1 Introduction

Territorial sovereignty in social policy, as conventional wisdom has it, is alive and well. We disagree, claimed Stefan Leibfried and Paul Pierson (1995: 44) in their overview of the impact of European integration on national social and health policies. Although EU treaties acknowledge Member States’ prerogatives regarding the organization and financing of their healthcare systems, European integration undermines the principle of territoriality. Health authorities of the EU Member States can no longer determine freely the consumption, purchasing and provision of healthcare within their territories (Leibfried & Pierson, 1995: 50ff). For example, socially insured citizens can obtain reimbursement for cross-border healthcare consumption according to Regulation 1408/71. After 1995, the European Court of Justice has further neutralized the principle of territoriality of healthcare states. In a series of rulings from Kohll/Decker (April 1998) to Watts (May 2006) and Acereda Herrera (June 2006), it has widened the opportunities for cross-border healthcare and its reimbursement.

Despite these widening opportunities cross-border patient mobility has remained fairly marginal in the European Union. Yet the European Commission recently expressed its intention to issue in 2007 a Community Framework for Safe, High
Quality and Efficient Health Services, after it failed to include health services in the so-called Bolkestein services directive. The framework is supposed to provide legal certainty particularly to citizens, health providers, and insurance institutions about the access to healthcare across borders as well as a basis for cooperation among healthcare systems in the European Union. Notwithstanding the limited size of cross-border patient mobility and Member States’ prerogatives, the European Commission thus seeks an active role in one of the last bulwarks of Member States’ legitimacy: healthcare.

The scholarly attention to the impact of European integration on healthcare states has been growing the last few years (see, e.g., Steffen, 2005; Martinsen, 2005; Greer, 2005). Further research is, however, required on the effects of European integration within the EU’s healthcare states (Lamping & Steffen, 2005). This paper traces the effects of European integration on their territorial fundaments. It first explains how European integration has undermined the territorial basis of healthcare states. Then, the focus is on cross-border patient mobility and its implications: do national citizens remain loyal to and satisfied with their healthcare states, or do they increasingly use the exit options offered? In the latter case, European integration may change the relationship between national citizens and their healthcare states fundamentally. The empirical results in this paper are predominantly drawn from the Dutch-Belgian border regions, as cross-border patient mobility in those regions provided important input for the European Commission’s policies regarding health services. To round off, the paper explores the evolving (territorial) nature of the compound European healthcare system: a supply state dominated by health providers and insurance companies like the USA (cf. Moran, 1999), a multi-level healthcare system like in Canada (cf. Banting, 2005), or a unique healthcare system, as a number of opinion leaders recently suggested (HFE, 2007)?

2 The territorial basis of healthcare states in the European Union

Healthcare systems in Europe have been developed within the territorial confines of national states. Since the Second World War they have been gradually extended towards almost universal, obligatory insurance or service coverage of citizens’ basic health needs. They take up a considerable share of a state’s public expenditures, labor force, and gross domestic product. Although the European systems are all (indirectly)
regulated by states, the organization, financing and delivery of healthcare differ from country to country.

Two families can be distinguished among the healthcare states in the EU (Moran, 1999). A **command-and-control healthcare state** is characterized by a state-guaranteed universal health insurance covering citizens’ basic health needs, state-led planning and provision of mainly publicly owned national health services, the funding of healthcare through taxation, and decision-making by elected politicians and public administrators at national, regional or local level. Costs of supplementary health can be covered by private voluntary insurance or direct payments. This model can be found in the United Kingdom and Scandinavia. Southern European and certain Central and Eastern European healthcare states are incomplete versions of this type. Though the universal coverage of basic health has been legally enshrined, in practice, many citizens rely upon private insurance companies and care providers or direct payments to obtain timely healthcare of better quality. Within a **corporatist healthcare state** insurance and provision of healthcare is largely in the hands of hospitals and health insurance funds within a public law framework in which the associations of health professionals and health insurance funds as well as social partners (labour unions and employer federations) have a large say in health policy-making and implementation. This type of healthcare state is largely financed through a social insurance system of income-related social security contributions. The state operates as a director of this corporatist amalgam, only showing its hierarchy in times of (financial) urgency. Countries like France, Belgium, and Germany have corporatist healthcare systems.

The Netherlands is a relative outsider within this corporatist group, as it has a partly tax-financed, universal, obligatory insurance for long-term, privately uninsurable, and high-cost medical treatments (AWBZ). In addition to the AWBZ insurance, until 2005 only two thirds of the Dutch population was covered by an obligatory social insurance for basic healthcare needs, while the rest had to rely on voluntary private insurance to cover health costs. Since 2006, a compulsory insurance covers all Dutch residents. According to this system, private healthcare insurers reimburse clients’ bills of healthcare obtained anywhere in the world (maximised by Dutch tariffs), or contract healthcare providers (if necessary abroad) to provide healthcare to their clients. The latter way of purchasing healthcare is called a benefit-in-kind system (also in Germany). In a reimbursement system (also in Belgium and
Luxembourg) patients can freely choose a care provider for treatment and send the bill to their health insurance funds for reimbursement afterwards.

Command-and-control centralization and corporatist entanglements have an inherent tendency to close off healthcare systems within state borders. The introduction of (nearly) universal, compulsory health insurance within the territorial confines of states has strengthened external consolidation by excluding non-residents as well as solidified loyalties between healthy and unhealthy, rich and poor, old and young, and manual and non-manual workers (Ferrera, 2005). The healthcare state has been the last phase in the formation of European states and nations; provision of healthcare is now part of the social contract between states and their citizens. Richard Freeman (1999) therefore speaks of *health citizenship* in European states.

A majority of citizens in EU Member States expresses themselves against the dismantling of their healthcare systems and cuts to their basic health package, adhering to the principle of solidarity and subscribing to the statement that health care rights of the lower incomes should not be diminished (European Commission, 1998). Since citizens perceive governments in command-and-control and corporatist states responsible for affordable and timely access to healthcare, waiting lists can be a hot topic in politics. Healthcare was the most important issue in the turbulent Dutch elections of 2002 and 2003. 57% and 52% of respondents, respectively, mentioned healthcare as the most important issue in the Dutch Elections Studies and held the government responsible for solving the problems of the waiting lists (Van Holsteyn, 2003: 104, 120; Centrum voor Verzekeringsstatistiek, 2002). Rising assertiveness and expectations among patients and the ageing population further heighten demand for healthcare. Since European governments have to curtail budgets in accordance with the EMU-norms and limit the burden of premiums and taxes to remain internationally competitive, the fulfillment of citizens’ healthcare demands is under pressure.

Until recently, the principle of territoriality designated the membership of healthcare states in the EU (Leibfried & Pierson, 1995: 50ff; Van der Mei, 2001: 7-8; Cornelissen, 1996: 441; Jorens, 2002). Health citizenship and the consumption of health were geographically circumscribed. The right to access to health facilities and reimbursement of the costs were delineated by state borders. Rights and membership obtained in a foreign healthcare system were not valid within the territory of the healthcare state. National health authorities were the only institution to designate membership; no other healthcare system was allowed to compete on the territory. That
was also the case regarding the control over access to the status of health providers and insurance, and the supervision of quality of health treatments and legitimacy of insurance policies.

Healthcare authorities have had various reasons to organise their systems according to the principle of territoriality (Van der Mei, 2001: 7-9; 264-265). Territorial delineation facilitates control of quality and the protection against contagious diseases. In addition, it may prevent patients to shop around for more expensive treatments and medical goods, putting the financial balance of the healthcare system under pressure. The territorial containment of patients also facilitates planning of the healthcare infrastructure. Fluctuations in health demand due to patient mobility would severely hamper efficient planning, resulting in oversupply or undersupply of healthcare facilities. In addition, territorial containment facilitates the compulsory payment for the healthcare system. The overlap of contributors of healthcare premiums and taxes, on the one hand, and health consumers, on the other, also enhances the necessary we-feeling to share the burden of health costs.

The territorial basis of healthcare state has left its imprint on the behaviour of health users. Only some patients made use of healthcare across these borders because of the dissatisfactory state of healthcare at home (Italy) or the insufficient availability of (top-clinical) healthcare (Luxembourg). The cross-border consumption of healthcare took a fairly negligible share of the total public health expenditures within the EU-area until recently, estimated at 0.50% in 1997 (Palm et al., 2000).

3 European breaches in the territorial basis of healthcare states
In principle, no barriers exist to access healthcare across borders. The real issue is the coverage of costs for healthcare obtained outside the healthcare states. Since the late 19th century, a few bilateral agreements have provided frontier workers access to and reimbursement of cross-border healthcare in Western Europe. Since 1958 regulations have existed to cover cross-border healthcare costs for all socially insured workers by coordinating the participating social security systems based on the 1957 Treaty of Rome article to facilitate the freedom of workers. The present Regulations 1408/71 and 574/72 provide various procedures to determine the competent healthcare state to cover the costs of cross-border healthcare. The regulations arrange frontier workers’ right of access of healthcare both in the country of residence and the country of work.
\textit{E-111} and \textit{E-112} are the most important procedures within this Regulation method to cover cross-border healthcare for socially insured citizens.

Coverage of costs of immediately necessary care during a temporary stay abroad for professional or private purposes alike are arranged via a E-111 procedure. In case of acute, unplanned health provision abroad, the health insurance institution ‘at home’ will then cover these health costs. Since 2004, emergency care also includes medical treatments necessary during a stay abroad. As a consequence, a chronic kidney patient can still receive renal dialysis, even though he or she knows in advance that treatment will be necessary during the stay abroad.

Initially, this procedure was foremost aimed at providing Southern-European workers in Northern Europe the possibility to obtain coverage of healthcare costs while being on holiday in their home country. Since the late 1970s, tourists increasingly made use of the E-111 procedure. Until recently, the procedure represented, however, quite an administrative burden for all those involved for only a potential treatment. An E-111 form had to be requested from a domestic health insurance institution before travel. Many tourists were, however, uninformed about the form’s existence (Hermans & Berman, 1998). In certain countries, the foreign health insurance institution also wished to approve the E-111 form in advance to obtain reimbursement for yet unforeseen emergency care. In addition, healthcare providers often preferred to arrange payment via travel insurance, as the payment is faster, direct and less bureaucratic. The national healthcare authorities and a special Administration Committee at European level dealing with the E-111 administration and finance, take much more time than a travel insurance company. Since June 2004, the bureaucratic E-111 paper procedure has gradually been replaced by the European health insurance card (Vollaard, 2006). In a few years, this eye-readable plastic card should also electronically store information on a patient’s personal data and insurance status as well as on medication and medical history. Problems of interoperability and compatibility seem however to prevent fast implementation of electronic cards. The present release of this card is rather slow in Belgium and the Netherlands; and many health providers are not used to it yet (Jorens et al, 2005: 41; AIM, 2007: 7). Next to workers and tourists, an increasing number of retirees use the E-111 form to cover healthcare costs when they stay a couple of months abroad (see contributions in Rosenmöller, McKee & Baeten, 2006).
When an employee plans to seek treatment in another Member State, he/she should request prior authorization from the competent health insurance institution based on an E-112 form. This authorization cannot be refused if two conditions are fulfilled, 1. the desired treatment is part of the employee’s healthcare package, and 2. the treatment cannot be given within the period that is normally necessary in view of his current state of health and the probable course of his disease. The first condition has thus been phrased by the Council of Ministers in 1981, after the European Court of Justice interpreted a previous version of the E-112 procedure too patient-friendly, allowing patients to use any more effective health treatment abroad if that would not be available in their home country (Jorens, 2002: 91-92). Both the E-111 and E-112 procedure cover costs based on the highest tariffs, disregarding it is the healthcare system where the patient received the actual treatment or the healthcare system where the patient is insured. The national healthcare authorities and Administrative Committee deal with the financial settlements. Unavoidable costs for a patient’s accommodation and food should also be covered, and also the travel and lodging costs of accompanying family or friends, provided that it is part of the healthcare package.

The right of coverage of healthcare abroad has been gradually extended from employees and their relatives to virtually all people legally residing in the EU, such as, those being self-employed and their families, students, transport workers, pensioners, posted workers, unemployed persons looking for a job in another Member State, civil servants, and to all legally resident socially insured third-country nationals. In addition, the Regulation method also fully applies in the European Economic Area (EU plus Liechtenstein, Norway, and Iceland), and (with certain restrictions) in Switzerland.

Regulation 1408/71 overrules the principle of territoriality of national healthcare systems. In certain cases, the Member States can no longer territorially delimit the coverage of healthcare costs, the consumption of health (even if a EU/EEA-citizen did not contribute), and the provision of healthcare: the co-ordination system (i.e. Regulation 1408/71, HV) deterritorialises the national systems in order to ensure that migrants are entitled to benefits on the basis of their own insurance record. (Van der Mei, 2001: 75). Healthcare systems in the EU-area are no longer closed shops within state borders (Leibfried & Pierson, 1995: 50ff; Leibfried & Pierson, 2000: 283). Insurance rights follow the worker anywhere in the area of the Member States, meaning a personalization of previously territorially restricted rights (Watson, 1980).
While regulation 1408/71 was originally aimed at the freedom of movement of workers, it has been expanded such that under certain circumstances, the fact that a person has never worked or resided in another Member State is not, as such, an obstacle to entitlement to medical care in another Member State. (Cornelissen, 1996: 463).

As long as cross-border patient mobility remained low this encroachment on territorial sovereignty was not of great concern to the Member States. The creation of a Single European Market changed that gradually. For instance, the liberal VVD party expressed its concern in parliament that foreign insurance companies might enter the Dutch health insurance system (Second Chamber, 1987-1988). In addition, law professors warned that European legislation on competition and free movement constrains the market-oriented health reforms in the Netherlands of the late 1980s and early 1990s. According to an interviewed health official, the law professors were initially not taken too seriously, because no one could imagine that Brussels or even Luxembourg would determine what happens in our Kingdom. The reforms partly failed, however, because of strong political opposition. The opponents also referred to the reforms’ alleged non-compatibility with European legislation. After a Conference on Health under Dutch presidency in 1991 the EU-health ministers recognize(d) that Member States need to make allowances for the effects that the completion of the internal market may have on the operation of health-care services and their nature and extent (Council/Ministers for Health, 1991). They therefore agreed to exchange information and initiate research on the impact of the internal market, which in turn led to a number of experiments with cross-border healthcare particularly in Dutch and Belgian border regions (Vollaard, 2004). Repeatedly, the governments of EU Member States emphasized in Council statements their prerogatives regarding the financing and organization of their healthcare systems. In 1997, they laid those prerogatives down explicitly in the Amsterdam Treaty.

Starting with its verdict on the Kohll&Decker case in April 1998, the European Court of Justice shattered Member States’ image of exclusive prerogatives in healthcare, particularly regarding the consumption of medical goods and services and its reimbursement. In the 1984 Luisi and Carbone cases (Joint Cases 286/82 and 26/83) the Court already stated that all European citizens have the right to travel to another Member State to receive medical services. According to the new Court’s
interpretation of European law, patients are also allowed to obtain reimbursement of cross-border healthcare under certain conditions. Freedom of services and goods also accounts for medical treatments and devices. The national healthcare states are not exempted from European legislation, neither with respect to competition and insurance, nor with regard to free movement of services and goods. Thus, the Court created a new method to cover costs of cross-border healthcare (as long it is in the health insurance package), neutralizing the Regulation method by directly referring to the Treaty articles on free movement (Jorens et al, 2005: 65). The Court’s interpretation caused much upheaval among national health authorities because– in the words of a Dutch health official - it ran counter to the principle of sovereignty, potentially opening the gates of national healthcare systems without any restraint.

According to another official, the Court’s rulings caused many sleepless nights for national health care policy makers, at least in the Netherlands. In its series of verdicts, the ECJ considers the Treaty articles on free movement applicable to both inpatient and outpatient care, as well as to all types of healthcare systems in the EU.

The Court, however, allowed limits to the free movement of health services and goods if they are motivated in advance upon the objective, non-discriminatory criteria of ensuring public health, sustaining the financial equilibrium of health systems, as well as maintaining balanced planning and accessibility of healthcare facilities. Patients are therefore free to seek cross-border healthcare that can be (not: is) provided extramurally, while they have to ask for permission (and the ensuing reimbursement) to receive intramural care abroad. A gatekeeper’s role for General Practitioners is allowed if necessary for the criteria mentioned above. If an effective and identical treatment is available without undue delay, health authorities are allowed to refuse permission and reimbursement. Adequate procedures for appeal should be present for a patient. Permission and ensuing reimbursement should be provided, however, if according to international (ergo, not national) medical standards a patient can no longer wait for treatment, while at the same time taking into account not only the medical, but also all other personal circumstances of the patient.

Regarding the costs of intramural care, the patient is reimbursed according to the tariffs of the system of treatment (although maximized by the tariffs ‘at home’). As far

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1 It is still somewhat unclear in the Court’s rulings how intramural and extramural care should be defined. The Dutch health authorities define intramural care as a hospital treatment with at least one night overstay. See CVZ (2003a).
as extramural care is concerned, the tariffs of the system of insurance determine the coverage (also maximized by the tariffs at home).

Governments responded vehemently to the Kohll/Decker rulings in April 1998. Many refused to discuss the impact of the internal market at European level emphasising their national prerogatives on healthcare (see Palm et al, 2000; Baeten, 2000; Vollaard, 2005; 2006). Interviewees spoke of a deafening silence from the Council and the Commission in 1998. The Commission waited until October 1999 to ask only for research on the impact of Kohll/Decker rulings on the Member States’ health systems (see Palm et al., 2000). The German Minister for Health Andrea Fischer also mentioned the governments’ suspicion towards the Commission: the Member States still fear (...) that the Commission might aspire to competencies in the health field is not entitled for. After all, next to everyone seems reluctant to give the Commission an inch, since doing so would be to risk it taking a mile. (Fischer, 1999). Some governments were, however, directly confronted with the court’s jurisprudence (the Benelux countries), or feared its potential effects because of their waiting lists (the Netherlands, the United Kingdom, Norway) oversupply (Belgium) or the number of foreign tourists and retirees requiring healthcare (Spain). They pushed for discussing the issue of internal market and health at European level. As a compromise between the governments that did and that did not want to discuss healthcare systems at European level, informal working groups of national civil servants were set up. At that time, the Open Method of Coordination was seven bridges too far for the Ministers for Health (cf. Baeten, 2002).

The health ministers decided in 2002 to discuss healthcare at the European level more extensively, because they did not want to leave it to the Court and other Councils. Other ministers also dealt with healthcare, including patient mobility. Throughout the 1990s, a debate on the balance between the internal market and social protection also touched upon health issues (see e.g. European Commission, 1997). This process, however, involved mainly ministers of employment and social affairs. Those also dominated the discussions on simplifying the Regulations 1408/71 and 574/72. Rising concerns about public finances due to an ageing population in the late 1990s (see e.g. European Commission, 2001) involved ministers of finance in discussions on healthcare systems at European level. The 2000 Lisbon agenda
involved prime ministers and heads of states, which decided upon the European health insurance card after about 25 years of discussion.

The continuous stream of Court rulings on patient mobility and the above-mentioned policy initiatives gave the European Commission the political space to put and keep patient mobility on the European agenda. After subsidising research and stimulating debate among health actors from all Member States, the Commission issued in the Spring of 2004 a communication on cross-border patient mobility and on an e-health action plan (European Commission, 2004a; 2004c). Following another communication on *Modernising social protection for the development of high quality, accessible and sustainable healthcare and long-term care* also in the Spring of 2004 (European Commission, 2004b), the Council of Ministers for Health also reluctantly agreed to start discussing their healthcare systems through the Open Method of Coordination. The European Parliament and the European Commission have been quite active in involving the health sector in discussing healthcare at European level. Under the aegis of the Dutch EU-presidency a European Health Community of health ngo’s was launched in autumn 2004.

Based on the Lisbon agenda, the European Commissioner for the Internal Market Frits Bolkestein drafted a services directive in 2004 which also covered health services. The European Parliament and many governments fiercely resisted, however, to adopt health services in a general European services directive. They considered a general directive unfit for the peculiarities of the health sector, resisted marketization of healthcare systems, or disliked European meddling with national healthcare systems at all. Bolkestein’s successor Charlie McCreevy eventually excluded health from the directive’s scope (McCreevy, 2005). That did not mean that healthcare and health services were no longer on the European agenda. The Council of Ministers for Health agreed in June 2006 upon the common values and principles of their healthcare systems: universality, access to good quality care, equity and solidarity (Council, 2006). Soon after, the European Commission started its consultation on a *Community Framework for Safe, High Quality and Efficient Health Services* (European Commission, 2006). According to the Commission, such a framework is necessary for legal uncertainty regarding cross-border patient mobility and to support cooperation between Member States in border regions and top-clinical centres of reference. Most governments, however, seem yet to prefer bilateral cooperation and non-binding cooperation at European level as opposed to European legislation on health services.
The Treaty method to obtain (reimbursement) for cross-border healthcare is in the words of a Dutch health official another *hole in the fence*, which further undermines the EEA healthcare states’ principle of territoriality. While health authorities could grant the *privilege* of cross-border healthcare to patients under Regulation 1408/71, the Court’s interpretation of free movement of services and goods implies that those legally residing in the European Economic Area have a *right* to healthcare within the EEA (cf. Van der Mei, 2004), albeit only under certain conditions.

4 Patterns in cross-border patient mobility

Do national citizens use the widening opportunities for cross-border healthcare or do they remain loyal to and satisfied with their healthcare states? According to research exercised previous to the Kohll/Decker-rulings on the implications of the internal market on the healthcare systems in the European Union, some researchers expected an increase of patient mobility: *When thinking about the creation of a Single European Market for health care, it is essential to consider that the present level of E112 cross-border care in the EU underestimates the actual demand for medical treatment abroad (…)* As shown by the Swiss case, *the more the barriers to cross-border health care are lifted, the larger the amount of suddenly effective potential demand* (Crivelli, 1998: 304). Until Kohll/Decker, Dutch health insurance funds often lacked accurate data on the use of the Regulation method, as they did not register the use of the Regulation method by their clients separately. The inaccuracy held for most other EU Member States. Despite the various research projects funded by the European Commission on patient mobility, the data are still *fragmentary* and *incomplete* (Rosenmøller, McKee & Baeten, 2006; see also Glinos & Baeten, 2006).

Nevertheless, experiments with cross-border healthcare in Dutch and Belgian border regions as well as the research reports referred to above give an impression of cross-border patient mobility: it is marginal in the overall EEA area (not more than 1% of total number of treatments or public health expenditures) and is concentrated only in certain areas (mostly not exceeding 5% of total number of treatments and total public health expenditures).

First, cross-border patient mobility concentrates in border regions because of close cultural-linguistic links across the national borders (particularly frontier workers) and the geographical proximity of healthcare facilities across the national border in comparison to the facilities in their own healthcare system. Due to a lack of
healthcare facilities in the geographically isolated Dutch border region Zeeuws-Vlaanderen (at least seen from the capital’s perspective) patients have access to nearby Belgian hospitals since the 1970s. Next to border regions, cross-border patient mobility is concentrated in tourist areas. Particularly emergency care (E111) is provided in those areas to tourists and the floating population of retirees (Rosenmöller & Lluch, 2006: 62). German health insurance funds have contracted via Dutch and Belgian health insurance funds hospitals at the North Sea coast to provide emergency care to their clients.

Also small healthcare systems like Luxemburg, Cyprus and Malta are confronted with cross-border patient mobility. The Maltese National Health Service has contracted British hospitals for top-clinical healthcare (Muscat et al., 2006). This also shows the significance of cultural-linguistic links, as culturally close British rather than geographically close Italian hospitals have been contracted. Health actors in systems struggling with waiting lists, such as, for example, the Netherlands, Norway and the United Kingdom, have also started initiatives for cross-border healthcare. Dutch health insurance funds contracted Dutch-speaking hospitals in Belgium for their clients, not only to provide them with faster care, but also to put pressure on the Dutch hospitals to offer more, faster, and, if possible, cheaper care.

Despite increasing opportunities to obtain healthcare abroad, most patients prefer to be treated in a good hospital close to their home. This rule holds particularly with respect to chronic patients (Van der Schee et al., 2005; Consumentenbond, 2002). That does not only explain the marginal size of patient mobility in the European Union, but also the inertia in patient mobility within the Netherlands, where patients predominantly visit healthcare facilities in their own or adjacent region (Brouwer, 1999; Brouwer et al., 2003). Research on mobility of Dutch patients shows that also in case of waiting lists most patients prefer to wait for domestic treatment, instead of going abroad (Boffin & Baeten, 2005). Furthermore, in other countries with waiting lists such as, for example, Denmark or Ireland, patients prefer domestic private healthcare providers above providers abroad in great numbers (Busse et al., 2007).

The low numbers of patients going abroad clearly contrast with surveys on the willingness to seek healthcare abroad. The Stockholm Network reports that 70% of the Dutch respondents would like to go abroad for better or faster treatment (Disney et al., 2004). Another survey comes to similar conclusions, showing that particularly
young, high-educated, high-income respondents would seriously consider healthcare abroad (RVZ, 2003). However, stated preferences might differ starkly from revealed preferences regarding health consumption (Brouwer et al., 2003: 96). The RVZ survey further shows that the large bulk of patients - chronic patients, and 55+, low-income and low-educated respondents - are oriented to local healthcare providers. That may be explained by the financial burden of travelling abroad, not only for the patient but also for his or her family and friends (cf. Muscat et al., 2006). The need for cultural and linguistic commonality between patients and healthcare providers in case of long-term or complex treatments can also explain their limited range of action.

Research on cross-border patient mobility also indicates that continuity of healthcare after a treatment abroad is problematic. That ranges from the availability of prescribed drugs and medical devices to the refusal of doctors at home to provide aftercare at all (Boffin & Baeten, 2002). In general, the medical profession is not too enthusiastic on cross-border healthcare. Often health providers believe to be working in the best healthcare system of the world and lack knowledge on other healthcare systems. As a result, they fear mistakes abroad and do not want to take responsibility for ‘foreign’ mistakes. Dutch, Norwegian and British doctors and hospitals also prefer national premiums and taxes to remain within their healthcare systems, instead of leaking abroad. Experiments with cross-border healthcare launched by healthcare authorities could therefore not count on large support among health providers. Dutch hospitals also complained about the unfair competition from Belgian hospitals contracted by Dutch health insurance companies to put pressure on them. Costs of treatments in Belgian hospitals are about ten percent lower than in the Netherlands, because construction costs of hospitals are not included in treatment prices. In recent years however, Dutch hospitals in border regions have started to cooperate closely with foreign hospitals in order to provide sufficient health supply within the Dutch health market (Baselmans & Hermans, 2003).

The opinion of doctors is significant regarding cross-border patient mobility, as GPs and hospital doctors are informant sources of information next to family, friends, health insurers, and the Internet (European Commission, 1998; Boffin & Baeten, 2005). Growing contacts across borders between doctors may thus foster cross-border patient mobility, which would probably be concentrated in border regions (personal links among GPs and hospital doctors) and top-clinical centres (more internationally oriented today). Independent cross-border patient mobility
seems to be limited to healthcare that is not covered by health insurance, but about which price-sensitive patients can easily find information themselves online or via commercial mediators. In this respect one can think of infertility treatments (Belgium, Turkey), dental care (Hungary), spa treatments (Czech Republic, Estonia), and cosmetic surgery (see contributions to Rosenmöller et al., 2006). Budget flights and cheap holiday locations make the step towards this type of healthcare abroad more attractive. Public health authorities confronted with an oversupply of healthcare facilities (e.g., Belgium and Schleswig-Holstein) as well as top-clinical healthcare providers (e.g., in Stockholm, Aachen/Maastricht, in Liège/Luxembourg/Strasbourg) may join the competition on the European patients. The Association of Belgian Enterprises recently suggested that Belgium should become an international health centre for an estimated potential of 100,000 EU patients (VBO, 2006). Since the much more mobile third-country nationals are covered by the Regulations on social security and healthcare abroad since 2004, the numbers of patients treated outside their insurance system might grow yet. Satisfaction with healthcare and loyalty seem to be high however among at least Dutch and Belgian citizens, suggesting that patient mobility will remain rather low in the near future.

5 Health citizenship in a European health area
Despite the formal de-territorialisation of healthcare states in the European Economic Area reluctance of national health actors and patients to go abroad keep cross-border patient mobility at a fairly low level. Most existing initiatives for cross-border patient mobility are of local nature and have often been motivated to keep control of the European Commission and the cross-border flows of patients (Vollaard, 2004). In addition, Eurobarometers consistently show national citizens preferring competences on healthcare to remain at national level. Accordingly, the Member States have resisted to adopt health services in the Bolkestein directive. So why did the European Commission launch its consultation regarding Community action on health services in September 2006?

The Commission refers in its communication to the Council’s conclusions on common values and principles in EU Health systems from June 2006. In these conclusions, the council notes that the European Commission has stated that it will develop a Community framework for safe, high quality and efficient health services, by reinforcing cooperation between Member States and providing clarity and
certainty over the application of Community law to health services and healthcare (Council, 2006). According to the European Commission, more legal clarity and certainty might be necessary with regard to, among other things, minimum quality standards, reimbursement arrangements, supervision of healthcare providers, responsibilities for harmful treatment, the balance between patients’ entitlements and the financial sustainability of healthcare systems, and the compensation of receiving healthcare systems for treating foreign patients.

Next to legal uncertainty, a European framework on health services may also be needed for other reasons. Patients do not cross a border using telemedicine services, and can therefore not use the E-112 procedure for coverage (AIM, 2007). Furthermore, medical-ethical patient mobility may raise voices for European action, such as, for example, in case of abortion tourism (Portugal/Spain; Ireland/UK) or suicide tourism (to Switzerland). Some Dutch parliamentarians pleaded for a European abortion directive after they had heard of late-time abortions provided to Dutch women in the Ginemedex Clinic in Barcelona. Nevertheless, the influential Association de la Mutualité sees no need for new European legal instruments yet (AIM, 2007). Bilateral agreements, national legislation and better registration in the Administrative Committee are sufficient in the eyes of AIM. And so think most Member States. It seems as if the European Commission is after other things than just legal certainty and clarity. The prime responsible directorate-general for health and consumer protection (DG SANCO) is established only in 1999. Some health officials interpreted its initiatives in health services as an attempt to fight for recognition within the European bureaucracy, competing with heavyweights like DG Internal Market and Services and DG Employment, Social Affairs and Equal Opportunities.

The European Commission justifies its involvement referring to its Citizens’ Agenda to enhance the legitimacy of the European Union after the French and Dutch voted “no” against the European Constitutional Treaty. It is striking that again and again initiatives on public health and healthcare have been accompanied by references to the link between Europe and its citizens. The European Parliament, the European Commission and the Council of Ministers referred to substantiate People’s Europe discussing the introduction of a European health card in the 1980s. The 2002 decision to introduce the European Health Insurance Card was celebrated by the European Parliament and the European Commission as an important step for European citizenship. The then president of the European Commission Romano Prodi proudly
presented the card as an important contribution the European identity: after the Euro
EU citizens would get *more Europe in their pockets* (European Commission, 2003). After the European Court of Justice underlined the rights of EEA citizens to obtain healthcare abroad and its reimbursement, the European Commission gradually described patient mobility in its communications and documents no longer as a side-effect of the internal market but as a *right* of European citizens (Martinsen, 2005). Today, healthcare is one of the strongholds of legitimacy of national governments and states (European Commission, 1998). As the legitimacy of the European institutions and the European Union in general is seen as weak, the European Commission and European Parliament may seek to foster its legitimacy by competing with national governments and states on it. In earlier times, it was authoritarian and paternalist states rather than liberal or democratic states to introduce compulsory health insurance, because the former were short of legitimacy (Freeman, 1999: 20). Having a similarly weak legitimacy, the European Commission may try to foster its acceptance through initiatives in healthcare policy.

The non-binding EU Charter of Fundamental Rights contains a compromise between the struggle for legitimacy on healthcare between national and European institutions. It acknowledges EU citizens’ right to healthcare of EU citizens according to national law and practices. Does this compromise indicate that cross-border patient mobility remain an extra facility to national health citizenship, thus representing another European rescue of the healthcare state? Or is it a first step towards substantial European health citizenship? That depends on the emerging nature of this *new compound European healthcare state* (Lamping, 2005: 43); is it a Canada-like federal healthcare system in the making, is it evolving towards a unique healthcare state, or is it developing towards a US-like healthcare system dominated by the suppliers of insurance and health services and goods?

In Canada, mobility of labour and demographic differences between the provinces resulted in fiscal imbalances in the provinces’ social security systems since the 1930s (Banting, 2005). Leaving the classic model of federalism (separation of competences between levels of governance) the Canadian authorities have shared the costs of healthcare. Federal health funding of provinces has an inclination towards joint decisions of federal and province governments on healthcare systems as the federal government tries to provide funds only under certain conditions. A unique Canadian healthcare state is, however, not to be expected in the near future – even
though healthcare is an important election issue in federal elections. The prospect of the European Union becoming a unique healthcare state is even smaller than of Canada, although a number of opinion leaders recently expressed otherwise (HFE, 2007). The European Commission seemingly tries to use cross-border patient mobility as a means to enhance its influence and legitimacy. However, its financial means to buy influence on healthcare policy at the national level are rather small, as the Commission has mainly regulatory powers. Although the Commission suggests launching a compensation mechanism at European level for countries receiving foreign patients, the chances of this kind of European health solidarity among the EU or EEA Member States similar to Canadian solidarity seem to be rather slim. The healthcare systems of the EU Member States are much further developed than the Canadian provinces in the 1930s, and are therefore less inclined to share the burden of healthcare in a European health area.

Instead, the European Union is developing towards another family among the healthcare states. Since the 1980s, most Member States have introduced more choice for patients to take into account criticism against declining quality of care, even though patients did not ask themselves for more choice, but rather for good hospitals close to their homes: nowhere did user dissatisfaction with health care states imply a demand for the quasi-marketization of health care, though that is the way in which, in part, governments have sought to meet it. (Freeman, 1999: 116). Emphasising choice is a way to redirect dissatisfaction: instead of voicing their complaints to the national governments, health citizens are responsible themselves to find timely, affordable, and good-quality healthcare (Vollaard, 2004). In other words, the burden of health responsibility has become too heavy for governments. In order to avoid a potential decline in their legitimacy, they have offered choice instead.

European market legislation, however, interferes with the introduction of more choice in national healthcare systems. Providing more choice is inviting more private and foreign suppliers of insurance and healthcare: The health area will be a first Europe-wide testing ground for the turf struggle between national welfare states and the community plus the market, as represented by private insurance, producers, etc. (Leibfried & Pierson, 2000: 283). The incentive of suppliers is not the accessibility of patients, but to sell (new) advanced medical goods and services and attract healthy (and thus cheap) clients. The USA is the best-known example of this supply state, continuously struggling with cost containment and access for unhealthy citizens.
(Moran, 1999). AIM already expressed its concern that cross-border patient mobility may entail two-speed Europe, in which better-informed and better-financed patients are going abroad, thus undermining solidarity at home (AIM, 2007: 5). As those patients are often the more eloquent voter-citizens, the other citizens lose strong defenders of good quality healthcare (Vollaard, 2004). That might not be only the factor weaken the pressure on national governments on the health dossier:

*Emphasising individual rights (e.g. mobility) over public objectives is likely to increase the role of the private sector, since public planning is less viable when factors of production and rules of consumption cannot be controlled (...)* Member States have a disincentive to educate doctors and other professionals publicly if a significant number are likely to emigrate. (Paton et al., 2002). Instead of Europe gradually replacing national governments as main focus of health citizenship, Europe is thus in the process of eroding the political significance of healthcare for all levels of governance. European integration may thus fundamentally change the relationship between national citizens and their healthcare states.

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