

Cross-border health care in the European Union: recent legal implications of 'Decker and Kohll'

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Abstract

In the European Union a growing number of citizens are receiving medical treatment in a country other than the one in which they are resident. This concerns migrant (frontier) workers, emergency treatment and preauthorized care. Since 1998 a 'new category' can be discerned of persons going abroad without prior authorization on the basis of the Decker and Kohll rulings of the EC Court of Justice. Local payers would, because of the Decker and Kohll judgements, be obliged to reimburse patients who travel abroad to circumvent the existing problems with the authorization rules.

During the past years studies within specific so-called Euregions have been performed to analyse cross-border flows and provide some more insight in the practical and health policy consequences of the Decker and Kohll judgements. The abolishment of current preauthorization is pleaded for by many respondents in these studies. Waiting lists form an important motive (in particular in the Netherlands) to consume health care in another Member State (Belgium and Germany). The familiarity with (health care in) Belgium eases the unofficial Decker and Kohll route. However, when some parts of the health care services seem to be more expensive in the other Member State, the patient has to pay the difference. New court cases are pending before the European Court of Justice. These cases raise new issues such as the tenability of 'benefits-in-kind' systems. So far, the Decker and Kohll rulings could be seen as an incentive to enhance access to cross-border health care in border areas.

Introduction

In the European Union (EU) a growing number of EU citizens are receiving medical treatment in a country other than the one in which they are resident. This situation particularly concerns migrant workers, persons benefiting from double access to health care (E106), travellers going to another state for temporary stay (tourism, short-term work, study) and who need immediate necessary care (E111), and patients who obtain prior authorization for medical

treatment in another Member State by their competent institution (E112).

Cross-border care is regulated at EU level using the basic principles of European and international (health) law, the European Community (EC) and European Economic Area (EEA) Treaties, in particular the free movement of persons (in the latest version, Article 39 EC Treaty), and the EC Regulations on the co-ordination of social insurance 1408/71 and 574/72. Since 1998 a 'new category' can be discerned of insured persons going abroad for medical

treatments without prior authorization and claiming reimbursement after returning to their country of origin on the basis of the Decker and Kohll rulings of the EC Court of Justice.

According to Article 18.1 of the EC Treaty: 'Every citizen of the Union shall have the right to move and reside freely within the territory of the Member States, subject to the limitations and conditions laid down in this Treaty and by the measures adopted to give it effect.'

This paper focuses on the cross-border care of patients and insured persons visiting other Member States and falling under the social health insurance system (or the national health service) of the country of origin and focuses in particular on the consequences of 'Decker and Kohll' rulings of the Court of Justice of the European Community in the border regions of Belgium, Germany and the Netherlands. What are the legal consequences for patients of these cross-border movements? Could the judgments be regarded as threats for the national health care systems or just as challenges for improving the right to access for patients of medical services in the EU?

The paper presents some empirical data of two recent cross-border health care projects in the border regions of Belgium, Germany and the Netherlands. Within these projects experiments have been set up on the basis of the existing legislation that guaranteed patients easier access to health care services abroad. However, these experiments do not prevent patients seeking medical treatments or buying products directly and without preauthorization in other Member States on the basis of the Decker and Kohll rulings of the European Court. Therefore, should these 'Decker and Kohll' rulings and new cases be regarded as incentives to enhance access to cross-border care or will they lead to considerable problems for both patients and the existing health care systems in the European Union?

Cross-border health care: some general aspects

Individual Member States of the EU are, in principle, exclusively responsible for the provision of health services within their national boundaries.

Unlike public health, health care is not defined specifically as a European responsibility in the Treaties of the EU. However, many formal EU policy areas contain provisions which impact on health care. Medical treatment received by EU citizens in a Member State other than the one in which they pay social security contributions is regulated by EU law. Regulations 1408/71 and 574/72 of the European Commission (1971, 1972) cover access to health care for workers and their families. The context for the development of these regulations, which provided for the preservation and co-ordination of national social security rights across EU Member States, was the need to ensure and promote the mobility of frontier workers. Originally, such regulatory provisions consisted of bilateral agreements between states. As more states became involved these agreements came to be organized multilaterally on the basis of the European Economic Community (EEC) Treaty and EEC Regulations, supplemented by continuing bilateral agreements. In December 1998 the European Commission (1998) presented a proposal for a new Regulation to update no. 1408/71 which would provide the extension of existing provisions to all persons covered by the social security legislation of a Member State.

The currently existing European Coordination Regulations 1408/71 and 574/72 permit three types of cross-border care: for migrant (mostly frontier) workers, emergency treatment during temporary stays, and preauthorized care.

Frontier workers benefit from double access to health care, simultaneously in both their state of residence and in the state in which they work. To initiate this right in the state of residence an E106 form is issued. In some cases, as with frontier workers between France and Belgium, this double access has been extended by bilateral agreement to family members.

The EU Regulations also provide for mechanisms for individuals to access health care abroad in emergency situations. It applies for tourist mobility and short-term business and professional mobility. The E111 form provides for emergency treatment for citizens of one EU State while they are visiting another. A condition for this type of care is that the person's state of health necessitates immediate care (Regulation 1408/71, Article 22, 1, a).

In cases where patients obtain prior authorization by their national social insurance authority, persons falling under the scope of the co-ordination rules can obtain medical treatment in another Member State. In those cases the treatment will be paid for by their national social insurance authority (Regulation 1408/71, Article 22, 1, b and c). Form E112 proves that the authorization has been given by the competent Institution. Article 22 of Regulation 1408/71 contains a clause which states that authorization cannot be refused in situations where treatment is available in the home state but cannot be provided within a normal time period, taking into account the patient's state of health.

Until recently the authorization policy remained largely a prerogative of national Member States. Cross-border health policy has traditionally been the responsibility of each Member State on the basis of the principle of subsidiarity (Article 5 of the EC Treaty). Subsidiarity empowers national governments to determine health policy within their national borders.

Implications of the Decker and Kohll judgements

The economic integration and the internationalization of capital and labour markets including the free movement of capital, persons, goods, and services, increased population mobility and the international division of labour in the health care sector on the European continent (Kyriopoulos *et al.* 1994). This should also include the pricing of medical goods and services, levels of reimbursement, and types and levels of co-payment.

The Decker and Kohll judgements of the European Court of Justice concerning the treatment of citizens of one Member State in another Member State introduced an entirely new dimension in European health policy making. For the first time, the court's rulings have made mainstream health services subject to two of the principles on which the EU was founded: the freedom of the movement of goods and the freedom of the movement of services. Health care is now deemed to be tradable and, thus, subject to the EC Treaty, thereby constraining the powers of national payers or providers. The implications of both these cases for health policy could be quite com-

pelling in the short term and far-reaching in the long-run.

In the first case (European Court of Justice 1998a) a Luxembourg health insurance fund refused to reimburse its insuree for the cost of a pair of spectacles. The court ruled that the refusal to reimburse goods purchased in another Member State was against the EC Treaty which covers the free movement of goods.

In the second Court ruling (European Court of Justice 1998b) the Court upheld the right of a citizen of Luxembourg to obtain and be reimbursed for dental treatment in Germany also without seeking prior authorization of his Luxembourg social insurance Institution. The Court rendered health services as 'tradable' and available to all EU citizens regardless of their country of residence or their health insurance status or insurance fund.

While the Kohll ruling allows citizens of one Member State to seek medical treatment in another Member State without prior authorization from their health authority or insurance fund it also gives due consideration to reimbursement of the services delivered by the health insurance of the patients' country of residence. Thus, reimbursement of patients will take place according to the rules prevailing in the patients' country.

To the extent that patients are allowed to move freely across borders without prior authorization, the ruling improves on existing regulations involving the E111 and E112 forms for transnational patients. However, there is still confusion as to whether the right applies to both ambulatory and hospital services.

The Decker and Kohll judgements have, thus, resulted in the present cohabitation of two systems for seeking reimbursable cross-border care: continued use of Regulation 1408/71 which provides for full payment of charges incurred by the insured persons with a prior authorization (E112), and a direct right based on the EC Treaty and be reimbursed in accordance with the scale of the State of insurance.

What are the present motives for patients seeking health care treatments abroad and are any increases in the volume of patients seeking care in another Member State already occurring or expected to occur as a result of these judgements?

Motives and consequences of cross-border health care

Cross-border health care occurs where specialized care is not (sufficiently) available in one Member State but can be obtained in another; when waiting lists are significantly shorter elsewhere and when elective care is significantly less expensive across the border (Leidl & Rhodes 1997). Local payers, using local capacity control as a mechanism for cost control would, because of the Decker and Kohl judgments, be obliged to reimburse patients who travel abroad to circumvent these problems. This could involve increased expenditures by local payers. The losers as a consequence of the rulings could not only be local payers, but also local providers since care provided abroad would imply loss of income for them.

Other motives for cross-border care include the increasing mobility of citizens due to tourism, business and short-term stays. Cross-border care is also of interest when workers live near the border of one Member State and work in another. It might also be highly relevant in emergency cases where patients are unable to receive timely and qualitatively appropriate care within their own national health care systems (Hermans 1999).

Finally, an increase in the volume of patients seeking care in another Member State may be due to differences in the perceived quality of the services. According to a recent study on the role of the EU in health care (produced at the request of the Dutch Council for Health and Social Service) one key factor influencing a patient's decision to seek health care abroad is the level of satisfaction with the domestic system (Belcher 1999). Italians, for instance, are particularly dissatisfied with treatment provided in Italy and have high expectations of what is available abroad (France 1997).

Cross-border practices between Belgium, Germany and the Netherlands

Although the aforementioned motives for cross-border health care seem to be strong, in practice the totality of flows of patients is small within the EU (Hermesse *et al.* 1997). However, as the Decker and Kohl cases have highlighted, the EU could have an increasing impact on the cross-border provision and

availability of health care. At present, cross-border flows of patients are concentrated in particular European border regions for reasons such as linguistic similarity or perception of the domestic health system vis-à-vis that available abroad. Traditionally, flows have been greatest between Belgium, France, Germany, Italy, the Netherlands and Luxembourg. During the past years a few studies have been performed to analyse cross-border flows for individual Member States, in particular within specific so-called Euregions. These studies could provide some more insight in the practical and health policy consequences of the Decker and Kohl judgments.

Cross-border health care in the 'Euregio Meuse-Rhine'

On behalf of the European Commission, and within the Inter-regional (Interreg II) programme, a cross-border health care project has been set up to explore how citizens living in the 'Euregio Meuse-Rhine' could obtain improved access to health services in the Member States concerned. The 'Euregio Meuse-Rhine', being one of the more than 60 Euregions in the EU involves a part of Belgium, Germany and the Netherlands and, moreover, three languages: Dutch, German and French. Approximately 3.7 million people live in this Euregio. More specifically, it consists of parts of the Dutch province of Limburg (Middle and South of Limburg); the province of Limburg (Belgium); the province of Liège (Belgium), including the German-speaking community, and the former district of the federal state Aachen ('ehemalig Regierungsbezirk Aachen') in Germany.

This project stimulated (contractual) relationships between purchasers (Dutch sickness funds, German 'Krankenkassen' and Belgian mutualities) and providers to make arrangements on behalf of patients living in the Euregio. On the side of health insurers initiatives have been started on reducing barriers for patients, such as creating possibilities of a flexible application of the forms E111, E112 and (recently E128) which are needed in cases of cross-border health care (Hermans & Ghajar 1999).

In the Interreg II programme, a project IZOM was introduced in which a registration system of the existing cross-border health care by monitoring patients

who received preauthorized care in the neighbouring countries on an experimental basis in which the existing regulations (E112) had been eased. At the beginning of 1999 the IZOM-project started in the Euregio Meuse-Rhine and was completed in December 1999 (Ghajar and Hermans 1999). The research focused not only on Dutch insured persons who crossed the Belgian and German borders to use health care services in the other Member States, but also the other way around. In this research reciprocity was a basic requirement. In total 281 persons participated in the research. From this total number of social insured persons 27% had Belgian nationality, 25% German nationality and 46% Dutch nationality. However, making a distinction between nationality and country of residence it appears that a major part of the participants live in a country other than their country of nationality (Table 1).

Most of the insured persons who participated in this study are between 50 and 59 years of age. Most respondents were informed about cross-border care by their family, friends and relatives (36.6%) and 34.4% by their referring GP (14%) or medical specialist (20%). From the total number of 281 participants, 155 (55.2%) indicated that they have been treated abroad before. Most of them were very content with their previous treatment. Some 11.5% had had a bad experience with reimbursement of the care or treatment that they received abroad. In most cases where preauthorization of a previous

treatment was refused to those insured by their competent health insurer, the refusal was based on the argument that the treatment was also possible in the country of residence, because the speciality was not recognized by the sickness fund, and because the person concerned did not carry his E112. It is important to analyse for what kind of care patients go abroad, and what their main reason is for crossing the border.

From Table 2 it can be seen that 'distance' is, for seven of the specialties, the main reason for being treated abroad (25.3%). 'Better treatment' is second with 15.7%. General surgery (17.5%), gynaecology (15.3%) and orthopaedics (13.1%) are the main other types of care patients crossing borders are being treated for.

'Distance' is not always the main reason to be treated abroad. When a further distinction between nationality and country of residence is made, 'waiting time', 'language' and 'recommended by the specialist' are also important indicators of choice of whether or not to consume health care in another Member State. Insured persons are mostly going abroad for general surgery and gynaecology, while pensioners generally require ophthalmology and general surgery.

The respondents were also asked for recommendations and improvements of the present system. A large number of respondents pleaded for more freedom of choice, abolition of the present preauthorization system, a faster, more simplified administration, and less bureaucracy. An important recommendation of some respondents was to keep their own GP when moving to another country, and the creation of the possibility to keep their own dentist.

Conclusions from this study are that general surgery, gynaecology and orthopaedics are the main types of care for respondents to go abroad for. The combination of nationality and country of residence shows that 'waiting time' is the main reason for Dutch respondents and Germans living in the Netherlands. For Belgians who also live in Belgium 'recommended by the specialist' is their main motivation.

As a consequence of the Decker and Kohl judgment it could be argued that, in the Netherlands, waiting times in particular could form a strong incentive to be treated abroad without preauthorization.

Table 1 Country of residence and nationality

	Country of residence			Total
	Belgium	The Netherlands	Germany	
Nationality				
Belgian	74	1	1	76
Dutch	47	76	5	128
German	—	58	14	72
Other	5	—	—	5
Total	126	135	20	281

Source: Ghajar S. & Hermans H.E.G.M. (1999) IZOM, Behoeft van verzekerden aan grensoverschrijdende zorg en hun ervaringen [Needs of insured persons for cross-border care and their experiences], Eindrapport inzake het project Integratie Zorg op Maat in Interreg II, Euregio Maas-Rijn [Final Report concerning integration Zorg op Maat in Interreg II], Rotterdam

Table 2 Types of care and reasons for cross-border health care

	Distance	Waiting time	Language	Costs	Recommended by GP	Recommended by specialist	Better treatment	More attention	Total
Gynaecology	19	5	4	3	7	3	6	1	48
Orthopaedics	13	11	2	2	5	1	5	3	42
Epilepsy	4	—	—	1	2	6	3	1	17
Psychotherapy	7	1	—	1	—	3	10	1	23
General surgery	21	5	4	3	9	8	12	2	64
Orthodontics	2	—	—	1	1	2	3	1	10
Paediatrics	2	—	1	1	—	1	—	1	6
Ophthalmology	14	10	2	—	3	5	3	1	38
Neurosurgery	3	3	—	—	—	7	4	—	17
Internal medicine	14	1	1	2	9	5	3	1	36
Hospital	1	1	—	—	—	—	—	—	2
Remaining	4	5	2	—	12	5	8	2	38
Total	104	42	16	14	48	46	57	14	339

Source: Ghajar S. & Hermans H.E.G.M. (1999) IZOM, Behoeft van verzekeren aan grensoverschrijdende zorg en hun ervaringen [Needs of insured persons for cross-border care and their experiences], Eindrapport inzake het project Integratie Zorg op Maat in Interreg II, Euregio Maas-Rijn [Final Report concerning integration Zorg op Maat in Interreg II], Rotterdam

The abolishment of current preauthorization is also pleaded for by many respondents in this study and forms another strong motive for levelling the existing barriers to cross-border health care. Therefore, strong motives for further cross-border care on the principles formulated by the European Court in the Decker and Kohll judgements can be derived from this study.

Cross-border health care in the 'Euregio Scheldemond' (subregion 'Zeeuws-Vlaanderen')

Almost simultaneously, another project was set up on behalf of the Dutch sickness fund OZ zorgverzekeringen to analyse, from an economic and legal perspective, the consequences of the Decker and Kohll judgements on cross-border health care in the Euregio Scheldemond (subregion 'Zeeuws-Vlaanderen') (Ghajar *et al.* 1999). This Euregio covers East Flanders and a part of West Flanders in Belgium, and the province of Zeeland in the Netherlands. The subregion Zeeuws-Vlaanderen (the most southern part of the province Zeeland, south of the river Westerschelde in the Netherlands) is historically and culturally more oriented towards Flanders in Belgium. This also includes Belgian hospital facilities. For this reason an unofficial bilateral agreement was

made in 1978 between the Belgian and Dutch sickness funds operating in that Euregio and (some) hospitals in Belgium for the treatment of Dutch patients in Belgian hospitals. In the beginning the number of patients asked for permission to be treated abroad was between 1000 and 1500. The agreement has been changed and adapted in the meantime and because of extended possibilities created in 1998, 2300 first requests were administered by the health insurers (mainly OZ zorgverzekeringen, being the principal insurance fund on the Dutch side for this subregion). This represents about 4% of the number of sickness-fund-insured persons. Some 4% cross-border care is exceptional compared with other (sub)regions in the Netherlands. The main reason for this relatively high percentage is that, in general, the level of health care facilities in this subregion has been less developed compared with other regions. There is a lack of highly specialized facilities such as neurosurgery, trauma centres, and transplantation surgery (Scoop 1999). Characteristic of this subregion is that it is a border region. The distance from 'Zeeuws-Vlaanderen' to Belgium (Flanders) is very short (nowhere more than 25 km). The combination of a lack of health care facilities and the short distance to the Belgian border has led to the situation where the basic conditions for cross-border

health care are present. Therefore, the Decker and Kohll judgements can also have a major impact on the cross-border health care in this subregion.

A first consequence could be that the health insurers (sickness funds) will no longer be able to refuse authorization to consume health care abroad. For that reason it could become even more attractive for patients to be treated in neighbouring country. A precondition is that patients must be reimbursed. The question is how many patients would want to consume health care abroad, in addition to the large numbers of patients already leaving 'Zeeuws-Vlaanderen' to look for absent health care facilities abroad?

Within the Dutch health care system, waiting lists form an important motive to consume health care in another Member State (Brouwer & Hermans 1999). Dutch research on waiting lists shows that waiting times in curative and mental health care in the Dutch province Zeeland are, on average, 32 days, while in the rest of the country the average is 27.7 days (Van Wolde 1999). Therefore, excessive waiting time in the Netherlands could constitute a reason for the sub-region 'Zeeuws-Vlaanderen' to consume health care abroad.

For these patients there is hardly any reason to be treated within the Netherlands in another region, because long waiting lists are also to be found there. When, as is the case in Belgium, waiting times are substantially shorter (or even absent) for certain specialties, it would seem attractive for the population in 'Zeeuws-Vlaanderen' to look for health care services and benefits abroad, even without the preauthorization of the insurer, which the Decker and Kohll judgement now enables them to do. What eases this unofficial route is the familiarity with (health care in) Belgium. Another stimulating aspect is that the language on both sides of the border is almost the same, which also eases communication between doctor and patient.

However, financially, there is a clear inhibition towards cross-border health care without preauthorization of the sickness fund. The general population are not only relatively unacquainted with the Decker and Kohll ruling but also of the rights that could be derived from these judgements. The price levels of Belgian health care services are also not as transparent as Dutch health care facilities. Under Decker and

Kohll, treatments abroad must be reimbursed against the national (Dutch) tariffs. When some parts of the health care services seem to be more expensive in Belgium, the patient has to pay the difference. The considerably higher number and amounts of co-payments in Belgium could also form a break on cross-border health care. At the moment these co-payments are being paid by the sickness fund (as kind of goodwill) when patients travel abroad with the authorization of the sickness fund.

From the aforementioned developments it can be concluded that there is a clear difference between the present agreement among the sickness fund 'OZ zorgverzekeringen' and the Belgian hospitals and mutualities and the possible future consequences of the Decker and Kohll judgements. Where the present agreement covers the full costs for Dutch patients against the Belgian tariffs, this is not the case when patients cross the border without preauthorization. This is important because the present price level of Belgian hospitals can differ from the Dutch maximum tariffs. Also, in cases of, for example, ambulatory care, the total amount of care consumed by the insured persons can rise and, as a consequence, the total sum of costs for the health insurance fund can also rise. While they themselves are responsible for keeping the total costs within the budget they receive, Dutch sickness funds, in particular those in border areas like 'Zeeuws-Vlaanderen', currently have hardly any instrument to control the costs of care consumed outside the Netherlands. The present contracting system provides (at least in theory) some (legal and financial) possibilities to control the costs and to steer the contracts made with Belgian hospitals. According to the Decker and Kohll judgements, the insured are free to be reimbursed for treatment abroad. New court cases will show whether or not the Decker and Kohll doctrine is also applicable to the hospital sector. If this is the case, a further undermining of the budgeting system is a real danger, particularly for the OZ zorgverzekeringen sickness fund in Dutch 'Zeeuws-Vlaanderen'.

Future perspectives and health policy conclusions

At least three new important new cases are pending before the European Court of Justice: Smits-Geraets

and Peerbooms (European Court of Justice, unpublished pending joint cases, C-157/99), Vanbraekel (European Court of Justice, unpublished pending case, C-368/98 Vanbraekel vs. ANMC) and Ferlini (European Court of Justice, unpublished pending case, C-411/98, Ferlini).

In the case of Smits-Geraets the Dutch sickness fund refused to reimburse a specialist treatment for Parkinson's disease provided in a German clinic on the grounds that adequate treatment could be provided in the Netherlands. The sickness fund argued furthermore that the German methods added nothing to those on offer in the Netherlands. The precondition for being treated abroad for reason of medical necessity was therefore absent.

In the Peerbooms Case, the Dutch sickness fund refused authorization for a Dutch patient to receive a neuro-stimulation therapy in Austria. This therapy is still experimental in the Netherlands and could be provided in two rehabilitation centres. It falls outside the legally defined compulsory health insurance package.

These pre-judicial questions put before the European Court of Justice are touching at the heart of the Dutch Health Insurance System. The cases raise new issues such as the tenability of the (Dutch) provision criterion that the treatment must be customary in the circle of health professionals, whether the Decker and Kohll judgements apply to 'benefits-in-kind' systems, and the tenability of agreements that are made within the system and the preauthorization for health care in other Member States.

The Vanbraekel case concerns a Belgian-insured patient who was treated in a French hospital without seeking prior authorization. The Belgian Court asked for the European Court ruling, believing that the operation provided in the hospital was necessary. The question here is whether or not the cost of hospital treatment should be reimbursed on the basis of the rules of the competent insurance company in Belgium or according to the rules of the Member State where the treatment took place.

In the Ferlini case, the wife of a European civil servant, covered by EU civil servants' policy, gave birth to a baby in a Luxembourg Hospital. The hospital charged a higher rate than would be customary for a Luxembourg citizen in a similar situation.

Ferlini pleaded that he was indirectly discriminated against because of his nationality, a contravention of the principle of equal treatment and the free movement of employees.

These new cases, as well as the observed practice in the Euregions, show that access to care is limited by present national health legislation and health care policies. For example, Dutch government requires that compulsory insured persons in the Netherlands may obtain care in another Member State as long as the care provider has contracted with the sickness fund of the insured person concerned.

At the moment the awareness of cross-border rights to health care is not widespread in most European countries. The recent cross-border projects in the Euregions 'Meuse-Rhine' and 'Scheldemond' have shown that even there, where the potential for cross-border health care is greatest, the lack of adequate information on cross-border care is conspicuous in its absence. Even where patients are well informed about their rights, practical barriers could prevent them travelling from abroad. As travel and health care costs have to be paid up-front by the patient using the Decker and Kohll system (e.g. co-payments), this may create a two-tier system whereby the more wealthy patients use the Decker and Kohll route, while others will still use the existing system of preauthorized care by using the E112 forms.

The results of the cross-border projects in the Euregions have also shown that the new cross-border health alliances could result in improved possibilities for patients to have access to more health care facilities than existed before, not by way of 'Decker and Kohll', but through a flexible use of the existing E112 route. Alliances between health insurers and providers have been approved and facilitated by the different governmental organizations, which were also involved in such projects.

The Decker and Kohll rulings could also be seen as an incentive to enhance access to cross-border health care in border areas. Rather than holding out against the decisions, governments could see the latest developments as a means of easing ever-lengthening waiting lists. Therefore, it is not only the legal environment that creates possibilities for cross-border health care for patients but also, and even more importantly, the health policy environment that

creates access to cross-border health care facilities for patients.

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