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Part One – **INTRODUCTION**

Health policy has traditionally been an area governed principally by the law of individual member states. There is a general consensus among the member states and also the European Union (EU) institutions that this should not fundamentally change in the future.

Despite a general acceptance of that principle, member states had also to realise that establishing an internal market – i.e. freeing the movement of goods, persons and services - requires at least to some extent a common approach – be it through the coordination of national policies or, in specific cases, even through harmonisation.

Healthcare is no exception. Already the original version of the EC Treaty acknowledged such a need. First, it called for a coordination of the national social security systems at Community level in order to avoid that using the freedom to move would entail a loss of the migrant worker's social security rights. Second, it enabled the Community to provide for the mutual recognition of national qualifications, including those giving access to health professions, to allow also healthcare professionals to practice in another member state than their own.

Although healthcare issues were thus never entirely excluded from the scope of Community action, they were traditionally only addressed by the Community as to facilitate the movement of *persons* (such as workers, self-employed, service providers and recipients, tourists, students, pensioners etc.).

The issue of cross-border healthcare *services* as such emerged only quite recently. In fact, during the 1990s patients started increasingly – and successfully – to rely on the freedom to receive cross-border services recognised by the European Court of Justice (ECJ) when claiming coverage by their national social security system for the costs of healthcare treatment received abroad.

The judicial recognition of the patients' right to seek healthcare services abroad (*patient mobility*) raises important questions regarding its practical application. Furthermore, if that right is not closely circumscribed and will at the same time be used on a larger scale, it will have important consequences for the management and funding of the different national healthcare systems.

A systematic 'opening' of such complex systems, which are generally based on the principles of closure and solidarity as defined within the political and economic context specific to each individual member state, will require a profound reorganisation and probably also involve liberalising effects. On the one hand, such a development might well help to improve in the long run the overall quality of healthcare services offered in the EU, and perhaps also stimulate the development of that sector. On the other hand, there is also a risk that this comes at the price of high social and political 'adaptation costs', in particular if such an improvement entails increasing (public and, at least indirectly, private) health budgets. It is thus not surprising that Commission has experienced considerable difficulties in coming up with a comprehensive legislative proposal.

Due to the limited length of a 'standard briefing' we have been required to select some of the most important issues relating to the health services in the EEA. The following Part Two of this paper describes thus briefly the most relevant legal provisions governing *patient mobility and cross-border treatment* and outline its potential impact on the member states' competences in the field of healthcare. Part Three summarises the position taken by the Council, the initiatives taken by the Commission and the work done by the EP in this field. Part Four draws some conclusions.

Part Two - **LEGAL FRAMEWORK AND ITS IMPACT FOR MEMBER STATES**

Although health policy, including healthcare, has traditionally been an area governed principally by the law of individual member states, a number of Community legal provisions (section 1) have a direct and indirect impact on the organisation and financing of public healthcare systems (section 2).

1. Current Legal Framework

Directly Title XIII EC Treaty entitled "Public Health" details the Community's role in coordinating and complementing member states actions in this field (1.1).

As already mentioned, the key provisions for patient mobility and cross-border treatment are those coordinating the national social security systems and in particular Article 49 EC Treaty ("Freedom to Provide Services") as interpreted by the ECJ (1.2)

Healthcare being indirectly affected as an economic activity, it is also subject to other EC rules on the single market, including state aids, public procurement, mobility of professionals and even private (anti-trust) competition law which cannot be addressed here. Furthermore, there are also other aspects of EC law and policy having an important impact on the provision of healthcare and may be taken into account in any future legislative proposal[1]. It is worth noting at this stage that healthcare is excluded from the controversial 'Services Directive'[2].

Finally, the Treaty of Lisbon incorporates Article 35 of the Charter of Fundamental Rights stating a fundamental right to receive healthcare (albeit under the conditions established by the member states). A new provision contained in the same Treaty dealing with "services of general interest" may also have an impact in the event of the eventual Treaty's ratification and entry into force.

1.1 Public Health (Title XIII EC)

Title XIII EC contains a single article, Article 152 EC. Two paragraphs are relevant for Community action in the field of cross-border healthcare. Firstly Article 152§1 allows and indeed requires the Community to take into account public health

[1] For an overview of the Commissions strategy on health see Commission Staff Working paper Together for Health**:** A Strategic Approach for the EU 2008-2013, COM(2007) 630 final

[2] See Article 2(f), Directive 2006/123. Healthcare was originally to be covered in Article 23 of the Directive but was removed during the legislative process.

considerations in the formulation of other pieces of legislation that may not have as their primary aim healthcare promotion or provision.[3]

Secondly Article 152§5 states that the Community shall respect the role of member states in the areas relating to healthcare. This however does not exempt the sector from the need to be compatible with other policies of the Community; notably the internal market[4].

It is interesting to note the changes that the Treaty of Lisbon brings to Title XIII; In particular the replacement of Article 152§5 by a new Article 152§7 stressing that "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". It is unclear what the legal impact of this particular change might be but it appears to rule out any Union action directly harmonising health policy or provision of health services from a European level.

1.2 Internal Market

There are two main provisions of relevance to the cross-border provision of health services namely Article 22 of Regulation 1408/71[5] and Article 49 EC on the free movement of services.

i. Regulation 1408/71[6]

Regulation 1408/71 is intended to facilitate migrants. It allows for emergency treatment abroad and non-emergency treatment subject to prior authorisation at the discretion of the home member state. A health care authority may not refuse such authorisation if two conditions are satisfied namely that the treatment is a treatment normally available under the legislation of the Member state of residence and secondly that the treatment is not available within a time limit that is medically unjustifiable.

ii. Article 49 EC – Freedom to Provide Services[7]

The free movement of services is one of the four "Fundamental Freedoms" that form the Internal Market[8]. Article 49 EC provides that restrictions on the freedom to provide services between member states are to be forbidden. The freedom to provide services implies a freedom to receive services[9]. In the context of health services this

[3] Such as under Article 95 EC for the Internal Market or Article 42 EC for the coordination of social security measures.
[4] This has been stated by the Court on a number of occasions. See C-385/99 *Muller-Fauré* (para 102), C372/04 Watts (paras 146, 147)
[5] This has now become Article 20 of Regulation 883/2004, without there being any change to the wording of the article.
[6] Integrated into the EEA Agreement by Annex VI, point 1. In interpreting this provision in relation to the EEA the EFTA Court has made reference to recent ECJ case law on Regulation 1408/71 EC see Case E-5/06 - EFTA Surveillance Authority v The Principality of Liechtenstein (para 61). See also E-3/05 - EFTA Surveillance Authority v The Kingdom of Norway
[7] The corresponding article, using virtually identical language, is contained in Article 36(1) EEA. As is common practice in interpreting his provision the EFTA Court has drawn extensively on the case law of the European Court of Justice e.g. E-1/06 EFTA Surveillance Authority v The Kingdom of Norway.
[8] The others being the free movement of persons, goods and capital.
[9] See Cases 286/82 & 26/83 *Luisi and Carbone v. Minestero del Tesoro*

implies that any rule of national law that has the effect of making the provision of services between Member states more difficult than in a purely national context is prohibited by Article 49 unless justified[10].

This general rule applies to all healthcare regardless of how it is organised and financed and whether it is hospital treatment or outpatient treatment[11]. An individual is thus entitled to access medical care in other member states based on the same conditions as in her own member state[12]. This is also true in the area of tariffs. Hence a patient receives the same coverage she would receive under the legislation of her own member state regardless of the coverage granted under the legislation of member state where the treatment is carried out[13].

As stated above refusal to pay for services received abroad or making payment subject to prior authorisation is a restriction on the freedom to receive services and is *prima facia* illegal. Such a restriction may be maintained in the light of over-riding considerations in the general interest[14].The Court has found however that such public interests only justify prior-authorisation in relation to hospital care and not out-patient care.[15]

iii. Relationship between Regulation 1408/71 and Article 49 EC

The Court has had occasion to clarify the relationship between the two legal provisions.[16]. Essentially Article 22 (c) expands on the rights already contained in Article 49 EC rather than limits them. On the one hand, under Article 49 an individual may receive medical services in other member states without prior authorisation but must pay for them and then seek subsequent reimbursement from his home health system on the basis of tariffs determined by his own Member state. On the other hand individuals who obtain prior authorisation via the Regulation are covered as if they were insured in the member state of treatment: the full cost of the treatment received is directly paid by the home authority to the provider[17].

[10] See C-158/96 *Kohll* (para 33)
[11] This general rule applies to both contributions based systems (C-157/99 *Geraets-Smits & Peerbooms*) and tax based national health systems (Such as Ireland, the UK and many Mediterranean states, C-372/04 *Watts*). The organisation of the benefits for the health system is also irrelevant; thus refund based systems and benefits in kind based systems are both subject to Article 49(For taxation based benefits-in-kind system see C-372/04 *Watts.* For an example of an insurance/contribution based benefits-in-kind system see C-157/99 *Geraets-Smits & Peerbooms*). Equally Article 49 applies to both hospital based care (C-157/99 *Geraets-Smits & Peerbooms*) and non-hospital or outpatient care (C-158/96 *Kohll*).
[12] Such as the requirement to be referred by a general practitioner. See *Muller-Fauré*
[13] See *Watts* paras 130, 131. This is also true of travel and accomodation (other than hospital) expenses.
[14] such as the need to avoid the "risk of seriously undermining the financial balance of the social security system" (CC-158/96 *Kohll para 41*), the maintenance of a balanced medical and hospital service open to all (*Watts note 4)* and the maintenance of treatment capacity or medical competence on national territory as essential for the public health (*Muller-Fauré note 4 para 67)*[14].
[15] See See C-385/99 *Muller-Fauré & van Riet*
[16] In particular see C-56/01 *Inizan* paras 83-85.
[17] For a lucid explanation see Dawes 'Bonjour Herr Doctor': National Healthcare Systems, the Internal Market and Cross-border Medical Care within the European Union' LIEI 33(2): 167-182, 2006.

2. Impact on National Competences

This legal situation has, in principle, significant implications for the organisation and funding of national health systems. Their precise extent depends, however, upon several factors.

2.1 Financial and Administrative Obligations

i. Emergency Treatment

Article 22 of Regulation 1408/71 imposes an obligation on a health authority to reimburse directly to the treatment provider in the host member state all costs incurred in relation to emergency treatment of its residents whilst abroad who possess an EHIC. This cannot be made subject to any other condition, including prior authorisation.

ii. Non-Emergency Outpatient Care

Under Article 22 of Regulation 1408/71 an individual may receive non-emergency *outpatient care* in another member state as if he was insured in that member state for which his home authority must pay. This is subject to prior authorisation on behalf of his home member state.

Under Article 49 EC an individual is also entitled to non-emergency outpatient care in another member state. This care is administered according to the conditions laid down in the home member state and subject to the same tariffs. The service is paid for by the individual who is entitled to subsequent reimbursement by his home member state. Such reimbursement may *not* be made subject to a prior-authorisation procedure. Member states are under a positive obligation to provide mechanisms for such re-imbursement if necessary[18]. This may cause administrative difficulties for those healthcare systems that are free at delivery and paid for out of general taxation and thus do not have individualised tariffs.

iii. Non-Emergency Hospital Care

Under Article 22 of Regulation 1408/71 an individual is entitled to receive hospital care in another member state according to the conditions and tariffs laid down in the legislation of that member state. This right is subjected to the requirement of prior authorisation which must be granted under specific circumstances (see below).

Under Article 49 an individual is entitled to receive hospital treatment in another member state under the conditions of his home member state. A Member state may make this entitlement subject to prior authorisation (see below) but the conditions used in the application of such a system must be objective, justified and proportionate.

[18] See *Watts* para 122.

iv. Prior-authorisation procedure

Member states may limit payment for treatment under both Article 49 EC and Article 22 of Regulation 1408/71 and subject it to a prior-authorisation procedure. The Court has held that the same conditions, both procedural and substantive[19] are to be applied in the same fashion in both contexts.[20]

In relation to the procedure the Court has insisted that it must be based on "objective, non-discriminatory criteria[21] which are known in advance… Such a system must furthermore be easily accessible and capable of ensuring that a request for authorisation will be dealt with objectively and impartially within a reasonable time and refusals to grant authorisation must also be capable of being challenged in judicial or quasi-judicial proceedings."[22]

For substantive conditions the Court has drawn a parallel with the conditions contained in Article 22 (c) Regulation 1408/71 namely that authorisation cannot be refused where firstly the treatment for which the authorisation is being requested is normally available under the legislation of the home state and secondly that the same or equally effective treatment cannot be carried out on the home member territory without 'undue delay'. The inverse is that where the treatment requested is available within a reasonable period of time in the national system, authorisation can be refused.

Undue delay is to be determined according to an "objective medical assessment of the patient's medical condition, the history and probable course of his illness, the degree of pain he is in and/or the nature of his disability at the time when the request for authorisation was made or renewed"[23]. In particular the mere existence of waiting lists cannot justify refusal to issue authorisation and that if the delay arising from such a waiting list is found to be 'undue' within the meaning given by the court the authority is under an obligation to issue authorisation. This effectively prohibits the blanket use of waiting lists to control patient flows.

Thus although a prior-authorisation requirement may breach the EC Treaty it may be justified for hospital care if applied in a proportionate manner as specified above.

2.2. Potential Implications

The main implications of the above legal situation is that member states and their health authorities appear, on the face of it, to have lost a considerable degree of control over patient flows i.e. what patients receive what care and where. This can potentially affect considerably the planning, managing and financing of national health infrastructures – and ultimately the public health budgets. The fear is that some

[19] See below p. 7
[20] This was implied by the court in *Inizan* and accepted explicitly in *Watts*.
[21] For example the condition that the proposed treatment
Is 'normal in the professional circles concerned' must be interpreted in such a way that the treatment is sufficiently tried and tested by international medical science (and not simply according to national medical opinion, see C-157/99 *Geraets-Smits & Peerbooms* at para. 97).
[22] *Watts* para 116.
[23] *Watts* para 119

hospitals and health services may be over-burdened by 'healthcare tourists' thus impacting on the degree and quality of care available to their own nationals while others will be under-used creating over-capacity and wastage.

This loss of control is certainly true in relation to *out-patient treatment* where, under Article 49 an individual is entitled to reimbursement without the need of prior authorisation.

For *hospital care*, however, where most careful planning is required, such prior-authorisation can be imposed and used to limit the number of individuals entitled to cross-border care. Such control has certain limits as demonstrated by the conditions contained in Article 22 of Regulation 1408/71 and in the case law of the Court dealing with Article 49.

Furthermore, the ECJ's case law indicates that it is difficult to justify refusals to reimburse healthcare service received abroad for reasons such as a risk for the financial balance of the social security system. To prove such a danger, a Member State or its healthcare system will probably have to produce evidence, i.e. on reliable data based on parameters such as comprehensive pricing and accountancy methods. However, introducing such methods would in itself already entail important structural changes to many national healthcare systems.

While there is a significant lack of reliable data, which makes any accurate assessment of the current situation and any potential future situation extremely difficult, it is safe to say that up to now the actual changes in patient flows have not been significant and expenditure on cross-border healthcare has only accounted for around 1% of national health expenditure[24]. Treatments in border areas and in specialised fields have been the most affected categories.

The lack of demand is due to two factors in particular. Firstly a lack of information and awareness regarding cross-border healthcare rights. Secondly due to the sensitive nature of healthcare, in particular hospital care, individuals are more likely to opt for a system or Doctor they feel more familiar and comfortable with for cultural and linguistic reasons.

It is expected that these factors limiting cross-border patient flows may diminish in the future. In particular it is expected that the provision of information is likely to increase by both private and public bodies. In addition it is suggested that with a clearer legal framework public and private agencies (including insurance companies) will be encouraged to organise and facilitate both diffusion of information and organisation of treatment[25]. To a lesser extent cultural changes taking place amongst young Europeans and developments in low cost and frequent travel may reduce reticence due to a lack of familiarity.

[24] See See *Summary report of the responses to the consultation regarding 'Community Action on Health Service'* (SEC (2006) of 26 September 2006 p.7

[25] This has already occurred to a degree see N.Hawkes and C.Brenner 'English Patients to take French Cure' The Times19 Jan 2002.

Thus while at present the level of cross-border health care is extremely low, this can be expected to increase moderately in the future – and perhaps more rapidly in bordering regions. On a planning level health authorities will have to take into account patient flows both into and from the health service. How this may affect different healthcare systems depends on their individual characteristics in particular on cost, coverage and availability. In any case it shall affect all member states' regulatory capacity depending on how cross-border health care is regulated. Significant demand could impact on the ability of authorities in both 'sending' and 'receiving' member states to manage waiting lists flexibly, determining provider choice and contracting arrangements, defining benefit packages and planning and regulating retail pharmacies and medical equipment.

Part Three – **INITIATIVES TAKEN BY THE EU INSTITUTIONS**

The Council, the Commission and the EP have all dealt with the problem of cross-border healthcare services and its possible implications.

1. The Council

In 2002, the Council and the Representatives of the member states took note of the fact that movement of citizens– who generally expect to receive high-quality health services - had led to an increasing interaction between the different national health systems and welcomed the Commission's objective to take forward work in this field.[26]

Following a Report of the EP (see below), the Council adopted in 2006 its conclusions on *common values and principles in EU health systems*.[27] It recognised that the case law of the ECJ in the field of patient mobility called for a clarification of the interaction between free movement of services and the health services provided by national health systems. In doing so, the Community institutions should, however, ensure the respect of common principles and values in EU health systems, considered to be "a fundamental part of Europe's social infrastructure", such as universality, access to good quality care, equity and solidarity. It is worth noting that the first point of these conclusions refers to the removal of healthcare services from the scope of the "Service Directive" proposed by the EP and accepted by the Commission.

2. The Commission

In 2004, the Commission published a *Communication on patient mobility and healthcare development in the EU*, providing responses to a number of recommendations emerging from a reflection process started after the conclusions

[26] Conclusions of the Council and of the Representatives of the Member States meeting in the Council of 19 July 2002 on patient mobility and health care developments in the European Union (OJ 2002 C 183/1).
[27] OJ 2006 C 146/1.

made on this topic by the Council in 2002.[28] The Commission considers that increasing patient mobility will contribute to improving health and better quality of life, to a better use of resources invested in health systems across Europe and also bring concrete benefits of integration closer to the people. The Communication recommends thus a wide range of possible activities to be developed in fields such as rights and duties of patients, capacity-sharing by national health systems, technology assessments, or information strategy.

After accepting the EP's request to remove healthcare services from the scope of the "Services Directive", the Commission launched, in 2006, a *consultation* to identify the scope of EC action on health services – aiming in particular at providing patients and operators with legal certainty (clarification of the ECJ's case law) and to support member state cooperation in this field.[29] The Commission published a summary report of the responses obtained, some of which point to possibly useful clarifications of issues such as patient rights, conditions of authorisation, clinical oversight, data protection, liability etc.[30] However, it also becomes apparent that there is a considerable scepticism - in particular from governments, unions and purchasers who fear that Community action – that such "clarification" would activate the full potential of patent mobility and undermine the provision of healthcare according to the principles recognised by the Council (see previous sub-section).
On the basis of that consultation, the Commission planned to elaborate a *proposal for a Community framework for health services* but has postponed the adoption of this proposal in December 2007.[31] One - no small - concern is that it could easily be vilified as 'second Bolkestein directive', with ensuing consequences for the ratification of the Lisbon Treaty, the image of the Commission[32] and of the EU in general.

Postponement also however has much to do with the very substance of such a framework for health services, although the Commission's precise intentions remain subject to speculation in the absence of any (published) formal or informal proposal. The documents mentioned before suggest that DG Health aimed at more than a 'mere' *codification* and clarification of the case law. In line with proposals made by the EP (see below), the Commission envisaged probably some 'flanking measures' to further *facilitate* the use of the rights recognised to patients by the ECJ - such as better information and improvement of the modalities governing cross-border healthcare. Furthermore, it seems that also a clear *extension of patients´ rights* was considered: reportedly, there were plans to further restrict (or even abolish) the requirement of a prior authorisation for planned hospital treatment abroad and also to allow a cross-border use of prescriptions.[33]

[28] Communication of 20 April 2004 COM(2004) 301 final.
[29] Communication of 26 September 2006, SEC (2006) 1195/4.
[30] For a detailed and comprehensive survey of issues to be addressed see European Commission, Report on the work of the High Level Group on Health Services and Medical Care (HLG/2006/8 FINAL, 10 October 2006).
[31] The Commission's White Paper "Together for Health. A Strategic Approach for the EU 2008-2013" (COM(2007)630 final) is not of an immediate relevance for cross-border health services discussed here.
[32] And, some would add, its President's ambitions to be reappointed in 2009.
[33] See e.g. EurActiv, "Confusion surrounds EU's health services directive" (28 January 2008, euractiv.com) and the section Europraxis in the Frankfurter Allgemeine Zeitung of 12 February 2008.

On that basis, one has to conclude that the Commission's (DG Health) approach so far does not just lack transparency but also fails to address openly and convincingly the most difficult yet crucial issue: the possible impact of the ECJ's case law and any legislative measure aiming at expanding patient mobility on the organisation, management, planning and, above all, the funding of the national healthcare systems.

3. The European Parliament

The works of the EP in this field have materialised in two rich and detailed resolutions: first, a resolution adopted in 2005 on *patient mobility and healthcare developments* in the EU[34] (rapporteur: John Bowis[35]); second, a resolution adopted in 2007 dealing with the *consequences of the exclusion of health services from the "Service Directive"*[36] (rapporteur: Bernadette Vergnaud[37]).

Both resolutions establish a long list of measures which should be taken by the Community in order to overcome the many shortcomings of a patient- and judge-driven development of patient mobility.

The underlying assumption of the EP is that neither the primary responsibility of the member states for providing healthcare services nor the considerable complexities inherent in 'approaching' the different national systems should prevent the Union to assume its main task: promoting public health through *facilitating cross-border mobility*.

This entails first of all *to conserve the individual patient's right to seek healthcare service abroad* as recognised by the ECJ. The possibility to access timely treatment in another member state when from suffering life-threatening conditions is defined as the patients' 'minimum right'. In case of need these rights have to be secured by the Commission (infringement procedures against non-complying member states).

Second, this requires *tackling the ensuing coordination and efficiency problems*, by adopting a new European regulatory framework for cross-border healthcare. The following points mentioned by the EP are worth pointing out:

i. The need to clarify the very definition of healthcare service, the concept of "reasonable waiting times", to define narrowly the scope of "hospital treatment", to establish an easily obtainable authorisation and an appeal procedure allowing for an independent review of negative authorisation decisions;
ii. The need to establish a set of reliable data on patient mobility, including refused authorisations, on health indicators and provide for exchange of

[34] 2004/2148(INI) of 9 June 2005, OJ 124 E/543.
[35] Report of the Committee on the Environment, Public Health and Food Safety (A6-0129/2005 final, 29 April 2005).
[36] 2006/2275(INI) of 23 May 2007.
[37] Report of the Committee on the Internal Market and Consumer Protection on the impact and consequences of the exclusion of health services from the Directive on services in the internal market (A6-173/2007 final, 10 May 2007)

information making use of electronic tools (whilst observing high standards of data protection);

iii. The need to inform patients properly about their rights to receive cross-border treatment, the procedures to be observed and the implications of such a choice (content, reimbursement, follow-up checks, liability etc.);

iv. To elaborate a charter of patients' rights, enhance member states' cooperation with regard to technical standards and supervision of healthcare professionals, to clarify liability issues (including the introduction of compulsory third-party liability insurances).

v. To encourage the development of cooperation between national health systems both in 'Euregions' and - with regard to specific diseases and treatments, but also pharmaceutical services – at a pan-European level, either through closer cooperation among member states or by means of open coordination.

Part Four – **CONCLUSIONS**

The free movement of citizens, one of the cornerstones of the internal market, entails inevitably an opening of the member states' healthcare systems in order to ascertain that the use of this freedom is not jeopardized by a possible loss of the migrants' social security rights. This has traditionally been operated by a coordination of the member states' social security systems, including mechanisms providing for financial settlements between them. Albeit not being perfect and suffering of some administrative sluggishness, that system managed to balance the migrants' and member states' respective interests.

The judicial recognition of patient mobility based on the freedom to receive a cross-border service within the Union privileges, however, by definition the interest of the individual patient. Some of the Commission's statements and in particular the EP's proposals are explicitly based on the (correct) assumption that generalizing and consequently applying this approach will promote the over all quality of healthcare services in the EU. It will thus not only benefit the individual patient negatively affected by the shortcomings some member states' healthcare systems but effectively also help to boost the entire healthcare sector.

What is, however, only implicitly acknowledged and not really addressed by the Commission and the EP is that the 'opening' of national healthcare systems inevitably implies a profound reorganization. Besides adaptation costs, better services are tantamount to higher prices. As these will be borne by the citizens, either directly (private funding) or indirectly (through contributions), raising healthcare budgets might well undermine the 'sacred' values and principles in EU health systems, endlessly reiterated by the Union institutions: universality, equity and solidarity. This is even truer in the context of the enlarged EU comprising important economic disparities between countries and regions.

There are essentially three options available to the Community legislator:

Firstly it could decide to do nothing. This may be the preferred option by certain member states who benefit from the obscure legal situation to continue to strictly control cross-border medical care[38]..

The second option would be a codification of the existing case law of the ECJ. Such legislation could clarify certain aspects of the jurisprudence such as the definition of 'undue delay' and the distinction between hospital and outpatient care but would not liberalise the sector any further.[39]

Finally, a third option would favour a more comprehensive approach dealing with all the issues and helping to facilitate cross-border health provision. This would include areas such as consumer information and protection, regulatory issues, information exchange (such as patient files to deal with continuity of treatment post-operation) and cooperation in border areas and specialised fields. This would empower the individual patient but would present considerable political, practical and legal difficulties and carries particular risks.

Downplaying the inherent risks of promoting cross-border healthcare services is a dangerous strategy for a legislator who has to strike a balance between two conflicting principles in this sensitive area: that of a system of closed, self-contained health services, and of the liberalising dynamic influence of free movement.

[38] In the event that the EFTA court does not follow the jurisprudence of the ECJ on the matter of healthcare, this divergence would need to be addressed by the political organs of the EEA, notably the EEA Joint Committee. Although this case law has been developed after the signature of the EEA Agreement and is thus not formally binding for the EFTA countries (see Art. 6 EEA), the EFTA Court is likely to endorse the ECJ's rulings. In line with Art. 3(2) EEA, the EFTA Court has in fact, from the onset drawn heavily on the case law of the ECJ in interpreting the those provisions of the Agreement being identical in substance to corresponding rules of the EC Treaty.

[39] This would normally be incorporated into the EFTA states by a decision of the EEA Joint Committee amending the relevant Annex of the EEA Agreement.

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