BRIEFING

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Policy analysis of potential modernised rights for patients in cross-border healthcare

Background paper

KEY FINDINGS

National public health systems in the EU Member States (MSs) are regulated by national laws, whereas EU law regulates access to cross-border healthcare in the European Union. Therefore, national and EU law regarding healthcare affect each other, working in tandem. National public health systems are diverse, with distinctive social health insurance and distinctive national health service systems, both complemented by private health insurances. In addition, EU cross-border healthcare involves two distinctive aspects, the coordination of public health systems and the free movement of medical services and medicines. Difficulties in accessing cross-border healthcare become apparent when the two systems, i.e. coordination of public systems and free movement of market (private) healthcare services and goods, interact.

The coordination of public health systems in distinctive situations is rather clear. Initially, when cross-border access to healthcare (not just public, but also private healthcare) was provided under free movement rules and no public reimbursement was requested, no major issues were detected. However, as soon as public funds pay for access to private healthcare in cross-border situations, questions of equal access and solidarity, which are features of public systems, are being raised.

The rules regarding the free movement of patients receiving private healthcare and regarding public reimbursement of cross-border healthcare in line with tariff thresholds in the Member State (MS) of affiliation (and not exceeding incurred costs) was initially, and still is, construed by the Court of Justice of the European Union (CJEU) and codified by the Directive 2011/24/EU. The latter is not fully applicable in all cross-border situations, such as for necessary treatment. Loopholes in provision may be detected. In addition, prior authorisation is distinct under both legal regimes.

Enhanced clarity in EU cross-border healthcare law is desirable, especially concerning telemedicine and access to public healthcare by economically inactive European citizens. Levelling the playfield by providing full and easily accessible information to cross-border patients (both public and private) is essential and healthcare providers should be well equipped and willing to share such information. Steering of public (cross-border) patients towards private healthcare provision should be avoided and genuine free choice should be enabled.

A solution could be to delineate more clearly between public and private provision of healthcare, nationally and across borders. Equitable access to high quality healthcare should be provided to all EU citizens, moving and non-moving. To this end public health systems should be strengthened to respond properly to any future health crisis, and perhaps private health insurance should be called into cross-border healthcare.

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Setting the scene

Interplay between national healthcare systems and EU cross-border healthcare

Social security, including public healthcare[1], is first and foremost regulated by national law, which takes into account various historically conditioned and somewhat distinctive structural (e.g. the type of educational system in place or living and working conditions) and cultural elements (e.g. the relative power of trade unions or civil movements), legal traditions and policy preferences in each state[2]. This is the reason why national social security systems show a considerable degree of heterogeneity.

To facilitate freedom of movement, EU legislation needs to address possible obstacles posed by incompatibilities between national social security systems. For instance, solely applying national social security rules could result in people having no social security coverage owing to what is termed a negative conflict of laws. E.g., if an individual works in a country where the social security system only covers residents (e.g. Denmark) but resides in a country that only covers workers (e.g. Germany), they would not be covered at all. The same applies *vice versa*, if the individual resides in a MS covering residents and works in a MS with social insurance covering all workers they might be covered twice (positive conflict of laws). This is why a complete and uniform system of conflict rules must ensure that persons moving within the EU are **subject to a single social security system**. Moreover, relevant periods of time (be it of social insurance, residence or work) have to be aggregated by all the MSs involved, vested rights have to be protected and EU citizens treated equally. Next to seamless cooperation between administrations, these are core principles of EU social security coordination law.

Patterns of movement have changed since the establishment of the EU. Initially, cross-border movements were characterised by long-term relocation, often for a person's entire professional career and to a single destination. Today, cross-border movements have become more frequent, lasting for shorter periods of time and including a large variety of destinations. They are also more unpredictable (with shorter posting periods) and can even be virtual (such as is the case for telework, including telemedicine). Cross-border movements have therefore become much more dynamic.

Any such changes in the way people live and work must be reflected in the evolving social security legislation at both the national and supranational (EU) level, so as to **guarantee the fundamental human right to social security for all EU citizens moving within the Union**[3]. Social security systems have to be linked (coordinated) when people move between them. Such cross-border movements are not necessarily neutral[4], since they may bring about enhanced or reduced benefits for those who move abroad, depending on the social security systems of the MSs concerned. Hence, all changes to national social security systems have repercussions for EU social security coordination law.

Diversity of national healthcare systems

Distinctive influences and the diversity of national social security systems are mirrored in public healthcare systems, too. When social risk of sickness occurs,[5] access to high-quality healthcare is governed by national laws and practices of MSs[6]. The organisation of public healthcare systems differs among countries and ranges from different types of health insurance, financed predominately by social security contributions, to distinctively organised national health services, financed by (local or state) budget.

Social health insurance systems may organise direct provision of healthcare to patients. This is referred to as the third party payment system or system of providing healthcare *in natura.* The other kind of social health insurance system is one whose role is limited to the reimbursement of healthcare costs, such as the systems operating in France, Belgium or Luxembourg. National health service architectures might also differ. It may be centralised and run by the state, such as in Ireland or the UK. It may also be left to local communities or national regions to operate the system in a more decentralised manner, such as in the Nordic countries or some of the southern European countries.

Besides the administration and funding of public healthcare systems which vary across MSs, there are also differences in the delivery of healthcare. In public healthcare provision, public and contracted or 'conventioned'[7] healthcare providers may be included. Such public healthcare provision networks fall under the competence of MSs and their local communities and regions.

National public healthcare systems, with their distinctive forms of administration, funding and provision of services, tend to be complex, even when people are moving within a country, from one region to another, and even more so when moving across borders. While it has not always been the case, today, legal relations in the healthcare sector are complex (at the financing and delivery sides) and publicly regulated. However, the simple rule of supply and demand, with a direct relationship between patients and their healthcare providers might still exist when healthcare is provided privately in the healthcare market.

The design of public healthcare systems provides more or less space for private health insurance. Such insurance provision may range from:

- Supplementary, covering the difference between public coverage and the full price of healthcare, i.e. of medical services or products.
- Substitutive, such as in Germany, where high-earners may opt out of public health insurance and choose private insurance instead. Such private insurance must by law offer at least a basic tariff.
- Additional, covering services and goods not covered by the public health system.
- Parallel, covering the same services and goods as the public health system, but offering it with no or shorter waiting lists.
- Basic, where there is no public scheme.
- Private insurance for organising cross-border healthcare, including within the EU[8].

The origins of EU cross-border healthcare

MSs can legislate by themselves (unilaterally)[9] and establish rules for reimbursement of (urgent) cross-border healthcare or agree upon regional cooperation, which may be bilateral or multilateral[10]. Bilateral instruments are the oldest social security coordination tools. They **remain the most common international social security coordination instruments** between MSs and non-EU states. They are tailored to the legal and social situations of the two contracting states, and reflect migration patterns (which are dependent on geography, language and culture) and the more or less restrictive immigration policies[11].

In the EU, the text on coordinating social security systems of the six founding MSs was agreed upon in a European Agreement concerning the Social Security of Migrant Workers, which was signed in Rome on

9 December 1957[12]. At that time, it was decided to make the coordination rules operational as soon as possible and to avoid the time-consuming procedure of ratification. Hence, the already agreed-upon rules became the third regulation adopted by the EU, i.e. Regulation (EEC) No. 3 concerning the social security of migrant workers. It was the first substantive legal instrument of what is now the EU[13]. The fourth regulation, i.e. Regulation (EEC) 4/58 was the implementing regulation, mainly laying down the administrative procedures and mechanisms for the institutions responsible for social security coordination[14].

The choice of a regulation rather than a traditional international convention had important implications. It gave the Court of Justice of the European Union (CJEU) the possibility to interpret secondary legislation and establish its conformity with the Treaties[15] or indeed apply the Treaties directly to situations under the material scope of EU law. The latter was the case with the free movement provisions being applied to cross-border healthcare.

Soon after the adoption of the initial coordination regulations, errors and omissions became apparent. In addition, the nature of migration was changing, and additional states with distinctive social security systems joined the EU. Consequently, Regulation (EEC) 1408/71 and its implementing Regulation (EEC) 574/72 were introduced in the 1970s. However, the regulations became a very complex piece of legislation due to their many modifications, some of which were meant to codify, and some of which were meant to oppose the judgments of the CJEU. In this way, the applicable rules have constantly been further developed by the CJEU[16] and the EU legislator[17].

In 1998, the process of modernisation and simplification of the social security coordination law began, and new regulations were passed. Interestingly, the currently applicable Regulation (EC) 883/2004 was passed only a few days before the largest enlargement of the EU to date. The 15 MSs agreed on the wording of the Regulation on the 29 April 2004[18]. However, with 10 new MSs joining the EU just two days afterwards, on 1 May 2004, it meant that the unanimity of 25 (and later 27) MSs would be required before the text could be applied[19].

Due to the required unanimity of all (by then 27) MSs, the implementing regulation, i.e. Regulation (EC) 987/2009[20], was adopted only in 2009. Hence, the Regulation (EC) 883/2004 was not applicable until after the implementing regulation entered into force in May 2010. Furthermore, Regulation (EC) 883/2004 is constantly being amended by legislative acts[21] and reconstrued by the CJEU.

Historically, the right to cross-border healthcare was already laid down in the first social security coordination regulations from 1958, although the rules were only applicable in cases of urgent treatment[22], and when patients were moving their residence to another MS[23]. Scheduled cross-border treatments were introduced later on and enabled cooperation between public healthcare systems, especially useful for when healthcare could not be provided in due time in one of the MSs.

For cross-border healthcare, the CJEU not only clarified the social security coordination regulations, it also established an alternative route to access cross-border healthcare, based directly on the free movement provisions in the Treaties. One of the basic freedoms enabling the functioning of the internal market is the freedom of movement of workers and other economically active persons[24], and EU citizens in general[25].

The free movement of services encompasses both an active side, meaning the free movement of service providers, as well as a passive side, meaning the free movement of service recipients. This was confirmed by the CJEU in case C-286/82 *Graziana Luisi and Giuseppe Carbone* v *Ministero del Tesoro*. However, the

ruling was not very alarming for the MSs, since Ms Luisi went to a private medical doctor and did not seek reimbursement from the public healthcare system[26].

The CJEU has always found that medical services are services in the internal market, since remuneration is due, regardless how the services are organised or delivered[27]. This was first established in cases C-158/96 *Raymond Kohll* v *Union des caisses de maladie* and C-120/95 *Nicolas Decker* v *Caisse de maladie des employés privés.* Both were insured in Luxembourg. The former took his minor daughter to an orthodontist for treatment in Trier, and the latter purchased a pair of spectacles from an optician established in Arlon. Neither had asked their insurer for prior authorisation. The CJEU argued that while the EU law does not detract from the powers of the MSs to organise their social security systems, they **must nevertheless comply with EU law when exercising those powers**. The coordination regulations only establish one possibility for reimbursement of medical treatments obtained in another MS. The CJEU circumvented the coordination regulations and relied directly on the Treaty provisions regarding the free movement of goods and services in the internal market.

The CJEU position has been refined in many subsequent judgments[28]. In general, medical services have been found to be services in the internal market to which the freedom of providing (and receiving) services applies. They are services provided for remuneration[29], regardless of who is paying for them (i.e. an individual person or a public health system), the delivery method (ambulant or hospital treatment) and the legal form of the healthcare providers (public or private).

Judgments of the CJEU are binding *for all*, but they are passed in an ad hoc manner, taking into account the circumstances of a concrete case, sometimes without a coherent social policy goal, undermining transparency and legal certainty. Therefore, MSs could still distinguish their situations from those covered by the judgments (and disregard them). Such arguments would no longer be possible, once the rules were set by a directive[30].

The Commission's proposal for a directive was published in 2008[31]. The Directive on the application of patients' rights in cross-border healthcare was adopted in 2011[32]. To a certain extent it has codified the decisions of the CJEU. Interestingly, not all MSs voted for adoption of the directive. Austria, Poland, Portugal and Romania voted against and Slovakia abstained from the vote.[33]

EU cross-border healthcare

Social security coordination rules

Social security coordination regulations impact the provision of healthcare to cross-border patients in three distinctive situations:

Firstly, when patients are residing in a 'non-competent' MS. For active persons, a competent MS is as a rule determined by their place of work. If a person resides outside of the competent MS, the responsible institution of this MS should issue an S1 form (it is the first of the sickness forms required for an effective coordination of social security systems)[34], which must be submitted to the responsible public health system authority in the MS of residence. This authority can then issue a national health insurance card (or enable use other identification document, such as an ID, which an insured national would use), guaranteeing equal treatment with national patients. Reimbursement from the competent MS can be on the basis of actual expenditure or on the basis of fixed amounts.

The second situation for cross-border healthcare concerns those who suddenly require healthcare while staying in another MS for reasons not related to healthcare, e.g. visiting family members or as a tourist, researcher, student or business partner. In these circumstances, the European Health Insurance Card (EHIC) should be used for necessary healthcare[35], as it is defined and delivered by healthcare providers in the MS of stay. However, patients have also tried using the EHIC for planned healthcare, for which it is not intended. For instance, in Slovenia there are well-known cases involving planned childbirth in Austria, for which the costs were claimed under the EHIC. The Slovenian Supreme Court did not recognise this to be necessary treatment in such cases[36]. As a result of the aforementioned cases, it seems that reimbursement of cross-border childbirth costs has been restricted across the EU. However, childbirth as such is not excluded from necessary treatment as it may occur unexpectedly while visiting another MS[37].

A person may also require continuous treatment of an existing or chronic disease, such as kidney dialysis, oxygen therapy, special asthma treatment, echocardiography in case of chronic autoimmune diseases, or chemotherapy[38]. Hence, this should also be counted as necessary healthcare. When assessing what necessary healthcare is, which is exceeding urgent healthcare, the nature of the benefits and the expected length of stay must be considered[39].

The third and last situation is, when patients move to another MS in order to receive scheduled medical treatment there. Prior authorisation from the competent MS is required as a rule in such circumstances. Authorisation must be given if the treatment is among the benefits provided in the person's own public healthcare system, but such treatment cannot be provided within a medically justified time limit, taking into account the state of the individuals' health and the probable course of the illness. In this case, a person is entitled to treatment in another MS, according to the rules of that MS. Also, the treatment is to be paid or reimbursed according to the tariffs applicable in the MS of treatment. If waiting times in a national public healthcare system are too long (assessed individually)[40], the patients obtain the right to cross-border healthcare, regardless of the reason why the treatment cannot be provided in due time[41]. In exceptional cases of urgent cross-border treatment, prior authorisation might be waived and reimbursement provided without the prior authorisation of such cross-border healthcare[42]. Moreover, the CJEU also argued that when a person with a pre-existing pathology travels abroad, it cannot be automatically presumed that the intention is to obtain medical treatment in the destination country[43].

Free movement of cross-border healthcare services and medicinal goods

The MS of treatment should respect the principles of universality, access to good quality care, equity and solidarity (although there is no indication as to what kind of solidarity is meant and to which groups it should be applied) and provide healthcare to cross-border patients according to the same quality and safety standards as for domestic patients.

The MS of treatment has to ensure that healthcare providers apply the same scale of fees for domestic and cross-border patients in a comparable medical situation[44]. The question might be, what is a comparable medical situation? The notion of patients is broader than the notion of insured persons[45] and the prices for both groups could be distinct. What is decisive here is the behaviour of the patients. If they act as public patients (and adhere to waiting lists), they should be entitled to public prices. If they act as private patients (going to private healthcare providers outside of the public healthcare network, who might not be familiar with the public prices) they should be treated as private patients. Comparisons should only be made between similar situations, and cross-border patients should be treated on the same terms as national patients in comparable situations. To achieve this, patients have to be well informed and they must not be steered towards private healthcare provision by healthcare providers.

One of the key obligations of the MS of affiliation is to reimburse the costs of healthcare provided in another MS. Moreover, the MS of affiliation must also provide medical follow-up if required, and remote access to or at least a copy of the medical records to the patient. Legal barriers shall be removed for the transferral of electronic medical data (e-health)[46]. However, the condition is that the treatment is covered by the MS of affiliation.[47]

The costs must be reimbursed up to the level of costs that would have been assumed by the MS of affiliation had this healthcare been provided in its territory. A more extensive coverage of healthcare costs by the public system of the MS of affiliation, compared to coverage of the public system in the MS of treatment, could be required, e.g. if the latter has a higher co-payment regime than the MS of affiliation[48].The reasoning is that healthcare costs shall be reimbursed and co-payments are part of such costs.

However, reimbursement should not exceed actual costs of healthcare received[49]. Hence, possible patient enrichment initially introduced with the so-called *Vanbraekel* supplement is no longer possible[50]. It had to be paid, even when the actual costs in the MS of treatment were lower than reimbursement tariffs in the MS of affiliation. This has already been indicated by the CJEU in case C-173/09 *Georgi Ivanov Elchinov* v *Natsionalna zdravnoosiguritelna kasa*[51].

The MS of affiliation is nevertheless free to reimburse higher actual costs of treatment and even related non-medical costs like accommodation and travel costs, or extra costs of persons with disabilities. However, it is not obliged to do so, even if it would mean reimbursement of such costs for persons whose planned cross-border treatment had been authorised on the grounds of the Regulation (EC) 883/2004.

Certain administrative requirements may remain. For instance, general practitioners' 'gate-keeping' function could be preserved (in MSs where it is regulated), preventing so-called doctor hopping or doctor shopping. The directive enables the MS of affiliation to impose the same conditions (criteria of eligibility, regulatory and administrative formalities) to a cross-border patient as they apply for healthcare provision on its territory. This includes assessment of the general practitioner with whom the patient is registered.

Interrelation between the regulations and the directive

A patient can choose freely between the rules of social security coordination and free movement of healthcare, i.e. between the social security coordination regulations and the cross-border healthcare directive[52]. While combining both systems for the same condition (claiming public direct payment alongside reimbursement for the same or related costs) has been attempted, the CJEU has clarified that only one legal path can be applied at the same time. In case C-489/23 *Casa Judeţeană de Asigurări de Sănătate Mureș and Others* the CJEU argued that legal instruments cannot be combined for the same instance of healthcare provision. That points to patients having to choose one or other legal path, not for the entire course of treatment of a certain health condition, but for each service within the overall required healthcare.

However, when healthcare does not overlap in the MS of affiliation and MS of treatment, either the regulations or the directive can be chosen. Similarly, the CJEU in case C-538/19 *Casa Naţională de Asigurări de Sănătate and Casa de Asigurări de Sănătate Constanţa* argued that cross-border medical assessment of equal or equally effective healthcare may be obtained under the directive, although, it is a condition for cross-border healthcare under the regulations.

There are two paradoxes of the social security coordination regulations compared to the directive. The first is that EU law does not unify the substance of national social security systems, but merely links them, even though regulations are unifying measures though which coordination is achieved[53]. What is unified is the part of formal social security law that governs the application of substantive social security law in cross-border situations. Each MS still enjoys exclusive competence to define the personal and material scope of their public healthcare systems.

Another paradox is that the directive has to be transposed into national law, whereas regulations apply directly. This is evident in the case of cross-border healthcare. The rules of the directive had to be transposed into national law by 25 October 2013[54], whereas the new regulations have been directly applicable since 1 May 2010. Yet, more public discussion was raised among the MSs when the directive was being transposed than the few (if any) discussions raised when the new regulations were negotiated and adopted. The reason might be that the rules of the current regulations were not modified much compared to their predecessors, i.e. Regulations (EEC) 1408/71 and 574/72, at least not concerning the rules governing cross-border healthcare.

Outstanding issues and possible options for improvements

Prior authorisation

Prior authorisation for scheduled (planned) cross-border healthcare in another MS may be given by the competent MS (under the social security coordination regulations) or the MS of affiliation (under the directive) in all cases. However, authorisation must be given if treatment is among the benefits in the patient's own public healthcare system, but cannot be provided there in due time.

If cross-border treatment is so urgent that the patient was unable to apply for prior authorisation or could not wait for the institution's decision (which might take some time), the patient is entitled to reimbursement of cross-border healthcare costs even if authorisation was not applied for[55]. If prior authorisation is issued under the regulations, a patient may receive healthcare at healthcare providers included in the public healthcare system in the MS of treatment and then, the competent MS will cover the costs of treatment (and sometimes travel).

The requirement for prior authorisation may be introduced also under the directive, although not every MS has done so. In 2024, it seemed to be in place in Austria, Belgium, Bulgaria, Croatia, Denmark, France, Germany, Greece, Hungary, Ireland, Italy, Luxembourg, Malta, Poland, Portugal, Romania, Slovakia, Slovenia, Spain (and Iceland, and EEA state to which the directive also applies), but not in Czechia, Cyprus, Estonia, Finland, Latvia, Lithuania, the Netherlands, Sweden (and Norway, as an EEA state to which the directive also applies)[56].

Under the directive, prior authorisation is an exception to the rule and has to be construed narrowly. It should be limited to what is necessary and proportionate to the objective it aims to achieve. Authorisation may not constitute a means of arbitrary discrimination or an unjustified obstacle to the free movement of patients[57]. However, it is only permissible for hospital and highly specialised treatment, involving particularly risky treatments, or where there are serious and specific concerns relating to the quality or safety of healthcare.

Prior authorisation for hospital treatment under the directive might cause certain difficulties in its implementation. Since the directive does not distinguish between unplanned and planned (scheduled) treatment, there might be a gap in the coverage for patients. For instance, a cross-border tourist might break a leg while skiing in Austria and be brought by a medical helicopter to a private clinic, not included in the public healthcare delivery (in a way purely private provider), meaning that under the regulations the EHIC cannot be applied, since it is a purely private and not a public hospital (or private hospital included in the public healthcare delivery). Moreover, no blanc (i.e. authorisation for possible, unpredictable treatment) or ex post authorisation is envisaged by the directive. This might be a blind spot in EU cross-border healthcare law[58].

Moreover, this also clearly shows that the directive was initially intended to (only) cover planned, cross-border healthcare and not unplanned, (but necessary) cross-border healthcare. According to its Recital 11, the directive should apply to individual patients who decide to seek healthcare in a MS other than the MS of affiliation. Hence, it could also be argued itis intended to apply only to planned medical treatment[59].

The problem could be solved by not applying the directive to unplanned healthcare (as initially intended, since the CJEU case law and later the directive evolved from the planned treatment cases), or by expressly stipulating that prior authorisation is not to be required for necessary treatment under the directive[60].

Even if prior authorisation is generally required under social security coordination and may be exceptionally required under free movement rules, the conditions under which it is granted are different. MSs might have used the same procedures for granting prior authorisation under both legal instruments, but the distinction has been clearly outlined by the CJEU, which made reference to the scope of social security coverage, i.e. the level of covered costs of cross-border healthcare. Under the regulations, cross-border healthcare is covered according to the prices in the MS of treatment, in the same way as for patients covered by that country's healthcare system. Under the directive, the level of reimbursement is capped at the price of treatment in the MS of affiliation (and may not exceed the actual cost of treatment).

Therefore, prior authorisation might be justified under the regulations (in order not to upset the financial balance of the social security system), but not under the directive (where costs are reimbursed in line with rates in the home country). The CJEU clarified that ascertaining whether equal or equally effective treatment can be given in the MS of residence constitutes an objective medical assessment, when used as an element for granting prior authorisation. Under the regulations, only the patient's medical condition may be taken into account, and personal healthcare choices are irrelevant. Not taking other personal circumstances (such as religious beliefs influencing the choice of healthcare) into account for refusing prior authorisation under the regulations may be a justified and proportionate measure, according to the court. Conversely, due to systemic differences in the reimbursement systems under the directive, prior authorisation in the MS of affiliation cannot be refused in such cases and cross-border healthcare has to be allowed and (partially) reimbursed. Indirect discrimination based on non-medical personal circumstances (such as religion) cannot be justified under the directive[61]. In this case, the CJEU invoked and gave priority to the non-discrimination provision (based on religion), enshrined in Article 21 of the Charter of Fundamental Rights of the European Union.

Different rules under the regulations and the directive may give rise to the question of who is in control and entrusted to dispose of public funds, i.e. whether it is MSs or patients.

Social security coordination regulations guarantee cooperation between national, public social security schemes and apply only to public cross-border patients (i.e. those covered by public healthcare schemes).

The control over planned, cross-border healthcare and hence public funds is in the hands of the MSs and their public systems, as prior authorisation is, as a rule, required for scheduled cross-border healthcare[62].

Conversely, the cross-border healthcare directive applies to all patients (public and private ones), treating them like consumers of cross-border healthcare[63]. Nevertheless, as one of the major points of the directive is reimbursement of healthcare costs by a public system, private cross-border patients also act as public patients upon return to their MS of affiliation. In practice this means that a patient decides where (and what, public or private) healthcare will be provided and financed by public healthcare funds. If 'money should follow the patient', the latter is in control of public funds. Of course, only if patients are willing and able to meet the additional cost of private healthcare from their own funds.

This is not only one of the major distinctions between the two legal instruments and two systems (the social security coordination regulations and the cross-border healthcare directive), but may be a key policy choice for future regulation of cross-border healthcare.

Telemedicine

Use of remote services and artificial intelligence when delivering healthcare (internally and across borders) is gaining importance. Telemedicine underlines remote healthcare provided using digital tools. According to the CJEU in case C-115/24 *Österreichische Zahnärztekammer*, telemedicine is an autonomous concept of EU law (defined independently of any single MS's domestic laws) and must be interpreted in accordance with its usual meaning in everyday language, while also taking into consideration the context in which it is used and the objectives pursued by the rules of which it is part. The court explained that According to the literal interpretation, the usual meaning of the term 'telemedicine', by its very etymology, refers to medical services which are supplied at a distance, the prefix 'tele' conveying precisely the idea of distance. Likewise, as is clear from the wording of Article 3(d) and (e) of Directive 2011/24, in order for healthcare provided in the case of telemedicine to be covered by the concept of cross-border healthcare, it is necessary for that healthcare to be provided or prescribed in a Member State other than the Member State of affiliation. Hence, cross-border telemedicine means healthcare provided across borders using digital tools.

Telemedicine is not specifically mentioned in the social security coordination regulations, but it is considered under free movement of healthcare and in the cross-border healthcare directive. For telemedicine, the place where the healthcare provider is established is decisive for establishing the MS of treatment. Such healthcare is also subject to the same reimbursement rules as for cross-border healthcare where both the healthcare provider and patient are present at the same place[64]. This means that for reimbursement to take place in the MS of affiliation, the healthcare in question must be among the benefits provided in that MS. The question is whether telemedicine is a substantive benefit as such, or is it just a way (procedure) for accessing substantive healthcare.

If it is considered a substantive benefit, then it would have to be included among the benefits available in the MS of affiliation too, for patients to be able to access it across borders as well. If it is considered merely as a way to access substantive healthcare benefits (e.g. consultation with a doctor), then it does not have to be among the benefits in the MS of affiliation, to be entitled for the reimbursement of cross-border healthcare costs. The latter would be more beneficial for patients, as it is not necessary that such a telemedicine service is available in the MS of affiliation too[65].

Another question is whether telemedicine must be provided directly to a patient (i.e. doctor to patient) or may also include a consultation between healthcare providers (i.e. doctor to doctor). In its definitions, the directive mentions that MS of treatment means the MS on whose territory healthcare is actually provided to the patient, and in the case of telemedicine, healthcare is considered to be provided in the MS where the healthcare provider is established. Combined with the rule that a patient can seek reimbursement for cross-border healthcare, would it mean that telemedicine has to be provided to a patient to be eligible for the reimbursement of cross-border healthcare costs, and that consultations between doctors are excluded? It could be argued that the latter is also a benefit for patients, thereby applying a broader definition, in which cross-border consultation between healthcare providers would be considered as healthcare provided to the (benefit of a) patient.

A further question may be whether telemedicine and conventional healthcare may be combined. The CJEU tried to shed some light on this question in the recent case C-115/24 *Österreichische Zahnärztekammer*. It argued that healthcare provided via information and communication technology is liable to be covered by the concept of telemedicine, even where it is provided as part of a complex medical treatment that includes healthcare by a provider who is physically present with the patient. Hence, the CJEU favours perceiving each healthcare service separately, and a combination of healthcare provision to both physically present and remotely in contact persons (by telemedicine) is possible (for distinctive services)[66]. The question remains, whether it could be possible for the same service, e.g. when exercising the right to a second opinion. Such a right would have to be among the benefits in the public system of the MS of affiliation in order to be eligible for reimbursement under the cross-border healthcare costs rules.

Issue of residence-based healthcare systems

It was mentioned earlier that public healthcare systems may operate according to different principles. National health service is provided to residents and there is no social health insurance in place. The question concerning cross-border healthcare is whether patients have to establish residence in an MS to have access to healthcare there. It relates mostly to necessary (unplanned) treatment during a temporary stay in another MS.

Stay means temporary residence[67]. However, for the first three months of a stay in another MS, there is no legal requirement to register residence there[68]. Sometimes it may take weeks or even months to solve all the administrative barriers and effectively register residence. But healthcare might be required before then. In some cases, staying in another MS for years, even more than a decade, does not mean that a person has established residence there, as the CJEU argued in case C-255/13 *I v Health Service Executive*. Mr I was resident in Ireland and travelled to Germany for the purpose of holidaying with his partner. While on holiday, he was admitted as an emergency patient to the hospital, where he was diagnosed a rare but serious disease, which later caused severe quadriplegia and loss of motor function. After a while the Irish Health Service Executive (HSE) refused to grant a renewal of a certificate (then the E112 form) committing them to pay for the treatment in Germany. The HSE argued that Mr I is now a resident of another MS. The CJEU argued that staying in another MS for 11 years, does not necessarily mean that a person has established residence there. Mr I was compelled to stay in Germany for medical reasons for a long time, but his centre of interest may have remained in Ireland (which was left for a national court to determine). Hence, next to *corpus manendi* (physically staying at a certain place), also *animus manendi* (intention to stay there and establish a new centre of interest) is required[69].

Therefore, at least during the first three months of a stay in another MS (and sometimes even longer), EU citizens should have access to all necessary treatments and not merely urgent ones. Their access to

healthcare should be equal to that of the residents of the MS of treatment, in order to effectively invoke freedom of movement. They should be enabled to stay in the MS concerned for the entire intended duration (e.g. also as students).

The CJEU touched upon a similar issue in case C-535/19 – *A (Soins de santé publics)*, concerning an Italian national who left Italy and moved to Latvia in order to join his spouse, who was a Latvian national, and their two minor children of Latvian and Italian nationality. He informed Italian authorities and was included in the register of Italian nationals residing abroad, and thus, he was excluded from the Italian public healthcare system. But, he was also refused by the Latvian national health service as he did not meet the conditions of Latvian law. The CJEU argued that national legislation, which excludes economically inactive EU citizens, who are nationals of another MS, from the right to be affiliated to the public sickness insurance scheme of the host MS, is against the EU law[70]. The decision applied for a period of residence for more than three months, but less than five years. In this period, an inactive EU citizen should have comprehensive sickness insurance cover in order to not become an unreasonable burden for the receiving MS. The court left open the question of how a citizen can be included in the public healthcare system of the MS of residence. It could be by paying a proportionate social security contribution or by private health insurance.

EU law might need to be amended to achieve the goal that no moving person (economically active or inactive) is left without access to the public healthcare system. For instance, the MS of residence for a period of more than three months could be obliged to allow access to its public healthcare system. Such access might not be free of charge, and may be granted by paying a proportionate social security contribution (or alternatively by taking out private health insurance). Perhaps the previous MS of residence could remain competent for up to three months, not to leave people unprotected.

Moreover, some MSs require private health insurance, e.g. for students to be admitted for Erasmus+ exchange. This might be an excessive condition, as the EHIC should be enough to cover all necessary healthcare during a temporary stay. One solution might be to not only amend the rules of EU cross-border healthcare law, but also to oblige MSs and healthcare providers to be fully informed and respect the rules on necessary healthcare for persons undertaking a temporary stay in another MS. Also, means of easily informing EU citizens must be readily available in every MS.

Co-payments for healthcare

Co-payments are part of cost-sharing arrangements between public healthcare systems and patients themselves (and sometimes their private insurers). Patients may be required to pay a flat fee per service or good, which does not necessarily bear any relation to the cost of the service or good. The same amount is charged regardless of the actual cost of the healthcare provided. More intensive use (more services) naturally leads to a higher total payment. Co-payments may also be in a form of a percentage of the cost of a healthcare provided, or as a deductible, which requires patients to cover healthcare up to a certain amount, before the public healthcare system is engaged[71].

Co-payment presents a barrier to universal healthcare, as it hits low-income patients the hardest. To avoid this, complex exemption mechanisms need to be put in place. Therefore, some MSs have abolished them (e.g. Germany abolished the *Praxisgebühr* in 2013 and Slovenia abolished co-payments and consequently private supplementary insurance in 2024). There are other mechanisms to increase healthcare cost awareness and reduce overall healthcare costs. They may range from better information sharing (like issuing invoices even when healthcare is fully covered by the public health system, although people might react in different ways to this information) to more control over healthcare providers[72].

The organisation of national public health systems has consequences for cross-border access to healthcare. Nationally, mutual insurance companies or other private insurers may cover the costs of co-payments for national citizens, while cross-border patients do not have access to the same healthcare, since they might not be covered for the co-payment part in the MS of treatment. Hence, if public healthcare systems are linked, perhaps mutual and other private health insurance would be attracted to cross-border healthcare as well.

Including private health insurance in cross-border healthcare

One issue is mentioned in the previous paragraph, i.e. attracting mutual and private insurance to cover the costs of co-payments in cross-border healthcare.

The other issue is whether individuals with private health insurance should have access to coordinated public, cross-border healthcare. When private insurance merely administers public healthcare systems (as in the Netherlands), the reply should be in the affirmative. Similarly, it should be affirmative for mandatory private health insurance, such as that for high-earners in Germany, where the basic tariff is legally regulated[73]. This dilemma, whether to include substitutive private health insurance in the social security coordination mechanism, might be resolved by the CJEU in a pending case C-331/25 – *Menhoff*, where Germany and the Netherlands would welcome the solution advanced by the court.

As mentioned above, if public and private cross-border healthcare are interwoven, then purely private health insurance should perhaps be included in cross-border healthcare too to enhance access.

Information – a key element

Information asymmetry is a well-known feature of healthcare. Healthcare providers know much more than patients. This holds true nationally, and even more so in cross-border situations. There are reports on how information on cross-border healthcare is and should be provided, especially by national contact points, which were established under the directive.

Information seems to be well communicated among social security institutions, and by means of the Electronic Exchange of Social Security Information (EESSI) system, which should soon be upgraded. Information is also shared among patients (within and among patients' organisations, if funds are available), but the information being shared is mostly medical rather than about the legal rules on cross-border healthcare. However, most importantly, patients shall be informed by public healthcare systems and by healthcare providers (public, private in the public network and purely private ones).

Patients are currently being steered towards private healthcare providers. The possibility of visiting purely private providers and being reimbursed by the public healthcare system was created by the CJEU, and this option has been broadened by the cross-border healthcare directive. The situation is the same in situations in which public providers may offer both public and private healthcare. For instance, in some MSs (e.g. in Croatia) special private ambulatories for tourists have been set up and are operating in public primary care centres (although since 2025 some of them are publicly financed). The complexity of foreign healthcare systems further amplifies the information asymmetry. Therefore, providing straightforward, up-to-date and transparent information is essential for proper implementation of EU cross-border healthcare law. Giving patients the option to make a genuinely free and informed choice to claim cross-border healthcare under the rules of the regulations or of the directive is crucial. Patients' ability to make informed choices must be guaranteed[74].

Therefore, all healthcare providers with whom patients usually have their first (and sometimes their only, maybe next to AI apps) contact, should be informed about all the cross-border healthcare options so they can advise patients appropriately. A separate question might be whether the providers would be interested in doing so, or if they would prefer to keep patients in their national healthcare system. One argument providers make against cross-border healthcare is that it means public funds are used to finance public and private healthcare in another MS, reducing the public funds available for national healthcare provision. At the same time, cross-border healthcare may incentivise more efficient national healthcare provision and reduce waiting times in order to keep funds in the MS where they have been collected as taxes or social security contributions.

The influence of EU cross-border healthcare law on national access to healthcare

The question is whether non-cross-border, national patients have, or should have, access to healthcare equal to that of moving patients. Even if EU law explicitly excludes any direct influence on national public healthcare systems[75], its provisions might result in their being modified. Not only should all kinds of access to healthcare be improved within the EU (particularly in some MSs, as shown by CJEU case-law), the standard of healthcare has been internationalised ('Europeanised') too by the CJEU (the standards of international medical science rather than those of national professional circles having been applied)[76].

Should publicly insured (or NHS covered) national patients be denied coverage by social security when they visit private healthcare providers (outside of public healthcare network) in their county? This issue relates to purely national law as a consequence of EU law, and raises the question of so-called reverse discrimination. It may occur when EU citizens find themselves subject solely to the domestic law of a given MS. Since, as the cross-border rules do not apply, they cannot rely on EU law on coordination of social security systems or on the free movement of services to obtain a particular benefit. Only the national law of the MS concerned could be invoked, which might turn out to be less favourable than EU law[77].

Cross-border patients relying upon the directive will have the option to choose between public or purely private healthcare providers in the MS of treatment. Conversely, a patient, whose situation is limited to just one MS, might not have access to purely private healthcare providers[78]. Also, national, purely private healthcare providers might argue that there is unjustified, unequal legal treatment with providers just across the border[79].

However, it could be argued that similarly as in international private law, when more than one legal regime applies to a person, the most suitable can be chosen. In the case at hand, EU law applies in cross-border situations and national law applies solely in national situations. Hence, there is no conflict and no choice of law available. However, could it really be argued that reverse discrimination is in complete accordance with EU law and national laws of the MSs? The CJEU has already recognised the rights (e.g. of no expulsion) based on EU citizenship without any direct movement within the EU,[80]hence, in purely internal situations of a given MS. It could be argued that EU citizenship could also be applied to combat the undesired results of reverse discrimination.

Additionally, the question is, what could be done under national law? Should the MSs establish open access to all kinds of public and private healthcare providers such that they are covered by their public healthcare systems in purely national situations as well? And in this case should reimbursement of private healthcare then be limited to a certain part of public fees (as it is in some MSs)? It could be set at 80 % of public cost, as in Austria and some other MSs providing lower reimbursement for healthcare provided by purely private providers (regardless of whether they offer services in the country or across the border). If a

lower amount of reimbursement is admissible, could it not be set below 80 %, even 0 % of public fees (as once proposed in the Netherlands)[81]?

If so, is that not a danger for solidarity, i.e. wealthier patients would use private healthcare (with more ambitious and better paid doctors) and settle for only partial reimbursement, whereas others would be forced to stay in the public healthcare system. Public healthcare, provided only to those who could not afford private healthcare might by itself become a poor system (with less ambitious doctors)[82].

Perhaps a solution could be to delineate between public and private provision of healthcare, one within the public healthcare network (and for secure payment) and the other on the private healthcare market, nationally and across borders. Both systems of public and private healthcare are welcomed and required to satisfy the health needs of patients. Difficulties may present themselves, when they are both competing for public funds. Should public systems not be financed by public funds and private by private funds? If both are financed by public funds, patients may be steered even more towards private healthcare provision with (higher) profits for healthcare providers. The costs should be more or less the same for patients, but the funds, collected by taxes and social security contributions, would be used solely for improving the public healthcare system, making it more resilient for future sanitary and health crises awaiting European nations. Perhaps incentives for steering patients in this way would have to be minimised or reduced, both nationally and across borders.

It might be that the CJEU is already paving the way towards distinguishing public and private cross-border healthcare. In the case C-489/23 *Casa Judeţeană de Asigurări de Sănătate Mureș and Others* from 2 September 2025, the court argues 'In so far as Article 7(7) of Directive 2011/24 provides that the Member State of affiliation may impose on a person seeking reimbursement of the costs of cross-border healthcare the same conditions, criteria of eligibility and regulatory and administrative formalities as it would impose if this healthcare were provided in its territory, it follows from this that, where a Member State has chosen not to reimburse costs of healthcare provided by healthcare providers established on its own territory unless those providers are part of the social security system or public health system of that Member State, the same condition may, in principle, be imposed in connection with that provision.'

Concluding remarks

To propose viable amendments to EU cross-border healthcare law, it is vital to understand the reasons for the current legal situation, at national and EU levels. National public healthcare systems differ, as does private health insurance. Moreover, there are several EU mechanisms that allow patients to access cross-border healthcare funded, at least in part, by public resources. One is based on cooperation between public healthcare systems, and the other on free movement of healthcare services and medicinal goods. Substantive rights to healthcare are regulated in each national public healthcare system (a so-called static, material part of healthcare), accessing them across borders presents a dynamic, procedural part of healthcare provision to patients. That is why both national regulations and EU law have to be considered together, as they influence each other.

The public policy ideal must be to provide high-quality healthcare to all EU citizens and residents in each of the MSs and with cross-border cooperation, which in turn incentivises improvements in national healthcare systems. The question is, who benefits or should benefit from cross-border healthcare, and who has limited or no access to the highest attainable standard of health as an international standard of the right to health. Distinctive, open issues present themselves mainly due to mixture of public and private healthcare solutions, i.e. coordination of public healthcare systems and free movement of (private-market-based)

healthcare. The latter is more emphasised in the internal market than in some MSs, which might lead to undesired results, if the aforementioned ideal is a public goal.

Then the question is, who should be in control of public funds, MS, EU, healthcare providers, patients, or all of them to some extent. If public funds are a responsibility of public entities (MSs, regions, and other local communities), they should not merely follow the patient cross-borders, especially when these are acting as private patients, since this option favours wealthier, better informed and better connected EU citizens and does not provide universal and equitable access to all.

Policy options depend on policy preferences. If universal access to healthcare[83] (including cross-border healthcare) is preferred, perhaps delineation between public healthcare systems and the private healthcare market shall be emphasised. If that is done so at a national level, it might be easier to distinguish between public and private responsibilities across borders as well.

Public systems may be subject to social security coordination rules and private ones concerned with free movement freedoms and cross-border private health insurance coverage. MSs would probably have to remain in control over public health funds with prior authorisation for planned cross-border healthcare being treated as an exception and applied narrowly. Public funds should probably not be completely left to cross-border patients and the healthcare providers who influence their choices. Cross-border healthcare also distinguishes between public and private patients, and such distinction might have to be followed more strictly, as CJEU seems to recognise. Enhanced clarity in EU cross-border healthcare law (from coordination and free movement aspects) would be desirable concerning telemedicine and inactive European citizens' access to public healthcare. Levelling the playfield by providing full and easily accessible information to cross-border (public and private) patients is essential, and healthcare providers would have to be well educated and willing to share such information with patients.

The starting point should be public health systems rather than the private healthcare market. Legally, it might be easier to shape public systems than to regulate private markets, which will always have space in the MSs. It should be a legally (not just politically) binding commitment of the MSs to maintain and improve high quality healthcare for all in a financially stable, public health system. Policy solutions should be agreed upon among the MSs and in the EU legislative process, not left to the CJEU's decisions. The Court does not have an easy task of construing EU law *erga omnes* (i.e. binding or effective vis-à-vis all) based on the facts of a concrete case at hand.

During recent sanitary and health crises in Europe and around the globe (e.g. with a rare Hantavirus and Ebola, caused by Bundibugyo virus outbreaks in some countries), the responsibility of states and their public healthcare systems comes to the fore. It is only public systems, which are concerned with equality and solidarity among people (as a connecting tissue of every society). Market-based healthcare pursues other (fully legitimate) goals of market competition and profits of (internal) market service providers. Both are required, and have their place in the MSs and the EU. The core question is, how to align the two? Is the purpose to fund profits of purely private healthcare providers from public funds, collected through solidarity mechanism and for solidarity purpose (only) across borders or at all? If there are mixtures of the two, should private health insurances not be included in the EU cross-border healthcare rules? Or should the delineation between the two be stressed and public healthcare systems strengthened, nationally and be publicly coordinated across borders?

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1 In some countries the national health system is not considered to be part of the social security system. For the purposes of the present paper it shall be included under the scope of social security, as is the case under international law (e.g. ILO Convention No 102 on minimum standards of social security) and EU law (e.g. Regulation (EC) 883/2004 on the coordination of social security systems).

2 J. Berghman, 'The invisible social security', in W. van Oorschot, H Peeters, K. Boos, *Invisible social security revisited* (Tielt: Lannoo 2014) 37.

[3] And legally residing and moving third-country nationals, according to the Regulation (EU) No 1231/2010 of 24 November 2010 extending Regulation (EC) No 883/2004 and Regulation (EC) No 987/2009 to nationals of third countries who are not already covered by these regulations solely on the grounds of their nationality, OJ L 344.

[4] For example, Judgment of the Court of Justice of 16 July 2009, *von Chamier-Gliszczinski*, C-208/07, ECLI:EU:C:2009:455.

[5] In some Member States the notion of sickness may be defined by law, in others it may be left to legal theory and the courts of law (e.g. in Germany). See for example R. J. Sticken, *Die Entwicklung des Krankheitsbegriffs der gesetzlichen Krankenversicherung- Ursachen aus Auswirkungen der Veränderung* (Verlag Peter Lang, Frankfurt am Main, 1985). A more general definition could be internally or externally caused irregularity in the functioning of the human body resulting in an inability to work and/or the need for healthcare. Sickness could hardly be defined as contrary to the definition of health by the WHO in the preamble of its constitution (as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity). On the development of social risks through time G Strban 'Social risks and their development' in M. Mocella, E. Sychenko (eds): The quest for labour rights and social justice (Franco Angeli, Milano, 2024) 143.

[6] Article 12 of the International Covenant on Economic, Social and Cultural Rights, Article 35 of the Charter of Fundamental Rights of the European Union.

[7] For instance in Belgium, 'conventional' (*geconventioneerd/conventionné*) healthcare providers are independent private practitioners who agree to the official fees established by the National Institute for Health and Disability Insurance (NIHDI). By accepting this agreement, they are bound by these set tariffs and are legally prohibited from charging patients additional extra-fees. Moreover, visiting a GP first is promoted. S. Gerkens, S. Merkur (ed) *Belgium: health system summary 2024* (European Observatory on Health Systems and Policies, 2024) 13, https://iris.who.int/server/api/core/bitstreams/d7c86178-b23e-4bb4-b7c5-d2d8ced89ca6/content.

[8] See e.g. https://hiva.kuleuven.be/nl/kalender/docs/8-frederic-de-wispelaere-preliminary-results.pdf.

[9] Article 12(4) of the (initial and revised) European Social Charter encourages the Parties to take steps, not only by bilateral and multilateral cooperation, but also by other means (hence also unilateral measures) to ensure coordination of social security systems.

[10] C. Mullan, P. Wilson, M. Guillermo-Ramirez, *Cross-Border Patient Mobility in Selected EU Regions* (Brussels: EU 2021).

[11] G. Strban, 'MSs' approaches to bilateral social security agreements' *European Journal of Social Security* (2018) 129.

[12] M. Fuchs, R. Cornelissen (eds), *EU Social Security Law, A Commentary on EU Regulations 883/2004 and 987/2009* (C-H. Beck-Hart-Nomos, 2015) 6.

[13] Regulations No. 1 and 2 dealt with the use of languages and the form of the *laisser passer* to the Members of the European Parliament, respectively.

[14] Both Regulations 3 and 4/58/EEC became applicable as of 1 January 1959.

[15] Treaty on European Union (TEU) and Treaty on the Functioning of the European Union (TFEU), both published as consolidated versions in OJ C 202, 7.6.2016.

[16] For instance, CJEU included special non-contributory cash benefits, as they are linked to one of the traditional social risks, and the legislature opposed to it, by introducing special rules for this kind of benefits in 1992. M. Fuchs, C. Hofmann, 'Artikel 70' in M. Fuchs, C. Janda (eds), *Europäisches Sozialrecht* (Nomos, 2026) 563.

[17] Cornelissen, Rob. Achievements of 50 years of European Social Security Coordination. In: Jorens, Yves (Ed.). 50 years of Social Security Coordination, Past-Present-Future. European Union, 2010 P. 63.

[18] Regulation (EC) No 883/2004 on the coordination of social security systems, OJ L 166 30.4.2004 as amended,

[19] Unanimity requirement was later modified to quality majority voting.

[20] Regulation (EC) No 987/2009 laying down the procedure for implementing Regulation (EC) No 883/2004, OJ L 284 30.10.2009, as amended

[21] The latest proposal can be found in the Final Compromise Agreement, i.e. Proposal for a Regulation of the European Parliament and of the Council amending Regulation (EC) No 883/2004 on the coordination of social security systems and regulation (EC) No 987/2009 laying down the procedure for implementing Regulation (EC) No 883/2004 – Analysis of the final compromise text with a view to agreement, 8387/26, Brussels, 23.3.2026.

[22] Only when (temporarily) staying in another MS benefits in case of urgent medical treatment, including hospitalisation were provided.

[23] Article 19 Regulation (EEC) 3/1958 on social security rights of migrant workers, OJ 30, 16.12.1958.

[24] Article 48 TFEU applies to 'employed and self-employed migrant workers'. It seems that self-employed persons were squeezed into the chapter of free movement of workers, just to provide a direct legal basis for coordination of their social security. Normally, other chapters, such as freedom of establishment and freedom of providing services would be applicable to them.

[25] Non-withstanding the fact that persons should have enough funds to move, not to become an unreasonable burden of the host MS according to the Free movement (or Residence) Directive 2004/38/EC on the right of citizens of the Union and their family members to move and reside freely within the territory of the MSs, OJ L 158, 30.4.2004.

[26] Under the Italian legislation then applicable, the export of foreign currency was authorised up to a certain limit. The Italian Ministero del Tesoro imposed on Ms Luisi two separate fines equal to the difference between the amount of currency she exported and the maximum permitted limit under the legislation. Ms Luisi contested the legality of the orders imposing the fines and stated that she had exported the currency in question in particular for the purpose of various periods spent as a tourist in the Federal Republic of Germany and France. At that time, she had also undergone medical treatment of various kinds in Germany. According to the plaintiff in the main proceedings, the Italian provisions limiting the exportation of means of payment in foreign currency for the purposes of tourism are incompatible with the provisions of Community law relating to the movement of capital and current payments. Similarly, Mr Carbone exceeded the limit and contested his fine. The CJEU emphasised that in order to enable services to be provided, the person providing the service may go to the MS where the person for whom it is provided, is established or else the latter may go to the state in which the person providing the service is established. Whilst the former case is expressly mentioned in the Treaty, which permits the person providing the service to pursue his activity temporarily in the MS where the service is provided, the latter case is the necessary corollary thereof, which fulfils the objective of liberalising all gainful activity not covered by the free movement of goods, persons and capital (Paragraph 10 of the judgment). Transfers in connection with tourism or travel for the purposes of business, education or medical treatment constitute payments and not movements of capital, even where they are effected by means of the physical transfer of bank notes, argued the court.

[27] G Strban, 'Cross-border healthcare and social security rights' in F Pennings, G Vonk (Eds.) *Research Handbook on European Social Security Law, Second Edition* (Edward Elgar Publishing, 2023) 337.

[28] In cases C-157/99 *Geraets-Smits and Peerbooms*, C-385/99 *Müller-Fauré and van Riet*, C-372/04 *Watts*, C-444/05 *Stamatelaki*, C-211/08 *Commission v. Spain*, C-173/09 *Elchinov*, and others mentioned below.

[29] Which is one of the conditions enshrined in Article 56 TFEU.

[30] G Strban 'Patient mobility in the European Union: between social security coordination and free movement of services' 14 *ERA Forum* (2013) 397.

[31] COM(2008) 414 final, Brussels, 2. 7. 2008.

[32] OJ L 88, 4. 4. 2011.

[33] C Diesenreiter, A Österle 'Patients as EU citizens? The implementation and corporatist stakeholders' perceptions of the EU cross-border health care directive in Austria' 11 *Health Policy* (2021) 1498.

[34] See https://europa.eu/youreurope/citizens/work/social-security-and-benefits/social-security-forms/index_en.htm, example available e.g. at https://impatria.com/wp-content/uploads/2025/12/s1-form-EN.pdf

[35] See also European Commission *Explanatory note on necessary healthcare* (January 2011).

[36] E.g. Slovenian Supreme Court decisions SI:VSRS:2012:VIII.IPS.182.2011 and SI:VSRS:2012:VIII.IPS.47.2012.

[37] The Decision S3 of the Administrative Commission for the Coordination of Social Security Systems (OJ C 106, 24.4.2010, in force since 2014) stipulates that healthcare shall include benefits provided in conjunction with chronic or existing illnesses as well as with pregnancy and childbirth, but not when the objective of the stay in another MS is to receive these treatments. G Strban, 'Cross-Border Healthcare Law Development: Connecting Points Between Slovenian and EU Law' in K Koldinská, G Strban, A Kun, M Wujczyk, *Labour Law and Social Security Law in Central and Eastern Europe, 20 Years of EU Membership* (Springer, 2025) 161.

[38] Article 19 Regulation (EC) 883/2004 and Article 25 Regulation (EC) 987/2009. Annex to the Decision S3 of 12 June 2009 defining the benefits covered by Articles 19(1) and 27(1) of Regulation (EC) No 883/2004 and Article 25(A)(3) of Regulation (EC) No 987/2009, OJ C 106, 24.4.2010.

[39] Case C-211/08 *Commission v Spain*.

[40] Case C-372/04 *Watts*.

[41] Case C-268/13 *Petru*.

[42] Case C-777/18 *Vas Megyei Kormányhivatal*.

[43] Case C-326/00 *IKA*.

[44] Article 4 of the Directive 2011/24/EU.

[45] Art. 3(b) and (h) of the Directive 2011/24/EU.

[46] Art. 14 Directive 2011/24/EU.

[47] Also Recital 13 of the Directive reiterates that only costs of healthcare to which a person is entitled according to the legislation of the MS of affiliation should be reimbursed.

[48] Explanation of reimbursement in case of comfort requests by the patient could be found in the Appendix to the Guidance note of the Commission, point II. 2.

[49] Recital 32 and Article 7 (4) of the Directive 2011/24.

[50] Case C-368/98 *Abdon Vanbraekel and Others* v *Alliance nationale des mutualités chrétiennes (ANMC).* Compare with Art. 26 (7) of the Regulation 987/2009.

[51] Paragraph 81 as well as operative part of the judgement (maybe not so explicit in English, but clear in other languages).

[52] Regulation has priority, 'unless the patient requests otherwise.' Article 8(3) Directive 2011/24/EU.

[53] Article 288 TFEU.

[54] As with every directive, the Directive is addressed to the MSs and if not properly transposed in time, it might be concrete enough to be directly effective. This would mean that prior authorisation even for e.g. hospital cross-border treatment would not be required. Prior authorisation is an exception according to the Directive (Art. 8) and has to be regulated in order to apply. Some MSs required a bit more time and infringement procedure for late or incomplete notification was launched against as many as 26 MSs. Commission report on the operation of Directive 2011/24/EU, COM(2015) 421 final, Brussels, 4.9.2015, p. 3.

[55] Case C-777/18 *Vas Megyei Kormányhivatal*.

[56] Hence, 19 out of 27 EU MSs (and Iceland) have a system for prior authorisation. F Puppo, A Roca-Umbert, F Lupiañez-Villanueva, *MS data on cross-border patient healthcare following Directive 2011/24/EU, Reference year 2024* (EU, 2026) 25.

[57] Article 8 Directive 2011/24/EU.

[58] G Strban (ed.), G Berki, D Carrascosa Bermejo, F Van Overmeiren, *Access to healthcare in cross-border situations, FreSsco Analytical Report 2016* (Brussels: EU 2017) 38.

[59] G Strban 'Patient mobility in the European Union: between social security coordination and free movement of services' 14 *ERA Forum* (2013) 398.

[60] G Strban, 'Cross-border healthcare and social security rights' in F Pennings, G Vonk (ed), *Research Handbook on European Social Security Law* (Edward Elgar Publishing, 2023) 348.

[61] Case C-243/19 *Veselības ministrija*.

[62] Articles 20 Regulation (EC) 8783/2004 and 26 Regulation (EC) 987/2009.

[63] Article 1 Directive 2011/24/EU.

[64] Articles 3(b) and 7(7) Directive 2011/24/EU.

[65] G Strban 'In need of care? Free movement for persons in need of health- and long-term care' (2026) in print.

[66] Ibid.

[67] Article 1(k) Regulation (EC) 883/2004.

[68] Article 6 Directive 2004/38/EC of 29 April 2004 on the right of citizens of the Union and their family members to move and reside freely within the territory of the MSs [2004] OJ L158/77.

[69] Article 11 (2) Regulation (EC) 987/2009.

[70] It was found to be against social security coordination Regulation, i.e. Article 11(3)(e) of Regulation (ES) 883/2004 and Free Movement Directive, i.e. Article 7(1)(b) Directive 2004/38/EC.

[71] More G Strban *Cost sharing for health and long-term care benefits in kind* MISSOC Analysis (2014) 13, https://www.missoc.org/documents/archive/analysis/2014_analysis_EN.pdf.

[72] Ibid 17.

[73] G Strban, 'Cross-border healthcare and social security rights' in F Pennings, G Vonk (ed), *Research Handbook on European Social Security Law* (Edward Elgar Publishing, 2023) 343.

[74] Article 4 Directive 2011/24/EU.

[75] Article 2 Regulation (EC) 883/2004 and article 1(4) Directive 2011/24/EU.

[76] Case C-157/99 *Smits and Peerbooms*.

[77] G Strban 'Cross-border healthcare and reverse discrimination: An (un)solved issue?' in A Aranguiz, B Bednarowicz, M Quené, D (ed) *Pioneering Social Europe, Lieber Amicorum Herwig Verschueren* (die Keure, Brugge, 2023) 317.

[78] Such a concern was voiced by several MSs. Minutes of the Working Party of the Administrative Commission, A.C. 532/14REV, Brussels 9 October 2014, EMPL/-2261/14 – EN, p. 9.

[79] D Carrascosa Bermejo, 'Cross-border healthcare in the EU: Interaction between Directive 2011/24/EU and the Regulations on social security coordination', (2014) 15(3) *ERA Forum*, 366.

[80] C-34/09 *Zambrano*; also C-212/06 *Government of the French Community and the Walloon Government v The Flemish Government*.

[81] G Strban (ed.), G Berki, D Carrascosa Bermejo, F Van Overmeiren, *Access to healthcare in cross-border situations, FreSsco Analytical Report 2016* (Brussels: EU 2017) 85.

[82] G Strban, 'Cross-border healthcare and social security rights' in F Pennings, G Vonk (Eds.) *Research Handbook on European Social Security Law, Second Edition* (Edward Elgar Publishing, 2023) 350.

[83] See UN Political declaration of the high-level meeting on universal health coverage (2023), https://docs.un.org/en/A/RES/78/4

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