Cross Border Health Care
Under the 1408/71 EC Regulation

INTRODUCTION

High-quality health services are a priority issue for European citizens. The EU has only resid-
ual competences in the field of health, by virtue of Article 152 EC (first introduced, with even
more restrictive content, as Art. 129 of the Treaty of Maastricht). This limited legal basis has
made possible the adoption of support programmes and the delimitation of the scope of com-
petence of some EU bodies and agencies. Rights to health care are also recognised in the
Charter of Fundamental Rights of the EU.

The main text of secondary legislation dealing with cross-border healthcare is Regulation
1408/71, as it now stands. This Regulation corresponds to an early and, hence, limited
attempt by the Community Institutions to comply with their obligations under Article 42 of
the Treaty. It falls short of achieving any substantial degree of harmonisation and limits its
ambit to the coordination of basic national rules in the field of social and welfare benefits.

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the Károli Gáspár University, Budapest, Hungary.
3 See Article 35 on health care.
4 http://www.europarl.europa.eu/charter/default_en.htm
5 Council Regulation (EEC) No 1408/71 of 14 June 1971 on the application of social security schemes to
employed persons, to self-employed persons and to members of their families moving within the Com-
munity. This Regulation has been modified at least thirty times, the last important modification extend-
ing its personal scope to cover nationals of non Member States legally residing within the EU, see
Council Regulation (EC) 859/2003 of 14 May 2003, OJ L 124/1. It has recently been codified and
repealed by Regulation (EC) 883/2004 of 29 April 2004, OJ L 166/1. Since all the legislative and judicial
developments of the present contribution refer to Regulation 1408/71, references will be made to this
legislative instrument.
6 On the qualification of this regulation as an instrument of coordination rather than as a means of har-
monisation see the first recitals of the Regulation. See on this issue, the ECJ judgment of 6 March 1979
in case 100/78 Rossi [1979] ECR 831, Rec. 13, where the Court expressly acknowledges that ‘the regu-
lations did not set up a common scheme of social security, but allowed different schemes to exist, cre-
ating different claims on different institutions…’
Nowadays, health systems and health policies across the EU are becoming more interconnected than ever in the past. This is due to many factors, including movement of patients and professionals [facilitated by rulings of the European Court of Justice], common public expectations across Europe, dissemination of new medical technologies and techniques through information technology, and the enlargement of the Union. This increased interconnection raises many health policy issues, including quality and access in cross-border care; information requirements for patients, health professionals and policy-makers; the scope for cooperation on health matters; and how to reconcile national policies with European obligations in general. One of the heated issues on European level is cross-border health care.7

In these days, Community law offers citizens two different ways of making their social security institution pay for the cost of health care which they received in another Member State.8 These are: 1. cross-border health care under the Coordination Regulation [Article 22 of 1408/71/EC Regulation] and 2. the Treaty-based method of cross-border health care.

1. Cross-border health care under the Coordination Regulation [Article 22 of 1408/71/EC Regulation]. The basic mechanism established by the said provisions is that, any person wishing to receive healthcare services in another Member State has to obtain an authorisation by the competent fund in his/her home state, except for emergencies; once this authorisation is given, the beneficiary is entitled to receive in the host state, both benefits in kind and cash benefits. Against this background the Court, on several occasions, has interpreted the Regulation in an extensive manner, so as to regulate issues not directly covered under the provisions of the Regulation. The activist approach of the Court has led the Council to amend the Regulation on several occasions, proceeding thus, at the reversal, by legislative means, of the Court's case law.9

2. In the scope of the Treaty-based method of cross-border health care for the first time in Luisi v Carbone10 and then again in SPUC v Grogan11 the European Court of Justice acknowledged that health services are deemed to fall within the ambit of the economic 'fundamental freedoms' of the EC. However, in these early cases the consequences of this finding had not been fully acknowledged, especially not in relation to social security.

The breakthrough came with case of the Kohll.12 Mr. Kohll, a Luxembourg national, was seeking reimbursement for a dental treatment received (by his daughter) in Germany, without having received prior authorisation by his home institution. In this case, the Court made it clear that Articles 49 et seq. do apply to health services, even when they are provided in the context of a social security scheme. Or, as the ECJ put it: ‘the special nature of certain services does not remove them from the ambit of the fundamental principle of freedom of movement’.13 Hence, the requirement of prior authorisation did, indeed, constitute a violation of Article 49 (then 59) of the Treaty.

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7 http://www.spsw.ox.ac.uk/fileadmin/static/Espanet/espanetconference/papers/ppr%5B1%5D.9.WL.pdf
8 http://ec.europa.eu/health/ph_overview/co_operation/mobility/patient_mobility_en.htm
13 Rec. 20 of the judgment. This passage of the judgment has been repeatedly cited by the Court in its more recent judgments, see the developments further down in this para.
Kohll was delivered the same day and based on the same opinion by Advocate General Tesauro as the judgment in Decker. In Decker the Court affirmed that national security and healthcare schemes should also respect Article 28 EC on free movement of goods. The finding that healthcare is a priori subject to the Treaty rules was further explained in the judgments in Vanbraekel and Peerbooms, as well as in cases Müller-Fauré and Watts. It has been repeatedly confirmed in other judgments of secondary importance. This finding, however, raises some definitional elements.

This article is an overview on the legal implementation of the Article 22 (1) (c) [E-112 forms] in the different Member States of the European Union. It is based on the different national reports prepared within the trESS-project.

1. THE EXISTING SOLUTION OF CROSS-BORDER HEALTH CARE IN EU LEVEL

1.1. Cross-border health care under the Coordination Regulation

According to the above mentioned first way, and until a decade ago, the only way is rooted in the free movement of persons and in particular Regulation 1408/71. The Regulation puts in place a coordination mechanism that gives its beneficiaries the right to receive sickness benefits in kind in a State other than the one in which they are insured. These benefits are provided in accordance with the legislation of the providing state, as if the person concerned was insured there, at the expense of the competent institution.

The conditions and modalities under which insured persons have access to treatment outside the competent state, on the same terms as the host state’s insured persons, vary depending on whether they reside or stay in that state. In the latter situation, which is governed, inter alia, by Article 22 of Regulation 1408/71, it is necessary to distinguish, in turn, between

18 The overwhelming majority of the information gathered by the national experts is obtained by studying the relevant material [legislation, guidelines, administrative instructions, web-sites...] as well as by interviewing the relevant competent institutions or persons – Involved in the application of article 22 (1) (c).
19 http://www.tress-network.org/TRESSAJAX/jsessionid=2912441199028279843
a) the position of a person who becomes in need of health care during a stay in another state other than the competent state (occasional care) [Article 22(1)(a)] and
b) that of beneficiaries who travel to another Member State with the purpose of obtaining health care (planned care) [Article 22(1)(c)]. This authorisation process is under the E-112 form.

The first situation is commonly referred to as occasional care. The relevant certificate is the European Health Insurance Card (EHIC). The focus of this article, however, is on the second situation, i.e. planned care. Article 22 (1) (c) grants the right to obtain health care to insured persons who have been authorised by the competent institution to go to the territory of another Member State to receive there the treatment appropriate to their condition. Prior authorisation is given by means of a form E-112 which states that the person is authorised to receive a given type of treatment and the period for which he/she is so entitled.

By virtue of Article 22 (2) such authorisation may not be refused where (i) „the treatment in question is among the benefits provided for by the legislation of the Member State on whose territory the person concerned resided” and (ii) „he/she cannot be given such treatment within the time normally necessary for obtaining the treatment in question in the Member State of residence, taking account of his/her current state of health and the probable course of the disease”.

It has long been believed that this provision obliged the institution to grant authorisation only in case the claimant could not be treated within the bounds of the average national waiting time, regardless the length thereof and irrespective of the claimant’s medical condition. Recently, it has become clear that this reading, which resulted in restrictive national authorisation policies, has never been good law. In 2003, the ECJ reinterpreted the second condition of Article 22 (2) in the light of its case law in relation to the free movement of medical services. It ruled that the request for authorisation to undergo treatment abroad cannot be turned down whenever the same or equally effective treatment, which forms part of the benefit package of the competent Member State, cannot be obtained in that State without “undue delay”. In order to determine whether this is the case, account must be taken – and must only be taken – of all the factors characterising the claimant’s medical condition. These factors, which include the patient’s medical history and the probable course of his/her illness, the degree of pain he/she is in and/or the nature of the disability, form the absolute yardstick. The existence of waiting lists in the competent State is not in itself valid ground for refusing authorisation. However, it neither necessarily entails that there is undue delay. In its much-awaited Watts ruling, the Court recognized waiting lists as a means of medical supply management and priority setting. The Court held that the authorisation should be granted when the waiting time which the patient faces exceeds the period which is acceptable on the basis of an objective medical assessment of the clinical needs of the person in light of all the factors characterising his/her medical condition at the time when authorisation is sought. In conclusion, patients may be asked to wait until treatment is available at home, but only insofar as this delay is compatible with their medical condition.

The European Court of Justice has further pointed out that the sole purpose of Article 22 (2) is to identify the circumstances in which the competent institution is precluded from refusing prior authorisation requested on the basis of Article 22 (1) (c). Cumulated satisfac-

20 For an overview of the use of this EHIC, we refer to http://ec.europa.eu/employment_social /social_security_schemes/healthcare/index_en.htm as well as the Note from the Administrative Commission on Social Security for Migrant Workers on Monitoring the Use of the European Health Insurance Card (CA.SS.TM.151/07)
21 Case C-372/04 (Watts)
tion of the two conditions identified in the former provision renders mandatory the grant of
authorisation to which it refers.\textsuperscript{22} Moreover, the case law of the Court has indicated that the
said provision is not in any way intended to limit the situations in which authorisation to
receive planned care abroad may be obtained.

1.2. The Treaty-based method of cross-border health care

The other way stems from the case law of the European Court of Justice, interpreting the
ECT provisions relating to the free movement of services (Article 49 and 50 of the ECT). The
“Treaty-based procedure” of patient mobility is beyond the scope of this report.\textsuperscript{23}

2. Authorisation policies of Member States

Member States must set up prior authorisation schemes in implementation of Article 22
(1) (c) and (2).\textsuperscript{24} These national schemes must offer certain procedural safeguards, similar to
those required of authorisation schemes for treatment abroad which fall outside the scope of
Article 22 and within the realm of Article 49 ECT. In particular, such schemes must be based
on a procedural system which is easily accessible and capable of ensuring that requests will be
dealt with objectively and impartially within a reasonable time. When the applicant is rejected,
he/she should be able to challenge the refusal in judicial or quasi-judicial proceedings. Refusals
must refer to the specific provisions on which they are based and should be properly reasoned.
Courts or tribunals hearing actions against such refusals must be able, if they consider it neces-
sary, to seek the advice of wholly objective and impartial experts.

2.1. Implementing the procedure of Article 22 (1) (c)

The system of cross-border medical care as enshrined in Regulation 1408/71 mirrors to some
extent the national traditions for cross-border medical care. Many national legislations have
longstanding provisions on the assumption of the costs of health care received abroad. In that
respect, and even though the conditions and modalities under which planned care abroad is pos-
sible are not always the same, the Regulation-based procedure could be seen as a reflection of the
existing national systems. This might perhaps explain why not all Member States have estab-
lished specific rules implementing the procedure of Article 22 (1) (c) of Regulation 1408/71.
Indeed, only a limited number of Member States have enacted specific legislation implementing
Regulation 1408/71 (Italy, Latvia, Lithuania, Luxembourg, Poland and Slovenia)\textsuperscript{25} whereas a lot of
other Member States have limited themselves to establishing administrative circulars or
guidelines (Belgium, Finland, Greece, Ireland, Malta, Portugal, Spain and Sweden). The UK con-
tents itself with providing online information and publications to explain the system.

Finding these administrative circulars is not always an easy task. In Spain, for
instance, the administrative circulars have not been published in any official bulletin nor

\textsuperscript{22} See e.g. Case C-368/98 (Vanbraekel)
\textsuperscript{23} http://www.iese.edu/en/files/6_25268.pdf
\textsuperscript{24} See e.g. Case C-56/01 (Inizan)
\textsuperscript{25} http://www.tress-network.org/TRESSAJAX/
can they be accessed electronically. The only way to get them is to ask the competent institutions.26

The Regulation being directly applicable in the national legal orders, specific implement-
ing rules are not strictly necessary from a legal point of view [even though compliance with
the Court’s teachings implies some national implementation].27 In several cases in which
they were called on to solve disputes relating to the cost of treatment abroad, Spanish judges
have directly applied the Regulation and refused to rely on the administrative circulars. In
France, the lack of a specific law or decree has led to ambiguous situations, where existing
national legislation could be said to be against the principles of the Regulation, resulting in
the fact that it was not always clear to social security institutions or judges if people could
claim rights directly from Article 22.28

Here we are going to present some more Member State practice. For example Slovenia,
according to the Slovenian practice there is a lot of scepticism regarding the free movement of
health services and cross-border health care. There is a strong feeling that it could undermine
the national health care system based on compulsory health insurance, considering the size of
Slovenia and the fact that the whole country could be considered as a border region. Main
concerns are related to the quality of health care provided abroad, the questions of continuity
of treatment and the protection against medical faults.

If it was interpreted [in competent institutions in the EU] that according to the rules on
the free movement of health services a person insured in Slovenia and residing in Slovenia
may choose a personal general practitioner (and other personal doctors the insured person has
to choose) in another EU MS, this interpretation would open many questions and cause many
problems. In the end it could result in a breach of the basic principle of equal treatment of
persons insured in the public health insurance in Slovenia and treated in Slovenia according
to the national legislation and rules and persons treated in other EU MS, who have the same
kind of health problems.

A recent problem which is more and more present in Slovenia is that pregnant women go
to private clinics in Austria or in other EU MS to give birth. They present the European
Health Insurance Card and the Health Insurance Institution [hereinafter: HII] is asked to
cover the costs. In cases when women are not staying in an EU MS, but go to a EU MS only
to give birth, the abuse of the rights by insured persons [Article 22.1.a of R 1408/71] and
abuse by the health care providers is quiet evident. In Slovenia there are sufficient obstetric
facilities in gynaecological and maternity hospitals in all geographical regions. All women in
Slovenia give birth in hospitals specialised for childbirth.

It should be also noted that in compliance with national rules the costs of childbirth in a
private clinic in Slovenia, which has not stipulated a contract of concession with the HII,
would not be covered by the HII.29

2.2. Conditions for granting prior authorisation

Although the conditions for granting differ, some general tendencies can be found. In many
countries prior authorisation may be granted only if the particular pathology cannot be treated

26 http://www.tress-network.org/TRESSAJAX/
27 Case C-56/01 [Inizan], at 48.
28 http://www.tress-network.org/TRESSAJAX/
29 Training and Reporting on European Social Security, Slovenian National Report 2006 by Anjuta Bub-
adequately in due time in the country concerned (Austria, France, Germany, Greece, Poland, Sweden and UK). However, in most cases, this concept is not further defined. Only a few countries explicitly determine the timeframe within which the treatment has to be provided domestically. In Denmark, a patient has a right to be treated in a non-public clinic or hospital established in Denmark or a hospital or clinic established abroad if necessary treatment cannot be provided within two months in the framework of the Danish health care system. This maximum waiting time will be further reduced to one month from October 2007 onwards. For life-threatening diseases, a maximum waiting time between two and four weeks is laid down. A provision is also made in Finland for maximum waiting time targets. For primary medical care, the need for a treatment must be assessed within three working days and the treatment must be provided within three months (which can be extended in certain circumstances with another three months). For specialised medical care, assessment of the required treatment must be accessible within three weeks from the date on which the referral has arrived from the primary care unit; the care must be provided within six months.30

In Spain, treatment abroad should be given when the claimant cannot obtain treatment within the time normally necessary. And this is precisely the problem in Spain, where a patient might have to wait several months for surgery. As medical practitioners and patients are not well informed about this possibility, the E 112 form is not used frequently.31

In several Member States, authorisation is only possible if it may be expected that the pathology can be treated more efficiently and effectively by medical institutions abroad (Austria, Estonia, Hungary, Malta) or if treatment has some probability of success (Estonia, Hungary, Ireland, Malta, Slovenia).

In more details, for example under Estonian legislation the conditions are even more precisely defined. According to Estonian legislation the following criteria are used, in which case the Health Insurance Fund may (but is not obliged to) give consent for medical treatment abroad: a) the health service applied for or alternatives to such health service are not provided in Estonia; b) provision of the health service applied for to the insured person is therapeutically justified; c) the medical efficacy of the health service applied for has been proved; d) the average probability of success of the health service is at least 50 per cent.32

In several countries, the granting of prior authorisation is subject to the condition that the treatment is part of the benefits package in the country concerned or is reimbursed by the country’s scheme (Belgium, France, Italy, Latvia, Malta, Portugal – although not explicitly laid down in the legislation of this country), but cannot be given in the country concerned (Belgium, Czech Republic, Estonia, Hungary, Ireland, Latvia, Luxembourg, Malta, Poland, Spain).

In Italy, the relevant rules provide that authorisation can be issued if the service cannot be obtained in a form that is suitable for the peculiarities of the clinical case and if the service requires specific professional skills or technical/therapeutic procedures that are not practiced or equipment that is not present in Italian public facilities. Likewise, in Luxembourg, one of the medical conditions for the granting of authorisation is that the provision in that country is inadequate and implies a complex treatment and diagnosis, the quality of which cannot be guaranteed in Luxembourg. Some countries make the granting of the authorisation contingent upon conditions of an administrative nature, on top of the medical conditions. Examples are Luxem-

bourg, where there are two different types of conditions (one type dealing with the form, i.e. the person who has to make the demand; and another type relating to the content, i.e. the provider designated must be a public provider) and Ireland, where treatment abroad must take place in a recognised hospital/institution and this hospital/institution should accept an E-112-form.33

In Ireland, the Health Service Executive (formerly health boards) makes a decision to authorise treatment abroad under provision of Regulation Article 22. It is understood that there are approximately 350 new referrals for treatment per annum under Article 22 (1) c, the majority of these to the UK. This does not take into account the number of individuals previously authorised who may have had repeat or follow-up visits which are about 1,000. One issued raised is that some women seek authorisation under article 22 to return to their home country to give birth. This is generally refused by the Irish authorities. While the Irish authorities are not obliged to grant such authorisation under EU law, some other countries do take a more flexible approach.34

In Slovenia, authorisation from the authorised body of the HII is necessary, based on the obligatory expert opinion of a body of doctors of the University Clinic. In 2006 there were 430 authorisations and referrals for treatment abroad in 2005. 13 insured persons had treatment abroad without authorisation and are claiming refunds from HII. The HII has analysed each case separately and decided that in 2 cases treatment abroad can be justified.

In Slovenia, urgent medical treatment and necessary medical treatment are defined in Rules on Compulsory Health Insurance.

According to the Rules on compulsory health insurance, treatment abroad for insured persons can be authorised if the available treatment in Slovenia has been concluded or treatment is not available, and it would contribute to the improvement of the health condition of the patient or prevent deterioration. An insured person can be referred for treatment abroad as well if treatment is not available in adequate extent in Slovenia (for instance due to long waiting lists). The problem in Slovenia is that there are no national waiting lists for different medical treatments (except for open heart surgery). Different hospitals have different periods of waiting. The patient has the legal right to choose the hospital in which s/he wants to be treated.35

2.3. The followed procedure

Most of the countries do not specify the procedure that has to be followed by an insured person to obtain prior authorisation. Apparently, this can happen in a rather informal way. In some countries, an attestation has to be appended to the request, issued by an academic hospital or another specific hospital, stating that the requested treatment abroad is needed and/or cannot be provided by domestic institutions (Austria, Czech Republic, Greece, Ireland, Italy, Latvia, Lithuania, UK) or that the treatment cannot be provided in due course (Denmark, Greece). Quite logically, this request will often imply the submission of documentation on the medical history of the patient concerned (Estonia, France, Germany, Hungary, Italy, Poland, Slovak Republic, Spain). In Ireland, the confirmation has to be given that the hospital or institution abroad will accept a form E-112 to cover the treatment or examination up to the level that would be covered for these medical acts there. In some countries,

33 http://www.tress-network.org/TRESSAJAX/
the foreign facility or institution where treatment will be provided has to be specified in the request [Italy, Poland, Spain]. In Hungary, the request has to be accompanied by a letter of acceptance of the foreign institution providing the medical treatment. In some countries, it is also explicitly provided that it will be the insured person’s medical consultant (doctor) who has to present the patient’s case to the competent institution or send the necessary forms [Luxembourg, Malta, Slovak Republic].

In follow up of some case-law, the Luxembourg competent institution UCM decided to inform, on Internet, the patients with a prior authorization for treatment in Germany, that supplement for first class hospitalization, called “Wahleistungen und Privatpatient”, mentioned under acronym “Goä” [which is “private treatment” not covered by social security] is not covered by E-112.

In Ireland a further issue concerns Czech persons working in Ireland but returning regularly (once a month) to their family in the Czech Republic. It is suggested that such workers may still be resident in the Czech Republic and that they should be able to have an E106 issued by the HSE [as Ireland is the competent state]. However, it is stated the HSE did not often issue an E-106 in such cases. It appears that the HSE asks all applicants from other EEA countries or from Switzerland to prove to its satisfaction that they are ordinarily resident in their home country and that they visit it at least once a week. To do so it asks them to produce receipts or evidence of weekly travel over a period of six months. While people may travel back to the UK on a weekly and sometimes on a daily basis, it appears that there are very few cases further a field in which the HSE accepts that residence still exists. It is not clear that the requirement to show a weekly visit to the home country is consistent with the Regulation. However, if a person from the Czech Republic was able to prove weekly trips back home as mentioned above, the HSE would issue the E-106.

2.4. Means of redress

In some countries, actions can be brought before the competent courts, either the social or civil labour law courts (Austria, Belgium, France, Germany, Latvia, Malta, Netherlands, Spain, UK) or the administrative courts (mostly after the refusal was first challenged before the relevant administrative institution) (Sweden, Lithuania, Italy, Greece). In other countries – before launching judicial proceedings (as the case may be), patients have to seek redress within the relevant competent institution (Cyprus: the permanent secretary and the ministry for health; Czech Republic: the general director of the health insurance fund; Denmark: the board for patients’ complaints; Hungary: the medical scientific council, which has to take a decision within 60 days of the submission of the redress; Ireland: the health service executive’s appeals officer; Italy: the general manager or even an extraordinary petition to the President of the Republic; Germany: the Health Insurance Fund; Latvia and Lithuania: the Ministry of Health; Luxembourg: the board of directors of the UCM within 40 days from the notification of the decision; the Netherlands: the insurance company or the Stichting Klachten en Geschillen Zorgverzekering; Slovenia: the health commission; UK: the Department of Health).

36 http://www.tress-network.org/TRESSAJAX/
39 http://www.tress-network.org/TRESSAJAX/
2.5. Timeframe for decision

The timeframe within which the competent institution has to decide on the application or authorisation differs.

In some countries, no specific timeframe has been defined other than the stipulation that the decision has to be taken within due delay (Belgium: although the relevant rule speaks of “immediate notice”; Cyprus; Czech Republic; Denmark: although this is mostly the waiting time; Finland; Greece; Ireland; Luxembourg; the Netherlands; UK).

Other countries do provide a particular timeframe, which, for some countries, is nothing else than the normal period for administrative procedures in general (Austria: in case of a claim for a formal decision, the health insurance body has to decide within two weeks; Estonia: decisions are normally taken within 30 days; Hungary: 30 days; Italy: 7 days; Lithuania: the relevant provisions applicable to all administrative authorities apply; Portugal: 90 days; Spain: 3 months; Slovak Republic: 30 days; Slovenia: 8 days; Poland: 7 days; and Malta: one month).40

In Spain, in case no decision is taken within the prescribed period, the request is deemed to be rejected.41

According to French law, a response must be given no later than 2 weeks after the receipt of the request. The decision must be taken within a period which is commensurate with the degree of emergency and availability of proposed treatments. This period of two weeks cannot be suspended for any reason. Even if the request is incomplete, unusual or necessitates a literature search, or if further information must be collected from the doctor who prescribed the treatment, the two-week period has to be respected.

Most of the countries mention that, notwithstanding these maximum periods, authorisations are most often delivered within a much shorter period.42

2.6. The certainty of prior authorisation

In most of the countries, decisions on the application for authorisation are taken on the basis of an individual assessment. Therefore, the possibility of prior authorisation is not a priori excluded in respect of certain types of medical treatment (Austria, France, Slovenia, Portugal, Hungary, Lithuania). In other countries, there are certain types of medical treatment for which prior authorisation cannot in any case be granted. This is the case in Belgium for treatments which are not included in the “nomenclature” or for which the conditions for reimbursement laid down in the national legislation are not met (see also Spain, Malta, Luxembourg). In Cyprus and the Czech Republic, no authorisation should be granted for treatment which is available in the country and for which there is no particular waiting list. In some countries, authorisation is refused where the medical treatment or examination concerned is not legally permitted, e.g. abortion (Ireland, Malta). Moreover, in some Member States, no prior authorisation will be given for care which is provided within the framework of clinical research or whose provision implies the use of experimental medical treatment technologies (e.g. Latvia, Estonia, UK, Poland). Several States refuse authorisation for alternative treatment (e.g. Denmark).

40 http://www.tress-network.org/TRESSAJAX/
42 http://www.tress-network.org/TRESSAJAX/
The Luxembourg legislation contains a list of six types of treatment for which no prior authorisation will be given, unless these treatments cannot be provided in Luxembourg without undue delay.\(^{43}\)

The Czech health insurance companies attempt to authorize the use of health care abroad (form E-112) as little as possible. Such attitude is understandable. Nevertheless in the Czech Republic until 2006 there were 23 requests for E-112, of which only 6 were refused, which means 70% of cases were approved. This would mean that when there is a case the insurance companies treat it in a benevolent manner.\(^{44}\)

2.7. The authorisation process for treatment which is not among the benefits provided by national legislation

Quite a number of countries grant authorisation for treatment which is not among the benefits provided for under their national legislation. This is the case, notably, in Czech Republic, Estonia, Hungary, Lithuania, Luxembourg, Poland, Portugal and the UK. Some countries do grant such authorisation, but only in respect of particular treatment and in specific circumstances, particularly the combination of high investment costs and low numbers of patients in need of the treatment concerned. In such cases, it would be extremely expensive to employ professional staff to perform these types of services. Moreover, for lack of a critical mass of patients, this staff would quickly become unskilled. This is the case, for instance, in Cyprus and in Denmark, where authorisation may be delivered for highly specialised, research-related or experimental treatment abroad of life-threatening diseases. The Italian legislation provides that a comparative assessment must be made between the Italian and foreign medical structures. Authorisation can be given if the foreign structures have superior features in relation to the standard criteria and definitions typical of the Italian system.

The fact that the legislation of some Member States lays down the principle that no authorisation may be granted for treatment outside the benefits package, should not automatically lead to the conclusion that, in these countries, forms E-112 are actually never delivered for these types of treatment. In practice, and in spite of the explicit terms of the applicable circular, the Belgian institutions exceptionally grant authorisation for treatment which is not as such within the Belgian benefits package. In those cases, rather than a literal reading of the “nomenclature”, a teleological interpretation is followed. Although the procedure of Article 22 (1) (c) should indeed not be relied on to circumvent the limitations of the “nomenclature”, there is a difference between treatment or pharmaceuticals which are consciously excluded from coverage and those which are just not – yet – included. The same problems can be encountered in France, where it is also emphasised that a clear-cut solution is difficult to be found. For the future, a line could be drawn between, on the one hand, pathologies which are not covered by the French social security scheme and for which treatments can never be refunded and, on the other, pathologies which are covered in France and for which treatment costs incurred abroad, although not in principle covered by the French scheme, may be assumed after prior authorisation and subject to certain conditions.\(^{45}\)

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2.8. Treatment appropriate to the patient’s condition

It seems rather difficult to determine when a treatment appropriate to the patient’s condition is or is not available in the country concerned, or is available abroad. A formal procedure or instruction is most often missing. It is basically up to the medical consultant or relevant institution to evaluate. As cases are in principle assessed on an individual basis, it is difficult to identify useful common criteria. Quite often a medical board of a particular hospital or specialised institution will issue a declaration or statement that it is unable to provide the requested treatment (Austria, Cyprus, Czech Republic, Hungary, Ireland, Italy, Latvia, Portugal, Slovak Republic, Slovenia, Luxembourg).

In some countries, treatments for some diseases might not be available for lack of sufficient cases (due to the small population) or because treatment facilities have not been developed due to the very specialised character of the treatment. The necessary human and technological resources to perform these treatments are missing. This is the case in, inter alia, Slovenia, Malta and Luxembourg.46

In Malta, available treatment abroad is considered when it is not experimental and there is evidence of a potential benefit for the patient. In Luxembourg, this is the case for complex treatment and diagnosis not available in Luxembourg under high-quality conditions. In Italy, in order to determine whether the appropriate treatment is available in the patient’s country, the greater or smaller therapeutic efficiency of the treatment delivered abroad compared with the same treatment delivered in Italian centres, is taken into account. In Greece, the appropriate treatment is considered to be available abroad in case there are hospitals or clinics abroad that are specialising in the seriousness of the illness.

The relevant evaluation criteria vary among the Member States. The Danish only look at the waiting time and availability as criteria. In Denmark it is emphasised that although the competent institutions have the responsibility to provide adequate and relevant treatment, they cannot be obliged to provide the most recent kind of treatment according to international medical science. It can indeed take some time for a new kind of treatment to become part of the benefit package. In Cyprus, previous experience with other patients’ treatments and statistical information is taken into consideration. The Czech Republic and Greece refer to all relevant criteria, as there is waiting time, effectiveness, safety, comfort, probability of success, possibility of return to work in process, quality, etc. Hungary, however, only considers the criterion of availability. In Italy, waiting time is taken into account, over and above the therapeutic efficiency plus, in case of experimental therapy, the case history and the chances of success. In Latvia, there appears to be no specific criteria, as it is an individual assessment by the doctor concerned. In Lithuania, two criteria are important: firstly, the available examination and the medical treatment in Lithuania were not successful and, secondly, the information that new methods of examination and treatment are applied abroad. In Luxembourg, safety and quality are the only relevant criteria. In Malta, the non-availability of the treatment on Maltese territory, its potential benefit and its being non-experimental constitute the relevant criteria. Portugal takes all criteria into account, whereas in the Slovak Republic the waiting time is the only crucial element. Also in Sweden, the waiting period is the decisive criterion. In Slovenia, account is only taken of medical elements. In the Netherlands, by care not given or not given in time, is also meant care that cannot be given in a qualitatively acceptable way in the neighbourhood of the place of residence of the insured person. The element of distance is therefore also taken into account.

For determining the legitimacy of the delay, both medical factors and generally accepted

46 http://www.tress-network.org/TRESSAJAX/
social standards of acceptability of waiting periods (on the basis of psycho-social, ethical and social factors) are taken into account.\textsuperscript{47}

2.9. The waiting time influence on authorisation process

It could be expected that the existence of waiting times, known in several countries, could influence to a great extent the granting of prior authorisation. As such, however, this factor not always impacts on the granting of an authorisation for treatment abroad. Quite surprisingly, many countries indicate that there is no direct correlation between the waiting time and the decision to issue or to refuse a form E-112. This is, for example, clearly the case in Hungary, Ireland, Italy, Latvia, Lithuania, Slovak Republic, Slovenia and Spain.

One explanation might lie in the fact that, if the public system cannot provide medical treatment in a reasonable time, the patient would be sent to the local private hospitals (Cyprus, Spain). Another reason might be that many patients still prefer to be treated near their homes and relatives, so that the option to go abroad is not considered to be very attractive.

A clear example where waiting time can have an influence is Denmark. There, the exceeding of the maximum waiting time guarantee of 2 months (one month in the near future) results in authorisation to go abroad. A similar system exists in Estonia for certain types of medical treatment. However, no cases have yet been reported where authorisation for treatment outside Estonia was granted due to the exceeding of the waiting time limit. Other countries, such as the Netherlands and Poland, also report a possible correlation. In Poland, the waiting time and its articulation with the health condition of the patient is a crucial argument for the authorisation of treatment abroad. Also the UK sees a possible correlation.\textsuperscript{48}

In Spain, a particularity is mentioned. There, a lot of EU-citizens request an E-112-form to be treated in their state of origin, not because the treatment they need is not available in Spain, but for their self-comfort and preference of doctors in the state of origin.\textsuperscript{49}

2.10. The criterias relied upon in assessing the application for authorisation

The criteria relied upon in assessing the application for authorisation are diverse, but overall medical criteria appear to be decisive in the different Member States. In Finland, Germany, Hungary, Poland, Portugal, Estonia and the UK, medical criteria are the only criteria used. But other elements could also play a role. The quality aspect is a factor of a growing importance in Belgium. If certain hospitals or medical centres abroad have developed a special expertise for a specific treatment, it is considered appropriate to send the patient to such hospital where, contrary to Belgium, the treatment concerned is applied on a routine basis. A special problem is mentioned in Belgium with respect to terminal patients, who are given up by Belgian doctors. Often, applications stemming from such patients concern very specialised treatment, which might be covered by the Belgian “nomenclature” in a couple of years’ time, but is now considered to be experimental. In Luxembourg, the fact that only one or two operations per

\textsuperscript{47} http://www.tress-network.org/TRESSAJAX/
\textsuperscript{48} http://www.tress-network.org/TRESSAJAX/
year are performed is considered to be a matter of quality and safety, leading to the conclusion that no appropriate treatment is available.

Other elements are the fact that the treatment abroad is to take place in a recognised hospital (Cyprus, Ireland), administrative reasons such as whether or not the treatment is among the benefits provided for by the national legislation (France, Greece, Ireland), the geographical and time-related accessibility (Czech Republic, the Netherlands), the possibility of return to work (Czech Republic, Sweden), the reasonable medical prognosis, the fact that treatment is regarded as a proven form of medical treatment and the potential benefit for the patient (Ireland, Malta, Latvia, Slovak Republic).

2.11. Considerations other than of a purely medical nature

Several countries only take account of considerations of a purely medical nature (Belgium, Estonia, Greece, Hungary, Ireland, Italy, Lithuania, Portugal, Slovak Republic, Slovenia, Spain), whereas in certain other countries, other considerations might also be taken into account. In Austria and in Cyprus, contrary to Luxembourg, distance and lower costs are taken into account. In Latvia, the economic expenditure of the treatment is considered. Certain countries also look at social factors, such as Denmark or Luxembourg, where the element of having a treatment closer to his or her family is considered in certain circumstances. Prior authorisation would for instance be given to a foreigner who works in Luxembourg, who is single and who is living alone, where he/she has to undergo a major operation. In the Belgian report, it was clearly emphasised that the sickness funds regretted the lack of “social-cultural” criteria (such as language, family proximity and distance) in the Regulation. Spain reports that in Andalusia, patients frequently asked for an E-112-form because they want to be treated in their country of origin. Provided the application is accompanied by a doctor’s report, the authorisation is always granted.

In Latvia, problems may arise because Latvian legislation guarantees a very broad scope of health care services. The Basic Care Programme (the health care minimum) defines a basket of health care services to be guaranteed and covered by the state health care budget. The Basic Care Programme includes emergency care, treatment for acute and chronic diseases, prevention and treatment of sexually transmitted diseases and contagious diseases, maternity care, immunization programmes, provision of pharmaceuticals free of charge for entitled groups. However, in practice the state is not able to ensure the provision of all formally guaranteed services due to limited resources. There are long waiting lists for some form of treatment, for instance for endoprosthesis. Under Regulation 1408/71 the authorization may not be refused where the person cannot be given a treatment within the time normally necessary for obtaining the treatment in question taking account of his/her current state of health and the probable course of the disease.  

The Swedish system is not a reimbursement system and there is no “free movement of patients” even within national territory. As a general rule, Swedish patients cannot go to a medical institution in another Swedish county to seek better or prompter care than that provided in their own “health care area”. Existing ‘guaranteed care’ (vårdgarantier) is offered within the ‘planned system’ of public services and pre-contracted private services. The Swedish authorities have interpreted Article 22.1 (c) of the Regulation in a narrow way. Permission to receive medical treatment abroad can be granted only if it is included in the

Swedish medical service package, but for some reason cannot be provided within normal waiting time in Sweden. The possibility to be granted medical care outside of the package, i.e. on the grounds that the medical care is different and better in the other Member States is even more difficult.\(^{51}\)

The Greek report mentions the following problem. In some Member States doctors in public hospitals (surgeons, in particular) have, to a certain extent, the discretion also to provide services in a private capacity [applying private tariffs] in parallel with their main functioning as care providers contracted with the sickness insurance system [within a contracted establishment]. When the patient is authorized by a Greek competent institution to go to one of these public hospitals of another Member State to receive there the treatment appropriate to his or her condition, very often the person receives treatment as a private patient. Usually, that situation is due to the fact that either there is an a priori agreement between the patient and the doctor involved (the ‘specialist’) for the specific treatment required [in the form of fixed appointments] or the patient is referred by the hospital’s administration [emergency cases].

In Greece, the Ministerial Decree on ‘treatment abroad’ explicitly precludes authorized treatment being provided in private establishments, emphasizing priority to the Regulation mechanism, i.e. the proposed treatment must be covered by the sickness insurance scheme of the other Member State, except for cases concerning ‘children’. However, given that in many cases the proposed treatment, although provided under a non or partially contracted status, is deemed appropriate for the patient, Greek competent institutions either refused to follow the authorization administrative procedure or were disposed to cover only the costs respectively born by the institution of the place of stay. In those cases, appropriate treatment abroad was no longer feasible, since the patient could not afford to bear the large part of the total costs.\(^{52}\)

In Slovakia, the main issue in the area of benefits-in-kind of medical insurance in the past year has been the question of priority of individual rights to healthcare social security over the derived/secondary right to healthcare. The reason was that dependent family members of a migrating worker, who have residence in the Slovak Republic, or the dependent family members of a pensioner receiving a pension from another Member State, who have residence in the Slovak Republic, have the right to be state-insured in the public system of medical insurance. This individual right had precedence over their derived right as family members of employed persons. This approach has since been abandoned since it created chaos with respect to other systems of social security.\(^{53}\)

## 2.12. The decision-making body

The decision as to which provider will supply the treatment abroad, is in most cases made by the relevant competent institution, like the sickness funds, the regions, the health service executive or the ministry. However, as a rule, it is the treating medical provider or the medical consultant who proposes the doctor [notably in Austria, Belgium, France, Estonia, Luxembourg, Malta, Slovak Republic, UK].

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Several countries mention that the academic or non-academic character of the hospital or the legal status of the provider (public or private) does not play a role (Czech Republic, Finland, France, Greece, Denmark, the Netherlands, Spain). In Luxembourg and the UK, the patient can be referred to a private provider in exceptional cases only. In case of a complex treatment or diagnosis which cannot be performed in qualitatively sound conditions in Luxembourg, an academic hospital or a specialised institution abroad must be designated.

3. Obtaining information by the patients

Usually, concrete information on the procedure of Article 22 (1) (c) of the Regulation or on treatments and providers in other Member States is provided either on the websites of the competent authorities and institutions like the health insurance funds, the ministries of health or labour and social protection. However, it seems to be essentially the treating doctor or hospital that provides the necessary information. In some countries this information is not always communicated to the insured persons immediately. In Austria, for instance, in many cases information appears to be given only on request. In France, no official information is available. Patients are therefore rather informed via unofficial ways of communication. A specific “caisse primaire”, located in Vannes, is now in charge of nationally centralising the service of benefits in kind in cases of cross-border care, which could be a source of institutional information.54

4. The influence of the ECJ case law on patient mobility policy with respect to issuing E-112 forms

The impact of the ECJ case law of patient mobility with respect to the issue of the E-112 forms is rather difficult to assess. Many countries, however, are of the opinion that the impact is rather limited, notably in the light of the fact that the national legislation already provided for similar possibilities [Austria, Belgium, Malta, Portugal, Germany, Latvia, Lithuania, Luxembourg]. Some countries only mention the relatively low number of people that make use of E-112 [Denmark, Finland], despite a slight increase [France, Germany, Luxembourg, Denmark]. There are many ECJ cases dealing with cross border issues. Because of the space limitation this paper is highlighting only three of the landmark cases: 1) Vanbraekel, 2) Keller and 3) Watts.

4.1. The influence of the ECJ judgement in Vanbraekel

The Vanbraekel-judgement has always been considered as one of the most difficult cases. According to this judgement, the competent institution should pay E-112-holders an additional reimbursement, covering the difference between the [lower] amount which that institution is required to bear under Article 36 of the Regulation and the [higher] amount which it would have borne if the treatment in question had been provided in the national territory.

54 http://www.tress-network.org/TRESSAJAX/
Almost all countries mention that they comply with the Court’s judgement in Vanbraekel. Some countries, such as Austria and France, have issued specific guidelines on this case. Other countries argue that this issue is not arising, due to the fact that their system does not have reimbursement rates. In Ireland, when patients are referred for treatment abroad, payment is made directly by the health service executive, rather than by the patient; thus, the Irish contend, no reimbursement arises. The same can be said of Spain. Several other Member States mention that it is not necessary to apply this case law as the costs of the health care services in their country are very low and the issue of additional reimbursement thus has not yet arisen [Estonia, Finland, Hungary, Latvia, Lithuania].

4.2. The influence of the ECJ judgement in Keller

In Keller case the European Court of Justice has ruled that medically necessary treatment outside the EU must be reimbursed for the holders of valid E-111 and E-112 forms.

The ECJ judgement addressed the situation of Annette Keller, a German national resident in Spain who arranged for a one month E-111 form to cover a trip back to her home country. During that period, she was diagnosed with a malignant tumour and required medical treatment. Ms Keller requested and was issued with an E-112 (extended several times), Spanish health system issued her with an E-112 form to cover the costs of her treatment in Germany.

The doctors treating Ms Keller decided that she needed care at a specialist clinic in Switzerland and she consequently underwent an operation in Zurich. Ms Keller paid the €56 300 cost of the treatment and asked her Spanish health insurer to reimburse these expenses.

The insurer refused because they had not been consulted by the German doctors about the decision to seek treatment in Switzerland and said that they should have had the opportunity to provide alternative options.

Ms Keller died in 2001 and her family challenged the Spanish insurers in the national courts which referred the case to the ECJ. The ECJ ruled on 12 April 2005 that the Spanish insurers should pay for the cost of the treatment.

The court stated that the doctors treating the patient are best placed to assess the treatment needed and that the health insurance structure of the home country places its confidence in the host country’s institutions, that the doctors have the same levels of professional competence as the home country. Therefore, the home country is bound by decisions of the doctors treating the patient. If the host country doctors decide to send the patient outside the EU for urgent treatment that they cannot provide, the home country insurance must accept their judgement and pay for the treatment.

The ECJ also re-stated the principle that in the case of a decision to send the patient outside the EU for treatment, it is the host country (e.g Germany) that would cover the cost of treatment in the same way that it pays for its own citizens. Afterwards, the host country is reimbursed by the home country, in this case Spain.

Since Ms Keller had paid for the treatment in Switzerland herself, the ECJ ordered the Spanish health insurance to reimburse her family.

55 http://www.tress-network.org/TRESSAJAX/
56 Judgment of 12 April 2005 in case C-145/03, Keller, [2005] ECR I-2529. In this case the patient had the authorisation of Article 22 of Regulation 1408/71, but presumably [in view of the parallelism established by the Court in Inizan and Watts] the same solution would apply if she had the authorisation which may be given under Article 49 EC.
57 http://www.epha.org/a/1794
4.3. The influence of the ECJ judgement in Watts case

In UK the Watts case\footnote{Case C-372/04 The Queen, on the application of: Yvonne WATTS v Bedford Primary Care Trust and Secretary of State for Health.} had an influence on the NHS’ attitude of prior authorisation. In the Watts Judgement the Court ruled that:

a) Its case law relating to patients seeking hospital treatment in another European country applies to the UK’s National Health Service.

b) Health systems can justify the use of systems of prior authorisation before patients go abroad for treatment in hospitals but that authorisation cannot be refused – and healthcare costs must be refunded – when the home health system cannot offer the service without ‘undue delay’.

c) Criticised the NHS for not having clear criteria for managing its prior authorisation systems.

In response to the Court’s criticism that the NHS lacks clear criteria for managing its prior authorisation procedures, the Department of Health announced that it was working with the NHS to develop detailed guidance to local healthcare commissioners on managing requests for treatment overseas.

The guidance for managing requests for treatment overseas\footnote{Department of Health, Patient Mobility: Advice to Local Healthcare Commissioners on Handling Requests for Hospital Care in other European Countries following the ECJ’s Judgment in the Watts case.} which was published on 16\textsuperscript{th} April 2007 sets out the following key principles:

a) Healthcare commissioners can [and should] set up systems for considering requests from patients for authorisation to go abroad for treatment which in the UK is provided in hospitals.

b) A commissioner is entitled to refuse to pay for healthcare services that are available in other Member States but that it does not offer to patients in the UK. A commissioner is entitled to refuse to authorise a request for treatment that it does not fund, even if that treatment is funded elsewhere in the UK.

c) If a commissioner agrees that a patient should be offered treatment on the NHS, and if that treatment is not available without ‘undue delay’ in the NHS, then the patient is legally entitled to go elsewhere in the EU for that service, and can request either E-112 or Article 49 authorisation.

d) Under the case law developed by the European Court in the Watts case (Article 49), commissioners are only required to refund up to the costs of treatment in the UK. If treatment costs elsewhere in the EU are higher than those in the UK, then the patient must pay the difference [Department of Health, Patient Mobility: Advice to Local Healthcare Commissioners on Handling Requests for Hospital Care in other European Countries following the ECJ’s Judgment in the Watts case].

These key principles are followed by more detailed guidance,\footnote{Department of Health, Patient Mobility: Advice to Local Healthcare Commissioners on Handling Requests for Hospital Care in other European Countries following the ECJ’s Judgment in the Watts case.} which includes:

a) Healthcare commissioners’ decisions about what constitutes ‘undue delay’ must be based upon a clinical assessment of the individual circumstances of the patient, and this assessment must be kept under review while the patient is awaiting treatment.

b) Where commissioners have ‘prior authorisation’ processes in place for handling requests, they can normally refuse to refund treatment costs to patients who go abroad for treatment without seeking prior approval, except where the patient faces undue delay.
c) The guidance acknowledges that there may be exceptional circumstances where commissioners will be prepared to agree a request for a service that is not otherwise funded: this must be determined on a case-by-case basis. In these circumstances, it is unlikely that ‘undue delay’ will, in practice, be a consideration.
Where the patient does not face ‘undue delay’, there is no requirement to authorise treatment outside the UK. However, the guidance states that it is good practice for commissioners to consider the best interests of the patients and points out that they should also bear in mind that an unjustified refusal where the patient does not face ‘undue delay’ might nevertheless infringe EU law.
In addition it must be ensured that patients can appeal against decisions made on requests for treatment in other European countries. Currently, the only means of challenging such a refusal is by way of judicial review.

5. AUTHORISATION OF HEALTH CARE TREATMENT IN ABROAD UNDER THE HUNGARIAN LEGISLATION

5.1. The relevant Hungarian legislation in force

1. Act LXXXIII of 1997 on the Services of Compulsory Health Insurance (Article 28 and Article 83 para (2) d). According to Article 28 of Act LXXXIII of 1997 the insured shall be entitled to medical treatment not available in Hungary in foreign countries – excluding the insured entitled to health services on the basis of an agreement – at the expense of the National Health Insurance Fund. The order of the support is regulated by Government Decree No. 227/2003 (XII. 13.).
2. Government Decree No. 227/2003 (XII. 13.) on Certain questions related to medical treatment abroad. This will be discussed in detail later in this paper. This is the core legislation relating to the topic.
3. Administrative circular: According to the other Member States practice it could be useful, but there is no special administrative circular in the Hungarian National Health Insurance Fund.

5.2. The conditions for granting prior authorisation

According to Article 2 (1) of Government Decree No. 227/2003. (XII. 13.) the National Health Insurance Fund Administration [hereinafter NHIFA] may support the foreign medical treatment of a person entitled to medical treatment abroad if the person entitled to medical treatment abroad has the supporting proposal:
a) from the institution with national authority concerning the type of the disease and the necessary treatment, functioning in the given field of medicine as a curative-preventive, organizational-methodological, further education and scientific-research basic institution [hereinafter: National Institute] or in the absence thereof
b) from the National Supervisory Methodology Centre [Országos Szakfelügyeleti Módszertani Központ].
The above rules shall be applied with the reservation that if the treatment abroad is realized through the application of the Coordination Regulation [hereinafter: Regulation], the costs of
the medical treatment abroad shall be reimbursed by NHIFA pursuant to the rules of the Regulation.

Medical treatment abroad is justified if the treatment already provided abroad has proved to be effective in clinical practice and the treatment has a probability of success, moreover, if the conditions of providing the treatment do not exist in Hungarian health care institutions and cannot be created with the participation of an invited foreign specialist either.

If medical treatment abroad is justified, the professional board shall propose the foreign health care institution, in the course of which it gathers information regarding the institute's hosting capacity, the date of admission, the expected duration of the medical treatment and the costs incurred in connection with the medical treatment.

The professional medical proposal for treatment abroad, the letter of acceptance of the foreign health care institution and the cost estimate shall be forwarded by the professional board to NHIFA.

The person entitled to medical treatment abroad or his/her relative may also forward the professional medical proposal for medical treatment abroad, the letter of acceptance of the foreign health care institution and the cost estimate directly to NHIFA.

5.3. The procedure to obtain prior authorisation

5.3.1. Submission of proposal

The proposal for the support of medical treatment abroad may be submitted to the director of the National Institute:
1. by the person entitled to medical treatment abroad,
2. by his/her relative or
3. by his/her treating doctor.

The medical documentation of the person entitled to medical treatment abroad has to be attached to the application.

5.3.2. Justification for medical treatment abroad

It can be decided exclusively on the basis of medical considerations. In this segment of decision making process financial conditions are not considered.

The justification for medical treatment abroad is stated by the board set up in the National Institute or by the board summoned by the national supervisor concerned according to the type of the disease or the necessary treatment (hereinafter together: professional board). The decision about the justification for medical treatment abroad is made by the professional board within 30 days of submitting the application.

Medical treatment abroad is justified if:
1. the treatment already provided abroad has proved to be effective in clinical practice and
2. the treatment has a probability of success, moreover
3. the conditions of providing the treatment do not exist in Hungarian health care institutions and cannot be created with the participation of an invited foreign specialist either.

The professional board, having considered the existence of the above criteria of the entitled person's examination and justification, states the justification for medical treatment abroad or refuses the application. The reasons for refusal shall be given in writing, and a national health care institution providing further treatment as well as therapeutic methods shall be proposed.
The patient’s treating doctor or the doctor who participated in previous treatment shall not be the member of the professional board.

In case medical treatment abroad is justified, the professional board shall propose the foreign health care institution, too. The proposal for medical treatment abroad, the letter of acceptance of the foreign health care institution and the cost estimate shall be forwarded to the NHIFA by the professional board, but the entitled person or his/her relative may also send them directly.

Having considered the circumstances related to the examination of the person entitled to medical treatment abroad and to the efficiency of treatment (the treatment already provided abroad has proved to be effective in clinical practice and the treatment has a probability of success, moreover, the conditions of providing the treatment do not exist in Hungarian health care institutions and cannot be created with the participation of an invited foreign specialist either), the professional board:
a) states that the medical treatment abroad is justified, or
b) refuses the application. The reasons for refusal shall be given in writing, and a national health care institution providing further treatment as well as therapeutic methods shall be proposed.

The person entitled to medical treatment abroad shall, within 30 days of returning to Hungary, a) send one copy of his/her final report and the invoices he/she received to NHIFA, b) settle accounts for the travel expenses received with the competent NHIFA.

The NHIFA or the person entitled to medical treatment abroad or his/her relative (Civil Code, Para b) of Article 685) shall send the copy of the final report within the deadline to the professional board stating the justification for medical treatment abroad, which shall provide care – with the participation of the regionally and professionally competent institute – for the returning patient.

Cost of control examination: NHIFA shall decide – upon a separate application – about assuming the costs of control examinations ordered by the foreign health care institution in connection with the permitted medical treatment abroad. The proposal of the professional board need not be obtained repeatedly in case of an application for a control examination within one year.

5.3.3. Letter of acceptance

In addition to the supporting proposal of the National Institute, the letter of acceptance of the foreign institution [hospital, clinic] providing medical treatment shall also be obtained. The Hungarian National Institute shall propose the foreign institution which may provide medical treatment abroad, or the Hungarian National Institution shall choose the foreign institution providing medical treatment.

Naturally, the patient himself/herself may look for a foreign institution which can provide the necessary treatment and is willing to receive him/her.

5.4. Application for support

The patient shall submit the supporting medical-professional proposal and the letter of acceptance of the foreign institution to the International Main Department of the National Health

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62 When the Regulation is applied, the obligation to hand over invoices ensuing from Para a) of Section (1) of Article 7 need not be applied.
Insurance Fund Administration. Here a form shall be filled in as the first step of applying for support. [The staff of the International Main Department provides the patient with the form, which is filled in on the spot.] A certificate of the patient’s earnings/financial position shall be attached to the form. The National Health Insurance Fund Administration shall decide on the extent of the support on the basis of the application.

5.5. **Travel abroad**

The professional proposal of the National Institute shall include suggestions about the manner of travelling abroad (e.g. by ambulance or with some other means of transport, alone or with a companion). If the patient travels to the place of treatment with a companion, the National Health Insurance Fund Administration shall support the companion’s travel expenses to and back only.

Travelling abroad may take place in the following ways:

- In case of travelling by train, the National Health Insurance Fund Administration shall reimburse the price of a second-class railway ticket for the patient and for his/her companion from the place of residence in Hungary to the place of medical treatment and back.
- In case of travelling by car – independently of the number of companions – the price of one second-class railway ticket shall be reimbursed by the National Health Insurance Fund Administration.
- If transportation by ambulance is necessary, the National Health Insurance Fund Administration shall organize, with the help of the Alarm Centre of the National Ambulance Service, transportation to and back, the entire cost of which shall be borne by NHIFA.
- The plane ticket for economy class shall be ordered and given to the patient and to his/her companion by the National Health Insurance Fund Administration.

In case the travel costs were advanced by the National Health Insurance Fund Administration, accounts shall be settled within 30 days of returning home and the actual expenses related to travelling shall be certified with invoices.

5.6. **The redress for denied prior authorisation**

A redress can be addressed to the Medical Scientific Council (Egészségügyi Tudományos Tanács) by the entitled person or by his/her relative in case of disagreement with the decision of the professional board. The redress, including all relevant medical documentation, should be submitted to the Medical Scientific Council, which will make a decision within 60 days of the submission of the redress.  

**Summary**

High-quality health services are a priority issue for European citizens. Health systems and health policies across the EU are becoming more interconnected than ever in the past. This is due to many factors, including movement of patients and professionals (facilitated by rulings of the European Court of Justice), common public expectations across Europe.

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In this article two main topics were dealt with: 1) Cross-border health care under the Coordination Regulation [Article 22 of 1408/71/EC Regulation], and the Hungarian national regulation relating to health treatment in abroad.

Nowadays, Community law offers citizens two different ways of making their social security institution pay for the cost of health care which they received in another Member State. These are: 1. cross-border health care under the Coordination Regulation [Article 22 of 1408/71/EC Regulation] and 2. the Treaty-based method of cross-border health care.

In addition, the European Court of Justice on several occasions has interpreted the Regulation in an extensive manner, so as to regulate issues not directly covered under the provisions of the Regulation. The activist approach of the Court has led the Council to amend the Regulation on several occasions, proceeding thus, at the reversal, by legislative means, of the Court’s case law. However, the first part of the article deals only with the above mentioned first topic (coordination-based cross border health care) with special regard to the Member States' practice and discusses briefly some relevant ECJ decisions (Vanbraekel, Keller and Watts). From the national reports it appeared that the interest of the cross border health care is gradually increasing almost every Member States.

The second part of the article deals with the relevant Hungarian national legislation. Regarding the Hungarian legislation for the procedure of authorisation for planned treatment abroad, the procedure can be introduced by the person in question by his/her relatives, and by the doctor who is treating him/her. It is a procedure of two levels, which means that first the person concerned needs the supporting certificate of the nationwide medical institution competent according to the type of the disease. The National Health Insurance Fund can give financial support – issue the form E-112 as base for the reimbursement – only on the grounds of the medical supporting certificate. At the competent nationwide institution a medical committee is set up for these issues. Against the decision of the nationwide medical institution the person concerned can contest to the Medical Science Council. Because of this special procedure - which starts at the nationwide institutes, the National Health Insurance Fund has no statistics on the refused/contested requests.

**ZUSAMMENFASSUNG**

Das europäische Gemeinschaftsrecht regelt grundlegend den Binnenmarkt, das Gesundheitswesen gehört zur Zugehörigkeit der einzelnen Mitgliedstaaten, aber solche Regelungssysteme wurden in der Hinsicht des freien Personenverkehr angenommen (die Koordination des sozialen Sichersystem), die sich auch auf die Gesundheitsleistungen auswirken.

Die Debatten über die Anwendung der Binnenmarktsregeln in Bezug auf Zugang zur Gesundheitsversorgung in anderen Mitgliedstaaten haben effektiv erst im 1988 nach den Urteilen der Europäischen Gerichtshof (Kohll und Decker) begonnen.

Die Verordnungen über die Koordination der sozialen Sicherheitsystems [Nr. 1408/71/EU und Nr.574/72/EU] wurden früher für den einzigen solchen Gesellschaftsmechanismus betrachtet, die die Krankenbehandlungen im Ausland ermöglicht (abgesehen von der Behandlung auf eigene Kosten)
