Grenzen aan Zorg* (23 January 1989), pp. 27-3, 27-19, 27-35.

<sup>52</sup> Kamerstukken II 1987/88 19945 *Gezondheidszorg: plan-Dekker* (2 June 1988), p. 84-4472; (9 June 1988), p. 87-4725; Kamerstukken II 1988/89 20800 XVI *begroting WVC* (24 November 1988), p. 28-1661.

<sup>53</sup> Kamerstukken II 1989/90 20596 no. 19 *De voltooiing van de interne markt* (24 October 1989), p. 19.

<sup>54</sup> Kamerstukken II 1989/90 20596 no. 20 *De voltooiing van de interne markt* (8 January 1990), p. 9.

<sup>55</sup> See, for instance, Kuile, B.H. ter, Pre, F.M. du & Sevinga, K. (1989), *Health Care in Europe after 1992: The European Dimension. Congress Paper* (16-18 October, Erasmus University Rotterdam); Harmonisatieraad Welzijnsbeleid (1989), *Het Europese Integratieproces: Gevolgen op Sociaal en Cultureel Terrein in Nederland*; Kuile, B.H. ter

interviewed, the law professors were initially not taken too seriously, also by fellow health law professors, “because no one could imagine that Brussels or even Luxembourg would determine what happens in our Kingdom.” However, the State Council (*Raad van State*), the main advisory board on legislation, also emphasised that European legislation might have consequences as soon as market elements are introduced in the Dutch healthcare systems.<sup>56</sup> For instance, doubts existed on how the mandatory health insurance could be executed by private health insurers, and of the possibility of a coupled supply of mandatory basic health insurance and voluntary supplementary insurance. Particularly the Senate urged Simons to contact the European Commission, while it followed a crash course on European legislation. Despite his regular contacts with the European Commission, Simons could not soothe concerns about the potential impact of European legislation since only the European Court of Justice could decide on the Euro-compatibility of the Dutch healthcare system. Right-wing parties in the Senate and employers federations eventually used, or abused according to Simons, this alleged incompatibility as one of their arguments to block healthcare reforms.<sup>57</sup>

The law professors also raised questions about the compatibility of the Dutch hospital planning system with increasing competition and mobility due to the creation of the European Single Market and the Dutch healthcare reforms. The Hospital Facilities Construction Board (*College Bouw Zorgvoorzieningen*) issued a report in June 1990 entitled “Healthcare facilities in a Europe without frontiers.”<sup>58</sup> It claimed that limiting the free movement of health goods and services was justifiable for reasons of cost containment, geographical spread, quality control, and public health. Hans Simons reported to parliament that he would discuss the possibility of cooperation regarding very expensive top-clinical healthcare at European level, also in response to a parliamentarian worry that Dutch top-clinical healthcare facilities (basically university hospitals) cannot be

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(16 January 1990), *Gezondheidszorg in de Greep van het Gemeenschapsrecht* (Lecture for Staff of the National Health Council).

<sup>56</sup> Kamerstukken II 1989/90 21592 B *Wet Stelselwijziging Ziektekostenverzekering tweede fase*, *Advies Raad van State* (8 March 1990), *Nader Rapport* (5 June 1990).

<sup>57</sup> Kamerstukken I 1991/92 21592 no. 52g *Wet Stelselwijziging Ziektekostenverzekering tweede fase*, *Nadere Memorie van Antwoord* (11 November 1991).

<sup>58</sup> *College Bouw Ziekenhuisvoorzieningen* (1990), *Ziekenhuisvoorzieningen in een Europa zonder Grenzen*. Utrecht: CBZ.

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considered “too isolated.”<sup>59</sup> In the second half of 1991, after a Conference on Health held under Dutch presidency, the European health ministers “recognize(d) that Member States need to make allowances for the effects that the completion of the internal market may have on the operation of healthcare services and their nature and extent.”<sup>60</sup> They agreed to exchange information and initiate research on the impact of the internal market on national healthcare systems, and to analyse how cross-border healthcare may help present problems in supply and demand. The High Level Committee on Health was established in 1991 as an informal body of health officials from the Member States. The establishment of this body indicates that governments, and in particular the Dutch one, were becoming aware that their healthcare states might no longer be unaffected by European integration. This de-consolidation of healthcare state borders further undermines the notion of geographical exclusivity.

#### *8.3.3 INTERREG: exit options in border regions*<sup>61</sup>

The Single European Market-programme officially aimed at balancing economic competition with social protection. The European Commission and ministers of social affairs emphasised throughout the 1990s in recommendations and communications on social protection the importance of universal access to healthcare for all citizens of Member States, and pleaded for optimal use of existing health resources, also in border areas.<sup>62</sup> In an answer to MEP Vincenzo Mattina, the Commission stated restrictions on the free movement and free residence were justified, if affordable high-quality care would require it.<sup>63</sup> Notwithstanding the lofty words spent on providing sufficient healthcare in each Member

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<sup>59</sup> Kamerstukken I 1990/91 21200 *Wet versterking WZV-instrumentarium* (23 April 1991), p.24-808.

<sup>60</sup> Council of Ministers/ Ministers for Health (1991), Resolution of the Council and Ministers for Health, meeting within the Council of 11 November 1991 concerning Fundamental Health-policy Choices. O J C 304/05.

<sup>61</sup> This paragraph is partly based on Vollaard, H. (2004), ‘Solidarity, Territoriality and Healthcare: Cross-national Policy Learning in Europe’, in E. Vigoda-Gadot & D. Levi-Faur (eds.), *International Public Policy and Management: Policy Learning beyond Regional, Cultural and Political Boundaries*. New York: Marcel Dekker. pp. 267-296.

<sup>62</sup> See, e.g., Council of the European Communities (1992), *Recommendation on the Convergence of Social Protection Objectives and Policies*. 92/442/EEC; European Commission (1997), *Communication: Modernising and improving Social Protection in the European Union*. COM(1997) 102.

<sup>63</sup> Mattina (13 January 1992), 2977/91, O J 92/C 235/27.

State, a formally non-binding, soft-law approach prevented citizens from claiming better healthcare from their governments based on these European policy statements.<sup>64</sup>

Since the Maastricht Treaty, the European Community has been formally competent regarding public health, involving health promotion and disease prevention (instead of cure and care). It thus elaborates on the general obligation of the Single European Act to enhance a high level of health protection in European harmonisation measures, and with previous initiatives to combat cancer and AIDS. Particularly for this reason, the health ministers of the Member States, who had previously only occasionally met to discuss matters as well as the budgetary pressures of their healthcare systems, started to meet regularly in 1986.<sup>65</sup> Beginning in 1993, the European Commission launched several programmes of action in the field of public health, in which several Dutch health organisations acted in a leading position.<sup>66</sup> Following the 1991 Council statement, research programmes have also been established to examine the potential effects of the internal market on healthcare systems. Even though EU-initiatives intend to improve health in general in all European policy areas, the European Commission has maintained a rather complementary role in public health.<sup>67</sup> Moreover, the governments of EU Member States have emphasized repeatedly in Council statements their prerogatives regarding the financing and organization of their healthcare systems. In 1997, governments set their prerogatives down explicitly regarding healthcare in the Amsterdam Treaty.

Nevertheless, the healthcare systems of the Member States did not remain unaffected by European integration. For example, harmonised legislation on competition, data protection, public procurement, the free movement of health professionals, the pharmaceutical industry and sales within the internal market have (indirectly) influenced the organisation, delivery and financing of healthcare. The impact of the Single European Market on cross-border patient mobility did not come immediately from initiatives regarding social protection, public health or harmonising

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<sup>64</sup> Belcher, P. (1999), *supra* note 1, p. 53.

<sup>65</sup> De Gooijer, W. (2007), *Trends in EU Health Care Systems*. New York: Springer. pp. 144-145.

<sup>66</sup> Belcher, P. (1999), *supra* note 1, p. 21.

<sup>67</sup> *Idem*, p. 38.

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legislation, but from elsewhere. The decision to create a Single European Market was accompanied by side-payments to Member States with economically weak regions to help absorb the shocks of economic integration in the form of enlarged regional funding. On instigation of the European Commission, regional funds were also directed towards cross-border areas (Euregions) where interregional cooperation was initiated. The so-called INTERREG programme projects sought to improve cross-border cooperation and use of health resources and facilities within the Euregions. These regions were also eligible for some financial support. Eligible Euregional projects had to involve national and regional authorities as well as non-governmental actors, and would be funded by the European Commission for at maximum 50%. A number of experiments with cross-border healthcare have been launched at the Dutch borders, often motivated by the idea of a borderless Europe.

#### *8.3.3.1 Euregion Meuse-Rhine*

Within the Interreg-I programme (1991-1993), several Interregional Projects on Healthcare (*Interregionaal Project Gezondheidszorg*) have been carried out in the Euregion Meuse-Rhine. This area of about 3.8 million residents comprises the cities of Sittard, Maastricht (the Netherlands), Aachen (Germany), Genk, Hasselt, Eupen, and Liège (Belgium). In the 1980s in each country, three university hospitals were built within a circle of 80 kilometres diameter. These hospitals analysed in the early 1990s which opportunities exist to co-operate and share specialised resources across borders, drawing up inventories of the differences among the systems regarding indications of health, patient treatment and hospital financing.<sup>68</sup> The regional administration of the Dutch province of Limburg subsequently urged that the issue of cross-border healthcare should be dealt with more extensively within the Euregional framework. In January 1994 the executive board of the Euregion Meuse-Rhine established a temporary committee to report on cross-border healthcare.

The primary objective was to propose practical solutions for the problems experienced by individual patients obtaining basic healthcare

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<sup>68</sup> Starmans, B., Leidl, R. & Rhodes, G. (1997), 'A Comparative Study on Cross-Border Hospital Care in the Euregio Meuse-Rhine', in *European Journal of Public Health*. Vol. 7, no. 3 (supplement), pp. 33-41.



across the border, while fully respecting the national healthcare systems. The committee proposed ways to overcome the problem of patients having to travel much further within their domestic system for (top-clinical) care while just across the border similar care was available but not easily accessible because of complicated administrative procedures.<sup>69</sup> The committee also pleaded for co-operation in the field of ambulance care. The Meuse-Rhine report inspired health insurers within the three countries to co-operate, while they had barely looked across the borders before. This turn towards cross-border co-operation originated from sessions during Euregional meetings and report hearings, as all health insurers started to realise they were confronted with the same administrative burden of the E112 authorisation procedures for cross-border care. They therefore concluded agreements to ease these procedures in 1994 and 1996, and submitted proposals to obtain funding within the Interreg-II programme (1994-1999) for their cross-border experiments.

In her response to parliamentary questions on healthcare for frontier workers, the Dutch minister for health Els Borst announced that the experiments could be exercised under the aegis of the Health Insurance Board (before 1999: *Ziekenfondsraad*; after 1999: *College voor Zorgverzekeringen*, CVZ) with co-financing from the ministry and the board in order to gain actual experience with cross-border care based upon the previous inventories and to establish information and communication networks in the Euregions. The minister and board, however, clearly stated that the projects should not become an extra burden to the national health infrastructure and the health budget, and the co-operation should be controllable, manageable, and not irreversible.<sup>70</sup> Based on the co-operation of the health insurers mentioned, simplified authorisation procedures were implemented to obtain certain types of healthcare in Belgium or Germany for Dutch socially insured clients in the Meuse-Rhine Euregion in the period April 1997 till

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<sup>69</sup> Bijzondere Euregionale Commissie Grensoverschrijdende Zorg (1994), *Zorg Dichtbij óók over de Grens: Advies over Grensoverschrijdende Zorg in de Euregio Maas-Rijn*. Maastricht: Euregio Meuse-Rhine.

<sup>70</sup> Kamerstukken II 1994 1995 Question no. 1164 *Tandartsverzekering voor Grensarbeiders* (15 June 1995), Appendix, p. 2395; Ziekenfondsraad (16 November 1995), *Besluit Regeling Ziekenfondsraad Subsiëring Onderzoek Experiment Grensoverschrijdende Zorg*. Amstelveen: Ziekenfondsraad.

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November 1998 within the *Zorg op Maat* Project (ZOM, Tailor Made Care Project). These clients only required a referral from their general practitioners (GPs) via a special E112 form to go abroad for ambulant specialist healthcare. The patient thus received unconditional approval to seek a doctor within the border region within a maximum period (usually 3 months), instead of obtaining permission from its health insurer for a specified doctor for one single case. The ministry of health and the Health Insurance Board requested a discussion on the need for further structuring of cross-border cooperation in an evaluation of the ZOM project. According to the subsequent evaluation report this would have economic advantages, but “it requires giving up the autarkic healthcare of each country.”<sup>71</sup> The ZOM project was extended on 1 October 2000 to Belgian and German patients from the Euregio within the so-called IZOM-project (*Integratie*, Integration ZOM). The simplified procedures still exist in the Euregio Meuse-Rhine. An international health card (since 2000) for those insured by the health insurers CZ (the Netherlands) and AOK (Germany), and the Euregio Health Portal ([www.euregiogezondheidsportaal.nl](http://www.euregiogezondheidsportaal.nl); since 2002) have facilitated further access to cross-border healthcare facilities in this and adjacent border regions.

Studies regarding ambulance care and the complementarities of top-clinical care in the Meuse-Rhine Euregio and other border regions have been made since 1998.<sup>72</sup> Concerns existed on the late arrival of ambulances particularly in peripheral border areas. This has resulted in agreements between border municipalities and hospitals at the German-Dutch and Dutch-Belgian borders to provide transport, blood transfusion services, or speed access to advanced hospital care. The issue of ambulance care has been adopted by broader cross-border consultative bodies. Co-sponsored by the Netherlands government, programmes were launched in 1998 to enhance co-operation among rescue workers, specialists and other actors involved in major accidents. Attempts were

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<sup>71</sup> Grunwald, C.A. & Smit, R.L.C. (1999), *Grensoverschrijdende Zorg: Zorg op Maat in de Euregio Maas-Rijn: Evaluatie van een Experiment* (report at the request of the Health Insurance Board, no. 816). Utrecht: Nzi (my translation).

<sup>72</sup> See, e.g., Biert, J. & Wolf, K. de (1999), *Grenzüberschreitende Traumatologie: Studie über die Möglichkeiten der Zusammenarbeit in der Unfallmedizin* (report at the request of the Euregio Rhine-Waal). Kleve: Euregio Rhein-Waal; Medisch Contact (29 March 2002), ‘Zorg in Limburg gaat over de Grens’.

also made to resolve the non-compatibility of communication systems, differences in tariffs, insurance coverage and qualified personnel required, and language problems (French, German, and Dutch).<sup>73</sup> After the 9/11 attacks in the United States of America, the implementation of a common mechanism for co-ordinating interventions for civil protection in cross-border emergency situations were sped up.<sup>74</sup> Most of the initiatives mentioned above in the Euregion Meuse-Rhine were also partly financed within the Interreg-III co-sponsored project "Cross-border Healthcare in the Euregion Meuse Rhine" (2000-2006). The aim is to present the Euregional healthcare cooperation as a model for the rest of Europe. In addition, an advisory committee issued a report at the request the Limburg government entitled "The Future of Limburg is across the border" which urged the national government in The Hague to allow more space for cross-border health cooperation in the Meuse-Rhine Euregion.<sup>75</sup> The committee blamed "nationalistic thinking" for neglecting the potential as well as the specific problems and needs of this border region. The other regional governments in the Euregion face similar problems with their governments in Brussels, Berlin and Düsseldorf. The committee proposed the creation of an Euregional political structure (at present, the Euregion is a private foundation), in order to establish cross-border cooperation among university hospitals. As a collective of interface regions, the Euregion Meuse-Rhine may thus seek an escape from its peripheral position within the territories of the Netherlands, Belgium, Germany and Nord-Rhein Westphalia. The Dutch government responded positively to the committee's report, expressing its willingness to facilitate concrete problem-solving through the various cross-border arrangements along the Dutch borders.<sup>76</sup>

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<sup>73</sup> Staatscourant (5 February 2002), *Gemeenschappelijke Verklaring van Nederland, België, Vlaanderen en Wallonië inzake Grensoverschrijdende Samenwerking*. No. 64, 27; Kamerstukken II 2001/02 26 670/ 28 800 no. 9, *Grensoverschrijdende Projecten/ Zorgnota 2002* (4 April 2002).

<sup>74</sup> Kamerstukken II 2001/02, 27 556 no. 3 *Internationale Aspecten van het Beleid inzake Brandweer en Rampenbestrijding* (28 November 2001), pp. 2-13.

<sup>75</sup> Commissie Hermans (2007), *De Toekomst van Limburg ligt over de Grens: met de Euregio's als Bruggenbouwers tussen de Lidstaten*.

<sup>76</sup> Letter to the Second Chamber of Parliament (6 November 2007), *Reactie op het Rapport van de Commissie Hermans "De Toekomst van Limburg ligt over de Grens"*. 2007-0000451176. The Hague: Ministry of the Interior.

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### *8.3.3.2 Other border regions*

In 1995, a report was issued to foster cross-border information, co-ordination and communication in healthcare in the Dutch-German Euregion Rhine-Waal, an area of about 2.7 million residents, comprising the Dutch cities of Arnhem, Oss, Wageningen and Nijmegen, and the German towns of Kleve, Wesel and Duisburg.<sup>77</sup> As in the Meuse-Rhine report, the continuing unification of Europe and the freedom of movement across borders were mentioned as reasons to launch cross-border cooperation on health. Planning and hospital financing regardless of cross-border healthcare consumption and the administrative burden to obtain healthcare in another Member State were denoted as obstacles to the free movement of services, knowledge and health professionals. The Dutch health insurer VGZ also carried out research on the possibilities of cross-border healthcare in the Rhine-Waal Euregion. Since 1997, German patients have been able to obtain top-clinical care in the University Hospital Nijmegen within the Interreg-II programme, for certain pathologies that were not available at a close distance in Germany. The visits of German patients almost never exceeded the maximum amount of treatments available for German patients.<sup>78</sup> Between 1996 and 1999, a few hundred German patients were treated in Nijmegen. Since 2002, the Rhine-Waal Euregion has joined the ZOM-project. In 2005, the Euregio Rhine-Meuse-Nord also joined the ZOM project, thus including an area of 2 million residents comprising the cities of Venlo, Roermond and Weert in the Netherlands, and Krefeld, Mönchengladbach and Neuss in Germany. Within the Interreg-III programme, several projects to facilitate cross-border movements of doctors, emergency transport, and patients between German and Dutch hospitals have been initiated, also aimed at developing an “how to do” book on cross-border healthcare. In other Dutch-German Euregions, activities in healthcare have remained fairly

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<sup>77</sup> Euregio Rhein-Waal (1995), *Grenzüberschreitende Gesundheitsversorgung: Deutsch-Niederländische Zusammenarbeit im Gesundheitswesen in der Euregio Rhein-Waal, Zusammenfassung*. Kleve: Euregio Rhein-Waal.

<sup>78</sup> Hermans, H.E.G.M. & Exter, A. den (1999), ‘Cross-Border Alliances in Health Care: International Co-operation between Health Insurers and Providers in the Euregio Meuse-Rhine’, in *Croatian Medical Journal*. Vol. 40, no. 2, pp. 266-272.

limited to a single application for Interreg-II funding for specialised ambulant care.<sup>79</sup>

Within the Interreg-II Programme, a healthcare project also started under the aegis of the Euregio Scheldemond, covering the Dutch regions of Zeeuws-Vlaanderen and Western Brabant and the West-Belgian region around Ghent and Bruges. In co-operation with the Dutch health insurer OZ and Belgian Christian, liberal and socialist health insurance funds, the project aimed at simplifying the E-112 authorisation procedures for cross-border healthcare and at fostering familiarity with cross-border healthcare. Between 1997 and 2000, 30 *Euregio-zorgloketten* (Euregio healthcare offices) and an ombuds office have been established, newsletters and booklets have been published and the issues have been brought to the attention of local and regional media.<sup>80</sup> This project builds upon the previous arrangement between the local health insurance fund OZ and Belgian hospitals to provide clients from the Zeeuws-Vlaanderen region access to Belgian hospitals, as well as on studies of possibilities for further cross-border co-operation within the Interreg-I programme.<sup>81</sup>

The ministry of health, the Health Insurance Board, and most health insurance funds initially considered cross-border co-operation as a “necessary evil.” Only after the issue of waiting lists became a hotly debated issue in the Netherlands, a more rewarding stance was adopted. In its report on cross-border care, the Health Insurance Board remained concerned that the further opening of Zeeuws-Vlaanderen borders might considerably weaken the already vulnerable supply of healthcare facilities.<sup>82</sup> The approach in these instances of Euregional co-operation in healthcare can be “characterised by caution” because of the restrictions on using budgets and infrastructure, which kept the patient flows effectively under complete control.<sup>83</sup> In addition, the ministry’s participation in the Euregional co-operation in health was motivated by health officials trying

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<sup>79</sup> Ros, C.C. & Zee, J. van der (1996), *Vooronderzoek Project Grensoverschrijdende Zorg* (report at the request of the Health Insurance Board, no. 703). Utrecht: NIVEL.

<sup>80</sup> Euregiozorgloket (2000), *Grensbewoners en Grensoverschrijdende Zorgverlening* (rapport deel 1, deel 2). Ghent: Euregio Scheldemond.

<sup>81</sup> Tits, M. van & Gemmel, P. (1995), *Haalbaarheidsonderzoek Samenwerkingsnetwerk Ziekenhuizen in de Euregio Scheldemond: Samenvatting, Conclusies en Aanbevelingen*. Tilburg: IVA/ Ghent: De Vlerick School voor Management.

<sup>82</sup> CVZ (2001). *Grensoverschrijdende Zorg* (report at the request of the Ministry of Health). Amstelveen: College Voor Zorgverzekeringen. p. 38.

<sup>83</sup> Mei, A.P. van der (2001), *supra* note 12, p. 325.

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to keep the involvement of the European Commission at bay. Notwithstanding the motive to keep control of the Dutch health territory, the Euregional experiments have fostered the image of the permeability of borders. As a consequence, geographical exclusivity and centrality have weakened particularly in border regions, offering not only exit options to individual patients, but also providing peripheral authorities the chance to (partially) escape from the jurisdiction of the national territory, as in the case of Euregion Meuse-Rhine. Peripheral exits are not made without consequences, as regional authorities consider “national egoisms and defenses” hindering factors in cross-border health cooperation.<sup>84</sup>

#### *8.3.4 The European Court of Justice creates another “hole in the fence”*

After healthcare reform failed in the 1990s, concern with the potential effects of European integration on the Dutch healthcare system waned. Moreover, EU treaties explicitly mentioned the national prerogatives regarding the organisation, financing and delivery in healthcare systems. If the Dutch parliament gave any attention to cross-border issues, it dealt basically with access to AWBZ care for frontier workers and pensioners living abroad, and with the possibilities of WTZ clients (private, standard health insurance) to obtain curative care abroad. This focus often originated from the government’s desire to restrict payment and use of universal insurance such as the AWBZ to only Dutch territory. Dutch people living abroad were no longer obligatorily insured for AWBZ according to the 1999 *Besluit uitbreiding en beperking kring volksverzekeringen* (Decision on enlargement and reduction scope of universal insurance). The emphasis was thus on the impersonal Dutch territory, and not on being of Dutch nationality regardless of location. Working on Dutch territory, foreign frontier workers were included in the scope of Dutch universal insurance. There were some exceptions to this territorial measurement. Students temporarily studying abroad and civil servants and diplomats serving abroad were covered by the AWBZ and other universal insurance. An exception was also made for those living in other EU/EEA countries or in a country with a bilateral treaty.

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<sup>84</sup> Ministry of German-speaking Community of Belgium Johanna Schröder (6 March 2007), Promoting and Hindering Factors in Cross-Border Cooperation in Health. EUREGIO Project Cross-border Activities meeting, Düsseldorf (FRG).

Also covered by Regulation 1408/71, ZFW-insured living abroad could also apply for AWBZ care in another EU/EEA country according to the latter's health insurance legislation. Their health rights obtained and paid in the Netherlands could thus yet be exercised abroad, and be covered by the Dutch health authorities. Those who were privately insured and living abroad could apply voluntarily for the continuation of AWBZ insurance.

Apart from this, only those involved with the Euregional experiments or those conducting European research programmes on the impact of the internal market, were aware of the potential of EU-inflicted breaches into the Dutch healthcare territory. For some reason, however, the Dutch Central Appeals Tribunal (*Centrale Raad van Beroep*; particularly active in social security issues) was confronted with cases of denied reimbursement for cross-border healthcare which it referred to the European Court of Justice for preliminary rulings. In other EU Member States, health insurance institutions were fairly lenient in reimbursing cross-border healthcare to avoid jurisprudence.<sup>85</sup> Cases were however also referred to the Court from Luxembourg. Citizens of Luxembourg, Raymond Kohll and Nicolas Decker's daughter, had obtained healthcare abroad. They then asked for reimbursement from their health insurance fund, even though they did not have prior authorisation as Regulation 1408/71 prescribes. Kohll demanded reimbursement for spectacles and Decker wanted reimbursement for his daughter's orthodontic treatment based on the free movement of goods and services.

In April 1998, the European Court of Justice shattered, with its verdict in these cases,<sup>86</sup> Member States' image of their exclusive prerogatives in healthcare with respect to the consumption of medical goods and services and their reimbursement. The Court stipulated in the 1984 *Duphar* case that Member States should respect the freedom of goods also in social security matters; in addition, it stated in the 1984 *Luisi and Carbone* cases, that all European citizens have the right to travel to another Member State to receive medical services.<sup>87</sup> According to the Court's new interpretation of European law, patients are also allowed to obtain reimbursement of cross-border healthcare without prior

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<sup>85</sup> Palm, W. et al. (2000), *supra* note 31.

<sup>86</sup> Case C-158/96 *Kohll* (1998) ECR I-1931; Case C-120/95 *Decker* (1998) ECR I-1831

<sup>87</sup> Joined cases 286/82 and 26/83 *Luisi and Carbone* (1984) ECR 377; Case C-238/82 *Duphar* (1984) ECR 523.

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authorisation, albeit under certain conditions. Freedom of services and goods also accounts for medical treatments and devices. Even though the Court stressed the national prerogatives regarding financing, organising and delivery of healthcare, national healthcare states are not exempted from European legislation, neither with respect to competition and insurance, nor with regard to the free movement of services and goods. And public health is not an appropriate justification for hindering free movement of health services and goods, as the existing mutual recognition of health professionals' diplomas shows that the quality of health is expected to be good enough everywhere in the EU territory. Thus, the Court created a new method to cover the costs of cross-border healthcare (as long as it is in the social health insurance package), "neutralizing" the Regulation 1408/71 method by directly referring to the Treaty articles on free movement.<sup>88</sup>

The Court's interpretation caused an uproar among national health authorities because— in the words of one Dutch health official - it ran counter to the principle of sovereignty, potentially "opening the gates" to national healthcare systems without any restraint. According to another official, the Court's rulings "caused many sleepless nights for national healthcare policy makers, at least in the Netherlands." After offering a series of verdicts, also on several Dutch cases, the ECJ ruled that the Treaty articles on free movement are applicable to both inpatient and outpatient care, as well as to all types of healthcare systems in the EU.<sup>89</sup> Moreover, patients can receive reimbursement for treatments in private healthcare facilities abroad, even when that is not allowed within their domestic system.<sup>90</sup> In several cases, patients argued that waiting lists made them seek healthcare abroad. The British government defended in court the existence of waiting lists as a necessary rationing device, guaranteeing demand for its hospitals. According to the European Court of Justice, waiting lists do not really contribute to the protection of public health. The Court, however, allowed limits to the free movement of health

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<sup>88</sup> Jorens, Y., Schuyter, B. de & Salamon, C. (2005), *Naar een Rationalisatie van de EG-Coördinatieverordeningen inzake Sociale Zekerheid?* Gent: Academia Press. p. 65.

<sup>89</sup> Case C-157/99 *Geraets-Smits and Peerbooms* (2001), ECR I-5473; Case C-368/98 *Vanbraekel and others* (2001), ECR I-5363; Case C-385/99 *Müller-Fauré and Van Riet* (2003), ECR I-4509; Case C-372/04 *Watts* (2006), ECR I-4325.

<sup>90</sup> Case C-444/05 *Stamatelaki* (2007), ECR I-3185.



services and goods if they are motivated in advance based upon objective, non-discriminatory criteria of ensuring public health, sustaining the financial equilibrium of health systems, as well as maintaining a (geographically) balanced and accessible supply of healthcare. Patients are therefore free to seek cross-border healthcare that *can* be (not: is) provided extramurally, while they have to ask for permission (and the ensuing reimbursement) to receive intramural care abroad.<sup>91</sup> A gatekeeper's role for General Practitioners and a contracting system delivering benefits-in-kind are allowed if they suit the criteria mentioned above. If an effective and identical treatment is available without undue delay, then health authorities are allowed to refuse permission and reimbursement. Adequate procedures for appeal should be presented to the patient. Permission and ensuing reimbursement should be provided, however, if according to international (not national) medical standards the individual patient can no longer wait for treatment, while at the same time taking into account not only the medical, but also other personal circumstances of the patient.

The Treaty method to obtain (reimbursement) for cross-border healthcare is in the words of one Dutch health official just another "hole in the fence", which further undermines the EEA healthcare states' principle of territoriality. While health authorities could grant the "privilege" of cross-border healthcare to patients under Regulation 1408/71, the Court's interpretation of free movement of services and goods implies that those legally residing in the European Economic Area have a "right" to healthcare within the EEA.<sup>92</sup> Albeit under certain conditions, the later ex-post reimbursement of unauthorised treatment abroad has thus been made possible. Regarding the costs of intramural care, the patient would be reimbursed the amount, if covered by the mandatory health insurance policy at home, providing that authorisation should have been granted. As far as extramural care is concerned, the tariffs of the system of insurance determine the amount refunded. Authorisation is not necessary for reimbursement, but coverage by the

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<sup>91</sup> It is still somewhat unclear in the Court's rulings how intramural and extramural care should be defined. The Dutch health authorities define intramural care as a hospital treatment with at least one night overstay. See CVZ (25 June 2003), *Arrest Müller-Fauré en Van Riet* (C-385/99). *Circulaire* 03/35. Amstelveen: CVZ.

<sup>92</sup> Mei, A.P. van der (2004), *supra* note 37, p. 57.

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mandatory health insurance at home is required. As a matter of fact, discrimination among domestic and non-domestic patients is not allowed regarding health prices.<sup>93</sup>

#### *8.3.5 The European Health Insurance Card<sup>94</sup>*

In 2000, Member States' concerns regarding unemployment, sluggish economic growth and social exclusion led them to launch a strategy in order to create the most competitive economy of the world by 2010, while preserving a Social Europe and maintaining a healthy ageing population (the so-called Lisbon strategy). Intergovernmental taskforces and the European Commission subsequently discussed the aims of the accessibility, quality and financial sustainability of healthcare systems, and of geographic mobility in the internal market.<sup>95</sup> In addition, the European Commission, EU and EFTA Member States initiated research on using innovative information and communication technology in healthcare. They aimed at creating a coherent European infrastructure for healthcare information, standardization of terminology and software in a "European e-Health Area" under the subsequent labels of AIM (Advanced Informatics in Medicine) and eEurope.<sup>96</sup> The coincidence of the political momentum of the Lisbon-strategy, increasing knowledge of advanced information and communication technology, and increasing attention to the issue of patient mobility due to the Court's verdicts, set the stage for the European health insurance card.

Long before, in 1978, the European ministers for health suggested that such a card would be helpful in particular in case of emergency care. In 1981, the European Parliament subsequently adopted a resolution concerning the European health insurance card which was intended to replace the E-111 form because of its complexity for both patients and

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<sup>93</sup> Case C-411/98 *Ferlini* (2000), I-8081.

<sup>94</sup> This section is largely based on Vollaard, H. (2006), 'European Integration and Unfreezing Territoriality: The Case of the European Health Card', in R. Holzacker & M. Haverland (eds.), *European Research reloaded*. Dordrecht: Springer. pp. 203-228.

<sup>95</sup> European Commission (2001), *Communication: The Future of Health Care and Care for the Elderly: Guaranteeing Accessibility, Quality and Financial Viability*. COM(2001) 723 final; European Commission (2002), *Communication: Commission's the action plan for skills and mobility*. COM(2002) 0071 final.

<sup>96</sup> European Commission (2004), *Communication on E-Health: Making Healthcare better for European Citizens: An Action Plan for a European e-Health Area*. COM (2004) 356.

insurance institutions.<sup>97</sup> Another advantage for patients would be the correct transmission of health information in case of emergency care to a doctor, whom most patients have never consulted before.<sup>98</sup> In 1986, the Council of Health Ministers adopted a proposal by the European Commission to introduce a voluntary health card to be issued by the Member States willing to participate. They considered the uniform emergency card as a means of enhancing the freedom of movement of “European citizens” helping to create a “People’s Europe.”<sup>99</sup> It appeared that by 1989 most governments of the Member States had not taken any action, and the Council requested the European Commission to conduct research to establish “a harmonized European social insurance card.”<sup>100</sup>

During the 1990s the technical feasibilities of a (European) health insurance card were explored in AIM-research and with the issuing of millions of national health cards in Germany and France. The standardization of medical terminology and health registration, the harmonization of the use of data cards in healthcare, and technical interoperability of telematic networks by AIM-research and the EU/EEA European Committee for Standardisation (CEN), all prepared the ground for the introduction of the European health insurance card. The adoption of a data protection directive (95/46) in 1995 has been part of the legal preparation to tackle the issue of privacy. Despite this progress and another call for a health insurance card from the European Parliament in 1996,<sup>101</sup> the governments of the Member States were fairly reluctant. They still foresaw “a number of legal, ethical, economic and technical difficulties” to be addressed before any idea of its introduction and awarded it no priority.<sup>102</sup>

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<sup>97</sup> European Parliament (1981), *Resolution on a European Health Card*. OJ 1981 C 287: 32.

<sup>98</sup> European Commission (1995), *Final Report AIM DG XIII “Eurocards” Concerted Action*.

<sup>99</sup> Council of Ministers (1986), *Resolution of the Council and of the Representatives of the Governments of the Member States, meeting within the Council, 29 May 1986, concerning the Adoption of a European Emergency Health Card*, OJ 1986 C 184, pp. 4-7.

<sup>100</sup> Council of Ministers (1989), *Council Conclusions of 29 September 1989 on a European Card for the Provision of Immediate Care*. O J 1989 C 277/03.

<sup>101</sup> European Parliament (1996), *Report on the European Health Card*. A4-0091/96.

<sup>102</sup> Council of Ministers (12 November 1996), *European Health Card: Presidency Conclusions*. Press release 314, no. 11437/96.

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The discussions of governments of the Member States regarding the Lisbon-strategy and patient mobility made them change their minds. While the ministers for health in early March 2002 emphasized the need to study the advantages of a European health insurance card for pensioners and workers staying abroad, by late March 2002 the European Council, consisting of the leaders of the Member States' governments, adopted the Commission's proposal for a common health insurance card by June 2004. That proposal says "an EU-wide health card should be introduced, aimed at transforming the relevant European paper forms into an electronic card. Card holders will be able to claim access to immediately necessary healthcare in a Member State other than the one where they are insured, the latter being nevertheless responsible for the costs."<sup>103</sup> The European Council emphasized that "such a card will simplify procedures, but will not change existing rights and obligations."<sup>104</sup> In February 2003, the Commission presented its plans to introduce the European health insurance card that "will facilitate temporary stays abroad, initially holidays, the E-111 form being the first to be replaced; and, later, employees posted to another country (E128), international road transport (E110), study (E128) and job seeking (E119)."<sup>105</sup>

Despite all research efforts, a common telematic infrastructure to read electronic health insurance card was still lacking. Therefore, an eye-readable plastic card was gradually introduced within a transitory period from June 2004 till December 2005 by the national health insurance authorities. The release of this card has been rather slow in Belgium and the Netherlands; and many health providers and health users are not used to it yet.<sup>106</sup> The card initially only mentioned the name and health

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<sup>103</sup> European Commission (2002), *supra* note 95, p. 16.

<sup>104</sup> European Council (March 2002), *Promoting Skills and Mobility in the European Union*. Presidency Conclusion no 34.

<sup>105</sup> European Commission (2003), *Communication concerning the Introduction of a European Health Card*. COM(2003) 73 final.

<sup>106</sup> Jorens, Y. et al. (2005), *supra* note 88, p. 41; AIM (2 February 2007), AIM Response to the Commission's "Consultation regarding Community Action on Health Services". Brussels: Association de la Mutualité. P. 7; Nederlandse Zorgautoriteit (24 November 2006), *Naleving Europese Verzekeringskaart*. ABIN/thok/CI/06/976 (letter to Dutch Hospital Association). Utrecht: NZa; European Commission (2007), *Summary Report of the Responses to the Consultation regarding "Community Action on Health Services"*. Brussels: DG SANCO. pp. 30-31; Kamerstukken II 2006-2007

insurance identification number of the cardholder and information on the competent health insurance authority. At a later stage, an electronic card should contain information such as the cardholder's personal data and insurance status as well as its medication and medical history. Problems of interoperability and compatibility have prevented the rapid implementation of electronic cards, but various initiatives have been launched by the European Commission to stimulate cross-border electronic health services and develop the necessary political, legal, digital, technical, and organisational framework for a European Health Record for each EU citizen.

In a 2003 press release, Anna Diamantopoulou, the European Commissioner for Social Affairs, pointed out that the card "will also have a powerful symbolic value: after the euro, the European health card is another piece of Europe in your pocket."<sup>107</sup> In a similar vein, the European Parliament stated that the introduction of a European health card would "contribute significantly to the promotion of free movement and European Citizenship."<sup>108</sup> The Charter of Fundamental Rights of the European Union seems to underline this European citizenship by effectively defining a European right of healthcare: "Everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human protection shall be ensured in the definition and implementation of all Union policies and activities" (Art. II-35). Thus, the health insurance card symbolizes the European challenge to national conceptions of citizenship, as well as the territorial control of the consumption of healthcare. While health citizenship was heavily entrenched into the states' territories, the European health insurance card further erodes state territoriality, at least formally.

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Parliamentary Question no. 2407 *Gratis European Health Insurance Card* (16 July 2007), Appendix, p. 5095.

<sup>107</sup> European Commission (2003), *European Health Card for 1 June 2004*. Press Release IP/03/271.

<sup>108</sup> European Parliament/Committee on Employment and Social Affairs (2003), *Draft Report on Proposal for European Parliament and Council regulation on amending Council Regulations 1408/71 and 574/72*. Provisional 2003/0138(COD).

#### **8.4 Propositions**

Not only the European health insurance card, but also Regulation 1408/71, the SEA programme, the INTERREG arrangements, and the European Court's rulings can be seen as contributing further to the erosion of territorial control over the membership, consumption, provision, and insurance of healthcare.<sup>109</sup> What implications may the opening of previously territorially closed healthcare states entail for the behaviour of health actors and healthcare systems in the European Union? First of all, the reconciliation of the principles of the Euro-wide internal market and delivery of services of general interests (such as healthcare) within Member States' territories has become a politically sensitive issue in the European Union, particularly in the aftermath of the ill-fated European Constitutional Treaty (see Chapter 9). Regarding the territorial underpinnings of the healthcare states, the implications are mapped out according to the propositions discussed in Chapter 5.

A striking aspect of European exit options is the possibility of accessing healthcare abroad and receiving reimbursement without the requirement of having to migrate abroad. That should in principle facilitate the actual exit by health consumers. Nevertheless, the proposition is that only if health consumers are dissatisfied, see no chance to improve healthcare by voice, and are less loyal to their home healthcare system, they use the European exit option. Waiting lists or low quality healthcare are two reasons for dissatisfaction, as indicated by Italians going to France (see above). Loyalty may be fairly strong, however, because healthcare territories are relatively deeply entrenched and broadly embedded being part and parcel of national states. National boundaries would therefore remain a significant hurdle, even if European integration has facilitated access to cross-border healthcare.

If nevertheless cross-border patient mobility would occur, a cleavage may emerge between those able to go abroad and those who cannot. Having the means and knowledge, affluent and well-informed health consumers are expected to be more inclined to cross borders for healthcare. Tensions between mobile and immobile health citizens can

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<sup>109</sup> Cf. Lamping, W. (2005), 'European Integration and Health Policy: a Peculiar Relationship', in M. Steffen (eds.), *Health Governance in Europe: Issues, Challenges and Theories*. London: Routledge. p. 31.

therefore rise, because immobile citizens (including health providers) would prefer affluent citizens to use their means within the national healthcare territory. This call for national solidarity may indicate a nationalist tendency due to differentiated exit options, as one proposition also holds.

As has already been argued above in the sections on the INTERREG arrangements, interface regions such as the province of Limburg would be more inclined to escape (partially) from their national healthcare territories. All border regions are confronted with a mismatch between socially defined and functionally effective healthcare territories. Interface regions now also have the opportunity to use the opening of previously closed healthcare states to Europe, by joining efforts with adjacent border regions, particularly when they feel less integrated, in other words, have less national loyalty. However, calls for national solidarity by national governments, citizens or other regions may restrain interface regions from using European exit options. This nationalism would once more indicate a shift from territorial to rather person-based boundaries to keep those regions inside.

The European breaches into principle of territoriality may thus result in using territoriality less as strategy for maintaining external boundaries and internal cohesion of healthcare systems. The image of a geographically fixed, territorially closed healthcare state should, however, leave its traces in the behaviour of governments and health authorities in the European Union, being deeply entrenched and broadly embedded in the national states at large. The SEA and Schengen initiatives would nevertheless gradually sap the logic of territoriality, as the proposition has it. The European openings would diminish the locking-in effect of closed, hard borders. Interface regions and mobile citizens can more easily imagine turning their back on the political centre of the healthcare state, and finding satisfaction elsewhere. European exit options would thus undermine geographical fixity, inclusion/exclusion, and centrality.

Territoriality as a principle and strategy at the national level would lose significance due to the European challenges to the closed healthcare state. A full replacement of national healthcare states by a European healthcare state is not foreseen however. The various enlargements keep the logic of territoriality at bay at the European level, because of the unfixed nature of

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its borders. The weak geographical locking-in effect hinders the organisation of cross-national functional alliances and other enduring voice structures in the healthcare sector. As a consequence, health consumers seek cooperation with those at a socially and geographically close distance to deal with dissatisfaction, which is expected to be the strongly institutionalised national healthcare systems. These systems have not only still elaborated voice structures, the thorough territorial imprint on the behaviour and institutions of national states would still leave its imprint on health consumption and loyalties. National governments would thus remain the centre for addressing dissatisfaction on healthcare issues. Being closely intertwined with the European Union, national governments would not seek full exit, but rather partial exit or voice. This would lead to a weakly centralised, compound healthcare system in the EU, in which national governments and partly de-territorialising national healthcare systems still remain prominent. Empirical results in Chapter 9 show whether these propositions are tenable.



