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The exclusion of the long-term services from Patients' Rights Directive – the issue of an ageing population

ABSTRACT

This paper presents some of the main aspects of the Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, commonly known as the Patients' Rights Directive, and as well treats the problematic exclusion of the long-term services from its scope. This Directive represents the latest EU initiative in regard to the European Health Care and the Single Market, but it is observed that the exclusion made by the Member States might lead to conclusions that the PRD is biased against the chronically ill and patients seeking long-term care, especially in an ageing Europe background that emerges in nowadays society.

Keywords: Patients' Rights Directive, cross-border healthcare, healthcare services, internal market law, long-term healthcare services, long-term care patients.

1. Introduction

In early July 2008, the European Commission introduced a proposal¹ for a Directive of the European Parliament and of the Council on the 'application of patients' rights

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1 COM (2008) 414 final. Available at: http://ec.europa.eu/health/ph_overview/co_operation/healthcare/docs/COM_en.pdf. (last consulted 08/10/2016)

in cross-border healthcare'. Such a proposal was truly deemed as 'daring'² due to the fact that Member States regarded healthcare problems as an issue that should remain within the context of national policy, and because of the earlier failed attempt of the Commission to originally include healthcare services in the Services Directive 2006/123.³ Eventually, years later this specific directive has been adopted, as a part of a broader social agenda,⁴ with the ensemble of measures on healthcare which again proved the art of codifying complex case law.⁵

No doubt that health policies throughout Europe were (and maybe still are) in a 'chaordic'⁶ state of being, situation which resulted from the factors such as dualism of competent authorities, both the European and national working in the field of health policies, the quite sensitive character of the health sector and rather vague treaty provisions. However, the acceptance that healthcare and other social services are services provided for the general interest, is approximated by a growing recognition at the international and national level that those rights are 'fundamental' and capable of enforcement at an individual level.⁷ The Court of Justice of the European Union has already made clear⁸ that market freedoms are also applicable to those areas of public policy that most national governments had explicitly excluded from the market. Therefore, healthcare is no exception and there is, as such, an EU wide access for union citizens to medical services and freedom of services which allows cross-border delivery of medical, dental, and other health services.

There was a confused conceptual background,⁹ but the Commission tried to codify the Court's case law under the free movement provisions which created opportunities

2 W. Sauter, *Harmonisation in Healthcare: The EU Patients' Rights Directive*, p. 4.

3 See Directive 2006/123/EC OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 12 December 2006 on services in the internal market, Article 2 (2) (f), where healthcare services are namely excluded from the scope of the directive. For the exclusion see also S.J.H Evans, *The Services Directive: (too) great expectations? An initial overview of the rights and obligations under the Services Directive*, based on an earlier publication by E. Belhadj, S.J.H. Evans and J.W. van de Gronden, "De Dienstenrichtlijn: de gebreken van de deugden? Een eerste verkenning van de Dienstenrichtlijn", SEW 2007, pp. 141-153.

4 Commission Communication of 2 July 2008 on the Renewed Social Agenda: Opportunities, Access and Solidarity in 21st Europe, COM (2008) 412 final.

5 Terms used in S. De La Rosa, *The Directive on Cross-Border Healthcare or the art of codifying complex case law*, (2012) 49 CMLRev. 15.

6 Term borrowed by Hock, Dee W. *Birth of the Chaordic Age* Berrett-Koehler Publishers; 1st Edition/ 1st Printing edition (January 1, 2000) p. 67.

7 In the academic literature, this has been called 'market citizenship', see Everson M (1995) *The legacy of the market citizen*. In: Shaw J, More G (eds) *New legal dynamics of European Union*. OUP, Oxford

8 Case C-158/96 Kohll, Case C-120/95 Nicolas Decker v Caisse de maladie des employés privés, Case C-358 Müller Fauré, Case C-208/07, Petra von Chamier-Glisczinski v Deutsche Angestellten-Krankenkasse (non-exhaustive list).

9 See for more E. Szyssczak, 'Patients' rights: a lost cause or missed opportunity?', in J. Van de Gronden, E. Szyssczak, U. Neergaard and M. Krajewski, *Healthcare and EU Law, Legal Services of General Interest* (The Hague, Asser Press, 2011) pp. 105-108.

for patients to travel abroad and receive medical treatments, and to be able to recover all or at least some of the costs from the respective Member State of affiliation. The aims of using a Directive on the Patients' Rights (PRD) are numerous and obviously deemed as very specific, which is one of the reasons why the European Parliament successfully excluded healthcare from the application scope of the Services Directive. The PRD aims to establish the general framework for efficient and accessible cross-border healthcare, also backed up by a reimbursement scheme by the Member State of affiliation of the healthcare obtained abroad. Most importantly, the PRD creates an EU set of procedural rights and guarantees for patients seeking healthcare outside of the state of affiliation. According to the PRD,¹⁰ the cooperation between Member States on cross-border healthcare is one of the main objectives which basically transfers the sole 'patients' rights' ideas into Union principles for healthcare and further Europeanisation of healthcare issues, which became too big and important to be sheltered by only strict national outlines.

Applying the free movement principles to health care issues has actually received different approaches and interpretations, from viewing the adoption of PRD as a 'small miracle'¹¹ and as a major step towards harmonisation in the context of a single market, to a challenge that Member States' autonomy will face in the area of healthcare. A cursory examination through academic titles reflects this judgement: 'the virus of cross-border patient mobility...'¹²; 'Killing National Health and Insurance Systems'¹³; 'Patients' Rights: a lost cause or missed opportunity?'¹⁴ These are just some of the titles that indicate not such a friendly approach towards the matter.

Not putting into question the steps towards building a vast single market taken by PRD, nevertheless, we might further argue in favour of several cogent arguments that seemingly remained intact by PRD's provisions. While looking at the subject matter and scope of the Directive enunciated in Article 1, we notice that actually the PRD keeps several barriers towards its aim still high, considering both recent and near future demographic changes and problems.

10 Directive 2011/24/EU OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 9 March 2011 on the application of patients' rights in cross-border healthcare, preamble, recital (10)

11 M. Peeters, 'Free Movement of Patients: Directive 2011/24 on the Application of Patients' Rights in Cross-Border Healthcare', 2012 *European Journal of Health Law*, no. 1, p. 60.

12 Kostera T (2007) *Unwelcome Europeanisation—the development of cross-border patient mobility*, master of European studies thesis, 2007, College of Europe, Bruges.

13 V.G. Hatzopoulos, 'Killing National Health and Insurance Systems but Healing Patients? The European Market for Health Care Services After the Judgments of the ECJ in Vanbraekel and Peerbooms', 2002 *Common market law review*, no. 4, p. 683.

14 E. Szyszczak, 'Patients' rights: a lost cause or missed opportunity?', in J. Van de Gronden, E. Szyszczak, U. Neergaard and M. Krajewski, *Healthcare and EU Law, Legal Services of General Interest* (The Hague, Asser Press, 2011).

Given the above context, the purpose of this paper would be to argue about the exception that PRD is deemed not to apply to services in the field of a long-term care, which support people in carrying out routine and everyday tasks. So, it appears that the exception is aimed at individuals who find themselves in long-term care facilities, residential or nursing homes, which consequentially fall outside the scope of PRD.¹⁵ In other terms, it means that this category of individuals have the right to travel for these purposes to another Member State, but have no right in the union law to be reimbursed for the treatment. Consequently, a protection gap towards this specific category emerges, which is only likely to increase as a result of ageing European population, taking into account demographic data and recent population studies. The main reason for applying the exclusion of services in the field of a long-term care can be found in the nature or characteristics of such services provided to the elderly population. Namely, they are not a pure form of health services, but a mix of social services as well, while the Directive has been put to regulate the domain of the health care services in particular.

It could also be argued that since the PRD is in its core a balancing act that encourages national health systems to retain their own character, this exclusion is in fact a possibility Member States to retain control over a large amount of their social security budgets.¹⁶ But on the verge of an ageing population, which would increase the above-mentioned category, is this absolute exemption fruitful? One of the main recommendations that this paper wishes to elaborate, would be to examine possible future solutions which would balance the Member States' needs to control their social security budgets and requesting cross-border assisted living care. The PRD indeed offers much more than cross-border healthcare and finally some clarity about reimbursement entitlements. But is the PRD biased against the increasing number of that ageing category, suffering from chronic diseases and in need for long-term care, irrespective of geographical barriers? This paper will aim to answer this question in specific.

In the second section of this paper we discuss the political, legal, and economic context of the Directive and the contention of the Member States regarding the long-term care issue. After examining Article 1 (3) of the Directive, which deals with its scope and application, we will assess the legal base of this Directive, to see if we are really considering exclusion in the light of the Treaties and the case law. Indeed, in the third section we will dive more deeply in the case law built up by CJEU, starting with the leading *Luisi and Carbone* and ending with a rather questionable

¹⁵ Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, Article 1

¹⁶ P. Quinn, *The European Patients' Rights Directive: A Clarification and Codification of Individual Rights Relating to Cross Border Healthcare and Novel Initiatives Aimed at Improving Pan-European Healthcare Co-Operation*, p.45.

judgment in *Von Chamier Gliszinski*. There are also lots of issues that long-term care services pose today. Therefore, we will discuss those issues and some attempts to possible alternatives in the fourth section, which undoubtedly will be followed by some conclusions and recommendations.

2. Political, legal and economic context of the Directive and the contention of Member States on long-term care

2.1 Background context

The regulation of healthcare issues in the EU has been since the beginning, an area of multiple discussions and reluctant behaviour from the Member States. The original EEC Treaty did not even contain any specific provisions related to health issues, whereas the Treaty of Maastricht 1992 created only a limited competence of the Community to regulate the area of public health (Article 192 EC). During the long process of evolution, the special contribution was the old Article 152 EC of Amsterdam Treaty, stating that any action by the Community in the field of public health shall fully respect the responsibilities of the Member States for the organization and delivery of health services and medical care.¹⁷ The picture that Article 168(7) TFEU created, however, seems to expand the limits of EU in public health. Although Member States are still responsible for the definition of their health policies and the delivery of health services, they will have to include the management of health services and the allocation of resources assigned to them while performing the relevant tasks.

In this background, we can argue that the legal competence for legislation regarding public health issues at the EU level was limited, although this area was of cross-border concern. But on the other hand, social services were depicted as core values of the new vision for Europe and were included in the Lisbon Agenda 2000-2010. The Health Council as well agreed, that social services, in particular healthcare, were part of 'European Values', though without underestimating the challenges that lie ahead in reconciling individual needs with the available finances, as the population of Europe ages, expectations rise, and medicine advances.¹⁸

The background did not seem to be very clear at the time when the Commission attempted to deepen the codification of the Court's case law under the free movement principles, which had already created a right of patients to seek healthcare

¹⁷ The Treaty of Amsterdam 1997 raised the profile of public health issues by adding it to the list of activities of the Community in the Article 3(1) (p) EC. It also introduced a "high level of human health protection" through Community policies.

¹⁸ Statement on Common Values and Principles in EU Health Systems, Health Council 1 June 2006

in other Member States and subsequently, reclaim some, or all, of the costs of the treatments by their Member State of affiliation. And indeed, this patients' right has shown to be different from time to time. From the dual system of access to care of Regulation 1408/71/EC,¹⁹ to the freedom to receive services in another Member State using the Article 56 TFEU²⁰ and more recently to Article 35 of the Charter of Fundamental Rights, which provides a right to preventive health care for everyone. Therefore, it is thought that the PRD is a step towards creating a broader framework for healthcare policy despite the few EU legislative competences to do so. During the discussion of the proposed Directive, Member States were understandably concerned about the difficulties that further developments aimed by the PRD would pose to actually accommodate its provisions with the diversity of existing national systems of healthcare.²¹ Furthermore, some aspects are considered as discriminatory, especially when it comes to dealing with chronically ill patients and the long-term sick who need longer and perhaps more complex forms of long-term social and healthcare, and social security support. And in fact, during the discussion of the proposed Directive, it was difficult to find consensus within the Council on three main points, namely, legal basis for the Directive, whether long-term healthcare services (LTHC) should be included in the scope of the Directive, and the situations in which Member States can refuse prior authorisation for the hospital treatment sought abroad. Subsequently and respecting this scope of this paper, we will further discuss the now excluded long-term healthcare services and the numerous problems which this situation arise and may appear in the not too distant future.

19 For more on this see, F. Pennings 'The Draft Patient Mobility Directive and the Coordination Regulations of Social Security' in J. Van de Gronden, E. Syszczak, U. Neergaard and M. Krajewski, *Healthcare and EU Law, Legal Services of General Interest* (The Hague, Asser Press, 2011).

20 The starting point is case law from CJEU, in the joined cases 286/82 and 26/83 *Graziana Luisi and Giuseppe Carbone v. Ministero del Tesoro* [1984].

21 Healthcare systems in Member States are organized according to two main models a) National Health Systems – based on the Beveridge model – which recognize a universal right for the whole population to receive (nearly) free medical care, financed from tax revenues; such systems are to be found in the UK, Ireland, Spain, Italy, Portugal, Greece, Denmark, Finland and Sweden and b) Social Insurance Systems – based on the Bismarck model – where coverage is dependant mainly upon payment of premiums. Such systems may be divided further into “benefits in kind” where the health provider gets paid indirectly by the social security institution, scheme to be found in Austria, Germany and the Netherlands and into “reimbursement systems” where the patient pays the fees but later gets reimbursed by the social security institution; such systems are present in Belgium, France and Luxembourg. By this whole picture, it is clear that National Health Systems leave very little room for the application of the free market principles. See further on this issue Jorens, *European integration and healthcare systems: EC Regulation 1408/71 between Status Quo and Upgrading*, paper delivered at the Conference: “European Integration and National Health Care Systems: A Challenge for Social Policy”, Gent 7-8 Dec. 2001.

2.2 Article 1(3) (a), the exclusion of services in the field of long-term care

While drafting the PRD, one of the hottest topics of the debate was whether to include or not LTHC in the patient mobility principle. And actually, the very recognition itself of a concept such as 'long-term care' in EU's social services is a part of a long process, culminated by the emergence of new social risks which come as a result of demographic changes in the EU, further discussed in this paper. In the draft proposal, the Commission used the definition of long-term care offered by the Organisation for Economic Co-operation and Development (OECD) as 'a cross-cutting policy issue that brings together a range of services for persons who are dependent upon help with basic activities of daily living over an extended period of time.'²² Thus, the concept of LTHC derives from the long-term care (LTC) because it would be provided to an individual patient. It is indeed difficult to set boundaries between social care and healthcare, not only towards the nature of the activity, but also the means of funding, especially when the state uses social security benefit systems to fund the possible provision of LTHC. Member States change their policies related to long-term care over time, accentuating institutional care of LTC in home care supported by professionals and community care services.²³ The degree of modernisation of LTC has therefore, posed challenges to Member States in relation to new policy designs alongside new structures for the organisation of the services. As a result, there is a great diversity in the concept of LTC in Member States, mostly because of different traditions and historical evolution, rather than strategic planning. To illustrate, in some Member States there is no definition of LTC at all,²⁴ whereas in other Member States there is an even more detailed definition than the one provided by OECD.²⁵ And of course, there are also Member States in between these limits, but which still provide a vague definition of the matter.²⁶ Overall, there are differences between Member States on how to provide and fund LTC but this should not be regarded as unexpected, since after all, legislative initiatives of the Commission hope to further harmonise Member States' laws and policies.

At this point, numerous questions arise. What is the nature of LTC in terms of the intramural/extramural division? Is it a social security or a health care system? How

22 The OECD health project, 'Long-term care for older people', published in 2005, available at http://www.euro.centre.org/data/1216815268_61772.pdf [last consulted 15/10/2016].

23 European Commission, *Long-term Care in the European Union*, 2008.

24 Bulgaria, Greece, Hungary, Malta, Romania, Slovenia, United Kingdom.

25 For example, in Spain LTC is defined as "the situation of a person who, on account of age, disease or incapacity and linked to lack or loss of physical, mental, intellectual or sensorial autonomy, requires assistance from (an) other person(s) or considerable help to carry out essential daily activities or, in the case of persons with a mental disability or illness, other forms of support for their personal autonomy." European Commission, *supra* n. 23.

26 For example, LTC is defined in Cyprus as "need of care due to mental or physical incapacity or social distress." European Commission, *supra*, n. 23.

should individualised care work? Should it be provided through State resources or through accredited bodies? Of course the answer to these questions requires more time but until now, the EU's response has been to monitor the Member States' approaches to LCT by collecting data through MISSOC.²⁷ But the Member States' final choice to exclude LTHC from the scope of the PRD may not be the best option, having in mind also the fact that more cases emerge before CJEU raising issues of payments under the social security Regulation or where long-term care patients choose to seek this treatment in other Member States relying upon the free movement provisions.²⁸

The exclusion of LTHC from the scope of the proposed Directive was agreed by the Commissioner for Health Vassiliou at the June 2009 Council meeting. In the 2009 version, the definition of LTHC excluded from the Directive is as follows: 'This Directive does not apply to services whose primary purpose is to support people in need of assistance in carrying out routine, everyday tasks. More specifically, this refers to those long-term care services deemed necessary to enable the person in need of care to live as full and self-determined life as possible. Thus, the Directive shall not apply, for example, to long-term care services provided in residential homes or housing ('nursing homes') by home care services or assisted living facilities.'²⁹

In later versions of the draft Directive, the above mentioned exclusion was reduced to the following: 'Article 2.1 This Directive shall not apply to (a) services in the field of long-term care whose purpose is to support people in need of assistance in carrying out routine, everyday tasks,' amendment which successfully became part of the adopted PRD, and more specifically, in Article 1 (3) (a).

2.3 Legal base of the Directive and the Treaties: Are we really talking about exclusion?

The decision regarding the choice of a legal base to sustain the Directive was again one of the discussions proven to be strongly debated between the Commission and the European Parliament. Article 114 TFEU, represented the first proposed legal basis, which went through all the stages until adoption. The use of Article 114 shows that PRD aims to secure the establishment and functioning of the internal market,

27 Mutual Information System on Social Protection in the EU Member States, the EEA and Switzerland; <http://www.missoc.org/index.htm> [last consulted 09/10/2016]

28 Case C-70/95 *Sodemare SA, Anni Azzurri Holding SpA and Anni Azzurri Rezzato Srl v. Regione Lombardia* [1997].

29 Recital 9b COREPER draft of 26 November 2009. Subsequently, article 2(2)(a) of the revised draft Directive and finally recital 14 of the Directive 2011/24/EU OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 9 March 2011 on the application of patients' rights in cross-border healthcare.

and since in paragraph 3³⁰ it contains requirements that any harmonisation measure should guarantee a high level of protection of human health, it was initially regarded as sufficient to serve as a legal basis for the Directive. However, we could argue in favour of interest groups, which expressed their concern about the explicit linkage of Article 114 TFEU to the free movement right to healthcare services as a purely economic right, blurring as such the social character intrinsic to the idea of healthcare services.³¹ In other words, if only Article 114 was used as a legal basis for PRD, this would mean a constant domination of economic integration issues, over recognising the, albeit limited, EU competence in the area of healthcare worded in Article 168 TFEU.³² The Commission supported the idea of using a joint legal base and so did the Committee of the Regions. It was proved to be impossible to use only Article 168 as a legal basis, since the PRD aims to go beyond public health improvement measures. In fact, looking at paragraph 5,³³ it seems that there is a certain inconsistency, because it explicitly deals with the exclusion of the harmonisation of the laws and regulations of Member States.³⁴ It remains to be seen if this choice is going to be unquestioned by CJEU, since it has already expressed preference for only one legal basis to be used for EU legislation,³⁵ with an exception that two legal bases may be used only where a proposed legal instrument has two parallel aims equally binding.³⁶ But judging from

30 Article 114 reads: (1) Save where otherwise provided in the Treaties, the following provisions shall apply for the achievement of the objectives set out in Article 26. The European Parliament and the Council shall, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee, adopt the measures for the approximation of the provisions laid down by law, regulation or administrative action in Member States which have as their object the establishment and functioning of the internal market. (2) Paragraph 1 shall not apply to fiscal provisions, to those relating to the free movement of persons nor to those relating to the rights and interests of employed persons. (3) The Commission, in its proposals envisaged in paragraph 1 concerning health, safety, environmental protection and consumer protection, will take as a base a high level of protection, taking account in particular of any new development based on scientific facts. Within their respective powers, the European Parliament and the Council will also seek to achieve this objective.

31 At the time of the draft proposal, the old Article 16 EC did not provide a legal base for legislation in the area of services of general economic interest. After the Treaty of Lisbon 2009, Article 14 TFEU allows the European Parliament and the Council to use the ordinary legislative procedure to enact regulations.

32 The reaction of national responses also ignores problems faced by regional governments in the EU. For example, in Scotland, the Scottish Parliament legislated with the NHS Reform Act 2004 to abolish the English NHS market-oriented healthcare system and re-introduced an integrate public healthcare system for Scotland, which is opposed using commercial healthcare providers in Scotland.

33 Article 168 (5) TFEU reads: The European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, may also adopt incentive measures designed to protect and improve human health and in particular to combat the major cross-border health scourges, measures concerning monitoring, early warning of and combating serious cross-border threats to health, and measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol, excluding any harmonisation of the laws and regulations of the Member States.

34 See for this purpose also the note of the Committee of Permanent Representatives to the Council, delivered on 26 November 2009.

35 Case C-377/98 *Netherlands v. European Parliament and Council* [2001], paragraph 27.

36 Case C-165/87 *Commission v. Council* [1988], paragraph 11.

the above arguments, proving the harmony between the two Articles in this case is going to be a difficult task for the Court.

At the same time, the Directive is required to respect other Treaty provisions, namely the general subsidiarity provision in Article 5 TFEU, but also provisions such as Article 6(a); 2(5) and 168(7), which contains a special subsidiarity clause with respect to the responsibility of Member States for the organisation and delivery of healthcare. Nevertheless, CJEU has already clarified in *Müller-Fauré* and *Watts* that this provision does not mean that adjustments to national systems may not be required by other Treaty provisions, such as Article 56 TFEU on the freedom to provide and receive services.³⁷

However, according to the previous case law of CJEU, the relationship between Treaty provisions and the Directive is going to be even broader than this. To explain the following, let us draw some parallels regarding Regulation 1408/71, subsequently replaced by Regulation 883/2004,³⁸ the core subject matter of *Kohll* and *Decker* case law, which according to the legal scholars' opinion opened up the market³⁹ of healthcare services. Briefly, these cases concerned the possibility of persons who had not obtained the prior authorisation provided in the Regulation, to receive refund of health expenses incurred in another Member State. The Court stated that the existence of the Regulation does not preclude the application of Treaty rules and went on to interpret the two in a complimentary way. So, the authorisation procedure provided in the Regulation allows the patient 'to receive sickness benefits in kind, on account of the competent institution but in accordance with the provisions of the legislation of the State in which the services are provided... without that person incurring additional expenditure.'⁴⁰ On the other hand, relying on the Treaty provisions alone, someone may claim 'reimbursement of costs incurred in connection with treatment provided in another Member State,' but only at the tariffs in force in the State of insurance.⁴¹ Therefore, the Court treats the Regulation as a specific application of the general Treaty rules on free movements and not as the only occasion in which social security funds may be called upon to reimburse expenses incurred in other Member States. This logical sequence might follow also the interpretation of the PRD in relation to long-term healthcare patients who seek treatment abroad. Since the PRD does not grant the right to have such treatment

37 Case C-358/99 *Müller-Fauré*, paragraph 102 and Case C-372/04 *Watts*, paragraph 147.

38 Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems (OJ L 166 of 30 April 2004, p. 1).

39 Barnard C., *The substantive law of the EU: the four freedoms* (Oxford University Press 2016), p. 315-316.

40 *Kohll* paragraph 26 and *Decker* paragraph 28.

41 *Kohll* paragraph 27 and *Decker* paragraph 29.

reimbursed,⁴² patients might try to obtain this reimbursement consequently, relying on the general Treaty rules. It remains to be seen if this is going to be successful and effective, having also in mind the previous case law of CJEU on this matter, which we will discuss in the next section. But overall, having in mind the close relationship between the PRD and Regulation 883/2004,⁴³ the existence of which basically sets two alternative procedures of reimbursing costs of cross-border healthcare, the above argument might effectively be used in favour of such long-term healthcare patients, trying to invoke their rights against the exclusion.

3. The art of codifying complex case law

3.1 Brief analysis of leading cases *Luisi and Carbone* and *Kohll and Decker*

In order to better understand the background of the PRD and perhaps to hollow out the roots of the long-term healthcare exclusion, let us turn briefly into explaining some pivotal judgments delivered by the Court of Justice in respect of opening the internal market as well the healthcare services. Maybe the line of case law would have been hard to follow without the *Luisi* and *Carbone* judgment of 1984,⁴⁴ in which the Court held that ‘freedom to provide services includes the freedom for the recipients of such services to go to another Member State in order to receive them there, without being obstructed by restrictions, even in relation to payments and that tourists, person receiving medical treatment, and persons travelling for the purpose of education or business are to be regarded as recipients of services.’⁴⁵ The deep meaning of this judgment can be traced in the Court’s endeavours to change its perspective, moving beyond the merely economic dimension of trade in services and opening a door towards the subjective rights of citizens as such. The mentioning of education and medical treatment as examples of services seems to further strengthen the above argument. However, after the *Luisi* and *Carbone*, the possibility created by the Court remained open for many years, without anybody making use of it. This was until 1998 when the Court had another chance to move forward with the *Kohll* and *Decker* cases.⁴⁶

42 It should be noted that there is nothing in the Directive 2011/24/EU to stop national social security systems or local organisations with such responsibilities to negotiate their own agreements with organisations that provide services in other Member States if they wish to.

43 See for this matter M. Peeters, ‘Free Movement of Patients: Directive 2011/24 on the Application of Patients’ Rights in Cross-Border Healthcare’, 2012 European Journal of Health Law, no. 1, pp. 29-60.

44 Joined Cases 286/82 and 26/83 *Luisi and Carbone* [1984].

45 *Luisi and Carbone*, paragraph 16.

46 Case C-158/96 *Kohll* and Case C-120/95 *Decker* [1998].

Since the *Luisi* and *Carbone* was a breakthrough case, it did not really give too many details for the subject matter. It was with the following *Kohll* case, that according to the academic opinion, shivers passed through all social security and healthcare funds.⁴⁷ According to the Court, ‘the special nature of certain services does not remove them from the ambit of fundamental principle of movement.’⁴⁸ In the *Decker* judgment, the Court ruled that the free movement of goods should also be respected by national social security and healthcare schemes. The clear confirmation from the Court’s side that Regulation 1408/71 on social security does not exhaust the field and has to be compatible and interpreted in accordance with the free movement rules that were mentioned even earlier in this paper.

In such cases, Member States should reimburse the patient on the same terms as if the treatment had been received within the territory. Prior authorisation according to the Court, could not be either justified by the need to preserve the financial balance of the medicinal and hospital system of the Member States, because since the reimbursement scheme is governed by the Member State’s of affiliation policies, the cost of treatment remains constant regardless of the place where Mr. Nicolas Decker bought his glasses, or where Aline Kohll had a dentist visit. What still was not clear after the *Kohll* and *Decker* judgment was to what extent these rules would be applicable in treatment offered in a hospital infrastructure.⁴⁹ Nevertheless, the Court confirmed and extended the ambit of *Kohll* judgment in *Vanbraekel and Peerbooms*.⁵⁰

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Until now, we have seen approaches of CJEU towards both extramural and intramural cases of healthcare services. But where did then the exception that Member States included in the PRD, to exclude long-term healthcare services from the harmonisation aims of the present directive originate? It is difficult to be sure,

47 V.G. Hatzopoulos, ‘Killing National Health and Insurance Systems but Healing Patients? The European Market for Health Care Services After the Judgments of the ECJ in *Vanbraekel* and *Peerbooms*’, 2002 Common market law review, no. 4, p. 688.

48 Case C-158/96, *Kohll*, [1998] ECR I-1931, paragraph 20. This line has afterwards been repeatedly cited by the Court in following judgments.

49 Opinion of Advocate General Saggio, delivered on 18 May 2000, for the *Vanbraekel* case C-368/98, paragraph 11.

50 The Court confirms its expansive approach to the notion of economic activity when confronted also with health services provided in hospitals with this case. The Court also introduced a number of well-known procedural requirements to be fulfilled if a prior administrative authorisation is deemed to be justified. These can be found at Case C-368/98 *Vanbraekel* and others [2001] ECR I-5363; ECJ, Case C-157/99 *Smits* and *Peerbooms* [2001] ECR I-5473, paragraph 90.

but the exception according to some authors⁵¹ intends to reflect the judgment in *Von Chamier-Glisczinski*.⁵² This lady, a German national, received from the *Deutsche Angestellten-Krankenkasse* combined benefits in kind and cash, as provided in the German law. When her husband decided to move to Austria, Mrs Von Chamier-Glisczinski also was put in a care home in the same state. At this point, the *Krankenkasse* continued delivering the monetary benefits, but stopped the full in-patient care, since that was a benefit in kind which could not be exported to Austria. After this, Mrs Von Chamier-Glisczinski sought in German courts the right to reimbursement of the costs linked to her stay in the Austrian care home, with the main argument that benefits in kind after all correspond to cash benefits and that they can be converted. Therefore, according to this point of view, there is no actual prevention for the possibility of exporting them. The German court decided to refer a preliminary question to CJEU asking whether social security regulation or the provisions on the free movement were opposed to such situation.

The Court basically stayed in line with its previous case law *Molenaar*,⁵³ stating that in-house care is a benefit in kind and that Regulation 1408/71 does not impose obligations to the State of affiliation to continue serving it. However, this does not mean that the competent institution is exempted of its duties to grant it, probably meaning that the Regulation remains neutral towards this matter. Subsequently, the Court recalls the *Kohll* and *Decker* principles, stating that the situation existing at the main proceedings does not prevent the person concerned from claiming, pursuant to primary law, the payment of certain costs relating to care received in a care home situated in another Member State.⁵⁴ However, provisions on the free movement of workers and services were not applicable, because first, there was no element proving Mr Von Chamier-Glisczinski as a worker and second, Mrs Von Chamier-Glisczinski had moved to Austria on a permanent basis. It looked that the judgment would make a positive turn for the German lady, when the Court mentioned that she nevertheless, enjoyed the status of an EU citizen, but CJEU instead of applying the test of barrier, justification and proportionality, it said that Article 42 EC,⁵⁵ provides for coordination and not harmonisation of the Member States' legislation. Therefore, this cannot guarantee that a move of an insured person to another Member State would be neutral as regards social security.

51 P. Quinn, P. de Hert, *The European Patients' Rights Directive: A Clarification and Codification of Individual Rights Relating to Cross Border Healthcare and Novel Initiatives Aimed at Improving Pan-European Healthcare Co-Operation*, p. 45.

52 Case C-208/07, *von Chamier-Glisczinski* [2009] ECR I-6095.

53 Case C-160/96 *Molenaar* [1998] ECR I-843.

54 Case C-208/07, *von Chamier-Glisczinski* [2009] ECR I-6095, paragraph 66.

55 Now Article 48 TFEU on social security of migrant workers; see also Case C-208/07, *von Chamier-Glisczinski* [2009] ECR I-6095, paragraph 84.

The Court's legal persuasiveness in this point appears to be vague, since there is a sort of contradiction between the earlier statement and what was said in paragraph 66 to the effect that the Regulation does not interfere with the application of primary law. Why did the Court accept this argument now, instead of following the usual line, stated also on the *Vanbraekel* case? There is not much choice, but to wait and see if CJEU will develop further practice in the light of the strict as opposed to the more lenient approach.

4. Issues that the LTHC poses today

4.1 Demographical changes, the future of an old Europe

'Driven by population ageing, the big challenge of long-term care systems is to meet the needs of a growing number of older people at risk of suffering from frailty and disability, while keeping costs affordable and public finances sustainable.⁵⁶ This is the opening sentence of the joint report on healthcare and long-term care systems, prepared by the staff of European Commission's Directorate General for Economic and Financial Affairs and the Economic Policy Committee. The fact that the size and age structure of Europe's population is going through important changes was and still remains an uncomfortable truth, reckoned by the highest Union institutions. Although it is true that all age groups can benefit from long-term care services, the majority of the patients consist of those in retirement age.⁵⁷ According to the joint report on healthcare and long-term care systems, the development of LTC policies is facing three big challenges today.⁵⁸ First, as estimated, the number of Europeans aged +80 will be constantly increasing and being in such conditions, this specific population will most likely require a combination between both medical and social care in a continuous basis. Second, according to studies, a foreseeable shift from informal house care towards formal care-giving is expected, forwarding such bill from family members of the patient, to the state's social security systems. Lastly, LTC makes an unquestionable growing share of GDP and public spending,⁵⁹ which is not

56 Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability Prepared by the Commission Services (Directorate-General for Economic and Financial Affairs), and the Economic Policy Committee (Ageing Working Group) Volume 1, chapter 5, p. 155.

57 Report of the European Social Network, *Services for older people in Europe*, published October 2008, page 2.

58 Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability Prepared by the Commission Services (Directorate-General for Economic and Financial Affairs), and the Economic Policy Committee (Ageing Working Group) Volume 1, chapter 5, p. 155.

59 Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability Prepared by the Commission Services (Directorate-General for Economic and Financial Affairs), and the Economic Policy Committee (Ageing Working Group) Volume 1, chapter 2, pp. 16-37.

a rather easy challenge for Member States, construing as such one of the reasons why there is an exclusion in respect of LTC in the Directive scope of this paper.

The above mentioned joint report frames the main policy elements, referring as such categories of budgeting and performance assessment, institutional arrangements, and specific policy tools for LTC system design. Overall, the joint proposal concludes that driven by population ageing, the challenge of LTC services is to meet the demand consequently in rise, while still keeping the costs affordable and public finances sustainable. The government officials stress that demographic changes have caused increasing costs of LTC services and as well the population expectations for better care services do not seem to help much in solving the issue. The core problem though, seems to be the huge discrepancies that exist among Member States. They have different approaches towards LTC services, different descriptions of what falls under a long-term service or not, different traditions into offering such care, different governance, which might be centralised or decentralised, and many different ways in which they finance LTC services, including the public-private financing mix, the sources of public funding and the levels of governments involved in the financing of services. The picture, as it stands, is indeed chaotic.

Demographic change happens at a different pace in each country. According to the OECD, it is estimated that by 2050 one third of the population in Poland, Italy, and Germany will be over 65 years old. In that time, the share of the elderly population in Belgium, Sweden and the UK will be around 25% of the total population.⁶⁰ Basically, it is expected that by 2040 those older than 80 years will constitute a share of the total population which will be more than twice the current proportion.⁶¹ Also, while translating this into costs and expenditure for the Member States, the Economic and Financial Affairs Council (ECOFIN) requested the Economic Policy Committee (EPC) to provide age-related public expenditure projections, and it resulted that in all cases long-term care expenditure increases more than that of the health care, based on estimations carried out previously.⁶² In the end, it is clear that now Europe is facing a major natural challenge, which is exactly the ageing of its population. As mentioned, this is a purely natural process, albeit influenced by low birth rates and increased life expectancy, which is not necessarily deemed to be a totally negative phenomenon. On the contrary, a possible further harmonisation of policies and

60 OECD Demographic and Labour Force database (July 2006), accessible at <https://data.oecd.org/pop/elderly-population.htm#indicator-chart> [last consulted 11/10/2016].

61 The Survey of Health, Ageing and Retirement in Europe (SHARE), which is the main source of comparable data on the number of old people that cannot perform activities of daily living due to physical limitations. <http://www.share-research.org/> [last consulted 11/10/2016].

62 Accessible at http://ec.europa.eu/economy_finance/publications/publication922_en.pdf [last consulted 11/10/2016].

legislation towards these services on a Union scale by the Member States will put the European Union at the front line of protecting this category of persons in need of care, setting such a good example of what good and enjoyable ageing should be.

4.2 More challenges to the exclusion principle

Given the above arguments, we might think that after all, Member States had their own strong reasons for being reluctant into including the LTC services in the scope of the Patients' Rights Directive. According to the above mentioned arguments, something needs to be done and some harmonisation needs to prevail into Member States' national policies and laws regarding elderly care and LTC services, if the Union wishes to remain faithful to its social agenda. On 25 October 2013, exactly the deadline for transposition of the PRD into national law, the European Commissioner for Health, Tonio Borg, made a public statement, stating among others that: 'Today is an important day for patients across the European Union. As of today, EU law in force enshrines citizens' right to go to another EU country for treatment and get reimbursed for it. From today, all EU countries should have transposed the Directive on Patients' Rights in Cross-border Health Care, adopted 30 months ago, into their National law. For patients, this Directive means empowerment: greater choice of healthcare, more information, easier recognition of prescriptions across-borders (...). For patients to benefit from the rights granted by EU law, the law needs to be properly transposed and enforced. The Commission has provided a great deal of support to Member States during the transposition period. Now I urge all Member States to deliver on their obligations and fully transpose this Directive.'⁶³

Clearly, the last sentence is a very diplomatic one, suggesting that not all Member States had completed the transposition process, which is something that happens rather frequently in most of the cases. But the true 'problem' is that although the PRD is binding in all its legal contents, the very fact that we are dealing with a directive, leaves the door opened to its implementation by the Member States. In our context, as we have mentioned before, it is true that LTC services do not fall within the scope of PRD, but this anyway does not prevent Member States or social security institutions in concluding agreements between them, as long as they are in conformity with the Treaties, and in principle with all primary legislation of EU law. Maybe a few good examples in the future will pave such a way.

⁶³ Available at http://europa.eu/rapid/press-release_MEMO-13-932_en.htm [last consulted 11/10/2016].

Additionally, some legal scholars,⁶⁴ acknowledging the fact that the Directive itself is not free of ambiguity, draw our attention at the preamble (Recital 14) which is very 'vague and short' regarding the exclusion of the long-term services from the general scope of the PRD: 'This Directive should not apply to services where the primary purpose is to support people in need of assistance in carrying out routine, everyday tasks.' Righteously, the author argues that this formulation seems to target social care and support, which in the end are not part of healthcare at all. While the second part of the recital is to clarify the ambiguous first statement, it actually creates more confusion. It seems that also a care of mixed nature (healthcare and social care) is excluded on the basis of being a long-term one. As we have already mentioned, the number of patients seeking these services is growing and due to their special circumstances, it is difficult to distinguish a line between *social* and *health* care. In this sense, the PRD may be seen as discriminatory⁶⁵ and create a new line of case law in the bench of CJEU.

4.3 Impact analysis of PRD and some discussions on alternatives

Given the enthusiasm with which a Directive on patients' rights was awaited, it is normal to expect also a certain degree of curiosity in the legal opinion⁶⁶ concerning the results of its transposition into national law. Has the patient mobility increased after the adoption and if so, to what extent? Will healthcare actors adopt the cooperation opportunities and will this lead to an accessible European system of healthcare? On September 2015, the European Commission drew a report⁶⁷ on the operation of the Directive, highlighting the main issues in the course of the transposition years and most importantly, the features of current patient mobility.

The report states that the transposition process was somehow neglected by the Member States, since infringement proceedings were launched against twenty six of them on the grounds of late or incomplete notification of the measures adopted.⁶⁸ However,

64 Herman Nys, editorial of the European Journal of Health Law 21 (2014), 'The Transposition of the Directive on Patients' Rights in Cross-Care Healthcare in National Law by the Member States: Still a Lot of Effort to Be Made and Questions to Be Answered', pp. 1-14.

65 E. Syszczyk, 'Patients' rights: a lost cause or missed opportunity?', in J. Van de Gronden, E. Syszczyk, U. Neergaard and M. Krajewski, *Healthcare and EU Law, Legal Services of General Interest* (The Hague, Asser Press, 2011), page 111; See also P. Quinn, P. de Hert, *The European Patients' Rights Directive: A Clarification and Codification of Individual Rights Relating to Cross Border Healthcare and Novel Initiatives Aimed at Improving Pan-European Healthcare Co-Operation*, p. 46.

66 M. Peeters, 'Free Movement of Patients: Directive 2011/24 on the Application of Patients' Rights in Cross-Border Healthcare', 2012 European Journal of Health Law, no. 1, pp. 50-51.

67 Commission report on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, COM(2015) 421 final, Brussels 04/09/2015.

68 COM(2015) 421 final, p. 3.

subsequently only four of these proceedings remained open and all four Member States had made commitments to fix the problems as soon as possible. In later years, the correctness of the transposition will be assessed by the Commission. The feature that needs to be looked upon with interest in the report is the data collection of patient flows. The Commission says that patient flows for healthcare abroad under the Directive are low. But this seems to be the issue concerning even the Social Security Regulation, whilst patient mobility, in terms of unplanned healthcare, is higher. The exceptions of this general observation are only France, Luxembourg, and to some extent Finland and Denmark, but generally, the usage of planned healthcare is far below the number suggested by Eurobarometer of people that expressed their interest in experiencing cross-border healthcare.⁶⁹

This might come as a surprise, but we still have to bear in mind that a number of Member States were late with the implementing process and that the data was collected during 2014, meaning that the transposition deadline had not expired yet. Secondly, as indicated by Eurobarometer,⁷⁰ the number of citizens who are well-informed about their right to reimbursement is very low. There are also some natural reasons for this, including the unwillingness to travel due to family proximity, language barriers or acceptable waiting times in the national health system.

According to Article 20 of the Directive,⁷¹ the Commission will draw similar reports every three years, so for a full picture of the facts and figures, we would have to wait until September 2018. By the above data, if we were to make a parallel line to the LTC service seekers, we would expect nevertheless a constant growth of their willingness to receive such treatment abroad, also due to the facts already mentioned earlier. Also, when there is an identification of such patients by the National Contact Point, data should be recorded in order to fill out further impact assessments.

Authors⁷² call the PRD ‘waiting time Directive’, in principle entitling patients only to reimbursement for treatments (when they are subject to prior authorisation, but most hospital treatments are) that cannot be provided within a reasonable time in the Member State of affiliation. If this is the case, would it be appropriate to adopt the same approach towards LTC services? After all, it should be noted that the exclusion of LTC from the scope of the Directive, does not mean that care-homes or even Member States cannot conclude cross-border agreements to facilitate this type of

69 Special Eurobarometer 425 / Wave EB82.2 – TNS Opinion & Social, available at http://ec.europa.eu/public_opinion/archives/ebs/ebs_425_sum_en.pdf [last consulted 12/10/2016].

70 *Ibid.*

71 Directive 2011/24/EU OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 9 March 2011 on the application of patients’ rights in cross-border healthcare, Article 20.

72 M. Peeters, ‘Free Movement of Patients: Directive 2011/24 on the Application of Patients’ Rights in Cross-Border Healthcare’, 2012 European Journal of Health Law, no. 1, p. 57.

patient mobility. Maybe a local action would be followed by a more 'European' one. Also, another thing we should bear in mind is that 'negative' judgments by CJEU such as *Von Chamier-Glisczinski* were issued before several developments reinforcing Europe's social dimension occurred. Thus, with entry into force of TFEU introducing the social progress clause in Article 9 or Article 168 expanding Union's competences in the field of public health and by a legally binding Charter of Fundamental Rights, the outcome of the ruling, might have been different.

5. Conclusions and recommendations

Predominantly, this article tends to agree that the adoption of Patients' Rights Directive is a crucial event in the cross-border healthcare area. With a correct transposition of this Directive, European patients can expect some clarity with respect to reimbursement proceedings and of course, more detailed information and support regarding their rights to cross-border healthcare. Overall, there is a diversity of services (health and/or social) and in this case they possess different natures, modes of application and reimbursement processes, which are equally a matter of assessment. An important relationship between national legislation and European regulations (minimum harmonisation regulations) can also be observed, as there is a different degree of development of health systems between Member States, and otherwise unified solutions could create problems. In the end, if this Directive is deemed to be biased against chronically ill patients and LTC seekers, this is for CJEU to decide after the transposition transitional period has ended and first cases come to knock on the Court's door.

After the exclusion of healthcare services from the scope of the Services Directive, it is natural that the PRD now presents itself as one of the most important legislative measures adopted by European health law. Coming to the end of this paper, we would recommend that in subsequent developments, EU's actions should respond to the new challenges brought in the table by social and demographic changes, considering drafting a specific proposal with regard to cross-border long-term care services.

And probably this should be the way to approach this exclusion. The fact that it was particularly difficult to find a political will of Member States, given the diversity of their national healthcare systems, and the not so supported idea to share their competences in organising healthcare systems provides a strong argument in favour of the LTC exclusion. But in the light of future developments, maybe this should be approached as an EU's intent to give more time and focus primarily on harmonising LTC policies within Member States, and then decide to adopt a harmonising legislation in cross-border LTC. The population of Europe is in a continuous ageing

process; therefore measures should be taken with regard to providing LTC and making them accessible through the internal market, backed up by reimbursement schemes or social security ones.

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Isključenje dugoročne skrbi iz Direktive o pravima pacijenata – pitanje starenja stanovništva

SAŽETAK

Rad predstavlja neke od glavnih aspekata Direktive 2011/24/EU koju su Europski parlament i Vijeće donijeli 9. ožujka 2011. Direktiva se odnosi na primjenu prava pacijenata u prekograničnoj zdravstvenoj skrbi, uobičajeno poznatoj kao Direktiva o pravima pacijenata, i tretira problematično isključivanje dugoročnih usluga iz svog djelokruga. Ova Direktiva predstavlja najnoviju inicijativu Europske unije u odnosu na europsku zdravstvenu skrb i jedinstveno tržište, ali se primjećuje da bi isključivanje od strane država članica moglo dovesti do zaključaka da je Direktiva pristrana prema kronično bolesnim pacijentima i pacijentima kojima je potrebna dugoročna skrb, osobito u europskoj pozadini sve starije populacije koja se pojavljuje u današnjem društvu.

Ključne riječi: Direktiva o pravima pacijenata, prekogranična zdravstvena zaštita, zdravstvene usluge, zakon o unutarnjem tržištu, dugoročne zdravstvene usluge, pacijenti kojima je potrebna dugoročna skrb.