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

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# Chapter 9

## Cross-border patient mobility in the European Union and the Netherlands

*One key factor influencing a patient's decision to seek healthcare abroad is the level of satisfaction with the domestic system.*  
Paul Belcher<sup>1</sup>

### 9.1 Introduction

The previous chapter presented the European exit options challenging the territorially closed healthcare states in the European Union. In exploring the tenability of the propositions on changing political territoriality, Chapter 9 first presents the response of the healthcare authorities in EU Member States to this challenge. Then, the focus is on cross-border patient mobility and its implications: do national citizens remain loyal to and satisfied within their healthcare systems, or do they increasingly use the exit options offered? In the latter case, European integration may change fundamentally the relationship between citizens and healthcare states. Moreover, the logic of territoriality may no longer characterise the organisation of healthcare systems in the EU area. Therefore, Chapter 9 ends by exploring the evolving (territorial?) nature of the compound European healthcare system. As mentioned before, the empirical focus is on the Netherlands and its border regions in particular.

### 9.2 Attempts to keep healthcare states closed at EU level<sup>2</sup>

#### 9.2.1 After Kohll and Decker: “a deafening silence”

When the European Court of Justice offered a patient-friendly interpretation of the E-112 procedure in the late 1970s, the Council of

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<sup>1</sup> Belcher, P. (1999), *The Role of the European Union in Healthcare: An Overview*. Zoetermeer: RVZ. p. 75.

<sup>2</sup> The following sections are based on Vollaard, H. (2005), *Frontiers et Fondements de la Mobilité des Patients dans l' Union Européenne*, in *Revue Belge de Sécurité Sociale*. Vol. 47, no. 2, pp. 225-256, and Vollaard, H. (2007), ‘*Patiëntenmobilité in Europa*’, 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. 291-306.

Ministers quickly changed Regulation 1408/71 to prevent patients from shopping abroad for health treatments by adopting a strict policy of prior authorisation (see section 8.3.1). The opportunity to exit a healthcare state would thus remain firmly in the hands of Member States' healthcare authorities. European legislation determining exit (and entry) of territorially closed healthcare states seemed far-fetched to them. During the hearings in the Kohll and Decker cases, several governments from the entire EEA area denied any influence of European legislation on their healthcare systems. When the Court ruled otherwise in April 1998, the governments of many Member States responded vehemently. The German minister for health Horst Seehofer declared that the Court's rulings would not be followed in his country and that he wanted the rulings to be overturned.<sup>3</sup> Yet, both federal and regional health authorities in Germany launched a working group to study the impact of the rulings. The group proposed to discuss the issue at EU level, even though the Kohll-Decker rulings were not considered applicable to the German benefit-in-kind system. Only the health authorities of Belgium and Luxembourg adopted new legislation on cross-border healthcare, because Kohll and Decker dealt with (their) reimbursement systems. The French health authorities argued that court rulings should first be discussed at the European level before the health sector should implement them.<sup>4</sup> Many governments, however, refused to discuss the impact of the internal market at the European level insisting instead on their national prerogatives on healthcare.<sup>5</sup> At EU-related meetings, government officials only informally discussed the Kohll and Decker cases at EU level. The European Commission did not dare to speak out publicly on such an explosive issue. Interviewees spoke of "a deafening silence" from the Council and the Commission in 1998. The Court rulings also caused increased concern among health insurance funds. The international association of health insurance funds AIM (*Association Internationale de la Mutualité*) organised a conference on the internal market and healthcare

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<sup>3</sup> Martinsen, D.S. (2005), 'Towards an Internal Health Market with the European Court', in *West European Politics*. Vol. 28, no. 5, p. 1052.

<sup>4</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. 83.

<sup>5</sup> Idem; Baeten, R. (2002), 'Over Patiëntenmobiliteit en hoe het EU-beleid hierop reageert', in *Belgisch Tijdschrift voor Sociale Zekerheid*. 4<sup>e</sup> trimester, pp. 863-880.

in November 1998, where government officials also expressed their views on the Kohll and Decker cases. Even though the Dutch government maintained the Dutch healthcare system was largely compatible with the Court rulings, it repeatedly urged to discuss the rulings at the EU level, fearing the potential effects of cross-border patient mobility on the rationing of healthcare consumption due to the Dutch waiting lists.

The new German minister for health, Andrea Fischer explained the reluctance of many governments to discuss healthcare at the EU level out of suspicion towards the Commission: “the Member States still fear (...) that the Commission might aspire to competencies in the health field it is not entitled for. After all, next to everyone seems reluctant to give the Commission an inch, since doing so would be to risk it taking a mile.”<sup>6</sup> In her eyes, however, the internal market “will gradually but inevitably” make national healthcare systems cooperate more closely. Furthermore, the ministers for health should not leave (European) health policy to the European Court of Justice to decide. In February 1999 during the German EU-presidency, she therefore organised a conference on the impact of the internal market on health in Potsdam. In addition, the informal High Level Committee on Health consisting of Member States’ health officials established an informal working group on Internal Market and Health in April 1999. The Health Council also declared officially in June 1999 that the impact of the internal market on healthcare and the Member States’ prerogatives should be monitored.<sup>7</sup> Subsequently, the Commission returned cautiously to the political scene in October 1999, asking the AIM to investigate the impact of the Kohll/Decker rulings on the Member States’ health systems.<sup>8</sup>

In 2001 a new impetus to discuss healthcare emerged at the EU level after the European Court of Justice ruled on a case regarding intramural care in the Dutch benefit-in-kind system. Again, many governments from the entire EEA area expressed their views in court. Although the Court ruled that governments have the right to limit free movement of expensive intramural health goods and services, its ruling

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<sup>6</sup> Fischer, A. (1999), ‘A new public health policy in the European Union: policy statement from Andrea Fischer’, in *Eurohealth*. Vol. 5, no. 1, pp. 2-4.

<sup>7</sup> Council (8 June 1999), *Council Resolution on the Future Community Action in the Field of Public Health*. OJ C 200 p. 2.

<sup>8</sup> Palm, W. et al. (2000), *supra* note 4.

indicated that free movement of health goods and services also applies to benefit-in-kind systems (such as in the Netherlands and Germany) and not only to the reimbursement system (such as in Luxembourg). In addition, a number of conferences and reports made clear that healthcare states cannot simply be exempted from the internal market.<sup>9</sup> For instance in December 2001, during the Belgian presidency of the European Union, the Belgian minister for health Frank Vandenbroucke organised a two-day conference in Ghent. In his preface to the published conference contributions, Vandenbroucke argued that the impact of the internal market on healthcare systems should be discussed at the EU level, and also by the ministers for health: “In order to safeguard the social features of our systems, as we cherish them in our nation states, it is necessary to discuss healthcare policy both at national and European level.”<sup>10</sup> Those involved in research projects on the impact of the internal market on health also argued that a coherent health policy and coordinated action at the European level was necessary.<sup>11</sup> The High Level Committee on Health came to the same conclusion in its final report in December 2001.<sup>12</sup> The report indicated that several governments were still not willing to discuss healthcare and health issues at the EU level. Instead, the Committee urged to “raise the profile of health policy at EU level” to prevent the European Court of Justice of making European health policy. It suggested, among other things, support for healthcare cooperation in border regions, to stimulate the mutual exchange of data and experiences, to develop a system of top-clinical health centres, to facilitate access to foreign healthcare by changing Regulation 1408/71, as well as introducing the Open Method of Coordination to discuss healthcare at the EU level, a soft-law method of policy-making by exchanging best practices, and

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<sup>9</sup> See, e.g., R. Leidl (ed.) (1998), *Health Care and its Financing in the Single European Market*. Amsterdam: IOS Press.

<sup>10</sup> Vandenbroucke, F. (2001), ‘Foreword’, in E. Mossialos & M. McKee (eds.), *EU Law and the Social Character of Health Care*. Brussels: P.I.E.-Peter Lang. p. 20.

<sup>11</sup> See, e.g., Berman, P.C. (1999), ‘The Impact of the Internal Market on Health Systems in the Member States: Report of Working Group 4: The New Public Health Policy of the European Union (Potsdam, January 27-29 1999)’, in *Eurohealth*, Vol. 5, no. 1, pp. 8-9; Paton, C. et al. (2000), *The Impact of Market Forces on Health Systems: A Review of Evidence in the 15 European Union Member States*. Dublin: European Health Management Association. pp. 51-53.

<sup>12</sup> High Level committee on health (17 December 2001), *The Internal Market and Health Services*. Brussel: DG SANCO.

evaluating the performance of healthcare systems according to certain benchmarks. The ministers for health admitted informally at the lunch of the Health Council meeting in November 2001 that they should discuss healthcare at the EU level.

### *9.2.2 Patient mobility officially on the European agenda*

Meanwhile, other ministers were also dealing with healthcare, including patient mobility, at the EU level. Throughout the 1990s, a debate on the balance between the internal market and social protection touched upon health issues. This process, however, involved mainly ministers of employment and social affairs. They also dominated the discussions on simplifying Regulation 1408/71, and its adjustment to the Court's rulings. Rising concerns about public finances due to an ageing population in the late 1990s also required ministers of finance to discuss healthcare systems at the European level.<sup>13</sup> The 2000 Lisbon agenda involved prime ministers and heads of states of the EU Member States, who decided upon the European health insurance card at the Barcelona meeting of the European Council in the spring of 2002. Meanwhile, the Spanish minister for health Celia Villalobos faced a growing number of foreign tourists and retirees requiring healthcare in her coastal constituency.<sup>14</sup> Local healthcare facilities are often not compensated for treating foreign patients within the Spanish health finance system.<sup>15</sup> When the Spanish government chaired the European Union in early 2002, she invited her colleagues to exchange thoughts informally on cross-border patient mobility and their (financial) implications in Málaga. The ministers stated that a cross-border perspective on health issues has an added value, also because of the anticipated EU-enlargement. They also agreed that European health issues should not be left to the Court and other Councils.<sup>16</sup> Formally meeting in the Health Council, they decided therefore to support the European Commission in establishing a "high level process of reflection on patient mobility and the development of healthcare systems in the European

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<sup>13</sup> See, e.g., European Commission (2001), *Communication: The Future of Health Care and Care for the Elderly: Guaranteeing Accessibility, Quality and Financial Viability*. COM(2001) 723 final.

<sup>14</sup> Baeten, R. (2002), *supra* note 5, p. 874.

<sup>15</sup> See Leidsch Dagblad (16 August 2007), 'Zieke Toerist kost Spanje Miljoenen.'

<sup>16</sup> Spanish EU-presidency (2002), Results of the Meeting of Health Ministers.

Union.” They thus sought to establish an informal body to discuss healthcare among mainly national health officials at the EU level.<sup>17</sup> The ministers basically followed the suggestions by the report of the High Level Committee on Health, but most governments considered the Open Method of Coordination “seven bridges too far.” It was consequently dropped.<sup>18</sup>

Continuing Court rulings on patient mobility and the above-mentioned initiatives put and kept cross-border patient mobility on the European agenda. In July 2002, DG Internal Market launched a consultation process among the Member States to determine to what extent they had complied with the verdicts of the Court.<sup>19</sup> Starting in February 2003, The High Level Process involved Member States’ health officials and several branches of the European Commission, as well as MEPs, interest groups of hospitals, health managers, patients, health insurance funds, and health professionals. Despite the initial hostility of many governments, the Belgian minister for health Vandembroucke also launched together with the Dutch delegation a working group on the reconciliation of national health policy with European Union obligations. At his Ghent conference, Vandembroucke not only became increasingly aware of the impact of the internal market on health services, but also the relatively high number of foreign patients seeking healthcare in Belgium.

At the first meeting in February 2003, the European Commissioner for the Internal Market Frits Bolkestein found it inexplicable that European citizens could not freely access health services across borders.<sup>20</sup> Subsequently, the DG Internal Market stated that it would seek close cooperation with the high level process, and that it would screen compliance to the court’s rulings on patient mobility, despite disagreement among governments about reimbursement of health

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<sup>17</sup> Council/ Ministers for Health (2002), Conclusions of the council and the representatives of the member states meeting in the council of 19 July 2002 on patient mobility and health care developments in the European Union. OJ C 183/01.

<sup>18</sup> Baeten, R. (2002), *supra* note 5.

<sup>19</sup> European Commission (2002), *The State of the Internal Market for Services*. COM(2002) 441 final.

<sup>20</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*. HLPR/2003/ REV1.

treatments abroad.<sup>21</sup> Meanwhile, the European Court of Justice explained in a number of rulings that prior authorisation is not required for retired chronic patients in need of treatment abroad (such as renal dialysis), and for extramural care. In its final report in December 2003, the high level process concluded among other things that the issue of patient rights should be explored, cooperation in border regions and among centres of reference throughout the EU should be supported, and research on patient mobility is required due to a lack of data. It also proposed setting up a “permanent mechanism” consisting of national and European health officials to support European cooperation in healthcare and monitor the impact of the internal market on health.<sup>22</sup>

### *9.2.3 DG Internal Market vs. DG SANCO*

In January 2004, the DG Internal Market proposed a directive on an internal market for services, including health services. It would thus seek not only legal certainty with respect to cross-border healthcare, but also foster the efficient use of healthcare resources throughout the EU. According to the European Commission, this would also bring the EU closer to European citizens. The European Parliament almost immediately expressed its concerns that the services directive would erode the social character of social healthcare systems, warning against the “purely individual approach to patient mobility and the provision of healthcare across borders.”<sup>23</sup> It defended the responsibilities of the governments of Member States regarding the geographical and functional planning of healthcare facilities, as well as their right to limit free movement of goods and services to maintain the financial stability and solidarity of their healthcare system. The European Parliament pleaded for a European Charter of Patients’ Rights, as it had done since the early 1980s. Particularly left-wing parties feared a two-tiered health system, for wealthy and more knowledgeable patients who could access cross-border healthcare more easily in the EU, while right-wing parties foresaw yet more advantages of market-driven proposals. Bolkestein’s services

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<sup>21</sup> European Commission (2003), *Internal Market Strategy: Priorities 2003-2006*. COM(2003) 238 final. pp. 24, 54.

<sup>22</sup> High Level Process (2003), *Outcome of the Reflection Process*. HLPR/2003/16.

<sup>23</sup> European Parliament (11 March 2004), *Resolution on Health Care and Care for the Elderly*. P5\_TA-PROV(2004)0184.



directive encountered outright anger from many Member States' governments. They considered a general directive unfit for the peculiarities of the health sector, resisted marketisation of healthcare systems, or disliked European meddling with national healthcare systems at all.

Meanwhile, DG SANCO (health and consumer protection) issued communications on patient mobility and an e-health action plan.<sup>24</sup> It also proposed establishing a "high level group on health services and medical care" which was intended to be another informal meeting place for health officials at EU level. Furthermore, it argued that patients, health providers, and health insurers should be better informed, also via e-technology (see the European Public Health Portal), on the possibilities of cross-border healthcare. Cooperation among European (top-clinical) centres of references and in border regions would not only help to make use of health resources more efficiently in the EU area, but also provides insight into the motives of patients who go abroad. Evaluation and research of cross-border patient mobility should therefore be funded. Presenting the communications, the European Commissioner for Health and Consumer Protection David Byrne also explained that "[m]y final goal is to achieve a European Charter of patients' rights to which everyone can refer...."<sup>25</sup> Thus, the European Commission no longer perceived patient mobility as a side-effect of the internal market, but elevated it to a right of European citizens and a policy aim in itself.<sup>26</sup> Following the communication issued in the spring of 2004 on *Modernising social protection for the development of high quality, accessible and sustainable healthcare and long-term care*,<sup>27</sup> the Council of Ministers for Health reluctantly agreed to start discussing their healthcare systems through the Open Method of Coordination. However, the Member States'

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<sup>24</sup> European Commission (2004), *Communication: Follow-up to the High Level Reflection Process on Patient Mobility and Healthcare Developments in the European Union*. COM(2004) 301 final; 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.

<sup>25</sup> Byrne, D. (21 April 2004), *Healthcare Cooperation: Patients to benefit from New Commission Proposals*. IP/04/508.

<sup>26</sup> Martinsen, D.S. (2005), *supra* note 3, pp. 1047-1048.

<sup>27</sup> European Commission (2004), *Modernising Social Protection for the Development of High Quality, Accessible and Sustainable Healthcare and Long-term Care*. COM(2004) 304 final.

governments in all official statements, including the European Constitutional Treaty, continuously emphasised their responsibilities regarding the organisation and the allocation of medical care and health services. During its final negotiations in 2004, Governments yet included in the draft treaty an article pleading for cross-border healthcare cooperation in border regions.

Because governments and the majority of the European Parliament fiercely resisted the inclusion of health services in a general European services directive, Bolkestein's successor Charlie McCreevy eventually excluded health from the scope of the directive.<sup>28</sup> However, this did not mean that healthcare and health services were no longer on the European agenda. The European Parliament and the European Commission have actively involved the health sector in discussing healthcare at European level. In the autumn of 2004 under the aegis of the Dutch EU-presidency, the launch of a European Health Community was discussed, expanding the number of non-governmental organisations involved with European health issues. DG SANCO launched in the same year a reflection process on its public health programme for the period 2007-2013. Meanwhile, the High Level Group on Health Services and Medical Care discussed issues such as patient rights, patient safety, e-health, and a European network of centres of references, and reported since 2004 to the Council of the European Union (Employment, Social Policy, Health and Consumer Affairs). Next to Member States' officials, observers from EEA member states and from the health sector attended various working groups. In November 2005, it issued non-binding guidelines for contracting healthcare abroad. In June 2006, the Council of Ministers for Health agreed upon the common values and principles of their healthcare systems: universality, access to good quality care, equity and solidarity. Carefully phrased, the Council also "notes that the European Commission has stated it will develop a Community framework for safe, high quality and efficient health services, by reinforcing cooperation between Member

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<sup>28</sup> McCreevy, C. (8 March 2005), *Statement to the European Parliament on Services Directive*. SPEECH/05/149.

States and providing clarity and certainty over the application of Community law to health services and healthcare.”<sup>29</sup>

Soon after, DG SANCO started its consultation on a *Community Framework for Safe, High Quality and Efficient Health Services*.<sup>30</sup> Such a framework would be necessary to limit legal uncertainty regarding cross-border patient mobility, and to support cooperation between Member States in border regions and among top-clinical centres of reference. DG SANCO also thought of setting EU-wide quality standards and launching a European “solidarity mechanism” between healthcare systems receiving and sending patients. The European Parliament also expressed itself regarding cross-border healthcare in favour of freedom of choice of patients. Notwithstanding the prerogatives of Member States regarding healthcare, a majority in the European Parliament supported the European Commission in its desire to codify and clarify the Court’s case law by issuing a directive on cross-border patient mobility, providing the necessary (legal) guarantees to all European patients to obtain equal, safe, and good-quality healthcare wherever they are in the EU.<sup>31</sup> It also welcomed flanking policy measures such as more information to patients, collection of data regarding cross-border healthcare, a charter of patient rights, and cooperation among Member States in centres of reference. An attempt by the EP Committee on the Internal market and Consumer Protection to re-include health services in the Services Directives failed.<sup>32</sup> Tied to discussions about protecting so-called “public services of general interest” from the internal market, the EP Committee on Employment and Social Affairs considered the authorisation procedure fundamental for the sustainability of national healthcare systems. In the final text of the resolution adopted in the plenary session, the EP eventually suggested

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<sup>29</sup> Council of the European Union (1-2 June 2006), *Council conclusions on common values and principles in EU health systems*. 273 3<sup>rd</sup> Employment, Social Policy, Health and Consumer Affairs Council Meeting, Luxembourg.

<sup>30</sup> European Commission (2006), *Communication: Consultation regarding Community action on health services*. SEC(2006) 1195/4.

<sup>31</sup> European Parliament (15 March 2007), European Parliament resolution on Community action on the provision of cross-border healthcare European Parliament. P6\_TA(2007)0073; (23 May 2007), *Resolution on the impact and consequences of the exclusion of health services from the Directive on services in the internal market*. P6\_TA(2007)0201.

<sup>32</sup> EUobserver.com (23 May 2007), ‘MEPs call for EU Rules on Patient Mobility’.

Member States' governments establish a testing period without prior authorisation.

For their part, most governments preferred bilateral cooperation and non-binding discussions at the European level as opposed to market-driven European legislation on health services.<sup>33</sup> The British government even rejected the Commission's interpretation that prior authorisation is no longer necessary for non-hospital care, seeing authorisation as fundamental to the planning and financing of its healthcare system.<sup>34</sup> Some health officials have seen the consultation on health services as an attempt by the relatively young DG SANCO (established in 1999) to gain recognition within the European bureaucracy, competing with heavyweights like DG Internal Market and Services and DG Employment, Social Affairs and Equal Opportunities.<sup>35</sup> DG SANCO already flexed its muscles by starting several infringement proceedings against Member States such as France and Portugal to make them apply the court verdicts to their health reimbursement policies. The European Commission did not encounter great enthusiasm from Member States' governments when it presented a proposal for a directive on cross-border healthcare at an informal Health Council meeting in Aachen, Germany in April 2007.<sup>36</sup> The ministers for health acknowledged that cross-border healthcare might help "to strengthen solidarity in the European Community, and to make patients benefit from the advantages of a joint Europe," but they immediately added that "healthcare systems need protection against undesirable consequences of health tourism and excessive healthcare utilisation."<sup>37</sup> More clarification for patients on their opportunities and monitoring of patient mobility would be acceptable for the governments,

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<sup>33</sup> European Commission (2007), *Summary Report of the Responses to the Consultation regarding "Community Action on Health Services"*. Brussels: DG SANCO.

<sup>34</sup> UK government (2007), *UK Consultation Response to Commission Communication on Health Services*.

<sup>35</sup> Cf. Guigner, S. (2004), 'Institutionalizing Public Health in the European Commission: The Thrills and Spills of Politicization', in A. Smith (ed.), *Politics and the European Commission: Actors, Interdependence, Legitimacy*. London: Routledge. pp. 96-115.

<sup>36</sup> The Guardian (20 December 2007), 'EU delays Move allowing Patients to travel for Care'; Kamerstukken II 2006/2007, 22 112 no. 523 *Nieuwe Commissievoorstellen en initiatieven van de lidstaten van de Europese Unie: Verslag van een Algemeen Overleg* (12 April 2007) p. 4.

<sup>37</sup> German EU-presidency (20 April 2007), *Notes of the Trio-Presidency: Health Care across Europe: striving for Added Value*.

but “with due acknowledgement of the Member States’ autonomy and sovereignty in determining the organisational and financial issues of healthcare delivery, as well as the principle of subsidiarity.” It nevertheless invited the European Commission to introduce legislation in addition to a bunch of policy measures to manage cross-border healthcare.

In a protocol attached to the Reform Treaty replacing the European Constitutional Treaty, the Member States emphasised in October 2007 their prerogatives with regard to *non*-economic services of general interests. Although health services are often considered to be economic services (because they are provided for remuneration), the protocol can be seen as a sign of the diminishing willingness to liberalise any sort of public services. In late 2007, DG SANCO still wished to introduce a directive on cross-border healthcare. By 2010, this directive should provide legal clarity, certainty and information to patients, health providers and healthcare systems concerning the provision, financing, safety, equity, quality, and continuity of cross-border healthcare, also in case of harmful treatment. According to the European Commission, this directive would particularly serve patients having rare diseases, seeking specialised care, or living in border regions. According to the proposal, only if serious distortions of the healthcare systems would occur, a system of prior authorisation would be justified.<sup>38</sup>

At the very last moment, however, the European Commission had to postpone the proposal, because of opposition from within the European Commission, the European Parliament, Member States, and civil society. Left-wing MEPs reacted particularly angrily, because they saw the proposal as liberalisation via the back door just a month after the European Commission refused to introduce legislation on services of general interests. Together with trade unions and social NGOs, they expressed their concerns that the proposal would lead to two-tier healthcare systems, because only those having the means to travel and stay abroad, and to pay for treatments in advance, would be able to enjoy cross-border healthcare. The Platform of European Social NGOs wondered why the European Commission did not emphasise the principle that all citizens, including vulnerable ones, should have equal

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<sup>38</sup> Euboserver.com (19 December 2007), ‘Brussels postpones Landmark Bill on EU Cross-border Health Care until 2008.’

access to affordable high-quality healthcare, instead of pushing forward with liberalisation. Thinly veiled threats from MEPs about the potential negative influence on the ratification of the Reform Treaty made the European Commission back down for the moment.<sup>39</sup> Also governments of Member States expressed their fears of losing control of their health budgets and their prerogatives in organising and financing their healthcare systems. In July 2008, the European Commission proposed a weakened directive “on the application of patients’ rights in cross-border healthcare.”<sup>40</sup> It allows Member States to introduce a system of prior authorisation if cross-border healthcare would seriously jeopardise the financial sustainability or the balance in the organisation, planning and delivery of health services. Reimbursement of cross-border healthcare are maximised by the tariffs in the home country. Existing domestic requirements to access hospital care, such as prior consult by a general practitioner, can also be applied to cross-border healthcare. The eventual decision on this sensitive proposal is expected to take place after the elections for the European Parliament in 2009.<sup>41</sup>

Notwithstanding the references to the Member States’ national prerogatives regarding healthcare systems, healthcare policy has eventually come to and remained on the European agenda. Spanish, Belgian and Dutch ministers for health have no longer been purely fixated on their own health territories. Partly based on experiences with cross-border patient mobility in their own countries, they now also take into account the position of their healthcare system within the European internal market. The spill-over from policy-making in adjacent policy-areas has been another impetus to start talking about healthcare policy (including patient mobility) at the EU level. The spill-over indicates the weakening institutional breadth of state territoriality in healthcare policy; it is now less embedded and coinciding with other policy areas based on state territories. Yet, the reluctance of most governments to discuss even healthcare at the European level indicates the lasting imprint of the logic

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<sup>39</sup> EuropeanVoice.com (20 December 2007), ‘Commission postpones Healthcare Plans’; Euobserver.com (10 January 2008), ‘EU Health Bill pulled amid National and MEP Criticism.’

<sup>40</sup> European Commission (2 July 2008), *Proposal for a Directive on the Application of Patients’ Rights in Cross-border Healthcare*. COM(2008) 414 final.

<sup>41</sup> Euractiv.com (17 July 2008), ‘EU faces “Long Row” over Cross-border Healthcare.’

of territoriality at the national level. Most governments have tried to avoid the interference of Europe within their health territories, showing how deeply geographical exclusivity and centrality within state territory have been institutionalised. The next sections will focus on the Dutch healthcare state, showing in more detail how deep state territory is still engrained *within* a healthcare state, even after the offer of European exit options. Section 9.3 focuses on Dutch health authorities, insurers and providers, section 9.4 on patients.

### 9.3 The Dutch healthcare state after the Kohll and Decker rulings

#### 9.3.1 *The Euro-compatibility of the contracting system*

The Dutch ministry of health, the Health Insurance Board and the Dutch Association of Health Insurers (*Zorgverzekeraars Nederland*) responded almost in unison to the Kohll and Decker rulings. They considered the Dutch health insurance system largely compatible with the Court's verdicts, foremost because the Kohll and Decker cases referred to a reimbursement system, and not with a benefit-in-kind system such as in the Netherlands.<sup>42</sup> Following an internal legal report on the Court's rulings<sup>43</sup>, the ministry of health concluded that a distinction could no longer be made between foreign and domestic health providers with regard to obtaining non-contracted care. In addition, those who were WTZ-insured, wherever they were living within the EU, should be allowed to obtain reimbursement also for non-emergency, non-hospital healthcare without prior authorisation.<sup>44</sup>

The Dutch benefit-in-kind system was based at that time on state-approved contracts that state-permitted health insurers established with state-permitted health providers for the needs of their clients. Concerns existed that clients could access non-permitted healthcare providers

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<sup>42</sup> See for instance Ministerie van VWS (1998), *Arresten Europees Hof hebben Weinig Gevolgen voor Ziektekostenverzekeringen*. Press release (18 September 1998).

<sup>43</sup> Interdepartementale Commissie Europees Recht (1998), *Advies van 8 september 1998 betreffende de Arresten van het Hof van Justitie van de Europese Gemeenschappen van 28 April 1998 in de Zaken C-120/95 (Decker) en C-158/96 (Kohll)*. ICER 98-6/60.

<sup>44</sup> Staatsblad (2000), *Besluit tot wijziging van het Verstrekkingsbesluit ziekenfondsverzekering en het Vergoedingsbesluit particulier verzekerden met betrekking tot ergotherapie, hulp in andere lidstaten van de Europese Unie en de eigen risico's* (20 November 2000), 511, pp. 1-8; Staatsblad (2002), *Wet tot wijziging Wet Toegang Ziektekostenverzekeringen* (30 January 2002), p. 82.

abroad without prior authorisation of their health insurer, not only for extramural care but also for more expensive intramural care. It was believed that this would severely undermine the planning and budgeting system of healthcare provision in the Netherlands. The Association of Health Insurers proposed including flows of ingoing and outgoing patients in the planning and budgetary policy for healthcare facilities.<sup>45</sup> The minister for health Els Borst argued somewhat hesitantly at that time that it might be necessary somewhere in future.<sup>46</sup> Yet she repeatedly noted in parliament the “inevitability” of consequences of a Europe without frontiers for the territorial gates of the Dutch healthcare system. After mentioning the Kohll and Decker cases, she stated in parliament that “borders would lose their significance for the healthcare system, also because of the increasing mobility.”<sup>47</sup> Parliamentarians expressed their concerns on the confusion in the health sector about the potential (budgetary) impact of the Kohll and Decker cases. They also regretted that the Dutch government did not take an official position in the Council. The minister responded that she would raise the issue at the EU level. She also announced that experiments were launched in border regions to know more about the impact of the Court’s rulings, also with regard to waiting lists.<sup>48</sup> Furthermore, she requested the advisory Council for Public Health and Health Care (*Raad voor Volksgezondheid en Zorg, RVZ*) to analyse and provide advice on the implications of Kohll and Decker.

A RVZ sub-report of cross-border patient mobility within and to the Netherlands showed that patient mobility even within the Netherlands was rather marginal.<sup>49</sup> The RVZ also invited someone not involved with the Dutch healthcare system to analyse in general the compatibility of the Dutch health insurance system to European legislation. This coincided with the cautious initiation in Dutch politics of the discussion for another

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<sup>45</sup> Palm, W. et al. (2000), *supra* note 4, p. 86.

<sup>46</sup> Letter from Minister for Health to Chairman Second Chamber (11 December 1998), CSZ/ZT/9819527.

<sup>47</sup> Kamerstukken II 1999/2000 26 800 XVI no. 2 *Begroting VWS* (28 September 1999) pp. 8-9 (my translation).

<sup>48</sup> Kamerstukken II 1998/99 26200 XVI no. 5 *Begroting VWS* (5 November 1998); Kamerstukken I 1998/99 26200 XVI *Begroting VWS* (30 March 1999), pp. 25-1106-1162.

<sup>49</sup> Brouwer, W.B.F. (1999), *Het Nederlandse Gezondheidszorgstelsel in Europa: Een Economische Verkenning*, Zoetermeer: RVZ.



attempt at full-scale reform of the health insurance system. The Belgian social security expert Danny Pieters found several obstacles for foreign health insurers and health providers in entering the Dutch healthcare system. For instance, the obligation for insurers to offer a standard health policy (WTZ) and to levy premiums for the overrepresentation of old patients in the obligatory ZFW (MOOZ) might discriminate foreign health insurers. In addition, the contents of the contracts between health insurers and health providers are based on cartel-like agreements at the national level, which might conflict with EU anti-trust legislation. The state-approved contracts between health providers and insurers were still exempted from the Dutch anti-trust law until 2003. He found the obligation for insurers to conclude a contract as soon as a provider delivers care to a client, might be discriminatory to foreign providers where the system of obligatory contracting did not apply. Furthermore, the permission of health providers is based on the criterion of geographical spread. Such criterion seems to be an unjustified restriction on the free access of foreign health providers. In its main report, the RVZ repeated Pieters' concerns about the vulnerability of the Dutch healthcare system to European legislation.<sup>50</sup> Debates on the compatibility of the private-public mix of the Dutch health insurance system with European and international law have continued even after the introduction of the Health Insurance Act in 2006.<sup>51</sup> Regarding the potential effects of Kohll and Decker on patient mobility, the RVZ proposed having it discussed at an EU level instead of leaving it to the judges, as well as to learn from experiments in the Euregions.

Between April 1999 and September 2000, the Dutch ministry of health and the Health Insurance Board carried out the experiment *Grensoverschrijdend Contracteren* (Cross-border healthcare contracting) in the Dutch-Belgian Euregion Scheldemond. The previous arrangements of the health insurer OZ with Belgian hospitals in Bruges, Ghent and Knokke were incorporated into an experiment to learn about the

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<sup>50</sup> Raad voor Volksgezondheid en Zorg (1999), *Europa en de Gezondheidszorg*. Zoetermeer: RVZ.

<sup>51</sup> Napel, H.-M. ten (2007), "In het Uiterste Geval moet je de Derde Schaderichtlijn toepassen": De Omgang van de Wetgever met Veellagigheid bij de Stelselherziening Gezondheidszorg', 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. 49-62.

problems of cross-border healthcare contracting. In contrast to previous Euregional experiments to simplify authorisation procedures for individual patients seeking cross-border healthcare in a certain hospital, in this experiment patients could only receive treatments in the contracted hospitals. Between 1998 and 2004 the number of Dutch patients treated in contracted hospitals in the Scheldemond region rose from 1,553 to 7,267.<sup>52</sup> The Dutch ministry of health also sponsored an experiment since 1999 with an international health insurance card issued by the Dutch health insurer CZ and the German health insurer AOK Rheinland. This card allows their clients to access contracted healthcare facilities within the Euregion Meuse-Rhine. In parliament, minister for health Borst argued that legislative changes regarding health insurance would also be based on the court's rulings and the lessons from the Euregional experiments. According to her, the experiment in the Rhein-Waal area had shown that cross-border healthcare is no burden for the Dutch health infrastructure.<sup>53</sup> Also experiments in other border regions indicated that cross-border patient mobility was a very marginal phenomenon, even in the Zeeuws-Vlaanderen region with only about four percents of the ZFW clients using Belgian hospitals.<sup>54</sup> In addition, the Dutch contracting system was considered compatible with the Court's rulings for the time being, pending further verdicts on cross-border hospital care.<sup>55</sup> Borst fiercely responded to a senator's remark that it is inexplicable to citizens to deny them free access to cross-border healthcare; that would undermine the contracting system, and thus the entire Dutch healthcare system.<sup>56</sup>

Following the RVZ report, Borst asked several executive bodies how obstacles might be removed to contract foreign health providers, which

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<sup>52</sup> Glinos, I.A., Boffin, N. & Baeten, R. (2005), *Contracting Cross-border Care in Belgian Hospitals: An Analysis of Belgian, Dutch and English Stakeholder Perspectives*. Brussels: OSE. p. 104.

<sup>53</sup> Kamerstukken II 2000/01 27400 XVI no. 2 *Begroting VWS* (4 October 2000) pp. 238, 250-251.

<sup>54</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.

<sup>55</sup> Kamerstukken II 1999/2000 27156 no. 2 *Notitie WTG Speelruimte en Verantwoordelijkheid* (25 May 2000).

<sup>56</sup> Kamerstukken I 1999/2000 26800 XVI *Begroting VWS* (14 March 2000), p. 20-822 and 20-849.

problems with tariffs and costs of cross-border healthcare may arise, and to collect data on cross-border healthcare. Among others, the Board of Healthcare Institutions (*CBZ, College Bouw Zorgvoorzieningen*) expressed in its report concerns about free movement of health services and goods, because that not only makes planning more problematic, but also increases the financial uncertainty of hospitals.<sup>57</sup> The Health Insurance Board suggested accepting health providers from the European Economic Area if they meet the qualifications of their domestic health authorities. The criterion of geographical spread should be dropped to be permitted in the Dutch system. In addition, the Dutch tariffs could not be obligatorily applied in the contracts. Meanwhile, contracts with foreign providers cannot be refused by the Dutch health authorities, because no rules existed on contracting foreign providers.<sup>58</sup>

The Dutch health authorities would have initially considered inviting tenders for hospital care from the Belgian and German border regions.<sup>59</sup> The potential discrimination of Belgians in favour of Dutch patients with this selective contracting abroad might have prevented them from doing so. The Health Insurance Board and the Supervisory Health Insurance Board (*College Toezicht Zorgverzekeringen, CTZ*) both preferred contracting by health insurers, and urged the health insurers and ministry of health to act accordingly.<sup>60</sup> In contrast to individual authorisation procedures, contracting provides a better overview in advance and afterwards for the supervisor, health insurers and insured clients. An additional advantage of contracting is the opportunity of keeping a certain control on the price, size and quality of healthcare. An ECJ ruling in July 2001 reinforced the position of the Dutch health authorities. In their opinion, their contracting system was a justified limitation of the

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<sup>57</sup> College Bouw Zorgvoorzieningen (13 November 2000), *Uitvoeringstoets Herziening Overeenkomstenstelsel ZFW/AWBZ*. Utrecht: CBZ.

<sup>58</sup> CVZ (19 July 2000), *Contracteren met Buitelandse Instelling: Circulaire 00/030*. Amstelveen: CVZ; CVZ (2 May 2002), *Grensoverschrijdende Zorg. Circulaire 02/21*. Amstelveen: CVZ.

<sup>59</sup> Baeten, R (2000), *De Gevolgen van de Europese Eenmaking voor de Organisatie en de Verstrekking van de Gezondheidszorgen in België: Patiëntenmobiliteit en Grensoverschrijdende Zorg* (report at the request of the Federal Ministry of Health). Brussels: OSE. p. 40.

<sup>60</sup> CVZ (2001), supra note 78; CTZ (2001). *Signalement Grensoverschrijdende Zorg* (report at the request of the Ministry of Health). Amstelveen: College Toezicht Zorgverzekeringen; CVZ (2002), supra note 156.

free movement of goods and services because it enables the maintenance of a financially stable, accessible healthcare system of good quality.

In March 2002, the ministry of health, the Health Insurance Board and the Dutch Association of Health Insurers responded immediately and furiously to a judgement by a Dutch regional court in Maastricht.<sup>61</sup> The court ruled that a Dutch patient should have the right to cross-border extramural care according to European legislation, despite the contracting system between the patient's health insurer and care providers. Notwithstanding the "sloppy reasoning" of the Maastricht judge, the European Court of Justice in May 2003 came to a rather similar conclusion in the Müller-Fauré/Van Riet-cases. The Dutch health authorities and the Dutch Association of Health Insurers remained silent in public about the potential implications of this ECJ-ruling for the contracting of extramural care *within* the Dutch healthcare system. Individual health insurers hoped the regional and European court rulings could be used to abolish the system of obligatory contracting with providers of extramural care within the Netherlands. Even for a few clients far away from its core operating area, a health insurer had to conclude a contract with such a provider. The Dutch Health Insurance Board considered the Court ruling only applicable to cross-border extramural care, and not to the system of prior authorisation for obtaining extramural care within the Netherlands.<sup>62</sup> The extent of obligatory contracting has been limited over the years (already starting in 1992), however, with particular regard to extramural care.

During the hearings of the Müller-Fauré/Van Riet-cases, the Dutch government defended its contracting system for extramural care whether it was in the Netherlands or abroad. After the Court's verdict, the government abolished obligatory prior authorisation for extramural care to be obtained abroad whether for pharmaceutical goods or outpatient treatments. The Health Insurance Board asked health insurers to inform their clients that they are still better off financially via Regulation

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<sup>61</sup> NRC Handelsblad (15 March 2002), "Rechter legt Bom onder Financiering Zorgstelsel."

<sup>62</sup> CVZ (4 February 2004), *Aanvullende Circulaire inzake arrest Müller-Fauré en Van Riet (C-385/99). Circulaire 04/07*. Diemen: CVZ.

1408/71.<sup>63</sup> If using the Treaty method, the maximum amount of reimbursement was based on Dutch tariffs (as long, however, as the Dutch health authorities have not made an official decision on the coverage of cross-border extramural care, the real costs have to be covered), and transport costs are covered for up to 200 kilometres. The ministry of health also announced that the court's verdict were in accordance with the proposed health insurance legislation.<sup>64</sup> Within the new health insurance system of 2006 for basic healthcare, health insurers reimburse clients' bills of healthcare obtained anywhere in the world (maximised by Dutch tariffs), or contract healthcare providers (if necessary abroad) to provide healthcare to their clients.

Regarding AWBZ care (basically long-term care), health users are free to seek extramural care abroad in the EU/EEA area, if it is covered by the AWBZ health package. The coverage is maximised by the Dutch tariffs. For intramural care, a patient has to ask permission from the health insurer to visit a not-contracted health provider (abroad), unless the health insurer cannot provide the required care in due time. The criterion of geographical spread was dropped. A four week holiday is allowed as a temporary stay abroad in which a patient can apply for urgent intramural care from non-contracted health providers through the E111 procedure. After a period of seven successive days, health providers will become (partly) financial responsible for a patient staying abroad to prevent empty beds in a sector with waiting lists.<sup>65</sup> AWBZ patients can also ask for an individual budget (*Persoonsgebonden Budget, PGB*) from the regional care insurance office to seek healthcare themselves instead of using contracted health providers. An amount of 2500 Euro can be spent annually without providing evidence of the expenses. According to a report by the ministry of health on the use of AWBZ care abroad, this should be sufficient for holiday periods abroad.<sup>66</sup> If someone stays longer

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<sup>63</sup> CVZ (25 June 2003), *Arrest Müller-Fauré en Van Riet (C-385/99)*. *Circulaire 03/35*. Amstelveen: CVZ.

<sup>64</sup> VWS (13 May 2003), *Press Release: Europees Hof van Justitie: "Vrije Toegang tot (Tand)arts in het Buitenland"*. Den Haag: Ministerie van VWS.

<sup>65</sup> Kamerstukken II 2007-2008 30 597 no. 13 *Toekomst AWBZ* (19 September 2007). p. 12.

<sup>66</sup> VWS (2007), *AWBZ-zorg in het Buitenland: Hoe 'Gloobaal' is Ons Zorgstelsel*. Den Haag: VWS.

than six weeks abroad, the rate of reimbursement will be set according to actual costs.

### *9.3.2 Dutch waiting lists and cross-border healthcare*

Just after the Kohll and Decker verdicts in April 1998, minister Borst reported to parliament that she did not know of cross-border initiatives from health insurers in order to circumvent waiting lists.<sup>67</sup> After the landmark judgement by a Dutch court on the health insurers' obligation to provide healthcare in due time, the health insurers did start to look across borders. Adopting the court's ruling as her policy, Borst promised in parliament to improve Dutch healthcare to make cross-border healthcare redundant.<sup>68</sup> According to the European Court of Justice in a verdict in July 2001, health insurers should authorise access to foreign intramural healthcare if they cannot provide it in due time to a patient considering his or her personal condition.<sup>69</sup> The Trekk norms on acceptable waiting times can provide an indication whether a patient has to wait too long for treatment. Minister Borst stated in parliament that health insurers might have to contract cross-border care in order to fulfil their obligation to provide healthcare to their clients in due time, and to press domestic health providers to provide more, quicker and cheaper treatments.<sup>70</sup> She preferred health insurers directly contracting with foreign providers, rather than patients individually seeking cross-border healthcare, since this keeps intact the authorisation procedure and the benefit-in-kind system.<sup>71</sup>

The ministry and the Health Insurance Board introduced a subsidy for the extra administrative costs incurred by health insurers when having

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<sup>67</sup> VWS (18 December 1998), *Inventarisatie Initiatieven Omzeilen Wachttijsten Gezondheidszorg: Brief aan de voorzitter van de Vaste Kamercommissie voor Volksgezondheid, Welzijn en Sport*. DBO-CB-U-981823.

<sup>68</sup> Kamerstukken II 1999/2000 *Parliamentary Question no. 170 Swiss Health Care* (8 October 1999), Appendix 353.

<sup>69</sup> CVZ (1 September 2004), *Tweede Aanvullende Circulaire inzake Arrest Müller-Fauré en Van Riet n.a.v. Uitspraken Centrale Raad van Beroep d.d. 18 juni 2004*. Circulaire 04/45. Diemen: CVZ.

<sup>70</sup> Kamerstukken II 2001/02 *Question no. 734 Grensoverschrijdend contracteren van huisartsen* (11 February 2002), Appendix, 1541; NRC Handelsblad (26 February 2002), "Vrij Verkeer kan Prikkel zijn voor Zorg".

<sup>71</sup> Kamerstukken II 2001/02 26834 no. 7 *Socialeverzekeringspositie Grensarbeiders* (11 January 2002), pp. 5-6.

to contract foreign health providers to limit waiting lists.<sup>72</sup> The Health Insurance Board also decided to take foreign treatments into account in the equalisation fund for the health insurers executing the ZFW and AWBZ. In 2002, Dutch health insurers contracted 21 foreign hospitals (compared to 110 in the Netherlands), and another 136 health providers.<sup>73</sup> The Health Insurance Board started to collect detailed data on cross-border healthcare in order to monitor it more effectively, since health insurers did not systematically register the costs of foreign treatments before. From its reports it appeared that waiting lists in particular were what motivated most health insurers to launch cross-border initiatives which then put more pressure on domestic health providers. However, most health insurers considered themselves responsible for providing healthcare in the vicinity of their clients. According to the health insurers, most Dutch clients preferred to be treated close at home rather than abroad. The Health Insurance Board concluded that the number of people seeking cross-border healthcare was rather marginal. With the notable exception of the southern-based CZ, and VGZ to a lesser extent, most health insurers used it for their clients as a symbolic, rather than as an effective means to limit the waiting lists.

The health insurers also reported reluctance among doctors and hospitals to provide aftercare to patients who went abroad. Some Dutch doctors are allegedly reluctant to take responsibility for mistakes made abroad, because they are often poorly informed about foreign healthcare systems and have a rather high self-esteem.<sup>74</sup> Dutch hospitals also have strict protocols on MRSA bacteria. A patient who went abroad for hospital treatment has to be quarantined before treatment can be given in a Dutch hospital, because most foreign hospitals including Belgian and German ones have higher rates of MRSA contagion. Since quarantine is a rather burdensome procedure, it has been reported that hospitals refused

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<sup>72</sup> Idem.

<sup>73</sup> ZN (25 June 2002), *Rapport: Contracteren in het Buitenland*. Zeist: ZN.

<sup>74</sup> Glinos, I.A. et al. (2005), supra note 52, p. 61; As a matter of fact, the performance of the Dutch healthcare system is considered one of the best in Europe along with the French, Swiss, German, and Austrian, at least according to an evaluation by the Health Consumer Powerhouse (2007), *Euro Health Consumer Index 2007*. Brussels/ Stockholm/ Winnipeg: Health Consumer Powerhouse.

even terminal patients from foreign hospitals.<sup>75</sup> According to the minister for health Hans Hoogervorst, patients might have to stay in foreign hospitals, if Dutch hospitals lack quarantine capacity, but he did not have any information on the refusals of patients from the Dutch Hospitals Association (*NVZ, Nederlandse Vereniging van Ziekenhuizen*) or the Dutch Healthcare Inspectorate (*IGZ, Inspectie voor de Gezondheidszorg*).<sup>76</sup> The Inspectorate has kept an eye on the accessibility of Dutch hospitals because of previous rumours on refusals because of MRSA infections.<sup>77</sup> In addition, a Dutch health insurer has adopted the MRSA protocol in a contract with a Belgian hospital to facilitate continuity of care.<sup>78</sup> Projects involving German and Belgian border hospitals aim at limiting the spread of the bacteria at both sides of the border, while the Dutch ministry of health and DG SANCO finance the *European Antimicrobial Resistance Surveillance System*, monitoring the spread of disease-causing bacteria with resistance to antibiotics, such as MRSA bacteria, in Europe (see [www.rivm.nl/earss](http://www.rivm.nl/earss)).

Reluctance among hospitals and doctors to cross-border healthcare has also emerged because they fear the entrance of foreign providers in a previously closed market. The Board of Healthcare Institutions expressed its concerns about the effects of competition on the planning and financial sustainability of hospitals.<sup>79</sup> European case law justifies planning and rationalisation of hospital care to prevent over- or under-supply within the Dutch healthcare system, but the minister for health Borst had to admit the Healthcare Facilities Act is territorially limited.<sup>80</sup> Competition from Belgian hospitals would therefore be possible. After the health insurer CZ launched its contracts with foreign health providers, Jan Carpay, the chair of the Maastricht University Hospital, blamed CZ for

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<sup>75</sup> NRC Handelsblad (2 August 2005), 'Ziekenhuizen weren vaker Zieke Toeristen wegens Besmetting MRSA.'

<sup>76</sup> Kamerstukken II 2004/05 *Question no. 2207 Weren van Zieke Vakantiegangers* (12 August 2005), Appendix 4405-4406.

<sup>77</sup> Inspectie voor de Gezondheidszorg (1 July 2002), *MRSA-beleid*. Circulaire 2002-07-IGZ. The Hague: IGZ.

<sup>78</sup> Glinos, I.A. et al. (2005), *supra* note 52, pp. 34, 36.

<sup>79</sup> CBZ (2001). *Sturing en Financiering van de Bouwkundige Zorginfrastructuur in Andere Landen van de Europese Unie: Signaleringsrapport*. Den Haag: College Bouw Ziekenhuisvoorzieningen.

<sup>80</sup> Kamerstukken II 2001/02 27659 no. 7 *Wet Exploitatie Zorginstellingen* (13 December 2001), p. 26.



being “completely irresponsible.” He felt facilitating patients going abroad would “exhaust” the Dutch healthcare system. He particularly feared the “unfair competition” from Belgian hospitals, because they include only 40% of the construction costs in their health tariffs.<sup>81</sup> Like the Norwegian and British doctors and hospitals confronted with health authorities’ initiatives of cross-border healthcare because of waiting lists, the Dutch health providers preferred to keep domestic money within their home system.<sup>82</sup> However, some doctors have launched initiatives to treat patients in Germany, Spain, and England to circumvent waiting lists. Also Dutch hospitals, including Carpay’s Maastricht University Hospital, have started to cooperate with foreign hospitals to offer more choice within the Dutch healthcare system.<sup>83</sup> Concerns about the competitiveness of Dutch hospitals have still not completely vanished.<sup>84</sup> However, some health insurers have reported that because of the pressure of international competition, Dutch health providers perform better.<sup>85</sup>

Belgian hospitals have struggled with structural under-occupation since the length of patient stays has decreased over the years. Foreign patients offered therefore the opportunity for small-sized hospitals to sustain a viable turnover, and for top-clinical centres the necessary influx of patients to afford certain advanced health technologies. The total budget per hospital is based on the number of patients treated the year before. The hospital budget is partly fixed, and partly variable according to the number of patients treated. The variable part of the hospital budget is corrected ex-post, but since 2003 only according to the number of Belgian patients and foreign patients using Regulation 1408/71, and not other foreign patients. If the turnover of a hospital exceeds the budget, it has to return the extra income to the health authorities. Hospitals may yet try to attract foreign patients, but only to meet the level of the budget. In

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<sup>81</sup> Trouw (21 March 2002), ‘Beter Bed in België.’

<sup>82</sup> Glinos, I.A. et al. (2005), supra note 52; Glinos, I.A. & Baeten, R. (2006), *A Literature Review of Cross-border Patient Mobility in the European Union*. Brussels: OSE (E4P).

<sup>83</sup> Baselmans, N. & Hermans, H.E.G.M. (2003), ‘Grensoverschrijdende Samenwerking: Oplossing voor Capaciteitsproblemen bij Ziekenhuizen?’, in *Zorg & Financiering*. Vol. 5, pp. 11-27.

<sup>84</sup> See NRC Handelsblad (25 November 2006), ‘In Duitsland is alles beter: Nederlandse Ziekenhuizen kunnen niet concurreren op de Europese Markt voor Gezondheidszorg.’

<sup>85</sup> Glinos, I.A., Baeten, R. & Boffin, N. (2006), ‘Cross-border Contracted Care in Belgian Hospitals’, in M. Rosenmöller et al. (eds.), *Patient Mobility in the European Union: Learning from Experience*. Copenhagen: WHO. p. 112.

addition, they would be less inclined to provide expensive treatments, because since 2002 hospitals were obliged to charge an average price of treatment for those foreign patients not using the Regulation method and not the real costs.<sup>86</sup> As a consequence, Belgian hospitals have had fewer incentives to treat foreign patients since 2002, to the regret of the Dutch health insurer CZ as well as small hospitals in the border regions. Moreover, the total governmental budget for hospitals is fixed. The more (foreign) patients would receive treatment in some hospitals, the smaller the budget share is for other hospitals. This consequence has been regretted in parliament (see below).

Flemish politicians expressed in 2003 their concerns about foreign patients from particularly England and the Netherlands.<sup>87</sup> That may not come as a surprise since Belgium has the highest number of foreign patients using the Regulation method in the European Union relative to its size, and the number of particularly Dutch patients using Flemish hospitals, partly via health insurers' contracts increased considerably at the turn of the century.<sup>88</sup> Precisely because construction costs are not fully included in hospital tariffs, the Belgian taxpayer thus, in the words of the Flemish *De Standaard* newspaper, "subsidises healthcare of neighbouring countries."<sup>89</sup> They also feared that Belgians might have to wait for treatment in Belgian hospitals, because foreigners would pay more than Belgians. The Belgian minister for health Frank Vandenbroucke shared the concerns of politicians. He aimed at controlling the patients' flow across borders in order to prevent overburdening the Belgian healthcare system. After a 3 months pilot project in 2002, the Belgian government concluded in February 2003 a very detailed contract with the British National Health Service on how to use the existing over-capacity in Belgian hospitals for British patients. Eventually, only a few hundred patients were treated, and the project effectively stopped prematurely in

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<sup>86</sup> Glinos, I.A. et al. (2005), *supra* note 52, p. 51.

<sup>87</sup> *Annales Sénat de Belgique* (6 February 2003) *Oral Questions by MPs Jan Remans* (2-1227) and *Erika Thijs* (2-1235), 2-267; *Belgische Kamer van Volksvertegenwoordigers, Commissie voor Volksgezondheid, Leefmilieu en Maatschappelijke Hernieuwing* (9 December 2003), *Interpellation by MP Jo Vandeurzen* (no. 124), CRABV 51 COM 094, pp. 18-21.

<sup>88</sup> Busse, R. et al. (2006), *Mapping Health Services Access: National and Cross-Border Issues. Final Report*. HealthACCESS project.

<sup>89</sup> *De Standaard* (11 December 2003), 'België subsidieert Gezondheidszorg Buurlanden.'

September 2004.<sup>90</sup> Vandenbroucke stated in a Dutch newspaper that the Dutch export of waiting lists would worsen the access of Belgian patients to Belgian hospitals. He and later on his successor Rudy Demotte therefore proposed to close a contract similar to a contract between the Belgian state and the British National Health Service.<sup>91</sup> However, the Dutch purchasing of healthcare is the responsibility of the private health insurers, and the Dutch ministry of health lacks any power to force them collectively to conclude a contract with the Belgian health authorities.<sup>92</sup>

In 2004, 15 Belgian healthcare facilities had been contracted by four Dutch health insurers, OZ, CZ, VGZ, and Achmea.<sup>93</sup> The Belgian health authorities did not full-heartedly support direct contracting of Belgian health providers by Dutch health insurers. The National Health and Disablement Insurance Institute (*Rijksinstituut voor Ziekte- en Invaliditeitsverzekering, RIZIV*) can monitor cross-border healthcare directly if it is based on domestic or European regulations to obtain healthcare abroad, but not if it is arranged through the contracts between foreign health insurers and Belgian health providers.<sup>94</sup> The control of flows of foreign patients in Belgium is exercised by health insurance funds, particularly by the largest one, the Christian Mutualities (*Christelijke Mutualiteiten, CM*). The local branches of CM intermediate between Dutch health insurers and Belgian health providers.<sup>95</sup> Knowledge of local branches helps Dutch health insurers when contacting Belgian hospitals (which are not known to a system of contracting), and to lower the transaction costs by using existing domestic administrative procedures. For its part, CM can monitor and partly steer the flows of Dutch patients to prevent its own clients from suffering from the effects of cross-border healthcare. In addition, CM also attempts to prevent direct contracting between Dutch health insurers and Belgian doctors. In contrast to the Belgian hospitals, doctors are paid fee-for-service. They

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<sup>90</sup> Glinos, I.A. et al. (2005), supra note 52, p. 38.

<sup>91</sup> See NRC Handelsblad (15 February 2003), ‘‘Zieke Belgen mogen niet de Dupe worden’’; Het Nieuwsblad (12 February 2004), ‘Steeds meer Nederlanders in onze Ziekenhuizen.’

<sup>92</sup> Kamerstukken II 2002/03 25170 no. 30 *Wachttijden in de Curatieve Zorg* (14 February 2003).

<sup>93</sup> Glinos, I.A. et al. (2005), supra note 52, p.33. In 2005, a fusion between CZ and OZ continued under the name of CZ. In 2007, VGZ fused with Univé and Trias into Uvit.

<sup>94</sup> I like to thank Dr. Rita Baeten for this insight.

<sup>95</sup> Glinos, I.A. et al. (2005), supra note 52, pp. 55-56; 68.

might therefore be more inclined to establish contracts in which they would give prior access to better-paying patients from the Netherlands. For their part, Dutch health insurers fear that those doctors would induce supply-driven demand.<sup>96</sup>

Flemish politicians were still not entirely at ease with the implications of cross-border patient mobility for the Belgian healthcare system. They therefore proposed to include all construction costs in hospital fees in order to stop the Belgian taxpayer from subsidising foreign healthcare systems. Moreover, foreign patients would no longer be included in the calculation of hospital budgets. They proposed a Observatory of Patient Mobility to monitor the flows of foreign patients and the accessibility of Belgian healthcare facilities for Belgian patients. The import of waiting lists and a two-tier system in which better-paying foreigners receive prior access while ousting Belgian patients should thus be avoided.<sup>97</sup> According to its name, the modification law aims nevertheless at “stimulating” patient mobility. The suggestion from the Belgian Federation of Enterprises<sup>98</sup> of turning Belgium into an international medical centre did, however, not receive full-hearted support. Cross-border patient mobility is seen as inevitable, but the access of Belgian patients in Belgium is the prior concern for Belgian politicians, health authorities and health insurance funds despite the European exit options offered. Despite this, in 2007 eleven hospitals in Flanders and Brussels started to collectively approach non-European patients.<sup>99</sup>

### *9.3.3 Cross-border healthcare: more than a temporary safety valve?*

While the beginning of this chapter may give another impression, the Dutch health sector has in general considered Europe as irrelevant or unjustly interfering with domestic health affairs. Cross-border healthcare was seen for the most part as a temporary safety valve for domestic

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<sup>96</sup> Idem, p. 67.

<sup>97</sup> Belgische Kamer van Volksvertegenwoordigers (4 April 2007), *Verslag Commissie Volksgezondheid, Leefmilieu en Maatschappelijke Hernieuwing over Wetsvoorstel tot Wijziging van de Wetgeving met het oog op de Bevordering van de Patiëntenmobiliteit*. DOC 51 2966/003; Belgische Kamer van Volksvertegenwoordigers (12 April 2007), *Wetsontwerp tot Wijziging van de Wetgeving met het oog op de Bevordering van de Patiëntenmobiliteit*. Doc 51 2966/005.

<sup>98</sup> VBO (2006), *Dare&Care: Internationalisering van de Belgische Medische Sector*. Brussel: Verbond van Belgische Ondernemingen.

<sup>99</sup> De Standaard (23 November 2007), ‘Ziekenhuizen zoeken Patiënten in Buitenland.’

problems with waiting lists. Free movement of health goods and services across borders could not count on broad support. The Health Insurance Board explained that free movement might seriously weaken healthcare infrastructure, as already happened in the isolated Zeeuws-Vlaanderen border region. When the local hospital at Terneuzen was not well perceived, more patients went to Flemish hospitals.<sup>100</sup> Dutch health authorities have suggested stopping the special arrangements with Belgian hospitals, since the Zeeuws-Vlaanderen region has become linked with the rest of the Netherlands in 2003 via a tunnel under the Scheldt River. For the time being, the strained relations between north and south of the Scheldt River make cross-river cooperation among hospitals a rather difficult affair.<sup>101</sup> The locally dominant health insurer OZ facilitates access to contracted Belgian hospitals only for those pathologies not available at the Terneuzen hospital trying to protect it from a decrease in the number of patients.<sup>102</sup> The suggestion from the Dutch health authorities also shows that they see cross-border healthcare mostly as an exception to the territorial rule of the Dutch healthcare system.

The Dutch minister for health Hans Hoogervorst claimed in 2004, however, that in contrast to most other Member States the Netherlands considers cross-border patient mobility as an “opportunity” and not as a “threat.”<sup>103</sup> For instance, it helped to shorten the waiting lists. When some socialist parliamentarians expressed their concerns that foreign patients might lengthen the Dutch waiting lists (because of the fixed hospital budgets, every foreigner treated in Dutch hospitals means one Dutch patient less that can be treated), Hoogervorst emphasised that the government is in favour of the internal market, offering maximum freedom of choice to patients.<sup>104</sup> Hoogervorst also supported the inclusion of health services in the services directive of his fellow conservative-liberal party member Frits Bolkestein. Hoogervorst also guided the adoption of a

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<sup>100</sup> CVZ (2001). *Grensoverschrijdende Zorg* (report at the request of the Ministry of Health). Amstelveen: College Voor Zorgverzekeringen.

<sup>101</sup> Vierhout, P.A.M. (2004), *Zeeuwse Zorg op Locatie: Een Noodzakelijke Vernieuwing* (Voortgangsrapportage Curatieve Zorg). Middelburg: Provincie Zeeland.

<sup>102</sup> Glinos, I.A. et al. (2005), *supra* note 52, p. 37.

<sup>103</sup> Kamerstukken II 2003/04 501-31 no. 50 *Raad voor Werkgelegenheid, Sociaal Beleid, Volksgezondheid en Consumentenzaken: Verslag van Algemeen Overleg* (27 May 2004).

<sup>104</sup> Kamerstukken II 2005/06 *Question no. 1632 Vergoeding Behandelingen in een andere Lidstaat* (12 June 2006), Appendix 3479-3480.

new health insurance system characterised by more choice and competition (including across Dutch borders). Political turmoil about the new system has been limited; Hoogervorst managed to introduce universal health insurance after decades of political and corporatist haggling. Most political fuss came from the privately insured living somewhere else in the European Union.<sup>105</sup> Within the new health insurance system, the privately insured are also covered by Regulation 1408/71.<sup>106</sup> As a result, they have to pay Dutch health premiums, but can exercise their health rights within the country of residence via the local health insurance institutions (for which the Dutch health authorities eventually pay for). They complained that their previous private health insurance offered much more than the social health insurance in their country of residence. Moreover, they had to pay not only Dutch health premiums but also taxes (also used for healthcare) in their country of residence. The privately insured considered it unfair to pay more while receiving less. A Dutch court eventually decided in these cases, the Dutch government should charge them health premiums according to the local prices. The Dutch health authorities set health premiums abroad accordingly, which are much lower for Moroccan *rémigrés*, while those in Iceland, Norway, and Ireland are charged higher premiums than in the Netherlands.<sup>107</sup> As a matter of fact, if Dutch living abroad would like to be treated in the Netherlands while being registered at a foreign health insurance institution within the EU/EEA-area, they have to ask permission for planned care via the E112-procedure or an equal procedure according to the health insurance system of their country of residence.<sup>108</sup> A health insurer decides what is considered living abroad with regard to AWBZ, and if it is in doubt, it can ask the Social Insurance Bank (*Sociale Verzekeringsbank*). The longer someone stays abroad, such as hibernating pensioners spending more than 6 months annually abroad for successive years, the weaker his or her link with the Netherlands, the more likely the health insurer is to consider him or her no longer living in

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<sup>105</sup> *NRC Handelsblad* (10 September 2005), 'Tienduizenden de Dupe van AWBZ'; *De Telegraaf* (1 maart 2006), 'Spaanse Zon peperduur door Zorgwet.'

<sup>106</sup> See CVZ (2005), *Wonen in het Buitenland: wat betekent dat voor uw ziektekostenverzekering?* Diemen: CVZ.

<sup>107</sup> *Staatscourant* (6 December 2006), *Wijziging Regeling Zorgverzekering*. Nr. 238, p. 15.

<sup>108</sup> See Case 156-01 *Van Duin* (2003) ECR I-7045.

the Netherlands.<sup>109</sup> According to health minister Klink, the new rule of thumb will soon be one year.<sup>110</sup>

According to the government's contribution to the European consultation on health services in the winter of 2007, patients' freedom of choice should be limited only "in exceptional circumstances."<sup>111</sup> A new directive on health services could not count on full support. The government would rather leave the implementation of the Court's rulings on cross-border patient mobility to the national authorities. Dutch health officials feared that a general European health services directive may not take into account the peculiar mixture of private and public elements in the Dutch healthcare system. The government still welcomes more information on the costs of cross-border healthcare and European standardisation of quality and safety norms. In contrast to Hoogervorst's support for an internal market of health services, his successor Ab Klink (since 2007) seems somewhat more hesitant to fully embrace the internal market, even though he, like Hoogervorst, does not consider Europe as a threat to national healthcare arrangements. According to Klink, a borderless Europe should also offer patients advantages, but he still shares the parliament's "reluctance" towards a role of the European Union in healthcare policy. His aim is now to keep the national competence regarding healthcare systems fully intact, welcoming concrete measures but not necessarily a European directive on cross-border healthcare.<sup>112</sup> Concerns about a two-tier healthcare system due to cross-border healthcare should be anticipated and addressed by offering better information and transparency on healthcare quality and costs abroad.<sup>113</sup> Klink also proposed to limit the use of AWBZ care abroad, although that

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<sup>109</sup> VWS (2007), *supra* note 66.

<sup>110</sup> Kamerstukken II 2007-2008 30 597 no. 13 *Toekomst AWBZ* (19 September 2007), p. 10.

<sup>111</sup> VWS (2007), Nederlands Regeringsstandpunt in Reactie op de Mededeling van de Commissie in het Kader van de Raadpleging over Communautaire Maatregelen op het Gebied van Gezondheidsdiensten.

<sup>112</sup> Kamerstukken I 2006/07 22112/ 30871 *Subsidiariteitstoets van de mededeling van de Europese Commissie 'De demografische toekomst van de Europa – van uitdaging naar kans'*. (8 January/ 30 March 2007); Ministerie van VWS (14 May 2007), *Grensoverschrijdende Gezondheidszorg. Letter from Minister for Health to Speaker of the House*. IZ-2768588.

<sup>113</sup> Kamerstukken II 2006/07 21 501-31/ 22 112 no. 127 *Raad voor de Werkgelegenheid, Sociaal Beleid, Volksgezondheid en Consumentenzaken/ Nieuwe Commissievoorstellen en Initiatieven van de Lidstaten van de Europese Unie: Verslag van een Algemeen Overleg* (24 May 2007), p. 5.

only involves an estimated 0.1% of the total expenditures on long-term care.<sup>114</sup> The logic of territoriality is thus still found in the motives and behaviour of the government in its desire to keep control of the Dutch territory regarding healthcare.

#### **9.4 Moves and motives of patients**

An important argument the European Court of Justice uses regarding cross-border healthcare is the financial balance of healthcare systems. Certain restrictions on free movement of health goods and services may be justified with regard to rather expensive intramural care. These restrictions should not be too tight, since the Court considers that cross-border patient mobility will remain rather limited anyway due to linguistic barriers, geographical distance, lodging costs, lack of information about foreign health systems, and predominant preference among health users to be treated close to home. Is this interpretation of health users' behaviour correct? Until the Kohll/Decker-cases, Dutch health insurance funds often lacked accurate data on cross-border healthcare. Like most other health insurance agencies elsewhere in the EU, they did not register the use of Regulation 1408/71 or domestic procedures to obtain healthcare abroad. The data are still "fragmentary" and "incomplete" despite the various research projects funded by the European Commission on patient mobility since the 1990s.<sup>115</sup> Nevertheless, experiments with cross-border healthcare in Dutch and Belgian border regions, as well as the research reports referred to above, give an impression of cross-border patient mobility. It is marginal overall in the EEA area, as it does not exceed an estimated 1% of public health expenditures. Cross-border healthcare is concentrated in certain areas (such as tourist and border regions), where it is often not more than 5% of the total number of treatments or of the total public health expenditures. These numbers corroborate the Court's judgement on the size of cross-border patient mobility. But what about the reasons and

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<sup>114</sup> VWS (2007), *supra* note 66.

<sup>115</sup> Rosenmöller, M., McKee, M. & Baeten, R. (eds.) (2006), *Patient Mobility in the European Union: Learning from Experience*. Copenhagen: WHO.; see also Glinos, I.A. & Baeten, R. (2006), *supra* note 82; Hermans, H.E.G.M. & Brouwer, W.B.F. (2003), *Quality Issues on Cross-Border Care: A Literature Research*. Rotterdam/ Utrecht; Busse, R. et al. (2006), *supra* note 88.



causes of patient mobility: is the logic of territoriality still deeply entrenched in health users' behaviour? Do they use the widening opportunities for cross-border healthcare within the EU/EEA area only if they have become less satisfied with and less loyal to their domestic healthcare system? Since the Dutch healthcare system has been confronted with patient dissatisfaction (particularly with waiting lists) as well as various EU-inflicted exit options, the Dutch case could provide the necessary insights whether and how political territoriality influences Dutch health insurers.

#### 9.4.1 (Voicing) dissatisfaction on waiting lists

Until the late 1990s, the Dutch have been comparatively satisfied with their healthcare system. The overall evaluation has been relatively high (see table 1).

<b>Table 1: Public satisfaction with the Dutch healthcare system</b>							
<b>Year</b>	1976 <sup>(1)</sup>	1992 <sup>(2)</sup>	1996 <sup>(3)</sup>	1998 <sup>(4)</sup>	1999 <sup>(5)</sup>	2005 <sup>(6)</sup>	2006 <sup>(7)</sup>
<b>satisf.</b>	83.9%	93%	72.8%	69.8%	73.2%	74%	87%
<p><i>Question:</i><sup>116</sup></p> <p>(1) satisfied with performance of government in medical care</p> <p>(2) think that the quality of the healthcare people receive in your country is good</p> <p>(3) fairly or very satisfied with the way healthcare is run in The Netherlands</p> <p>(4) fairly or very satisfied with the way healthcare is run in The Netherlands</p> <p>(5) fairly or very satisfied with the healthcare system in general</p> <p>(6) fairly or very satisfied with Dutch healthcare</p> <p>(7) fairly or very satisfied with Dutch healthcare</p>							

Despite overall satisfaction, dissatisfaction may increase about certain issues such as waiting lists. In the late 1990s, many initiatives were

<sup>116</sup> Source 1: Pescosolido, B.A., C.A. Boyer & W.Y. Tsui (1985), 'Medical Care in the Welfare State: A Cross-National Study of Public Evaluations', in *Journal of Health and Social Behaviour*. Vol. 26, pp. 276-297; Source 2: Ferrera, M. (1993), *Citizens and Social Protection: Main Results from a Eurobarometer Survey* (Spring 1992). Pavia: University of Padua; Source 3: Mossialos, E. (1997), 'Citizens' View on Health Systems in the 15 Member States of the European Union', in *Health Economics*. Vol. 6, pp. 109-116; source 4: European Commission (1998), Eurobarometer 49; source 5: European Commission (1999), Eurobarometer 52.1; source 6 and 7: TNS-NIPO (2007), *Innovaties in de Gezondheidszorg: Trend- en Draagvlakonderzoek*. E-6235. Amsterdam: TNS-NIPO. P.4.

launched to inform patients how to avoid waiting lists within the Netherlands and abroad by the Dutch Hospitals Association, health insurers, commercial intermediary agencies, and patient organisations. That must have made Dutch citizens aware of the issue. The number of newspaper articles published on healthcare waiting lists also gives a rough impression of the focus on waiting lists over the years (see Table 2). At the turn of the century, waiting lists particularly received a lot of attention.

Table 2: Attention to healthcare waiting lists in Dutch newspapers															
Yr	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06
#	77	98	74	48	147	181	185	267	338	296	355	160	73	40	49
Source: LexisNexis; number of articles with the combination of 'waiting lists' ( <i>wachtlijsten</i> ) and 'healthcare' ( <i>gezondheidszorg</i> ) in <i>Algemeen Dagblad</i> , <i>Trouw</i> , and <i>NRC Handelsblad</i> .															

The Dutch system has performed rather well, also with regard to waiting lists, in comparison with other healthcare systems.<sup>117</sup> In addition, some waiting lists for certain pathologies were most probably shorter in 1989 than in 2001.<sup>118</sup> Nevertheless, electoral surveys indicate that dissatisfaction concerning waiting lists has risen in the 1990s, and in the 2002 and 2003 elections healthcare topped the list of national problems. While patients considered in 2000 a waiting time of 2.8 weeks (inpatient care) or 2.4 weeks (outpatient care) as acceptable, they had to wait for 5.2 and 5.4 weeks respectively.<sup>119</sup> The waiting lists were concentrated in the West of the country with shortages in orthopaedics and ophthalmology. In 2006, surveys show that citizens still perceive waiting lists as the main problem in healthcare.<sup>120</sup> How did Dutch citizens express their dissatisfaction? Did they voice or exit?

The main target of Dutch dissatisfaction concerning waiting lists has been the government. In a 2002 survey, 81% of the respondents

<sup>117</sup> See, e.g., Siciliani, L. & Hurst, J. (2003), *Explaining Waiting Times Variations for Elective Surgery across OECD Countries* (OECD Health working papers). Paris: OECD.

<sup>118</sup> Maarse, H., Mur-Veenman, I. & Made, J. Van der (2003), 'Oud Nieuws: Wachtljsten in de Zorg bestaan al Jaren', in *Medisch Contact*. Vol. 58, no. 22, Pp. 889-890.

<sup>119</sup> Friele, R.D., Dane, A. & Andela, M. (6 April 2001), 'Wachten duurt lang', in *Medisch Contact*.

<sup>120</sup> TNS-NIPO (2007), supra note 116.

perceived the government as primarily responsible to solving the problem of waiting lists. Only 2% hold health insurers responsible, and 14% regarded the health providers as responsible.<sup>121</sup> Moreover, respondents in another survey considered the government's policy to shorten the waiting lists very bad (29%) or fairly bad (48%).<sup>122</sup> In the 2002 election campaign, the newly established Fortuyn party emphasised "the mess" the incumbent government left in the Netherlands by mismanaging the waiting lists.<sup>123</sup> Since 2004, waiting lists no longer seem to be news according to the number of newspaper articles. According to the Eurobarometers, however, healthcare has kept a place among the Top 3 national problems facing the Netherlands together with the economic situation and criminality over the years. On average one third of Dutch respondents identify healthcare as the most important national problem, whereas only one-sixth do so on average in the EU area. In addition, 79% (2005) and 67% (2006) of Dutch citizens still consider the government responsible for healthcare.<sup>124</sup> Dutch citizens grade Dutch healthcare with a 7 out of 10, but are less confident about the future.<sup>125</sup> In the campaign for the 2006 parliamentary elections healthcare did, however, seem to receive less attention than in the 2002 and 2003 elections.

Next to voting, citizens/health users also have other possibilities to voice their dissatisfaction. Since the 1980s, the Dutch health authorities introduced voice opportunities through issuing patients' rights laws, implementing complaint procedures in hospitals, and consultative platforms at national, regional and hospital levels. Increasing patients' involvement in healthcare decision-making can be seen as a means of fostering health authorities' legitimacy by channelling potential

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<sup>121</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>122</sup> TNS NIPO/ 2 Vandaag (2002), *Verkiezingen 2002: Zorg belangrijkste Thema; Kabinetsbeleid Wachtlijsten volgens 77% van de Nederlanders Slecht*. [www.tns-nipo.com](http://www.tns-nipo.com) (accessed on 25 November 2003).

<sup>123</sup> Fortuyn, W.S.P. (2002), *De Puinhopen van Acht Jaar Paars*. Rotterdam: Karakter/Academy. Chapter 2.

<sup>124</sup> TNS-NIPO, 2007), supra note 116, p. 5.

<sup>125</sup> Schee, E. van der & Delnoij, D. (2005), 'Dokter geniet nog steeds Aanzien', in *Zorgvisie*. Vol. 8, pp. 28-29.

dissatisfaction.<sup>126</sup> Patient and consumer organisations are, however, weak in comparison to health insurers and the medical profession, because they often depend on volunteers. In addition, patients are a highly fragmented and volatile group. Mainly (representatives of) chronic patients and (mentally) disabled persons are willing and able to sustain efforts of expressing voice. Citizens' knowledge about patients' rights law is rather limited.<sup>127</sup> Many patients still try to solve problems informally with their doctor. Formal complaint procedures are not always considered satisfactory by patients. While the procedures only focus on the individual complaint, patients hope and expect their complaint would induce change in the way the hospital or doctor functions.<sup>128</sup> Regarding health insurance, the Dutch Association of Health Insurers (*Zorgverzekeraars Nederland*, ZN) established a Health Insurance Ombudsman in 1995. In 2006, ZN and the Dutch Patients and Consumers Federation (NPCF, *Nederlandse Patiënten Consumenten Federatie*) established the Health Insurance Complaints and Disputes Foundation (SKGZ, *Stichting Klachten en Geschillen Zorgverzekeringen*), which also include the Health Insurance Ombudsman. It receives complaints, also regarding cross-border healthcare, but involving at maximum some hundred citizens.

The various collective and individual voice options may channel some of citizens' dissatisfaction regarding healthcare, particularly from chronic patients and disabled persons. Their pressure might have been an incentive to improve healthcare at home, among others by shortening the waiting lists. That would be a disincentive for seeking healthcare abroad. The general improvement of healthcare provision may, however, not be sufficiently effective for an individual (urgently) in need for healthcare. Then, at an individual level, exiting is the alternative option.

#### *9.4.2 Patients' exit?*

Studies of patient mobility have shown that Italian patients in the South went to Northern-Italian hospitals, while Italian patients in the North

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<sup>126</sup> Freeman, R. (1999), *The Politics of Health in Europe*. Manchester: Manchester University Press. p. 126.

<sup>127</sup> Friele, R.D., Albada, A. & Sluijs, E. (2006), *Patiënten over hun Rechten in de Gezondheidszorg: Een Overzichtsstudie*. Utrecht: NIVEL.

<sup>128</sup> Sluijs, E.M., Friele, R.D. & Hanssen, J.E. (2004), *WKCZ Klachtbehandeling in Ziekenhuizen: Verwachtingen en Ervaringen van Cliënten*. Den Haag: ZonMw.

went to French hospitals. This was in part because of the bad reputation of Italian hospitals, but also because of waiting times.<sup>129</sup> Most reports on Euregional experiments in cross-border healthcare have found that waiting lists are an important motive for looking for healthcare abroad. Paul Belcher has pointed out that “[o]ne key factor influencing a patient’s decision to seek healthcare abroad is the level of satisfaction with the domestic system.”<sup>130</sup> Analysis of cross-cantonal consumption of healthcare in Switzerland suggests that patient mobility would increase, if exit is facilitated: “When thinking about the creation of a Single European Market for healthcare, it is essential to consider that the present level of E112 cross-border care in the EU underestimates the actual demand for medical treatment abroad (...) As shown by the Swiss case, the more the barriers to cross-border healthcare are lifted, the larger the amount of suddenly effective potential demand.”<sup>131</sup> Since dissatisfaction on waiting lists coincided with the Court’s rulings on patient mobility in Europe, cross-border exit behaviour is therefore to be expected.

Indeed, some surveys indicate that two-thirds of the Dutch respondents are willing to travel abroad for shorter waiting times and to visit health providers with a better reputation.<sup>132</sup> While in the United Kingdom many respondents also expressed their willingness to avoid waiting lists by going abroad, just half of the respondents from Belgium, France, and Germany did so.<sup>133</sup> In a survey among Belgians living in border regions, 72.2% of the respondents claimed that they were staying within the Belgian healthcare system because they were “satisfied” with

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<sup>129</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>130</sup> Belcher, P. (1999), *supra* note 1, p. 75.

<sup>131</sup> Crivelli, L.A. (1998), ‘Cross-Border Care between Swiss Cantons: A Testing Lab for the Single European Market’, in R. Leidl (ed.), *Health Care and its Financing in the Single European Market*. Amsterdam: IOS Press. p. 304.

<sup>132</sup> TNS-NIPO in Raad voor Volksgezondheid en Zorg (2003), *De Wensen van Zorgcliënten in Europa*. Zoetermeer: RVZ. pp. 103-105; Disney, H. et al. (2004), *Impatient for Change: European Attitudes to Healthcare Reform*. London: Stockholm Network.

<sup>133</sup> Idem; MORI (2002) Many Patients “Willing to travel abroad for Treatment”, [www.mori.com](http://www.mori.com) (accessed on 5 June 2003); Lowson, K. et al. (2002), *Evaluation of Treating Patients Overseas, York, York Health Economics Consortium*. (report at the request of the British Department of Health).

it.<sup>134</sup> So did Dutch patients go abroad because of their dissatisfaction with waiting lists? Well, between 1998 and 2003, the number of Dutch patients treated in Belgium via the E112 procedure tripled from 3,970 to 12,503 (in 2006: 10,379), while the number of Dutch patients visiting contracted hospitals in the Scheldemond Euregion rose from 2,934 in 2001 to 7,267 in 2004.<sup>135</sup> In comparison with the number of patients treated within the Netherlands, about 1.7 million hospital treatments in 2003 (excluding treatments in psychiatric hospitals), these numbers are still marginal. The small numbers of Dutch patients going abroad clearly is in contrast to the previously mentioned surveys which showed the willingness to seek healthcare abroad.

Analyses of patterns of health consumption indicate that patients' range of action is limited. A very large majority of patients return to the hospital where they were treated before.<sup>136</sup> Patients predominantly visit healthcare facilities in their own or adjacent region; Brouwer therefore speaks of "inertia in patient mobility" within the Netherlands.<sup>137</sup> And this rule of patient *immobility* particularly holds for chronic patients.<sup>138</sup> Policlinic treatments are preferred by patients to be delivered at a close distance.<sup>139</sup> Dutch patients often take only one nearby hospital into consideration if asked about travelling time to hospitals.<sup>140</sup> According to research exercised at the request of the Dutch Competition Authority (*Nederlandse Mededingingsautoriteit, NMa*), the "geographical market" of top-clinical hospitals covers about 2 to 4 provinces, while the market for other hospitals and policlinics covers at most a city and its

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<sup>134</sup> Jorens, Y., Schuyter, B. de & Salamon, C. (2005), *Naar een Rationalisatie van de EG-Coördinatieverordeningen inzake Sociale Zekerheid?* Gent: Academia Press. p. 199.

<sup>135</sup> Glinos, I.A. et al. (2005), *supra* note 52, p. 22; De Standaard (20 December 2007), 'Almaar Minder Buitenlanders in Belgische Ziekenhuisbedden.'

<sup>136</sup> Centrum voor Verzekeringsstatistiek (2002), *supra* note 121.

<sup>137</sup> Brouwer, W.B.F. (1999), *supra* note 49; Brouwer, W.B.F., Exel, J. van, Hermans, H.E.G.M. & Stoop, A. (2003), 'Should I stay or should I go? Waiting Lists and Cross-Border Care in the Netherlands', in *Health Policy*. Vol. 63, pp. 289-298.

<sup>138</sup> See also Consumentenbond (August 1999), 'Patiënten worden ongeduldig', in *Consumentengids*. pp. 60-61; Consumentenbond (July 2002), 't Ene Ziekenhuis een stuk Beter dan het Andere: 37 Ziekenhuizen vergeleken', in *Consumentengids*. pp. 39-45.

<sup>139</sup> ECORYS-NEI (2003), *Vraagfactoren Ziekenhuizen. Eindrapport* (at the request of the Dutch Competition Authority). SMi/AR8780. Rotterdam: ECORYS-NEI.

<sup>140</sup> *Idem*.

surroundings.<sup>141</sup> Van der Schee and Delnoij have concluded that while many may say they want to go abroad for better hospital doctors or to avoid waiting lists, only a few actually do so.<sup>142</sup> Apparently, stated preferences differ starkly from revealed preferences in health consumption.<sup>143</sup> Questions regarding dissatisfaction about waiting lists and willingness to go abroad for healthcare may be treated hypothetically as long as someone is not confronted with an (urgent) need for healthcare. Most Dutch patients prefer foremost to be treated in a good hospital close to their home with short waiting lists by doctors they know.<sup>144</sup> Another survey has indicated that, depending on treatment, one-fifth to one-third of those living within 10 kilometres of the national border are willing to consider cross-border healthcare equal to domestic healthcare, which is high when compared to only 14% of health users in the Netherlands on average.<sup>145</sup> This also suggests distance matters in patient choice.

The decision to choose a non-local (whether foreign or not) health provider depends on the interplay of the various options for exit and voice, as well as loyalty. For example, exit options *within* a healthcare system may limit exits to *another* healthcare system. Most healthcare systems in Europe have experienced reforms oriented towards more choice and competition over the last two decades: “[n]owhere did user dissatisfaction with healthcare states imply a demand for the quasi-marketisation of healthcare, though that is the way in which, in part, governments have sought to meet it.”<sup>146</sup> Also the Dutch government offered more choice within the healthcare system since the late 1980s, which may siphon off rising dissatisfaction about healthcare, and waiting lists in particular. Since 1992, Dutch health insurance funds could compete for clients in every region in which they have been registered. Although they tried to attract patients with waiting lists mediation since

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<sup>141</sup> Nederlandse Mededingingsautoriteit (2004), *Visiedocument in de Ziekenhuissector*. 3128/05. Den Haag: NMa.

<sup>142</sup> Schee, van der E. & Delnoij, D.M.J. (2004), *Voor Zorg naar het Buitenland: Veel Mensen willen het, weinigen doen het*. Utrecht: NIVEL.

<sup>143</sup> Brouwer, W.B.F. et al. (2003), *supra* note 137, p. 96.

<sup>144</sup> Schee, E. van der, Delnoij, D. & Kerssens, J. (2005), ‘Keuze van Ziekenhuizen? Welke Overwegingen zijn Belangrijk voor Consumenten?’, *Tijdschrift voor Gezondheidswetenschappen*. Vol. 83, no. 2, pp. 113-115.

<sup>145</sup> ECORYS-NEI (2003), *supra* note 139.

<sup>146</sup> Freeman, R. (1999), *supra* note 126, p. 116.

the late 1990s, it is predominantly for financial reasons (amount of premium) people switch from one to another health insurer.<sup>147</sup> A large group switched between 2005 and 2006 when the new health insurance system was introduced. Before and after, the number those changing health insurers were rather limited. Nevertheless, that may have siphoned off dissatisfaction, as choice could have (partly) replaced voice.

Not all Dutch patients seem to be used to the idea of choosing among health providers yet.<sup>148</sup> Information on choosing non-local health providers has also been rather limited.<sup>149</sup> As British research on patient choice indicates, the trade-off between treatment by the local health provider and non-local health provider somewhere else involves among other things the costs of travelling (time; transportation), the seriousness of the illness, the healthcare specialty required, waiting times, information about and reputation of the health providers' quality.<sup>150</sup> Because clear indicators of quality are often missing, many patients choose their local health providers.<sup>151</sup> In addition, referral networks between GPs and hospital doctors often results in strong localism for health consumption.<sup>152</sup> Next to the lack of (unbiased) information on the choice of non-local health providers, Dutch citizens are not used to having choice in health providers because of the shortages in healthcare supply, the increasing scale of healthcare companies due to fusions, and the peculiar health needs of chronic patients.<sup>153</sup> Lack of healthcare supply may yet stimulate patients to look across borders for treatments, but they encounter similar choice problems as within their domestic healthcare systems. A lack of knowledge concerning the procedure of how to obtain cross-border healthcare is considered (very) obstructive for patients choice in going abroad by almost half of the respondents in a health consumers' panel.<sup>154</sup>

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<sup>147</sup> Gress, S., Groenewegen, P., Kerssens, J., Braun, B. & Wasem, J. (2002), 'Free Choice of Sickness Funds in Regulated Competition: Evidence from Germany and The Netherlands', in *Health Policy*. Vol. 60, pp. 235-254.

<sup>148</sup> RVZ/TNS-NIPO (2003), *supra* note 132, p. 23.

<sup>149</sup> Friele, R.D. et al. (2006), *supra* note 127.

<sup>150</sup> Exworthy, M. & Peckham, S. (2006), 'Access, Choice and Travel: Implications for Health Policy', in *Social Policy and Administration*. Vol. 40, no. 3, pp. 267-287.

<sup>151</sup> *Idem*, p. 268.

<sup>152</sup> *Idem*, p. 271.

<sup>153</sup> Friele, R.D. et al. (2006), *supra* note 127.

<sup>154</sup> Schee, E. Van der & Delnoij, D.M.J. (2004), *supra* note 142.



Even people working or living in border regions have often been unaware of the possibility of accessing cross-border healthcare.<sup>155</sup> Belgians living in the border regions were motivated to stay within their domestic healthcare system because of a lack of information about the Dutch healthcare system, while they were better informed about other health providers in Belgium.<sup>156</sup> The Euregional experiments in the Dutch-German border regions showed that foremost (former) frontier workers, and patients having earlier experiences with hospitals across the border used cross-border healthcare. Familiarity with another healthcare system limits the costs of exit (information), eliminating the uncertainty of the exit option. As in the British case, the opinion of health professionals is fairly significant, because GPs and hospital doctors are informative sources of information next to family, friends, health insurers, the Internet, and patients' associations.<sup>157</sup> Many patients vest a lot of trust in their GP and hospital doctor, particularly regarding the information they give. For 40% of the Dutch citizens, Van der Schee and Delnoij even speak of "almost implicit faith" (*bijna blind vertrouwen*).<sup>158</sup> As referral from GP or hospital doctor is necessary to access (another) hospital doctor, health professionals are an important factor in a patient's choice of a foreign health provider.

As mentioned before, the Dutch medical profession has not been too enthusiastic about cross-border healthcare. Euregional experiments showed Dutch doctors did not know much about healthcare systems in Belgium and Germany. In addition, health insurers report, they often believe that they work in the best healthcare system in the world. Doctors' reluctance to refer their patients to foreign health providers has been gradually diminishing in Dutch border regions, however, after health insurers provided information to GPs on foreign health providers, and cross-border networks of health professionals have been growing over the

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<sup>155</sup> See, e.g., Calnan, M. et al. (1998), 'Implementing a Policy for Cross-border Use of Health Care: A Case Study of Frontier Workers' Knowledge, Attitudes and Use', in R. Leidl (ed.), *Health Care and its Financing in the Single European Market*. Amsterdam: IOS Press. pp. 306-311.

<sup>156</sup> Jorens, Y. et al. (2005), supra note 134, p. 199.

<sup>157</sup> Boffin, N. & R. Baeten, R. (2005), *Dutch Patients evaluate Contracted Care in Belgian Hospitals: Results of a Mail Survey*. Brussel: OSE; European Commission (2003). *Eurobarometer 58.0: European Union Citizens and Sources of Information about Health*; ECORYS-NEI, 2003, supra note 139.

<sup>158</sup> Schee, E. van der & Delnoij, D.M.J. (2005), supra note 125.

years, particularly in the Zeeuws-Vlaanderen region.<sup>159</sup> Furthermore, cross-border networks of health professionals have been growing among top-clinical centres of reference, such as between RWTH University Hospital Aachen (Germany) and the University Hospital Maastricht.

Health insurers are another source of information on cross-border healthcare, reducing the uncertainty of exit. Among Dutch health insurers, Belgian healthcare providers have a good reputation with respect to quality and technological advancement.<sup>160</sup> Particularly the Dutch health insurer CZ has been fairly active in informing its clients about healthcare abroad, often competing with other health insurers by offering an escape from the waiting lists within the Netherlands. CZ clients report that their health insurer has been quite influential in helping them choose a Belgian hospital in which to be treated.<sup>161</sup> A health insurer may also help to lift the administrative burden of the procedure to receive reimbursement of cross-border healthcare. Simplifying the lengthy and complex E112 procedures in the Euregional experiments may thus remove another barrier to foreign health providers. At first sight, the European Court of Justice also seems to have simplified the access to foreign health providers in the EU/EEA area by neutralizing the E112 procedure. The uncertainty about the level of reimbursement and potential extra costs, however, still restrain patients from seeking healthcare abroad via the Treaty method instead of the Regulation method. In addition, (legal) uncertainty is still present on other issues among them patient safety, liability, and the privacy of patient data. However, the contracts between Dutch health insurers and foreign health providers to treat their clients have limited this uncertainty. In addition, several calls have been made for further standardisation of norms regarding patient safety, reimbursement, the supervision of health providers, patient rights regarding information, consent, confidentiality and privacy, as well as responsibilities for harmful treatment within the EU/EEA area, following existing norms agreed upon in the World Health Organisation, the Council of Europe, and the United

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<sup>159</sup> Glinos, I.A. et al. (2005), supra note 52, p. 60; Boffin, N. & Baeten, R. (2005), supra note 157.

<sup>160</sup> Glinos, I.A. et al. (2005), supra note 52, p. 45.

<sup>161</sup> Boffin, N. & Baeten, R. (2005), supra note 157.

Nations.<sup>162</sup> The more healthcare systems in the EU/EEA area will resemble each other, the easier cross-border exit and entry would be.<sup>163</sup>

However, many factors are at play in the choice between treatment from a local health provider or from a non-local (foreign) health provider. Depending on the required treatment, level of education, age, and sex, patients are more or less inclined to seek non-local (foreign) healthcare provision. Particularly young, high-educated, high-income respondents seriously consider healthcare treatment abroad.<sup>164</sup> This segment of the population with the exception of pregnant women, are usually in less need of healthcare. Due to their education and age, they can also more easily inform themselves via the Internet about possibilities of healthcare abroad. The large bulk of patients, consisting of the 55+, low-income and low-educated respondents, and chronic patients, are often more oriented to local healthcare providers. For older patients, distance is most important, more than the reputation of a health provider.<sup>165</sup> Surveys indicate a serious barrier for going abroad for healthcare are the number of return visits required for follow up care.<sup>166</sup> That can be explained by the financial burden of travelling abroad, not only for the patient but also for his or her family and friends.<sup>167</sup> The need for cultural and linguistic commonality between patients and healthcare providers in case of long-term or complex treatments can also explain the limited area in which chronic patients seek treatment. Patients see linguistic differences as the main barrier for cross-border healthcare.<sup>168</sup>

Surveys on cross-border patient mobility also indicate that continuity of healthcare is considered problematic by patients. That ranges from the availability of prescribed drugs and medical devices to alleged refusals of doctors at home to provide aftercare.<sup>169</sup> Continuity of care could be

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<sup>162</sup> See, e.g., Bertinato, L. et al. (2005), *Policy Brief: Cross-border health care in Europe*. Copenhagen: WHO (European Observatory on Health Systems and Policies).

<sup>163</sup> Cf. Hirschman, A.O. (1970), *Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations and States*. Cambridge: Harvard University Press. p. 81.

<sup>164</sup> RVZ/ TNS-NIPO (2003), *supra* note 132.

<sup>165</sup> Exworthy, M. & Peckham, S. (2006), *supra* note 150, p. 278.

<sup>166</sup> Schee, E. van der & Delnoij, D.M.J. (2004), *supra* note 142.

<sup>167</sup> Lowson, K. et al. (2002), *supra* note 227; Muscat, N.A. et al. (2006), 'Sharing Capacities: Malta and the United Kingdom', in M. Rosenmöller et al. (eds.), *Patient Mobility in the European Union: Learning from Experience*. Copenhagen: WHO. pp. 119-136.

<sup>168</sup> Schee, E. van der & Delnoij, D.M.J. (2004), *supra* note 142.

<sup>169</sup> Boffin, N. & Baeten, R. (2005), *supra* note 157.

guaranteed by Dutch hospital doctors treating their patients in foreign hospitals and providing aftercare back home, as some doctors from Leiden and The Hague have done in Spain and England. The opportunities for these kind of initiatives are limited, however, because they depend both on the willingness of hospitals to let its doctors go, and of health insurers to cover the costs. Although problems with prescription and aftercare are also reported within the Dutch healthcare system, the differences between healthcare systems regarding patient data exchange, and registration of medicines exacerbate these problems.

Costs of exit limit patients' choice of accessing non-local (foreign) providers. Patients' preference to be treated close to home is highly dependent on geographical distance. However, patterns of (territorial) loyalty also matter, as a comparison between clients from the health insurers CZ and OZ shows respectively. It must be noted that the geographical distance to Belgian hospitals barely differs between CZ and OZ clients. Most OZ clients live in the Zeeuws-Vlaanderen region, and their socio-cultural orientation is directed towards Belgian Flanders. OZ clients going to Belgium for healthcare are often not aware of the length of waiting lists in the Netherlands, and do not prefer Dutch above Belgian hospitals.<sup>170</sup> They just go to a hospital in a country and a system, which they and their doctors know. If, however, CZ clients go abroad it is because of Dutch waiting lists or the better reputation of a Belgian health provider. However, many CZ clients prefer to wait for treatment within the Netherlands, instead of going abroad. And as soon as the healthcare supply would be sufficient within the Netherlands, they would not consider Belgian hospitals anymore. Despite linguistic commonality between the Netherlands and Flanders, they would thus remain loyal to the Dutch healthcare territory. Similarly, Danish and Irish patients confronted with waiting lists prefer domestic private healthcare providers above providers abroad, even though the latter would provide faster healthcare at a closer distance in Germany or Northern-Ireland.<sup>171</sup> Thus, the territorial border has an exclusionary effect, preventing the exit to another healthcare system. The focus of dissatisfaction thus remains

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<sup>170</sup> Idem, p. 24.

<sup>171</sup> Glinos, I.A. & Baeten, R. (2006), *supra* note 82, p. 60; Busse, R. et al. (2006), *supra* note 88.

focused predominantly within national health territories. As shown before, attempts by some health insurers and patients to seek healthcare abroad have been countered by initiatives from health authorities, health providers, and health insurers to improve health delivery in the Netherlands. Next to possibilities to voice and exits within the healthcare systems, this is another disincentive for cross-border patient mobility despite dissatisfaction with waiting lists.

#### *9.4.3 Patterns of cross-border patient mobility*

If cross-border patient mobility is narrowly defined as a patient purposely seeking a non-local health provider abroad, then it would not cover emergency care. In an emergency, a patient has little choice other than a local health provider. More broadly understood, however, as a patient receiving healthcare outside his or her domestic healthcare system, cross-border patient mobility may also include emergency care. The number of emergency treatments largely depends on the mobility of people within the EU/EEA area. People have increasingly gone abroad for skiing vacations or summer holidays, retirement, study, or temporary work, and then (suddenly) need care. Health providers and health insurers start to take into account flows of tourists, and the “floating population” of retirees in the EU/EEA area.<sup>172</sup> German health insurance funds have contracted hospitals at the North Sea coast via Dutch and Belgian health insurance funds to provide their clients with emergency care.<sup>173</sup> Health authorities in Venice have set up a special health infrastructure in the tourist seasons.<sup>174</sup> The increasing attention to the European health insurance card will help make socially insured EU citizens aware of their rights to access healthcare abroad in cases of emergency. Nevertheless, if pensioners become (chronically) ill, they seem to seek healthcare from their native speaking doctors, close to their family and friends. Problems

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<sup>172</sup> Rosenmöller, M. & Lluch, M. (2006), ‘Meeting the Needs of Long-term Residents in Spain’, in M. Rosenmöller et al. (eds.), *Patient Mobility in the European Union: Learning from Experience*. Copenhagen: WHO. p. 65.

<sup>173</sup> Nebling, T. & Schemken, H.-W. (2006), ‘Cross-border Contracting: the German Experience’, in M. Rosenmöller et al. (eds.), *Patient Mobility in the European Union: Learning from Experience*. Copenhagen: WHO. pp.137-156.

<sup>174</sup> Scaramagli, S. et al. (2006), ‘Health Care for Tourists in the Veneto Region’, in M. Rosenmöller et al. (eds.), *Patient Mobility in the European Union: Learning from Experience*. Copenhagen: WHO. pp. 79-96.

have already been reported among some British retirees in Spain who after the loss of their spouse long for Britain while being in need of healthcare.<sup>175</sup>

Besides tourist areas, cross-border patient mobility is also concentrated in border regions, because of close cultural-linguistic links across the national borders, and the geographical proximity of healthcare facilities over the national border in comparison to facilities within the domestic healthcare system. Only in cases of cultural-linguistic commonality do patients cross borders more, not just for elective care, but also long-term care, such as in Belgian-French border region of Thierarche, and the Meuse-Rhine Euregion. Cross-border contacts among GPs and hospital doctors also foster patient mobility in border regions, since doctors are an important source of information for patients. Hospitals in border regions in most healthcare systems in the EU/EEA area have started to cooperate.<sup>176</sup>

Patterns of patient mobility are not only steered by the information and assistance provided by health providers, but also from health insurers and health authorities. Dutch, Norwegian, and British health authorities launched initiatives for cross-border healthcare when waiting lists emerged. Dutch health insurance funds contracted Dutch-speaking hospitals in Belgium for their clients, not only to provide them with faster care, but also to put pressure on the Dutch hospitals to offer more, faster, and, if possible, cheaper care. Health insurance institutions in Italy have provided permission to access healthcare abroad relatively easily (at least until the early 1990s), resulting in a high number of Italians receiving healthcare abroad.<sup>177</sup> Small healthcare systems like Iceland, Luxembourg, Cyprus, and Malta, are confronted with a permanent lack of supply, particularly regarding top-clinical healthcare. Many Luxemburg citizens have received permission to go abroad for healthcare. The Maltese National Health Service has contracted British hospitals for top-clinical healthcare.<sup>178</sup> This also shows the significance of cultural-linguistic links,

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<sup>175</sup> Rosenmöller, M. & Lluch, M. (2006), *supra* note 172.

<sup>176</sup> HOPE (2003), *Hospital Co-operation in Border Regions in Europe*. Brussels: HOPE (Standing Committee of the Hospitals of the European Union); Glinos, I.A. & Baeten, R. (2006), *supra* note 82.

<sup>177</sup> France, G. (1997), *supra* note 129.

<sup>178</sup> Muscat, N.A. et al. (2006), *supra* note 167.

as the culturally in common British rather than the geographically close Italian hospitals have been contracted. The inter-professional links between Maltese and British doctors, due to a common educational background, also explain the close ties between Malta and the UK. However, as soon as certain top-clinical treatments were made available in Malta, the number of Maltese patients visiting the UK dropped significantly. Geographical proximity matters for patients and their family and friends.<sup>179</sup> Nevertheless, top-clinical healthcare facilities require an increasing scale for a sufficient turnover. Healthcare systems like Ireland might therefore become also too small for top-clinical care in the near future.

Certain healthcare systems may not offer certain healthcare goods and services, not only because of economies of scale, but also due to lack of funding. The Dutch health authorities could improve the health supply in response to citizens' dissatisfaction because of the resources they can rely on. Health authorities in poorer healthcare systems within the EU/EEA area often struggle with a shortage of healthcare supply, smaller healthcare budgets, and medical personnel going abroad for better salaries. In combination with the Court rulings on patient mobility, this lack of resources may create a serious challenge for them. The Court decided that international (and not national) standards determine whether a patient would receive permission for a treatment abroad in the E112 procedure. If a certain (advanced) treatment is not available in those poorer healthcare systems, the health authorities might be forced to give permission, and reimburse costs according to the system of treatment. The reimbursement of the costs would put extra pressure on the already small healthcare budget. The Central and Eastern European healthcare systems may particularly be confronted with this problem since they have been in the EU/EEA area. Nevertheless, health providers in poorer healthcare systems can also compete with richer healthcare systems, since they can offer treatments usually at lower prices. For example, many Austrians visit Hungarian dentists. Meanwhile, the relative low standard of living in Central and Eastern European Member States increases the level of labour mobility, entailing more (emergent) healthcare provision

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<sup>179</sup> Idem.

in the richer Member States. Enlargement may thus have a stimulating impact on cross-border patient mobility in both ways.

Information not only matters for healthcare systems “sending” patients abroad, but also for those “receiving” patients. Confronted with oversupply of healthcare facilities, health authorities in Belgium and the German Land of Schleswig-Holstein have been active in arranging healthcare for patients from (neighbouring) countries confronted with waiting lists. Top-clinical centres of reference may also join the competition for European patients. A collection of top-clinical hospitals in Stockholm attracts patients from Scandinavia, Russia, and Greece. As already mentioned, the Association of Belgian Enterprises suggested that Belgium should become an international health centre for its estimated potential of 100,000 EU patients. This competition often regards, however, healthcare that is *not* covered by a social health insurance. Regulation 1408/71 and the Court rulings deal with reimbursement for socially insured healthcare received abroad. Empirical evidence presented from Euregional experiments and other sources is also concerning socially insured healthcare.

The potential growth of cross-border patient mobility may yet be healthcare services and goods not covered by mandatory health insurance. Until recently, also those covered by a voluntary health insurance did not cross borders for healthcare in large numbers.<sup>180</sup> Dutch health insurers reported, however, that the privately insured are more inclined to go abroad,<sup>181</sup> which may in part be explained by their higher income and higher education. Cross-border consumption of price-sensitive, uncovered healthcare has been increasing in recent years, such as infertility treatments (Belgium, Turkey), dental care (Hungary), spa treatments (Czech Republic, Estonia), body checks (Germany), and cosmetic surgery.<sup>182</sup> Outside Europe, India, Singapore and Thailand have

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<sup>180</sup> Mossialos, E. & Thomson, S. (2002), *Voluntary Health Insurance in the European Union* (report at the request of European Commission DG Employment and Social Affairs). London/ Copenhagen: LSE/ European Observatory on Health Care Systems. p. 7.

<sup>181</sup> CVZ (2003). *Grensoverschrijdende Zorg* (internal report). Amstelveen: College Voor Zorgverzekeringen. p. 13.

<sup>182</sup> See contributions to Rosenmöller, M. et al. (2006), note 115.



become important places for medical tourism.<sup>183</sup> Patients can themselves relatively easily find information online or via commercial intermediary agencies on this type of healthcare. In addition, budget flights and cheap holiday locations make these destinations more attractive.

Patients may also be seeking treatments that are untested or not yet approved by domestic health authorities, and therefore are not covered by the mandatory health insurance. As soon as the coverage of the mandatory health insurance will be expanded, the main reason to go abroad for an abortion or a new treatment will have been removed. Therefore, this type of cross-border patient mobility highly depends on whether health authorities' include certain treatments in the mandatory health insurance. Inclusion means it is not just the responsibility of the individual patient, but of the domestic health authorities or health insurers to deliver the treatment to their citizens/health users. They are usually more focused on health provisions within the domestic healthcare system, reducing cross-border patient mobility.

Healthcare not covered by mandatory health insurance also includes ethically sensitive cross-border patient mobility, such as "abortion tourism", (e.g., from Ireland to the United Kingdom), "fertility tourism" (e.g., to Turkey), or "suicide tourism" (e.g., to Switzerland).<sup>184</sup> A few thousands women from the EU travel annually to the Netherlands for an *abortus provocatus*.<sup>185</sup> A Dutch parliamentarian pleaded for a European abortion directive after she had heard of late-term abortions provided to Dutch women in the Ginemedex Clinic in Barcelona.<sup>186</sup> Most often, however, governments like to keep prerogatives regarding medical-ethical issues at the national level, as has been exemplified by the fierce protest of the Polish, Portuguese, and Irish governments when a Dutch "abortion

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<sup>183</sup> See, e.g., Woodman, J. (2007), *Patients beyond Borders: Everybody's Guide to Affordable, World-Class Medical Tourism*. Chapel Hill (NC): Healthy Travel Media.

<sup>184</sup> See *Information for Irish Women about Abortion Services in the UK and Europe*, <http://flag.blackened.net/revolt/ireland/choice/index.html> (accessed on 2 March 2007); Kamerstukken II 2005/06 *Question no. 1597 IVF in het Buitenland* (2 June 2006), Appendix 3407; BBC News (20 January 2003), 'Dignitas: Swiss Suicide Helpers', <http://news.bbc.co.uk/go/pr/fr/-/2/hi/health/2676837.stm>. (accessed on 2 March 2007);

<sup>185</sup> See Inspectie voor de Gezondheidszorg (2006), *Jaarrapportage 2006 van de Wet Afbreking Zwangerschap*. The Hague: IGZ.

<sup>186</sup> Kamerstukken II 2006/07 *Question no. 987 Late Abortussen in Spanje* (15 March 2007), Appendix 2103-2104; Leidsch Dagblad (31 October 2006), 'Kamer geschokt door "Late" Abortussen'.

ship” visited international waters close to three countries involved.<sup>187</sup>

Eventually, the Dutch government prohibited abortions on the ship any further than 25 kilometres away from an Amsterdam hospital since if complications occur special treatment should be available at short distance.

The abortion ship is an example of doctors going to patients, instead of the other way around. Also before the large-scale establishment of intramural care in the nineteenth century, doctors rather than patients travelled to administer healthcare. Due to technological innovation, healthcare can now increasingly be provided extramural and by mobile health providers (think, for example, of the breast scan bus). That may foster the possibilities for cross-border healthcare, because restrictions on receiving reimbursement for extramural care across borders are limited. In contrast, telemedicine services would limit patients’ mobility, because patient data and doctors’ advice can be sent electronically across borders. The E112 procedure is not applicable for this type of cross-border healthcare, because the patient does not cross the border of his or her healthcare system. The increasing use of ICT in the so-called “European e-health area” may yet foster this type of cross-border healthcare.

## **9.5 Conflicting territorialities in the EU**

Notwithstanding the reluctance of the governments of Member States, and the marginality of cross-border patient mobility, a European layer of policy-making regarding healthcare has been developed in addition to national and sub-national layers. The question of this section is to what extent does political territoriality mark this multilevel European healthcare system, guided by the propositions presented in the previous chapters. The focus has been cross-border patient mobility in the EU. However, healthcare involves much more. The view on the evolution of health and healthcare systems in Europe is therefore necessarily limited.

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<sup>187</sup> BBC News (24 June 2003), ‘Poland acts against Abortion Ship’, <http://news.bbc.co.uk/go/pr/fr/-/2/hi/europe/3017164.stm> (accessed on 2 March 2007).

*9.5.1 A European healthcare territory in the making*

The boundaries of the European layer of healthcare policy-making are relatively clear, because it consists of the well-known territories of the EU Member States. However, the partial inclusion of Iceland, Norway, Liechtenstein, and Switzerland blurs the clarity of the entire European healthcare territory. The successive rounds of EU enlargement have further undermined the consolidation of the European healthcare territory, as one of the propositions discussed before also holds. Although the territorial scope of European healthcare policy-making is clear (*i.e.*, the territories of the participating Member States), its unsettled nature complicates deep and broad institutionalisation of a geographically fixed image. Geographical fixity would have provided the locking-in framework in which healthcare user-citizens, healthcare providers, health insurers, and health authorities develop a territorially defined commonality in which they share their resources. As of yet, the immobility of patients does not put the lack of commonality under extreme pressure. The increasing differences in the European healthcare territory regarding quality, accessibility and affordability due to the 2004 and 2007 enlargement with Central and Eastern European Member States may change that. Certain Belgian reactions to patient mobility already indicated the limits of willingness to share basic healthcare resources with other EU citizens.

The expanding European healthcare territory has developed as a collective of fixed national healthcare territories. This hampers the territorial reification of the European political relationships regarding healthcare. Nevertheless, the borders of this collective of territories have entailed impersonality. The various rights to healthcare in the European healthcare territory have been gradually expanded from socially insured workers to all socially insured citizens. Today, someone's whereabouts instead of personal characteristics (or function) determines the rights to healthcare, and what stands out now is the increasing inclusion of third-country nationals, refugees, and stateless persons into Regulation 1408/71. The membership space of the European healthcare territory is thus increasingly coinciding with geographical space. Calls for a further standardisation of patient rights across the EU area have already been heard.<sup>188</sup> A certain measure of standardisation might also be expected

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<sup>188</sup> Bertinato, L. et al. (2005), *supra* note 162.

regarding treatments, partly because the Court decided that authorisation for treatment abroad depends on international (and not national) medical standards.

The boundaries of the European healthcare territory are also increasingly defining exclusion and inclusion of the European healthcare system. In principle, people from outside cannot count on healthcare provision in the European healthcare territory, unless the European Union or its Member States has concluded treaties with outside healthcare systems. However, the inclusive, locking-in effects of the European healthcare territory have been relatively weak. The only partial entrance of Iceland, Norway, Liechtenstein, and Switzerland indicates the weak inclusive impact of the European healthcare territory. The attempts by governments of many EU Member States to exclude their healthcare territories from any European interference also indicate that weak impact. The institutional legacy of their territory-based healthcare systems still leaves its imprint on the behaviour of national healthcare authorities, health providers and health users, although territory is less broadly institutionalised because adjacent policy areas (such as the internal market) have become more Europeanised.

The unconsolidated borders, weak geographical fixity, and limited inclusive impact of the European healthcare territory are added to the limited centralisation of voice and decision-making. Instead, the politics of healthcare is concentrated in the healthcare systems of the Member States. The weak logic of territoriality at the European level results in the geographical concentration of the politics of healthcare. Considering the local orientation of most patients and health providers, a local scale of the politics of healthcare would be expected. The institutional legacy of the territory-based healthcare systems of the Member States concentrates at a national (or in some cases regional) level. Enmeshed in the corporatism of the Dutch healthcare system, the various players in the healthcare sector attempted to keep its territorial basis intact. One European institution has, however, severely limited any exit option from the European healthcare territory. After it proclaimed the supreme status and direct authority of European law, the European Court of Justice has increasingly locked national healthcare systems in the EU/EEA area into the European

healthcare territory. As the “Ersatz legislator”<sup>189</sup>, the European Court of Justice has increasingly encroached on the prerogatives of national health authorities regarding healthcare in the EU/EEA area. The centrality of law in the EU/EEA area weakened the institutional breadth of Member States’ territories. The logic of territoriality within the European healthcare territory is weak, but the centrality of law has forced the governments of Member States to discuss healthcare at the EU level.

#### *9.5.2 Unfreezing state territoriality*

As the proposition was phrased in Chapter 5, the creation of a European internal market and the Schengen area has weakened the logic of territoriality in the Member States. Regulation 1408/71, the Single European Act, the INTERREG programmes, and particularly rulings of the European Court of Justice made the health authorities in the Netherlands aware that they (at least formally) no longer hold full territorial sovereignty regarding organisation, consumption, production, and purchasing of healthcare. Just when the territorial closure of the Dutch healthcare state brought about further political centralisation, the image of relatively impermeable borders has thus been undermined by European exit options. The weakening of geographical fixity is best illustrated by the increasing references of health authorities to a borderless Europe since the launch of the internal market and the Schengen agreement in the mid 1980s. The European exit options induced a certain personalisation of healthcare rights (since access to the Dutch healthcare system depended less on place but on personal characteristics, *i.e.*, being a socially insured EU/EEA person), breaching the inter-territorial, mutual exclusivity among healthcare states in the EU/EEA area.

Next to weakening fixity and increasing personalisation, geographical exclusivity/inclusion and centrality also weakened. Although the corporatist entanglements of the Dutch healthcare system offered health insurers manifold voice options and sustained strong bonds of loyalty, they also start to (threaten to) use the exit option within the European healthcare territory. Health providers generally resisted the use

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<sup>189</sup> 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. 38.

of exit options, referring to national loyalty; it was thought Dutch premiums should be spent in Dutch hospitals. However, the image of an increasingly permeable healthcare territory also brought about cross-border cooperation among health providers, particularly in the interface regions of Zeeuws-Vlaanderen (Euregion Scheldemond) and Southern Limburg (Euregion Meuse-Rhine). Although the coordination of healthcare policy and planning of healthcare facilities fully took place within the Dutch territory in the 1980s (with the exception of Zeeuws-Vlaanderen), the mismatch between patterns of healthcare consumption and provision in border regions could be dealt with after the borders of the Dutch healthcare system became less fixed. Health providers, health insurers, local authorities, and patients in border regions were less bound within the Dutch healthcare system. Attempting to leave its peripheral status within the Netherlands, the Limburg authorities have tried to gain more prominence within the European healthcare territory as an example of cross-border health cooperation. Blaming the Dutch health authorities for being “nationalistic,” the Limburg authorities still apparently experience the tendencies of geographical exclusivity and the centrality of the Dutch healthcare system.

Nevertheless, the Dutch health authorities have pushed to discuss healthcare at the EU level. A healthcare system such as the Netherlands that sends patients abroad has an interest in keeping the health consumption at home at a certain level to maintain the healthcare infrastructure, and uphold legitimacy based on health performance. (Potential) cross-border patient mobility is also an incentive for a healthcare system like Belgium and Spain that receives patients to discuss healthcare at the EU level since the access to healthcare facilities for domestic patients could be under threat. In 2002, under the Spanish EU presidency, an informal council of ministers of health reluctantly concluded doing nothing is not an option. The defence of Member States’ healthcare system against ECJ-inflicted breaches requires a political response at the EU level. The construction of voice structures at the EU level has been severely hampered, because many governments of Member States have clung to the image of territorial sovereignty regarding healthcare. Contrary to the proposition outlined in Chapter 5, governments have for quite a while attempted to exit partially from the

European healthcare territory, instead of putting their weight behind institutionalisation of voice on healthcare at the EU level. The free movement of goods, services, capital and persons gradually has more effect on the national healthcare systems. This is partly due to the efforts of the European Commission and the European Court of Justice to push forward with liberalisation in the EU, and partly due to the efforts of Member States' governments to push forward with market-oriented reforms in their healthcare systems. That may eventually lead to the development of an effective collective voice at the European level to counter the potential negative consequences of the European liberalisation of the consumption and production of health services, unless the national governments themselves seek a way to avoid patients' or citizens' voice by allowing choice at both the national and the European level.

Notwithstanding the formal European encroachments on the *principle* of territoriality, health authorities have continued to use territory as a *strategy* to control people and phenomena. For example, anticipating potential cross-border health tourism with the Schengen agreement and a borderless internal market, Dutch health authorities have tried to limit the possibilities for consuming AWBZ entitlements across national borders. Place instead of person still determines what can be consumed within the AWBZ framework in the EU/EEA area. In addition, the spread of infectious diseases like MRSA has still been countered by territorial control strategies of hospitals (quarantine). For the time being, the planning of hospital facilities is also based on their geographical distribution within the Dutch territory. Nevertheless, the Dutch health authorities use territory less as a strategy for control. Within the 2006 Health Insurance Act (replacing ZFW and WTZ), Dutch health authorities have offered more options to receive reimbursement for healthcare obtained outside the Dutch territory, and to contract foreign healthcare providers. Dutch health authorities and health insurers have also used contracting as a means to control the quality of healthcare provision, whether inside or outside the Dutch territory.

*9.5.3 Voice vs. choice*

State territoriality has been unfrozen by European integration in the healthcare policy area. Non-territorial strategies such as contracting have been used to channel cross-border patient mobility. However, the institutional legacy of the Dutch healthcare territory has left a deep imprint on the behaviour of health users. Similarly, the legacy of regional healthcare territories within the Netherlands has left its imprint on health consumption. Since 1992, Dutch health insurance funds have no longer been restricted to a single region to attract clients. Many cross-regional mergers of health insurance funds, cross-regional contracts between health insurance funds and health providers, and cross-regional membership of health insurance funds have followed. Notwithstanding the clients' possibilities of choice, cross-regional patient mobility has remained limited. And so did cross-national patient mobility. Considering the Dutch patients' range of actions taken, the chapter title of patient *immobility* would have been more appropriate. As the proposition was phrased in Chapter 5, it is not just because of the opportunity to go abroad, health users do go abroad. The choice of visiting a non-local (foreign) health provider depends on the existence of dissatisfaction, the various voice options and (internal) exit options to express dissatisfaction, the possibilities to improve the dissatisfactory state of healthcare, the costs involved with external exit, and loyalty towards local doctors and the healthcare system. Information about cross-border healthcare lowers the costs of exit. However, the most important source of information, doctors remained predominantly loyal to the Dutch healthcare system and the local health providers. To summarise the intricate interplay of various options and objects of voice, exit, and loyalty shortly, Dutch patients prefer to be treated close to home.

Nevertheless, a potential cleavage between mobile and immobile health users has become visible in surveys on patient mobility. Education and income provide some health users access to (information on) healthcare elsewhere more easily. They are also more willing to use it. These mobile health users are usually the more eloquent and more affluent citizens, because of their education and income. If they would increasingly use their exit options, immobile health users would lose a relatively strong voice to urge their domestic health authorities to provide



affordable and accessible care of good quality.<sup>190</sup> Health authorities can bet that it would thus become free from complaints on their performance. However, because the highly educated are often more healthy and affluent, the healthcare system would be left with the less healthy and less contributing. In addition, the highly educated comprise a considerable share of the population of Western countries. Both in command-in-control and corporatist healthcare states the vested interests in the healthcare sector would therefore be challenged if the exit-prone citizens were allowed to leave. For example, Dutch health providers protested against patients leaving the Dutch system.

Concerns have been expressed that cross-border patient mobility may create two-tiered healthcare systems in Europe, in which better-informed and better-paying patients are going abroad undermining solidarity at home.<sup>191</sup> The de-consolidation of the borders of the healthcare systems thus has put its internal cohesion under pressure. Is person-based nationalism a new means of bonding for exit-prone citizens (and interface regions for that matter), as one of the Rokkanian propositions holds? Will the territory-based healthcare *state* be replaced by attempts to preserve a person-based healthcare *nation* in the European healthcare territory? The initial reluctance of health providers regarding cross-border healthcare would suggest so. The protest against cross-border healthcare has also been directed towards mobile patients from elsewhere. For example, nationalistic tendencies have been visible in Belgium. Belgian health authorities have expressed their concerns about Belgian patients waiting for treatment in Belgian hospitals because of an influx of foreign patients. Although European anti-discrimination law prohibited treating Belgians first, measures have been taken to ensure Belgian citizens access to Belgian hospitals. In the Netherlands, politicians worried about Dutch patients waiting in Dutch hospitals because of the increasing entry options of foreign patients, expressing limits to their

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<sup>190</sup> cf. Horstman, K. & Made, J. Van der (2004), 'Exit and Voice in de Verzekeringswereld: Gebrekkige Gezondheid, Gebrekkig Verweer?', in *Beleid & Maatschappij*. Vol. 31, no. 1, pp. 42-51.

<sup>191</sup> AIM (2 February 2007), AIM Response to the Commission's "Consultation regarding Community Action on Health Services". Brussels: Association de la Mutualité. p. 5.

willingness to share the healthcare system with non-Dutch clients. Indirectly, European exit options have also stimulated national solidarity.

A main political problem in the Dutch healthcare system over the last years has been domestic waiting lists. Collective action of health authorities, health insurers, and health providers, supported by their mutual corporatist entanglements, was particularly directed to the improvement of healthcare delivery within the Dutch system. Corporatist glue also prevented some health insurers from using the European exit options. Furthermore, cross-border provision of healthcare served as a temporary safety valve to sustain the legitimacy of the health authorities. Dissatisfaction with waiting lists and the ensuing (threat to) use healthcare facilities outside the Dutch healthcare system have been an incentive for domestic improvements. Dutch citizens still consider the national government mainly responsible for healthcare delivery in the Netherlands, and prefer to keep competences with respect to healthcare within the Dutch healthcare system. Cross-border patient mobility has therefore been an extra facility for national health citizenship. To paraphrase Alan Milward, European exit options have rescued some governments' legitimacy, when they were confronted with domestic dissatisfaction on waiting lists. Even though the European exit options opened territorially closed healthcare states, the resultant might thus be a stronger person-based healthcare system.

European institutions have perceived initiatives for cross-border healthcare differently. Instead of an extra facility for national health citizenship, they have often referred to European citizenship. The European Parliament, the European Commission and the Council of Ministers referred to "People's Europe" discussing the European health card in the 1980s. The 2002 decision to introduce the European Health Insurance Card was celebrated by the European Parliament and the European Commission as an important step for European citizenship. The then president of the European Commission Romano Prodi proudly presented the card as an important contribution to European identity. After the European Court of Justice underlined the rights of EEA citizens to obtain healthcare abroad and its reimbursement, the European Commission gradually started to describe patient mobility in its communications and documents no longer as a side-effect of the internal

market but as a “right” of European citizens.<sup>192</sup> Today, healthcare is still one of the strongholds of legitimacy of national governments and states.<sup>193</sup> Since the legitimacy of European institutions and the European Union in general has been considered weak, the European Commission and European Parliament may seek to foster its legitimacy by competing with national governments. In earlier times, authoritarian and paternalist states rather than liberal or democratic states introduced compulsory health insurance, because the former had less legitimacy.<sup>194</sup> Having a similarly weak legitimacy, the European Commission may try to foster its acceptance through initiatives in healthcare policy. For example, after the French and Dutch voted “no” against the European Constitutional Treaty in the spring of 2005, the European Commission justified a renewed initiative regarding health services in 2007 on the basis of its “Citizens’ Agenda” to enhance the legitimacy of the European Union.

The attempt by the European Commission to extend its European say in healthcare via the issue of cross-border patient mobility has faced many hurdles. The attempt yet shows the conflicting territorialities of the foremost right-based EU healthcare territory and (unfreezing) domestic healthcare territories, in which healthcare provision is concentrated. This pattern of conflicting territorialities is reminiscent of other multilevel healthcare systems, such as Canada. In Canada, mobility of labour and demographic differences between the provinces resulted in fiscal imbalances in the provinces’ social security systems since the 1930s.<sup>195</sup> Leaving the classic model of federalism (strict separation of competences between levels of governance), the Canadian provincial and federal authorities have started to share the costs of healthcare after centralisation in WWII. Federal health funding of provinces has an inclination towards joint decisions of federal and province governments on healthcare

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<sup>192</sup> Martinsen, D.S. (2005), *supra* note 3.

<sup>193</sup> European Commission (1998), *supra* note 116.

<sup>194</sup> Freeman, R. (1999), *supra* note 126, p. 20.

<sup>195</sup> Banting, K.G. (1995), ‘The Welfare State as Statecraft: Territorial Politics and Canadian Social Policy’, in S. Leibfried & P. Pierson (eds.), *European Social Policy: between Fragmentation and Integration*. Washington DC: Brookings. pp. 269-300; Banting, K.G. (2005), ‘Canada: Nation-building in a Federal Welfare State’, in H. Obinger, S. Leibfried & F.G. Castles (eds.), *Federalism and the Welfare State: New World and European Experiences*. Cambridge: Cambridge University Press. pp. 89-137.

systems, for the federal government tries to provide funds only under certain conditions.

In its 2006 health services consultation the European Commission suggested, when referring to cross-border patient mobility and the costs for less-developed Member States, the launch of a “compensation mechanism” at the EU level. Italian and Spanish governments favour a European compensation fund, because reimbursement according to the Treaty method is maximised by the tariffs of a patient’s country of origin. The Treaty method thus functions as a penalty for patients from less well-off countries, also those patients have less means to pay for travel and lodging costs as well as the treatment in advance. A fund can provide the necessary means to compensate those patients. The chances of this kind of European health solidarity among the EU Member States similar to Canada-wide solidarity seem to be rather slim in the coming years, although some structural funds are available to reduce differences in health provisions across Europe. The healthcare systems of the EU Member States are much further developed than those in the Canadian provinces in the 1930s. The changes required for adapting institutions and behaviour to share the burden of healthcare within the European healthcare territory is much larger. In addition, the political power and financial means of the European Commission are more limited regarding healthcare than those of the federal government of Canada. While the Canada-wide welfare system has been an important instrument for territorial integration into Canada<sup>196</sup> (many Canadians consider the compound Canadian healthcare system as typically Canadian), the prospects for European loyalty are less likely.

There is also another reason why the European compound healthcare system is most probably not going Canadian. Since the 1980s, several national health authorities in the EU/EEA area have introduced more choice for patients within their healthcare systems.<sup>197</sup> Often patients did not themselves ask for more choice, but rather for good hospitals close to their homes. Emphasising choice is, however, a way to redirect dissatisfaction. Instead of voicing their complaints to the national governments, health citizens are responsible themselves to find timely,

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<sup>196</sup> Idem.

<sup>197</sup> Freeman, R. (1999), *supra* note 126.

affordable, and good-quality healthcare. The burden of health responsibility has become too heavy for governments. In order to avoid a potential decline in their legitimacy, they have offered choice instead. The European orientation on rights and markets interferes with the introduction of more choice in national healthcare systems. More choice is an invitation to competition among suppliers of insurance and healthcare. Competing suppliers may care less about the universal accessibility of health insurance and healthcare facilities. Instead, the attraction of wealthy and healthy (and therefore cheap) insurance clients or the sale of (renewed) advanced medical goods and services is an important incentive. The USA is the best-known example of such as “supply state,” continuously struggling with cost containment and access for unhealthy citizens to health insurance and healthcare facilities.<sup>198</sup>

Due to the tendencies towards competition and choice in healthcare policy across the European healthcare territory, governments may be less inclined to provide (particularly immobile) health users-citizens with accessible healthcare: “[e]mphasising individual rights (e.g. mobility) over public objectives is likely to increase the role of the private sector, since public planning is less viable when factors of production and rules of consumption cannot be controlled (...) Member States have a disincentive to educate doctors and other professionals publicly if a significant number are likely to emigrate.”<sup>199</sup> Voice against fully free choice has, however, been expressed. In national elections, at least in the Netherlands, healthcare has become a primary issue. And when in 2004 Bolkestein proposed to create the European market of services, many governments, health funds, and part of the European Parliament defended the national healthcare systems at the EU level. Thus, voice structuring at the European level has taken place against the penetration and standardisation of EU law on competition and choice. The EU Charter of Fundamental Rights contains the current compromise between the struggle for legitimacy on healthcare between national and European

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<sup>198</sup> Moran, M. (1999), *Death or Transfiguration? The Changing Government of the Health Care State* (EUI Working paper 99/15). Florence: EUI.

<sup>199</sup> Paton C et al. (2002), ‘The European Union and Health Services: Summary’, in R. Busse, M. Wismar, & P.C. Berman (eds.), *The European Union and Health Services: The Impact of the Single European Market on Member States*. Amsterdam: IOS Press. Pp. 1–13.

institutions. It acknowledges EU citizens' right to healthcare, but according to national law and practices.

As expected by welfare state experts Stephan Leibfried and Paul Pierson, the conflicting territorialities of the compound European healthcare system will most probably continue to clash: "The health area will be a first Europe-wide testing ground for the turf struggle between national welfare states and the community plus the market, as represented by private insurance, producers, etc."<sup>200</sup> The European Court of Justice and the European Commission enhance patients' exit options, while limiting the Member States' options to exit from European policies regarding free movement of goods, services, capital, and persons. Depending on the quality of healthcare provided in national healthcare systems, and the possibilities of national healthcare authorities to improve that quality, a cleavage between mobile and immobile citizens may subsequently emerge in addition to the conflicting territorialities in Europe. The budgetary restrictions following from the Economic and Monetary Union may further limit the means of Member States' governments to improve their healthcare, and they could delegate further responsibility to health insurers, health providers, regional authorities, or citizens, instead. Despite a widely shared agreement on the principles of universal access to good quality care, equity, and solidarity within the compound European healthcare system, the European disclosure of the healthcare state may eventually cause a weakening of national solidarity and universal equal access for all.

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<sup>200</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.

