

Medical University Graz

**Cross-border healthcare in the European Union:
Movement of patients**

Bachelor Thesis 2

**Submitted at the Bachelor Degree Programme Gesundheits- und
Pflegerwissenschaften for the degree of „Bachelor of Science in health
and nursing science“**

**Module:
“Fachenglisch”**

**Author:
Eike Bartelt**

**Supervisor:
Mag. Marion Trattner
Institut für Pflegewissenschaft
Billrothgasse6/1
8010 Graz**

Graz, 14.06.2013

DECLARATION

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma of the university or other institute of higher learning, except where due acknowledgement has been made in the text.

Graz, 14.06.2013

Eike Bartelt

TABLE OF CONTENTS

Declaration.....	2
Table of Contents.....	3
List of Abbreviations.....	5
Kurzfassung	6
Abstract.....	7
1 Introduction	8
1.1 Presentation of the Topic	8
1.2 Research Aim	10
1.3 Research Question	11
1.4 Structure and Sources	12
2 Healthcare in the European Union	13
2.1 Article 114 and Article 168 of the TFEU	17
2.1.1 Article 168 of the Treaty on the Function of the European Union (TFEU) 18	
2.1.2 Article 114 of the Treaty on the Function of the European Union (TFEU) 19	
2.2 Conclusion and discussion of Art.114 and 168 TFEU	20
3 Patient right's Directive 2011/24/EU	22
3.1 The social security coordination Regulation	25
3.2 Case Kohll and Decker	27
3.3 Conclusion of the different legal bases	28
4 Questions and Examples	29
4.1 Examples for Cross-border Healthcare:	30
5 Conclusion	38
Literature	40

Online Sources..... 41

LIST OF ABBREVIATIONS

ARP	Address Resolution Protocol
Art	Article
C	Case
Dir	Directive
EEA	European Economic Area
EHIC	European Health Insurance Card
EU	European Union
MS	Member State
TFEU	Treaty on the Function of the European Union

KURZFASSUNG

In den letzten Jahren üben der demographische Wandel und der europäische Binnenmarkt Einfluss auf das Gesundheitssystem der europäischen Mitgliedstaaten aus. Die Förderung von nachhaltiger Gesundheit für alle EU Bürger in Bezug auf grenzüberschreitende Gesundheitsversorgung (Regulation des Austausches von qualifizierten Arbeitskräften im Gesundheitsbereich und Patientenmobilität) wird seitens der EU angestrebt. Der Fokus dieser Arbeit liegt auf der europäischen Gesetzgebung da Grenzüberschreitende Gesundheitsversorgung als ein sehr komplexer Politiksektor mit unterschiedlicher gesetzlicher Basis gesehen werden kann. Als Grundlage dient die Vereinbarung 2011/24 und Richtlinie 883/24 sowie der EU- Vertrag (Treaty on the Functioning of the European Union –TFEU). Ein Überblick über die rechtliche Situation wird gegeben als auch werden Beispiele angeführt, wann und wie grenzüberschreitende Gesundheitsversorgung stattfindet Im Prinzip steht es jedem EU Bürger zu, innerhalb des erweiterten wirtschaftlichen EU Raums (EEA), Gesundheitsleistungen in Anspruch zu nehmen und Behandlungskosten, soweit eine beschlossene Berechtigung vorliegt, rückerstattet zu bekommen. Tatsächlich wissen nur wenige EU Bürger darüber Bescheid, und als Konsequenz daraus suchen noch weniger Patienten um Hilfe außerhalb ihres Landes an. Alles im Allen, kann ein Wissens- und Informationsdefizit über grenzüberschreitende Gesundheitsversorgung innerhalb des EEA beobachtet werden. Weiters stellt der intransparente Prozess möglicherweise einen Grund da, welcher die Patienten und Arbeitskräfte davon abhält grenzüberschreitende Gesundheitsversorgung in Anspruch zu nehmen.

ABSTRACT

In the recent years the demographic patterns and the internal market had an impact on healthcare systems in all Member States of the European Union. The promotion of sustainable health for all European citizens in cross-border healthcare (Regulation of movement of qualified health professionals and patient mobility) is fostered through the EU. The focus of this thesis is on EU legislation because Cross-border healthcare can be seen as a very complex political sector with different legal bases. The Directive 2011/24 and Regulation 883/2004 as well as the Treaty on Functioning of the European Union (TFEU) are taken as a basis. A short overview about the legal situation and outlines examples in which cases cross-border health applies and how it is done will be given. In principle, every EU citizen is free to seek healthcare in the EEA and to get the costs reimbursed by their home state as long as an allowance above prior authorisation is given. But in fact, only a few people in the EU know about it and as a consequence even less patient search for help outside their home country. All in all, a knowledge- and information deficit about Cross-border health care in the EEA can be seen. Furthermore the intransparent procedure might be reason which holds patients and professionals off from making use of Cross-border health care.

1 INTRODUCTION

1.1 PRESENTATION OF THE TOPIC

In recent years the demographical, medical, economical and migration developments show a huge impact on healthcare systems in all Member States (MS). Each MS is confronted with limited resources while a growth of population (mainly elderly), claim for high quality of treatments for everyone and cost-effective healthcare set out the frontiers. In order to promote sustainable health for all European Citizens, decisions need to be made.

Public health, especially cross-border healthcare, can be seen as a very complex political sector. On the one hand it is a service sector and on the other hand it is a highly regulated market as it can be seen with pharmaceuticals or medical equipment. The question arises why there are gaps at patient cross-border care and movement of professionals (shortage problem).

Nevertheless, the European Union (EU) hasn't been dealing with healthcare for a long time. The competence of the EU remained outside whereas legal entitlement of patients to access healthcare services was based on national law.

One reason for this might be the fact that in each Member State healthcare services and systems are organized and financed differently. Mainly the social insurance Bismarck systems and the publicly funded Beveridge systems can be mentioned (Hervey et al. 2004; Mossialos et al. 2010). Additionally each MS has different rules and laws how health, public health, healthcare and data protection should be obtained.

Moreover it should be mentioned that cross-border healthcare is not restricted to patients (also for health- professionals) but this thesis covers patient movement only.

However, health, care and medical treatments must be considered in every dimension and at all levels. Healthcare and in particular cross-border healthcare has a multidimensional impact which can be seen in cases of prevention of chronic diseases, epidemics, high-specific medical surgeries which are not available in a country.

In the Information Paper “Opening the doors for better Healthcare across Europe” the European Commission (2008) pointed out, that EU citizens prefer to receive healthcare close to their home. Furthermore only 1% of healthcare budgets are spent on cross-border healthcare and many inhabitants do not know anything about their opportunities. But it is essential for patients to know how it is exercised, because otherwise patients will not benefit from it. One of the missing links might be transparency, quick procedure, especially the reimbursement procedure and the allowance of prior authorisation. Only this can ensure benefits and effectiveness of cross-border care. Relevant information (e.g. from national contact points) is needed in order to make decisions of whether using cross-border healthcare or not (cf. [ec.europa.eu][1]).

The way to cross-border healthcare has been a long track. The first steps, to access the right to receive healthcare in another EU Member State, was established by Regulation 1408/71 (Senn, 2007). It was the application of social security schemes to employed people and their families moving within the community. It was later replaced by Regulation 883/2004 on the direction of social security systems. The new regulation should be clearer and more effective for all European nations.

Over the years, well known cases like Kohll (Case C-158/96 *Kohll v Union des Caisses de Maladie* [1998] ECR I-1931) and Decker (Case C-120/95 *Nicolas Decker v Caisse de maladie des employés privés* [1998] ECR I-

1831) changed the surface of how Member States should deal with cross-border healthcare.

With these steps, the European Court of Justice (“Court of Justice” or “Court”) used the Treaty on the Function of the European Union (TFEU) rules on free movement. This opened the doors to the internal market and created an area where the right of patients, to seek healthcare services outside their home country and reimbursement of cost from their home state, has been given.

By the time more and more cases were brought to Court. After diverse proposals and long negotiations the EU adopted legislation with the aim to coordinate and clarify the patients’ rights. The patients’ rights Directive 2011/24 on cross-border healthcare was passed in 2011 and has been enforced in late 2013.

In other words the Directive 2011/24 should give access to safe and high-quality cross-border healthcare as well as accountability and transparency for patients who seek healthcare abroad.

In principle every citizen of the EU is now free to seek healthcare in another EU Member State and to get the costs reimbursed by their home State as long as an allowance over prior authorisation is given. But in fact only a few people in the EU know about it and even less search for help outside their home country.

1.2 RESEARCH AIM

Health policies and health systems across the European Union are interconnected in many ways. The globalisation and the demographic patterns put pressure on policy- makers and stakeholders: First, the legal change as the Treaty of Lisbon or the Directive 2011/24 show impact on health policy in each Member State.

Secondly, nowadays patients have a high expectation of healthcare (hospital with “hotel- component” and patients with more knowledge about their health status and rights). Wilsmar et al. (2009, p.1) added:

“When in need of medical treatment, patients increasingly act as informed consumers who claim the right to choose their own provider, including beyond their national borders.(...) patient mobility is often motivated by dissatisfaction with healthcare provision in the home country and experiences involving deficiencies in the health system at home.”

Thirdly, movement of health professionals and health technologies like e-Health and telemedicine modify the healthcare setting. Wilsmar et al. pointed out:

“Cross-border healthcare is also not restricted to patients. Medical doctors and nurses go abroad for training, to provide services temporarily or to establish themselves in another Member State. “

The aim of this thesis is to show how far cross-border healthcare in the European Union can be realized and to which extent European citizens benefit from it. For this reason an overview of questions which may arise from patients will be discussed.

1.3 RESEARCH QUESTION

Is cross-border healthcare in the European Union practicable in order to establish benefits for European citizens?

How far do Article 114 and Article 168 of the Treaty on the Function of the European Union (TFEU) interfere or facilitate each other regarding the movement of patients?

Does the double existence of Regulation 883/2004 and Directive 2011/24 smother patient mobility?

1.4 STRUCTURE AND SOURCES

In this paper information has been gathered from a variety of sources. Mainly basic literature about the European Union as well as articles and studies from official sides of the EU has been used. Furthermore judgments and EU legislation and Directives were used to point out different parts. In this work independent sources, which are not from the EU but from Public Health Journals, are included as well.

This bachelor thesis consists of five chapters. The first chapter is an introduction to the work, in which the research aim and question is set out. It gives an overview over the topic, where cross-border healthcare is currently up to and towards which direction it leads.

Chapter two presents important parts of the Treaty concerning cross-border healthcare. Different articles of the Treaty on the Function of the European Union (TFEU) are demonstrated. Thereby diverse Article (Art.) as Art.3, 4, 114 and Article 168 are discussed shortly. In particular Article 114 and Article 168 of the TFEU are of interest. It shows how healthcare is obtained at EU level and to what extent healthcare on the territorial basis of the MS is influenced. In other words, it gives an overview of how healthcare is handled on EU level. The main purpose of this chapter is to show the rules and objections of the Treaty related to cross-border healthcare.

In the next chapter the Directive 2011/24 on patients' rights in cross-border healthcare is introduced. Patients will be able to choose the healthcare institution of their preference for servicing their needs in the EU. The topics of Articles 7 and 8 of the Directive, e.g. the right to reimbursement of healthcare expenses obtained in another EU Member State and the prior authorization will be explained. Furthermore the social security coordination Regulation will

be posed. The chapter closes with a conclusion and discussion about the Directive and the Regulation.

Chapter four deals with questions and situations which patients might want to know if they seek for healthcare outside their home state. It shows guideline character but should not be considered as it. Cross-border healthcare gives patients in the EU more options where and from whom they want to receive treatments. At the moment it is mostly the idea of the patient to go abroad while it is not being considered by physicians who recommend a specialist or specific clinic. Thereby treatments are usually not arranged by health services since it has to be done independently. Furthermore the national contact points in their home country are established for “visitors”/ patients from abroad and not for outgoings. This is why examples are given in chapter four.

The last chapter include the conclusion and concluding remarks. It highlights the main points of the work and emphasises the barricades, like intransparent procedures or lack of information, patients have to deal with by themselves.

2 HEALTHCARE IN THE EUROPEAN UNION

In order to understand what is meant by cross-border healthcare in the European Union and in particular patient movement between the Member States the rules of healthcare in the European Union have to be explained. This is briefly achieved in this chapter.

The European Union has integrated activities in the healthcare setting in the health strategy with the main focus on strengthening cooperation and coordination between the MS. Therefore the exchange of evidence-based information and knowledge is important for contributing to the decision making process. In addition the EU aims to enlarge the capacity to react fast on health threats. Essential for this is to ensure patient safety and the quality of healthcare also in the area of cross-border care. Nevertheless, the mobility

of health professionals and patients must be taken into account. The realisation runs through the Health Programme of 2008-2013 (European Commission, *Health – EU. Policies*. cf. [ec.europa.eu][2]).

How powerful the EU is in terms of regulation can be determined by the Member State and it is governed by the Treaty.

Either the competence is on EU level (The EU alone is in the position to legislate and adopt binding acts) or on MS level (MS have most of the power to adopt binding acts and the EU could support or coordinate (e.g. education) or there can be shared competence (e.g. social policy) (Mossialos et al. 2010 and cf. [europa.eu][1]).

In relation to healthcare many debates whether the European Union has the competence to act in the area of healthcare, have been made. It appears still to be unclear for EU citizens and also for health professionals where the emphasis lies and who is responsible for what (e.g. in case of an epidemic emergency). Another point might be the understanding and interpretation of legal material and lobbying (“similar to national level”) behind it. Hervey (2004 p.85) emphasises:

“Because the EU has no formal legal powers to develop its own healthcare law, the EU’s emergent healthcare policy is also something of a patchwork. EU healthcare law and policy is formed from a variety of provisions that constitutionally ‘belong’ to different policy domains, principally those of the internal market, social affairs, public health, enterprise and economic policy.”

As the Gallup Organization (2007, p.4) states in the Flash Eurobarometer framework:

“Recent cases of the European Court of Justice show that cross-border healthcare is surrounded by legal uncertainties.”

Regardless of the misunderstandings, the Lisbon Treaty of 2009 made the final step in integrating health services in the European Union.

Thereby, Article 3 of the TFEU, clarifies that the European Union has the exclusive competence, but it does not include health.

Furthermore, as stated in Article 4 of the TFEU, the competence in public health matters shall be shared between the EU and the Member States:

Article 4

(...)

2. Shared competence between the Union and the Member States applies in the following principal areas:

(a) internal market;

(b) social policy, for the aspects defined in this Treaty;

(c) economic, social and territorial cohesion;

(...)

(f) consumer protection;

(...)

(k) common safety concerns in public health matters, for the aspects defined in this Treaty.

([eurlex.europa.eu][1])

In addition, Article 6 of the TFEU clarifies the situation insofar as that the EU has supportive competence as well as the responsibility to coordinate or supplement the actions of the Member States concerning the protection and improvement of human health:

Article 6

The Union shall have competence to carry out actions to support, coordinate or supplement the actions of the Member States. The areas of such action shall, at European level, be:

(a) protection and improvement of human health; (...)

([eurlex.europa.eu][2])

Also Articles 9 and 168 underline the European direction as well as the aim and provide how and from whom health policy should be committed.

To a considerable extent the question why cross-border health is being dealt with at EU level nowadays, comes from the circumstances that patients who have gone to the European Court of Justice to claim their rights and changed the surface (Senn, 2007). Thereby, the Treaty gives the legal basis for health.

The preamble includes the aims, goals and values of the European Union. In regard to this the principles were set out. Article 3 claims fundamental values of the European Union and explains the main purpose and aim of the EU. In addition, Article 3 provides the creation of an area without frontiers (bases for the internal market Art. 114).

***Consolidated version of the Treaty on European Union -
TITLE I: COMMON PROVISIONS - Article 3 (ex Article 2
TEU):***

- 1. The Union's aim is to promote peace, its values and the well-being of its peoples.*
- 2. The Union shall offer its citizens an area of freedom, security and justice without internal frontiers, in which the free movement of persons is ensured in conjunction with appropriate measures with respect to external border controls, asylum, immigration and the prevention and combating of crime.*
- 3. The Union shall establish an internal market. It shall work for the sustainable development of Europe based on balanced economic growth and price stability, a highly competitive social market economy, aiming at full employment and social progress, and a high level of protection and improvement of the quality of the environment. It shall promote scientific and technological advance.*

(...)

([eurlex.europa.eu][3])

As it can be seen above, one of the main tasks of the European Union is the creation of the internal market and the regulation of health area thereby.

Furthermore, the Council concludes on common values and principles in European Union Health Systems, universality, access to good quality care, equity and solidarity as common principles for healthcare in the European Union (Council Conclusions, Luxembourg, 1-2 June 2006).

As many debates on European level about cross-border health have shown previously, Article 114 and 168 TFEU are of particular interest. The main concern is determined by the often unclear situation between the impact of the internal market and health.

2.1 ARTICLE 114 AND ARTICLE 168 OF THE TFEU

This part addresses legal uncertainties surrounding cross-border healthcare. To examine cross-border healthcare carefully the link or rather unlinked situation of Article 114 and Article 168 of the TFEU are illustrated.

The Treaty of Rome of 1957 gave limited reference to health either to “protection of health” or “public health” (Articles 36, 48 and 56). Even the Treaty of Maastricht had no clear competence with regard to health (Hervey et al. 2004, p.72).

Since then several Treaty amendments have been made until health has been taken into account through the Lisbon Treaty of 2009. The Lisbon Treaty stated that Member States should work closer together and if necessary get support relating to public health from the EU (shared competence).

2.1.1 Article 168 of the Treaty on the Function of the European Union (TFEU)

Addressing health on European level, the Article 168 of the TFEU seems to be one of the most important ones. The title of XIV of the TFEU refers to public health. What makes Art.168 so special?

Mainly because the article offers a direction, that helps the Member State with the implementation. In other words, it provides cooperation between the Member States in the area of health and the European Union, where the MS adopt their new laws on national level and the EU complement it.

Underneath paragraphs of Article 168 TFEU are present and conclude:

Article 168

(ex Article 152 TEC)

1. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.

Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education, and monitoring, early warning of and combating serious cross-border threats to health.

The Union shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.

(eurlex.europa.eu)[4])

What can be read out of the first paragraph of the Article is that a high level of health protection shall be ensured in all EU policies and actions. Furthermore, it “*shall complement national policies*” and prevention, research and education is included.

The concluding paragraph (Art.168, 7 TFEU) states that:

7. Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them. The measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

(eurlex.europa.eu)[5])

Furthermore it is clearly said that the EU shall respect the responsibilities of the MS which leads to the conclusion that the competence of the European Union is limited in that regard. The MS are therefore responsible to define their own health policy. Health policy includes the management of health services, medical care and resources.

2.1.2 Article 114 of the Treaty on the Function of the European Union (TFEU)

The legal base for the internal market is integrated in Article 114 TFEU. The aim of the first paragraph is put on the fact that legislation has to follow the ordinary legislative procedure.

*Article 114**(ex Article 95 TEC)**(...)*

3. The Commission, in its proposals envisaged in paragraph 1 concerning health, safety, environmental protection and consumer protection, will take as a base a high level of protection, taking account in particular of any new development based on scientific facts. Within their respective powers, the European Parliament and the Council will also seek to achieve this objective.

([eurlex.europa.eu][6])

Article 114(3) claims that, when measures are adopted by the Union regarding to the internal market, they must guarantee a high level of protection of health. Besides that all legislations have to be based on the latest research. These two points might be inconsistent by looking at the current health setting. Furthermore, Art. 114 highlights the function of the internal market and its classification.

2.2 CONCLUSION AND DISCUSSION OF ART.114 AND 168 TFEU

The EU law has a major impact on health services as well as national health on EU law. From the EU side the most powerful influence comes from laws which are not designed for health policy for example Art. 114 TFEU. Likewise the MS bring cases to EU level and change it through this way, as in the cases of Kohll and Decker, Dr. Morris or Case Watts. The cases will be explained in chapter 3.2.

Generally, Art. 168 concerns public health and the cooperation between the MS (e.g. cross-border health). The Article 114 (free movement of goods, persons, services and capital) is mainly a regulation and harmonization

measurement and not about public health or in particular about cross-border healthcare.

Nevertheless, tobacco legislation, which is a public health concern and has impact on cross-border healthcare, is based on the internal market. This might be because there is no other law in which it can be discussed at the moment.

Furthermore, the shortage of health professionals also affects the internal market. Moreover it affects health aspects of European Citizens e.g. shortage of nurses in care settings or a shortage of health professionals who work in the prevention area or open questions about bio-banking and data-protection.

The disagreement from Art. 168 and Art.114 concerns the free movement of health services which is mainly based in Art. 114. Thereby, the economic side could become too much weight so that healthcare providers might put the main focus on market benefits. Patient- and medical outcomes or preventive needs could eclipse. In addition, the extent of eHealth (e.g. electronic health records or institution-to-institution data transmission or telemedicine services) in regard to patient benefits is still at the beginning.

Nevertheless, the EU should spend money on European health projects but is not allowed to harmonize. Since 2007 (Health Strategy) and now, Together for Health, ways for global health were set out. It fosters health in all policies and the link between health and economics. But this leads to a double dynamic which can be seen on the health market and economic area as well as in social elements.

With regard to Art. 114 and 168 cross-border care could have a lot of power on the internal market (e.g. private insurance sector, intramural care). In the debate about cross-border healthcare and patient movement keywords like health tourism, health professional shortage, eHealth, and data protection have to be mentioned.

The Kohll and Decker cases show clearly how economic rules and social security systems are linked together due to the Treaty. The cases can be considered as the basic judgements which opened the doors to the possibility of refunding care carried out abroad (Senn, 2007). For further information about the cases see Case C-158/96 (*Kohll v Union des Caisses de Maladie* [1998] ECR I-1931) and Case C-120/95 (*Nicolas Decker v Caisse de maladie des employés privés* [1998] ECR I-1831).

Nevertheless the single market (Art.114) is governed at EU level while social policy mainly stays at national level- but still both show impact on each other (e.g. quality of life, human welfare).

3 PATIENT RIGHT'S DIRECTIVE 2011/24/EU

In March 2011 the Directive 2011/24 of the European Parliament and of the Council on the application of Patients' Rights in Cross-border Healthcare has been adapted (Directive 2011/24, OJ 2011 L 88/45).

The EU Directive 2011/24 gives all EU citizens the right to access healthcare services in another European Member State and in the European Economic Area (EEA) as long as the treatment is medically necessary. Furthermore it has to be available in their home country. The Directive thereby allocates a fundamental right to healthcare services in the EU for its' citizens. However long-term care, organ transplants and national vaccination campaigns are not covered, so that the Directive does not apply in those cases.

Frans Pennings (2011, p. 437) compiled the article "*The Cross-border Healthcare Directive*" which is published in the European Journal of Social Security:

"This appeared to be a very sensitive issue, and during the discussions in the Council, the definition of healthcare was narrowed considerably. The Directive now defines healthcare in terms of health services provided by health professionals

to patients, to assess, maintain or restore their state of health, including the prescription, dispensing and provision of medicinal products and medical devices.”

Article 3 of the Directive 2011/24/EU defines healthcare as followed:

(a) ‘healthcare’ means health services provided by health professionals to patients to assess, maintain or restore their state of health, including the prescription, dispensation and provision of medicinal products and medical devices; (...)

(e) ‘cross-border healthcare’ means healthcare provided or prescribed in a Member State other than the Member State of affiliation;

(eurlex.europa.eu)[7])

The Directive stated that long-term care is excluded from the scope and only applies to curative healthcare. Furthermore it guarantees reimbursement of spending as long as a patient is insured in a MS and can show proof of prior authorization.

Elisabetta Zanon emphasizes the following:

“Its underpinning rationale is that it should be as easy as possible for patients to have access to healthcare abroad, subject to the same conditions that apply to accessing healthcare at home. The legislation confirms that it is always the home health system that decides what healthcare is available to its citizens, regardless of whether they are treated at home or abroad. (...)

Importantly, it allows EU Member States the option of introducing prior authorisation for patients seeking care abroad, applicable to healthcare which is subject to planning

requirements and which involves at least one night in hospital, or which requires the use of highly specialised and cost-intensive medical equipment. Authorisation can only be refused in limited circumstances and decisions have to be taken in an objective and non-discriminatory manner, for example when a patient could be exposed to a high safety risk that cannot be regarded as acceptable.”

([Zanon 2011, P. 34])

Through the law, it is clear that EU citizens have the right for healthcare in another MS under certain circumstances. But reimbursement depends on what is included and offered in each Member State where the patient is insured. This could lead to the situation that individuals who got treated abroad end up paying expenses out of their own pocket if the treatment is set out as more expensive than what it would cost at home. But in the other way round (lower costs in another MS, less in the insured State) where the patient could make a financial win is forbidden.

National contact points should help patient who would like to get healthcare in another MS. (cf. [eu-patient.eu][1]).

These drop-in centres shall improve transparency about price, providers and redress procedures. All this information is important on the way to informed decisions.

The National Contact Point for Austria is seated in Vienna. On the website of europa.eu a summary about cross-border healthcare, patients' rights and the Directive 2011/24/EU of the European Parliament and of the Council headlined that:

*“Each Member State shall designate one or several **national contact points** for cross-border healthcare. These contact points shall consult with patient associations, healthcare providers and healthcare insurers. They are responsible for*

providing patients with information on their rights when they decide to take advantage of cross-border healthcare and with the contact details of the other contact points in the other Member States.”

([europa.eu][2])

In addition, the Directive emphasizes the promotion and cooperation in healthcare setting in comparison to the MS. The Directive changed the surface but the Regulation of social security coordination still remains in place.

In the next point the Regulation 883/2004 will be discussed.

3.1 THE SOCIAL SECURITY COORDINATION REGULATION

The Regulation 1408/71 was created for employed persons and their families moving within the EU and who were in the need for healthcare. It was later replaced by the social security coordination Regulation 883/2004 (Regulation 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems (OJ L 166 of 30 April 2004, p.1)). One of the big and important differences between Regulation 1408/71 and Regulation 883/2004 is that now all EU nationals (and their family), who are covered by a social security scheme, are included.

The cross-border health pattern is mostly linked to reimbursement. Nevertheless the knowledge about it is very limited.

“If it is asked as a simple trivia question, the significant majority of EU citizens believe that they are free to use health services elsewhere in the Union: 70% think that they are entitled to receive medical treatment in another EU Member State and be reimbursed by their national health authority or healthcare insurer. Just under a fifth of citizens

(18%) do not share that opinion, and 12% are not sure if the statement is true or false.”

([ec.europa.eu][3])

In regard to the research question of the thesis how far patients benefits from cross-border healthcare Chapter 1 of Title III of Regulation 883/2004 gives a first hint.

If a person with prior authorization seeks healthcare in another MS, two kinds of benefits can be receive: either in form of cash e.g. income replacement or in form of personal services (e.g. medical treatment) and medical equipment/help aids (e.g. crutches, glasses or wheelchairs). (Zaglmayer 2009)

Besides that, in Article 19 of the Regulation 883/2004, treatment that becomes necessary when the patient is on a short term stay in another MS e.g. on holidays or business trip are explained. The procedure works through the European Health Insurance Card (EHIC) and no “carried with you” formula as in earlier times is needed. Furthermore no authorization for treatment is required by the home State and the payment follows the same way as if the patient is insured in that MS where the treatment takes place. But the reimbursement could only be half of the costs. It becomes important because more and more people travel within the EU (e.g vacation or business trips).In this cases the EHIC covers the costs when EU citizens fall ill during the trip.

The next Article as quoted below, concerns the rights of insured patients that travel to another MS with the purpose of seeking medical treatment (planned treatment). In this case the prior authorisation is required to get cost reimbursed.

Article 20 of the Regulation 883/2004:

2. An insured person who is authorised by the competent institution to go to another Member State with the purpose of

receiving the treatment appropriate to his condition shall receive the benefits in kind provided, on behalf of the competent institution, by the institution of the place of stay, in accordance with the provisions of the legislation it applies, as though he were insured under the said legislation. The authorisation shall be accorded where the treatment in question is among the benefits provided for by the legislation in the Member State where the person concerned resides and where he cannot be given such treatment within a time-limit which is medically justifiable, taking into account his current state of health and the probable course of his illness.

([eurlex.europa.eu][8])

Usually, the costs for the treatment are paid directly by the home insurance to the foreign healthcare provider as long as prior authorisation has been granted.

3.2 CASE KOHLL AND DECKER

The frontier-free area of the European Union with its' "four freedoms" (free movement of persons, goods, capitals and services) is also applicable for cross-border healthcare. It was underlined by the Case of Mr. Kohll, a Luxembourg citizen who brought his daughter to a dentist seated in Germany without prior authorization. The case provides the fact of free movement of people and of services with the equality of giving and receiving services within the EU.

The case of Mr. Decker, who is also from Luxembourg, deals with reimbursement for spectacles bought in Belgium, where the Court argued on free movement of goods in favour for Mr. Decker.

For further information about the judgements, which are not explained in this thesis, please see Case C-158/96 Kohll v Union des Caisses de Maladie

[1998] ECR I-1931 and Case C-120/95 Nicolas Decker v Caisse de maladie des employés privés [1998] ECR I-1831.

3.3 CONCLUSION OF THE DIFFERENT LEGAL BASES

Concerning the cross-border health pattern the European Union has three different legal bases available. As mentioned first, the Treaty of Lisbon (as mainly discussed Art.114 and 168 TFEU), then the Directive 2011/24/EU on cross-border healthcare and the social security coordination Regulation 883/2004. This might confuse patients with regard to patients' rights on cross-border healthcare. Pennings (2011, p. 446) stressed

“As Article 2 reads, the Directive shall apply, without prejudice, to the Regulation. Thus, the system of the Regulation has remained in place next to that of the Directive. This is important, since the Regulation is, if authorisation is granted, more beneficial to patients than the Directive.”

Nevertheless, the Regulation on social security covered full reimbursement of costs but the Treaty only provides the reimbursement up to the extent of what it would account in the home state. The ruling produced a strong debate about organizing, financing and providing healthcare. The fear of rising costs due to allowing hospital treatment and nursing care or the influence of the private health sector became intense rather than the benefits of reimbursement for individuals. (Hervey, et al. 2004, p. 127)

However, in principle EU citizens are allowed to receive healthcare in other MS but in practice it is limited. This can either be due to the ability of the patient to pay for the care (e.g. glasses or dental care) or by national and/or EU legislation where the right of patients is expanded. The distinctions from the Court between treatment provided in the hospital (where prior authorization is required) or outside might restrict individuals. Furthermore,

prior authorization can also handicap the freedom to receive/provide services and might overwrite patients' rights of freedom of choice.

Nevertheless, prior authorization provides a safety of costs for patients but in the end it is justified for financial reasons of health policy and to coordinate the intramural setting. Pennings (2011, p. 442) indicated that as follows:

“in Article 7(9) the room for Member States to restrict cross-border movement is increased. They can limit the application of the reimbursement rules based on overriding reasons of general interest, such as planning requirements relating to the aim of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned, or to the wish to control costs and to avoid, as far as possible, any waste of financial, technical and human resources.”

In regard to Pennings (2011) it could lead to the situation where a lower amount or no reimbursement is given at all.

As long as reimbursement is unclear for patient it will constrain cross-border care seekers as well as national authorities in their healthcare planning.

4 QUESTIONS AND EXAMPLES

This chapter includes examples and questions which may arise for patients who seek medical treatment abroad. It should clarify how cross-border healthcare works in practice. It shall obtain answers which are important to make an “informed decision” if treatments are still of interest and applicable in certain situations.

Most patients prefer to get treatments near to their home. But in certain cases, cross-border healthcare becomes interesting to them. A common case would be if the citizen lives in a border region e.g. between Germany and the Netherlands where the next physician is closer abroad. However, the need for certain treatments contributes that some patients seek for

healthcare abroad e.g. when the specialisation in this field is not given (e.g. rare diseases) or the waiting list is too long.

Cross-border healthcare does not only include patient mobility, it also includes movement of health professionals, making information available and exchanging information for health professionals (for example about rare diseases, new research outcomes or treatment opportunities) or e-health technologies. It does not automatically mean that patients move directly to another MS for treatment, it can also be that the x-ray of the patient is sent to another country and get diagnosed by a specialist. But commonly by cross-border healthcare, patient mobility is meant.

Cross-border healthcare can be beneficial for everyone within the EU. The directive should provide a clear framework for patients about the rights and how to make use of them in practice. In addition it should support the MS to regulate and improve health systems (plan and organize it, exchange data/statistics) and make sufficient use of resources. Nevertheless uncertainties arise and the cross-border healthcare is not free of barriers.

The questions and answers constituted below should give an overview about cross-border healthcare and patient concerns with regard to patient mobility. It should indicate how patients can benefit from cross-border care.

4.1 EXAMPLES FOR CROSS-BORDER HEALTHCARE:

Case A:

Mrs M., a 35 year-old Italian waitress normally resident in Turin, whose sister is now a permanent resident of the UK, applied to come to the UK for surgery on her nose. Her nose has caused her pain and has been taking her sleep since an accident. The local hospital in Italy had agreed to carry out the operation within three months but Mrs M. wanted to have the surgery in London, where her sister lives and could care for her afterwards. The

authorisation was granted in Italy but with a waiting period of up to six months.

Explanation for Case A: Mrs. M., a 35 year-old Italian authorised for treatment abroad, is put on a waiting list and would have to wait longer as at home. The treatment is available in her home state in a respectable time. This leads to the situation where no other state is obliged to fund the surgery. Furthermore, it would be unfair to treat her earlier than others who are already on the list. The same would apply if the treatment is not included in the health service of the home state. An exception of it would arise if the treatment falls under exceptional circumstances.

Case B:

R. a six year old boy from the border region in Slovenia has pain because of his milk tooth. A well-known children dental surgery is placed only 30 minutes way in Austria. The father of the little boy already got bitten by him while helping him to get the tooth out. It cannot be denied that the bigger brothers do not support the situation by trying to pull the tooth out of his mouth with a yarn connected to the door by smashing it. The worried parents are not sure if a regular dentist is empathetic enough for their son and think about their options. What would be applicable in this situation? Would dental treatment then need prior authorization?

Explanation of Case B: When the treatment is necessary during a temporary stay in another country with his family for example during the summer holidays this treatment will be covered by the EHIC. It falls under an emergency treatment for the son as well as for the father. The reimbursement can be claimed at the health insurance at their home state.

But if the father wanted to travel abroad with the purpose of receiving dental treatment for his scared son a prior authorisation is advised. The bill will be paid upfront and then be reimbursed under the conditions of their health insurance. Furthermore, he has to find the right doctor by himself

Case C:

Mrs P. a 28 year-old mother from Germany developed carpal tunnel syndrome in her left hand, and has been put on a waiting list for a surgery in her hometown. She expected to receive surgical treatment within two months. The healthcare situation in Germany is embossed by health professional shortage and administrative errors. After four months there was still no settled surgery appointment. Her condition had worsened. How could a young mother in maternity leave stop lifting her baby and doing the household? A strong medical prescription is not an option as long as she is breastfeeding. A hospital in Belgium, which is in the border region for her, is willing to do the surgery within three weeks and applied for authorisation under the Directive.

Explanation for Case C:

The prior authorisation for the young mother was given because she had experienced an „undue delay“. But if she had been rejected the Directive 2011/24 rules clearly how and when it is applicable. In Mrs. P’s case if a healthcare provider or another MS would refused a treatment then she would have to prove that she needs it (carpal tunnel syndrome and the situation of undue delay).

Case D:

Mr. D., a 69 year-old English landlord wants to spend his retirement in a nice nursing home after being divorced the second time. His children and grandchildren live in the cities and have neither time to take care of him nor interest to support him with the property. He, as a wine and beer gourmet, has gout and high blood- pressure but besides that he enjoys his life. He sold half of his land and wants to spend the rest of his life in Spain near the sea where he can go sailing and fishing. Mr. D. found a good arrangement where he first can stay in a sheltered living home and then move into a nursing

home complex if necessary. The living standards and the quality of care are excellent.

Explanation for Case D:

Mr. D, a well-situated man, is rejected for financial support in Spain. Not because he might be able to afford it on his own but because long-term care is not covered under cross-border healthcare. Neither the Directive 2011/24 nor the Regulation 883/2004 are applicable in Mr. D's case. Nevertheless he is still allowed to spend his retirement in another country but he cannot expect medical support in the context of long-term care. However, he could seek for prior authorisation for treatment concerning his high blood pressure under the Directive. As long as he only needs further medication the Regulation would cover these.

What are the reasons why people seek health care abroad?

People who make use of cross-border healthcare often live in cross-border regions where the next doctor is closer in the other country. They also might live, work or study temporarily in another MS and it is more convenient to seek healthcare right there. However, patients might prefer getting treated by a health professionals who are more experienced in the procedure or sometimes the quality of care is better. In other cases the waiting list is shorter abroad or the treatment is not included in the health service in the home country.

What does the Directive tell European nationals?

It clarifies which rights citizens have to get healthcare and medical treatment in another MS and how it applies as well as the legal obligation of the MS. The Directive mainly does not give any new rights to cross border healthcare for EU citizens. Usually the premise for treatment abroad is that a patient is insured within the European Economic Area (EEA), is entitled to the same services in this country under a certain time (but exceptional circumstances are taken into account) and prior authorization is given. Furthermore, it does

not mean that everyone will automatically receive reimbursement for the treatment costs. In addition, cross-border healthcare costs will only be reimbursed up to the amount of the treatment in the home state.

Where can patients find information about cross-border healthcare?

Through national contact points and other sources e.g. official website of the EU as DG SANCO. It shall be mentioned that national contact points only provide information for patients who seek care in this country and not for those who are going elsewhere. In other words, national contact points in an MS are only for incomings and not for outgoings.

What needs to be considered?

It is advisable to follow the set of procedures for pre-approval otherwise problems with the funding and reimbursement can appear. Through pre-approval a link between the two countries could be arranged and exchanged between medical records and later follow-up care can be managed.

Health services and quality of treatments can be considered as good in Europe, nevertheless there might be differences between the countries with regard to standards and procedure. Nevertheless language barriers can be experienced.

The next questions are stated on official side and placed in addition to complied the topic.

Do I need authorisation from my national authority before going abroad for treatment?

National authorities can introduce a system of "prior authorisation" in 3 cases:

1) For healthcare which involves overnight hospital stay of at least one night;

2) *for highly specialised and cost-intensive healthcare;*

3) *in serious and specific cases relating to the quality or safety the care provided abroad. In these 3 cases, patients may need to ask for permission in advance from their national health authority in charge of reimbursement).*

([europa.eu][3])

How much can be reimbursed after receiving a treatment abroad?

Patients will be reimbursed the same amount as they would receive in their own country for the same type of healthcare. Member States where care is free of charge will need to inform patients about their reimbursement tariffs.

([europa.eu][4])

In addition, in the paper about “EU Directive 2011/24/EU the European Patients’ Forum emphasis the application of patients’ rights in cross-border healthcare: Legislation Guidance for Patient Organisations” in regard to prior authorization and reimbursement is an important point for patient. It concerns the pattern if patients have to pay upfront. As stated under the Directive, patients

“will have to pay the healthcare provider upfront, and will then be reimbursed by their home Member State. However, Member States may lessen the financial burden on patients by making use of a prior notification. Prior notification could work in two ways:

- Patients, in exchange for the notification, may receive a written confirmation of the level of reimbursement they are entitled to receive, before having the treatment.*

- *Or a Member State can decide to go further, and instead of asking the patient to pay upfront they can put in place a mechanism for a direct transfer of costs, using the under Regulation No. 883/2004.”*

([eu-patient.eu][2])

What does the cross-border healthcare Directive say about non-hospital treatment?

If you travel from your own country to another Member State you can gain access to any non-hospital care that is available to you in your own country, without prior authorisation. This means you do not have to have permission from your own healthcare system first. The cost of the treatment will be reimbursed in full, as long as the treatment you have can be provided within your own healthcare system. Reimbursement above and beyond that may not be granted.

([treatmentabroad.com][1])

What does the cross-border healthcare Directive say about hospital treatment?

The Regulations about hospital treatment say that you can apply to go to another Member State for treatment as long as your case meets specific criteria. You must get pre-authorisation from your own healthcare system before you go, and then the healthcare system will reimburse the cost of treatment direct to the hospital in the Member State you have chosen in most cases. In others, you will need to pay, but will be reimbursed without too much delay, by your healthcare

system. The size of the reimbursement will cover the cost of the treatment that you have, not the cost of the treatment in your own country.

([treatmentabroad.com][1])

Can a patient receive medication with the prescription from its home state?

The prescriptions a patient has from his/her home state is valid in all other EU-countries. The total cost for the drug has to be paid first and can then be refunded back home. Keep in mind that the same medicine might not be available or allowed in other MS.

If something goes wrong during a treatment abroad which legal system is responsible? What are my rights as a patient?

As a cross-border patient the right where the healthcare is provided is taken into force.

5 CONCLUSION

As the present thesis shows, the Directive and the Regulation represents a step forward in improving access to care for European citizens across borders. As a consequence the interest in cross-border healthcare rises. The media, stakeholders and politicians spark a fire towards a change. Nevertheless it is still unclear how many patients move within Europe for medical treatment. In the paper “Worrying about the wrong thing: patient mobility versus healthcare professional mobility” the problem of patient mobility and in addition, health professional shortage is highlighted. As Glinos A. (2012 p.1) emphasis

“While it is impossible to know the exact numbers of patients travelling for healthcare within the EU – the famous 1% estimate of all healthcare consumption put forward by the European Commission is elusive since it is unclear what this percentage covers and how it has been calculated – it is tempting to suggest that there might be more policymakers, lobby groups, researchers and commentators devoting attention and working hours to patient mobility than there are EU patients who travel to another Member State for planned care at the expense of their home state” Glinos A. (2012 p.1).

Patient mobility within the European Union has been and is still uncertain. The problem of shortage in the health sector is left uncut on EU level neither was it the focus of this thesis.

Summing up, the Directive and the Regulation create a unified cross-border healthcare option within the EU. Nevertheless certain aspects like who has the responsibility on national level, where the authority lies and where applicable solutions in relation with the Regulations are left out. Both legal bases allow patients more space regardless if patients have enough knowledge about their steps.

The cross-border healthcare situation remains controversial but increasingly embossed from a dynamic relationship. In regard to the Directive the application in practice might be intransparent for most patients. This might be due to the lack of guidelines and information in daily language. Furthermore the interplay and distinctions from the Directive with the Regulation might cause more confusion than clearness. If cross-border healthcare and especially patient mobility is addressed, in first place it has to be clarified what is applicable and then which patients benefit from it.

It is likely that the organisation of cross-border healthcare will cause coordination and financial problems for the Member States when more EU citizens claim the rights for healthcare abroad. But as long as no trustful statistics are available in Europe and more patients change their mind and want to receive healthcare abroad, worries should better be on the shortage of health professionals! It is true, that if many patients decide to go to another country where healthcare might be of better quality, the health resources can shrink and the financial spending can rise. A longer waiting list has to be taken into account too but in the end the problem of demographic pattern and the lack of qualified health professionals will overflow the anxiety of patient mobility.

LITERATURE

European Commission. . *Health – EU. Policies*. Retrieved November 11, 2008 from the European Commission Web site: http://ec.europa.eu/health-eu/health_in_the_eu/policies/index_en.htm

Directorate-General for Health and Consumers, European Commission – B-1049 Brussels http://ec.europa.eu/dgs/health_consumer/index_en.htm
http://europa.eu/legislation_summaries/institutional_affairs/treaties/lisbon_treaty/ai0020_en.htm

Health Systems Governance in Europe: The Role of European Union Law and Policy, Elias Mossialos [et al.]. Cambridge, (Cambridge University Press) 2010, p.12.

Case C-158/96 Kohll v Union des Caisses de Maladie [1998] ECR I-1931

Case C-120/95 Nicolas Decker v Caisse de maladie des employés privés [1998] ECR I-1831

Council Conclusions, Luxembourg, 1-2 June 2006

Directive 2011/24 of 9 March 2011 of the European Parliament and the Council on the application of patients' rights in cross-border healthcare (OJ L 88, 4 April 2011 p.45)

Regulation 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems (OJ L 166 of 30 April 2004, p.1)

Hervey, Tamara K. and McHale, Jean V. *Health Law and the European Union*. Cambridge, (Cambridge University Press) 2004, p.72

Frans Pennings “The Cross-border Healthcare Directive” in *European Journal of Social Security*, Volume 13 (2011), No. 4 p.437

The Gallup Organization, Hungary upon the request of the Health and Consumer Protection Directorate- General (DG SANCO), Health Strategy Unit (C5). Survey organised and managed by the Eurobarometer Team of Directorate-General Communication: *Cross-border health services in the EU*

(Zanon 2011)

Healthcare across borders: Implications of the EU Directive on cross border healthcare for the English NHS, Elisabetta Zanon, 2011, p.34.

Irene A. Glinos . Worrying about the wrong thing: patient mobility versus healthcare professional mobility *Journal of Health Services Research & Policy* Vol 00 No 0, 2012: 1–3

Zaglmayer, Bernhard and Einarsson, Olafur, Access to and Reimbursement of Healthcare in the European Economic Area, (2009) *Tidsskrift i Erstatningsrett* – nr. 3 2009/årgang 6, chapter 2.2

Senn, A. (2007). Les services de la santé en Europe en 2007: quels enjeux? Robert Schuman Foundation Questions d'Europe n° 72. from the Robert Schuman Foundation web site: <http://www.robert-schuman.eu/pdf.qe.php?num=qe-72>

ONLINE SOURCES

[ec.europa.eu]

[1] http://ec.europa.eu/dgs/health_consumer/index_en.htm; visited on 05.05.2013

[2] http://ec.europa.eu/health-eu/health_in_the_eu/policies/index_en.htm; visited on 07.05.2013

[3] http://ec.europa.eu/public_opinion/flash/fl_210_en.pdf; visited on 13.05.2013

[europa.eu]

[1] http://europa.eu/legislation_summaries/institutional_affairs/treaties/lisbon_treaty/ai0020_en.htm; visited on 25.05.2013

[2] http://europa.eu/legislation_summaries/employment_and_social_policy/social_protection/sp0002_en.htm; visited on 29.05.2013

[3] http://europa.eu/rapid/press-release_MEMO-1132_en.htm?locale=en#PR_metaPressRelease_bottom; visited on 25.05.2013

[4] http://europa.eu/rapid/press-release_MEMO-1132_en.htm?locale=en#PR_metaPressRelease_bottom; visited on 27.05.2013

[eurlex.europa.eu]

[1] <http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2008:115:0047:0199:en:PDF>; visited on 20.05.2013

[2] <http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2008:115:0047:0199:en:PDF> visited on 20.05.2013

[3] <http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:12008M003:EN:HTML>; visited on 22.05.2013

[4] <http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2008:115:0047:0199:en:PDF>; visited on 23.05.2013

[5] <http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2008:115:0047:0199:en:PDF>; visited on 23.05.2013

[6] <http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2008:115:0047:0199:en:PDF>; visited on 25.05.2013

[7] <http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:EN:PDF>; visited on 27.05.2013

[8] <http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2004:166:0001:0123:en:PDF>; visited on 30.05.2013

[eu-patient.eu]

[1] http://www.eu-patient.eu/Documents/Events/2012_Regional-Advocacy-Seminar/Presentations/12%20%20Patients%20rights%20on%20Cross%20Border%20Health%20Care%20Directive.pdf; visited on 11.05.2013

[2] <http://www.eu-patient.eu/Documents/Policy/Cross-borderHealthcare/EPF%20Guidance%20on%20Cross-Border%20Healthcare.pdf>; visited on 12.05.2013

[treatmentabroad.com]

[1] <http://www.treatmentabroad.com/eu/questions-and-answers/>; visited on 15.05.2013