The impact of EU patient mobility rules on health systems in Germany and Norway

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Professor Frode Veggeland (Supervisor)

"Thesis submitted as a part of the Master of Philosophy Degree in European Master in Health Economics and Management"

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http://www.duo.uio.no/

Trykk: Reprosentralen, Universitetet i Oslo

Acknowledgements

Foremost, I would like to express my sincere gratitude to my supervisor, Professor Frode Veggeland, for his comments, guidance and inspiration throughout the process of writing this thesis.

My sincere thanks also go to experts that shared their knowledge on the subject. I am most grateful for their help and availability.

Last but not the least; I would like to thank my family, for their patience and support.

Abstract

The title of this master thesis is "The impact of EU patient mobility rules on health systems in Germany and Norway". It examines the output of European Union (EU) patient mobility rules and preliminary effect of the new Patients' Rights Directive in two different healthcare models: the Bismarckian model (Social Health Insurance) and the Beveridgean model (National Health Services) in Germany and Norway, respectively. The analysis uses the method of qualitative case study. It is based on a theoretical understanding of European integration, and data and documents from national and EU legislative documents, European Court of Justice (ECJ) rulings and six expert interviews. We found that the impact of EU rules on patient mobility has both convergent and divergent effect. The objective of the Patients' Rights Directive was to harmonize EU rules on patient mobility and it has succeeded to a certain extent. It is because the basic rules for patients receiving health treatments abroad were adopted differently in both countries but show nearly identical outcome. Nevertheless, it still has divergent effect due to flexibility to filter and adjust these rules in line with the countries' individual health systems.

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List of abbreviations and acronyms

AOK	German sickness fund
DRG	Diagnostic / Diagnosis Related Group
EEA	European Economic Area
EFTA	European Free Trade Association
EC	European Communities
ECJ	European Court of Justice
ESA	EFTA Surveillance Authority
EU	European Union
GmbH	Gesellschaft mit beschränkter Haftung (company with limited liability)
GP	General practitioner
HELFO	the Norwegian Health Economics Administration
HELTEF	Stiftelsen for helsetjenesteforskning (The Foundation for Health Services Research)
MRSA	Methicillin-resistant Staphylococcus aureus
NHS	National health services
NIA	National Insurance Administration
NIS	National Insurance Scheme
OECD	Organisation for Economic Cooperation and Development
OOP	out-of-pocket
PHI	Private health insurance
RHA	Regional Health Authority
SHI	Social health insurance
SI	Statutory insurance
SGB V	Sozial gesetzbuch (Social Security Code V)
TK	Techniker Krankenkasse (German sickness fund)
WHO	World Health Organisation

1. INTRODUCTION TO THE WORK

The objective of this master thesis is to analyse the impact of European Union's (EU) patient mobility rules on health systems in Germany and Norway. Especially, we set focus on the preliminary outcome of the new Patients' Rights Directive[1] that was just recently adopted in both countries. We would like to find out how the Directive was transposed and what possible implication it brings for health systems. We decided to make case studies of Germany and Norway as a basis for comparative analysis, given that these two countries have different ways of organising their health systems, most notably in terms of *who* provides services, and *how* it is paid for.

Germany represents the Bismarckian model based on Social Health Insurance, in which individuals can chose among several insurance providers, although in practice the choice is often decided by their profession or place of employment. In terms of treatment the insurers can chose among different providers where private sector is dominant. Norway's National Health Insurance on the other hand is an example of the Beveridgean model, characterised by tax financed universal coverage and predominantly public service providers.
In addition to this variation, there is also difference in the EU laws on patient mobility. These are divided based on their legal application[2] and the scope. The first one is the EU regulation also as known the Social Security Regulation. This EU law on the coordination of social security systems does not replace national systems by a single European system but it is applicable in all EU countries, Iceland, Liechtenstein, Norway and Switzerland. The Regulation covers all the traditional branches of social security, namely: sickness, maternity and paternity, old-age pensions, pre-retirement and invalidity pensions, survivors' benefits and death grants, unemployment, family benefits, accidents at work and occupational illness[3]. The second law as previously mentioned is the Patients' Rights Directive. The Directive legally sets out general rules to be transposed into national law by each country, as it deems appropriate. The deadline for EU countries to transpose the Directive was 25 October 2013. However the reality shows significant delays. The scope of the new EU law is to clarify the

[1] 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
[2] There are three basic types of EU legislation: regulations, directives and decisions: A regulation is similar to a national law with the difference that it is applicable in all EU countries. Directives set out general rules to be transferred into national law by each country as they deem appropriate. A decision only deals with a particular issue and specifically mentioned persons or organisations (EU Commission, 2015a)
[3] Regulation No 883/2004 of the European Parliament and of the Council on the coordination of social security systems of 29 April 2004

rules on access to healthcare in another EU/European Economic Area (EEA) country, including reimbursement (EU Commission, 2015a). Because the two countries differ in many aspects of health system financing and organisation, we can expect that transposition output and outcome will differ. Nevertheless the findings show not only divergent impact but also some convergence.

The thesis is divided into five parts, of which this introduction is the first. Part two describes the analytical framework, methods and data. The third part provides the reader with background: development of EU rules on patient mobility and health systems description of Germany and Norway. The fourth part provides analysis of the EU patient mobility rules impact on the health systems: the Patients' Rights Directive transposition into German and Norwegian legislation, implementation of EU patient mobility rules, factors affecting the impact and discussion: convergent versus divergent impact of the rules and their challenges for health systems in both countries. The last part provides concluding remarks.

2. ANALYTICAL FRAMEWORK, METHODS AND DATA

2.1. Analytical framework

2.1.1. The research question

The subject of this master thesis is already stated in its title: the impact of EU patient mobility rules on health systems in Germany and Norway. Especially we ask how these rules are implemented and whether their impact is convergent or divergent. In other words, whether these rules make various European health systems more homogeneous or rather differentiate them. For our case study we selected Germany and Norway that represent two fundamentally different health systems and have relatively high level of responsiveness to EU measures in general, including EU health policy.

2.1.2. The theoretical framework

Adaptation and impact of EU rules can harmonize or differentiate. According to the convergence hypothesis, the constitutional and institutional setup of member states will converge towards one common model that is a result of Europeanization and fusion in response to similar challenges given by the policy cycle in the European Communities (EC)/EU arena. Even if there are pre-existing differences among member states, they will disappear, slowly and partly unnoticed (Rometsch & Wessels, 1996, p. 36). On the other hand recent developments show significant divergence (Olsen, 2002). Forces that are driving EU policy making and implementation towards convergence or divergence are further explained in the following subchapter.

Convergence: driving forces

Presence of convergence in the area of EU policy making and implementation of EU legislation can be explained using two theories:

1. rational choice institutionalism according to Hall and Taylor (1998)
2. institutionalism in organizational analysis introduced by DiMaggio and Powell (1991)

According to the first theory, institutions in a shared institutional environment are likely to grow increasingly similar, as they converge around the most efficient organizational form.

EU member states tend to copy from their counterparts those structures and procedures that proved to be the most successful. According to the second theory, organizations in a common institutional environment become similar (Featherstone & Radaelli, 2003: 88-89).

The driving forces that lead to convergence are following:

1. coercion
2. mimicry
3. socialization

The first force of convergence is **coercion**[4]. It is present when the obligations and pressures flow from "hard" and "soft" rules (DiMaggio and Powell, 1991). In the case of EU cross-border care it is the Social Security Regulation (No 883/2004) that is legally applicable in all EU countries. As explained earlier this EU law is applicable in all EU countries, Iceland, Liechtenstein, Norway and Switzerland and represents hard law (Trubek & Trubek, 2005). The other main type of EU law that represent hard law is directive that needs to be transposed into national legislation and allow more discretion (EU Commission, 2015a).

In the area of EU patient mobility, we also observe coercion after the number of ECJ rulings in the second half of 1990's. Kohll-Decker's ruling. This ruling concerns legal proceedings between two Luxembourg nationals, Mr Decker and Mr Kohll, and their sickness funds, the Luxembourg Social Insurance Arbitration Council and the Court of Cassation sought a ruling from the Court of Justice of the European Communities. The fundamental question of these proceeding was whether national rules under which reimbursement of medical expenses incurred abroad is subject to prior authorization are compatible with Community law. Mr Decker was refused reimbursement of the cost of spectacles that he had purchased from an optician established in Arlon, Belgium, on the ground that he had purchased them abroad without prior authorization. In Mr Kohll's case, his doctor established in Luxembourg had requested authorization from the "Union des Caisses de Maladie" for his daughter to receive treatment from an orthodontist established in Trier, Germany. That request for authorization, made in accordance with the Luxembourg Code of Social Insurance, was turned down on the grounds that the treatment was not urgent and

[4] The concept of coercion has two different faces, corresponding to the two parties involved in its most ordinary cases. On one face, it picks out a technique agents (coercers) can use to get other agents to do or not do something. On the other face, it picks out a kind of reason for why agents (coerces) sometimes do or refrain from doing something (Stanford Encyclopaedia of Philosophy, 2015).

could be provided in Luxembourg. Eventually the ECJ decided that Community nationals may obtain medical treatment in another member state without prior authorization and be reimbursed in accordance with the tariffs of the state in which they are insured (European Court of Justice, 1998). These rulings confirmed coercive effect of EU laws in EU member states. Especially, it is with regards to free movement of services and the EU completion law. These cases are rather exemplary because they led to reformulation of existing EU laws (regulation) as well as development of Patients' Rights Directive which is meant to clarify the rules on access to healthcare in another EU country, including reimbursement.

Enforced EU law put on EU member states similar pressures to implement their policies. Similar actors are empowered and are likely to learn from each other in searching effective ways of responding to European pressures (Börzel, 1999). This may lead to **mimicry** as it is the second force of convergence. This act occurs during interaction and information sharing of national representatives. Governmental institutions use the copying features and mechanisms from other countries' public organizations in order to implement EU patient mobility rules in their health systems. One example of this is implementation of EU rules by health authorities of Nordic countries (Denmark, Finland, Norway and Sweden), where mimicry is also facilitated by similar health systems. According to a representative of the Norwegian Directorate of Health (7th October 2015), there is active exchange of information and reports between Nordic health administrations and countries' National Contact Points. These contacts and exchanges of information may lead to mimicry. A proof of this driving force is the consultation paper from the Ministry of Health of 27 June 2014 that does not propose application of the prior authorization under the Patients' Rights Directive. The argument not to apply the prior authorization was statistical evidence from Sweden indicating that the extent of cross-border health care use will be too low to justify the bureaucracy needed for such a system (Ministry of Health, 2014b).

The third force of convergence is **socialization**. It has harmonizing effect when frequent contact and interaction between national officials leads to development of common norms resulting in a gradual diffusion of them into national systems (Olsen, 1997, p. 161). Such frequent contact and interaction happens for example during meetings of Ministers at the EU Council, Parliamentarian groups, experts sent for meetings or short postings from national ministries and other governmental institutions. These meetings typically take place in Brussels.

Divergence: driving forces

In principle, driving forces of divergence can be said to include the following:

a) types of law that can open up for national adaptation,
b) empowerment of national institutions that can filter EU rules
c) level of national sovereignty corresponding to rational choice

With respect to **types of law that can open up for national adaptation**, Vogel (1997) and Schneider (1998) point to global convergence on one hand and national continuities and therefore persisting cross-national variation, on the other hand (Knill & Lenschow, 2001). The cross-national variation can be the effect of EU law that needs to be transposed into national legislation. Each country can transfer a directive into national law as deems appropriate contrary to a regulation that is similar to a national law with the difference that it is applicable in all EU countries. In case of EU patient mobility rights, it is the Patients' Rights Directive that opens up for national adaptation. Germany as a federal state transposed the Directive democratically by respective parliaments in its each state (of total 16 länder). We can illustrate it with two cases: the State of Bremen and the State of Brandenburg. Bremen State transposed the Directive into "Bremen Patients Mobility implementing law" (Parliament of Bremen, 2013) slightly different than the state of Brandenburg whereas Brandenburg adopted a legal act on the implementation of EU law in the field of health professions (the European Commission representative, personal communication, 24th April 2015). Differences are described in more detail on page 27 (Transposition of the Patients' Rights Directive in Germany). In this point of view we observe divergence, different implementation of EU patient rules in German federal states. Jain, J. (2013) also stressed that we should not expect any revolutionary change in any of the national systems and no major convergence towards creating a common institutional model. Structural divergence is present. Even if we observe some convergences in economic policy-making areas, policy-making institutions remain divergent even though implementation is based on the same EU directive.

Another force of divergence is **empowerment of national institutions that can filter EU rules** (Saurugger & Radaelli, 2008). According to March & Olsen (1998), states are the important actors, and international institutions are less important. EU laws can be indifferent to the interest of powerful member states. Such elements are likely to matter more when power is concentrated in the international system. Therefore divergence is rather present when member states' national institutions have empowerment to filter EU rules into national legislation (e.g. transposition of the Patients' Rights Directive).

Level of the national sovereignty corresponding to rational choice theory: The rational choice approach assumes that individual behaviour (in our case the behaviour of each EU member state) is motivated by self-interests, utility maximization, or more simply put, goal fulfilment (Petracca, 1991, p. 298). The level of the national sovereignty in this context means how much power the respective EU member state has in regulating its internal affairs without foreign interference. For example, Norway decided to transpose the Directive in a more liberal way where the interests of political parties played important role. By not introducing prior-authorization mechanism it shows that Norway decided independently and above expectations of the EU.

Vogel (1997) also refers to "appropriate adaptations" linked to the particular structural background of state and administrative traditions. As already stressed, the divergent impact varies on level of the national sovereignty. Börzel & Risse (2006) argue that the process of Europeanisation has not caused divergence among states, either in the sense, driving them further apart. There are no indications that member state variation in their domestic institutions and policies has increased. *Persistence and diversity play important role in adaptation process. Since there is different standard of the level at which one looks for convergence or divergence, measuring convergence and divergence may be of limited use in analysing the domestic impact of Europe* (Knill and Lenschow, 2001b, Kassim, 2003, p. 90-2, Radaelli, 2003, p. 51-2). This is especially applicable in the area of EU patient mobility rights where health systems vary and each member state have inclination to adopt the new law based on national interests and preferences.

Driving forces of divergence also significantly affect the duration of the legislative process. In particular it has impact on the length of decision making in the key domains of EU integration. The larger the distance between the member states' positions, the longer the EU decision-making process takes (König, 2007). Transposition of the Patients' Rights Directive as a process and its eventual output and outcome is conditioned by many factors that form member state's polities, policies and politics. *Consequently, we can expect that similar health systems will have analogous transpositions because they are influenced by comparable factors. Conversely, the greater the variation is among member states' systems, the greater the differentiation of their transposition outputs is likely to be* (Martinsen & Vasev, 2015). Health systems among EU member states vary therefore such diverging factor can significantly slow down the EU's legislative process and different transposition output.

From the cited above, we can conclude that both convergence and divergence are present in EU policy making. In the same time, there are also unintended consequences[5] that lead to harmonization and differentiation in the process of EU legislation application. The following comparative study of two countries with different legislative organisation and health systems shall seek to answer to what extent implementation of EU patient mobility rules is characterized by forces of convergence or divergence. Which forces of convergence and divergence are more present than others? As a basis for this analysis, we use the case of Germany and Norway in responding to external pressures in the form of EU patient mobility rules.

2.2. Methodology

2.2.1. Methods and data sources

The methodology of the thesis is based on a qualitative case study to examine how and to what extent the implementation of EU patient mobility rules have different effect for the health systems of Germany and Norway. We decided to choose these countries because they represent two different health systems and due to their relatively high level of responsiveness to EU measures, in general including EU health policy. The basic logic of analytical approach involves a comparison of the countries' health systems. Based on their differences we shall further investigate what was the outcome of the EU Patients' Rights Directive transposition. At the same time these countries not only represent two different health systems but also different configuration of political organisation that make the analysis more valuable in order to identify institutional factors possibly affecting the implementation as well as possible impact of the EU rules on health systems.

Data of the qualitative research were collected from public documents, academic literature, six semi-structured interviews and forms of information such as emails, notes and press releases. The analysed documents were mostly gathered through literature search using database of University of Oslo library, Internet (Google Scholar) and snowballing[6].

[5] In the social sciences, unintended consequences are outcomes that are not the ones foreseen and intended by a purposeful action. The term was popularized in the twentieth century by American sociologist Robert K. Merton (1936)

[6] A snowball sample is a non-probability sampling technique that is appropriate to use in research when the members of a population are difficult to locate. A snowball sample is one in which the researcher collects data on the few members of the target population he or she can locate, then asks those individuals to provide information needed to locate other members of that population whom they know. Snowball sampling is hardly

The literature and documents review proceeded as a search for material from mainly secondary sources that were collected from academic literature. Data collection was also done using a snowballing method by which experts were contacted to provide with documentation and information on the topic. These sources provided further research paths that lead to new data. Systematic searches online revealed documentation in English and in national languages (German and Norwegian).

The primary sources were:

- ECJ court rulings.
- working documents provided by national state administrations: the European Commission, the European Observatory on Health Systems and Policies, the European Social Observatory Centre, the German National Contact Point, the Norwegian Ministry of Health and the Norwegian Directorate of Health.
- information provided by experts from:
    - the European Commission, 24th April 2015.
    - the European Social Observatory, 30th April 2015.
    - the German Contact Point for Patients Mobility (email communication), 10th March 2015.
    - the Norwegian Directorate of Health, 7th October 2015.
    - the Norwegian Ministry of Health and Care Services, 17th April 2015.
    - the Oslo University Hospital, 29th April 2015.
    - the University of Hamburg. 1st October 2015.

    This was gathered in the form of six semi-structured interviews in addition to email communication.
- data published on the official websites of public institutions.

Patient mobility is rapidly evolving. Therefore internal reports (e.g. Health Directorate) and media reports (e.g. the Guardian, NRK) have been used to document developments not covered elsewhere. Experts specialised in the subject were interviewed to provide more specific insights on recent developments.

2.2.2. Limitations

The main limitation of the research was the inadequate and uneven availability of data

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likely to lead a representative sample, but there are times when it may be the best or only method available (Crossman, 2015)

with regards to patient mobility. There is also unreported information concerning application of the Patient's Rights Directive due to its very recent implementation and therefore it is challenging to measure its outcome and impact on the national systems where large quantitative data were not available. Another limitation was only intermediate knowledge of German and Norwegian that made searching for documentation and data more difficult. Since Patients' Rights Directive was implemented in Germany (by establishing the national contact point on 25th October 2013, different dates on the level of länders) and Norway (1st March 2015) quite recently, there was only a limited amount of data available at the time of the writing of the Master thesis.

3. BACKGROUND

3.1. Development of EU rules on patient mobility

3.1.1. "The Social Security Regulation"

The Social Security Regulation[7] from 1971 was adopted as a complement to the free movement of workers and has developed in parallel with the gradually extended right of free movement. This EU law was used as a legal basis for EU patient mobility until 1998. It gave EU citizens the right to the same emergency treatment in EU member states as residents but also health services for cross border workers. According to this law, patients from other EU member states are entitled to claim the same benefits as domestic patients. As of 1998 we can observe extended patients' rights in cross-border care mostly thanks to a series of the ECJ rulings. In its Kohll and Decker decisions, the ECJ ruled that healthcare services provided on a remunerated basis in another EU member state constitute services as defined in the EU Treaty of Rome (Treaty establishing the European Economic Community, 1957). Measures rendering the reimbursement of amounts paid contingent upon prior consent were seen as obstacles to the free movement of services, and as such needed to be justified or be deemed contrary to EU competition law. These and later rulings placed limits on the provisions of healthcare in the member states which up to then were exclusively framed by the EU member states. In 2004, the Social Security Regulation (EEC No. 1408/71) was replaced by a new regulation (EC) No 883/2004, which currently serves as legal basis for cross-border health care. It is particularly relevant for frontier workers who are members of the EU healthcare system in the country in which they work but reside in another EU country. It also specifies the access to healthcare in both states (the European Commission representative, personal communication, 24th April 2015).

3.1.2. "The Patients' Rights Directive"

Even if the Social Security Regulation established the right to healthcare in another EU member state, it only gave right for treatment to help people in acute need while temporarily abroad, those working in another EU country and those who received prior authorization from their own payer (e.g. a sickness fund in Germany or Health Economics

[7] The Council Regulation (EEC) No. 1408/71 of 14th June 1971 on the application of social security schemes to employed persons and their families moving within the Community) also known as the Social Security Regulation.

Administration (HELFO) in Norway respectively). However the legislation was not sufficient to avoid complaints of patients, some of whom took their grievances to the ECJ (Legido-Quigley et al., 2011). Consequently, and without EU member states' explicit prior authorization, health services were given the status as a service subject to internal market law. This significantly caused rerouting of the EU's approach to health care services. It was not only a social security issue subject to the social security coordination mechanism, but it became an issue with respect to principles of internal market and thus subject to free movement and free competition legislation (Greer, 2008, p. 222, Veggeland & Time, 2014).

EU member states initially reacted to the ECJ decisions (e.g. Kohll and Decker, European Court of Justice, 1998: Case C-158/96) with contained compliance, interpreting them narrowly and substantively and avoiding policy changes for as long as possible (Greer, 2008). Most member states argued that the Kohll and Decker decisions (see more details on page 4) applied only to Luxembourg or any other state that has similar social health insurance system to Luxembourg. When Germany held the EU presidency in 2007, the German federal Health Minister, Horst Seehofer, instructed his officials to "destroy those decisions". The way to block further development of the policy was to commission research, hold conferences and develop a reflection process that would try to delimit the powers of the EU and reassert member state control of the issue (Greer, 2008).

In addition, the Kohll and Decker rulings (European Court of Justice, 1998: Case C-158/96) caused increased uncertainty in member states due to effects of the internal market law on health systems. National health authorities namely British, French and German were alarmed by results from their in-house impact analysis (Greer, 2011, p. 193). The main reason for worries was that ECJ case law could actually require major structural reforms. This situation created a necessity to call for a legislative proposal on cross-border health care (Veggeland and Time, 2014: 21).

Santuari (2013) argues that the ECJ has confirmed the responsibilities of EU member states in the health care sector. ECJ has also underlined the right for patient mobility outside national borders in order to access health care services in other countries. Additionally, the ECJ, in the case Leichtle (European Commission, 2015b) has stated that prior authorization must be regarded as a hindrance that prevents patient mobility to other countries, there is no need for a scientific test that proves that thermal spa treatment is better at home rather than abroad and the thermal spa centres and establishments abroad must be recognized by the national health service concerned and appropriately registered within it. This case concerns Mr Leichtle, a German national and an official of the Bundesanstalt für Arbeit (Federal

Labour Office). In 2000 he requested the expenditure associated with a health cure he took in Ischia to be reimbursed (Italy). The reimbursement of the expenditure was subject to obtaining prior recognition of eligibility and to the condition that the health spa is listed on a Register of Health Spas. So far as a health cure taken outside Germany that recognition is granted only after a medical report establishing that the cure envisaged is absolutely necessary because of the greatly increased prospects of success in another country. Mr. Leichtle took the cure without the prior approval. The fact that the person concerned has not awaited the conclusion of any court proceedings brought against the decision that refused his request for prior recognition of eligibility, before commencing the cure in question, cannot exclude the reimbursement of the expenditure. The Court decided that, were it otherwise, the practical effect of Community law would be jeopardized since the majority of patients cannot await the result of proceedings before receiving the treatment that their state of health requires (Santuari, 2013). The ECJ decision underlines that German legislation applying to civil servants and governing the reimbursement of expenditure in respect of a health cure is, in part, contrary to the freedom to provide services. The condition by which the prospects of success must be greater outside Germany constitutes an unjustified barrier (European Court of Justice, 2004).

As an outcome of the ECJ rulings on cross-border care that were also brought up before national courts (Mossialus and Palm, 2003; Palm and Glinos, 2010), the European Commission began preparations for drafting the new EU Patients' Rights Directive. The aim of the Directive was to clarify patient mobility rules and complement the existing Social Security Regulation (Wismar et al., 2011; Greer, 2013). The first proposal of the Directive was presented in July 2008 (Legido-Quigley et al., 2011). The main objective was to establish a clear legal framework within the European Union by resolving ambiguities about the mechanisms involved in providing such care and establishing systems in which member states can co-operate to resolve outstanding issues (Sauter, 2011; Greer, 2013, p. 416). After presenting the draft of the Directive in 2008 and after considerable debates and amendments (European Commission, 2008), the Directive was finally adopted in 2011. Finally it came to force on 25 October 2013 (European Parliament and Council of the European Union, 2011). It represents a very important and strategic piece of European legislation and it is especially important due to replacement of the prior authorization procedures that were previously required to allow patients to go abroad to access health care services. Therefore the Patients' Rights Directive has contributed to improving the level of freedom of choice for the European citizens (Santuari, 2013).

3.2. Health systems of Germany and Norway

Health systems are organized differently between EU/EEA member states. In general, we can divide systems in Europe into three types of health systems:

a) social health insurance based Bismarckian system with a further distinction between benefits in kind and restitution systems,
b) national health insurance based Beveridgean system,
c) private health insurance (PHI) systems (Landwehr, 2013).

The extent of coverage, the mode of financing and delivery of healthcare distinguish the National Health Services (NHS) from the social health insurance model (SHI), and the PHI model. The NHS model features: universal coverage, funding from general tax revenue and public ownership of the health infrastructure. The SHI model combines universal coverage with funding coming mainly from earnings-related contributions and public or private delivery. Finally, in the PHI model, coverage is based on private insurance only, which is also the major funding source. Delivery is characterized by private ownership (Landwehr, 2013).

NHS and SHI differ according to the relationship between contributions and benefits. Bismarckian systems provide earnings-related benefits, while Beveridgean systems offer flat payments (Cremera & Pestieaub, 2003). The systems also differ in financing. Whereas the Beveridgean model is financed through the state budget, a core element of Bismarckian model is the management of healthcare by self-governing corporatist bodies and the funding primarily by income-related contributions, not by taxes (Gerlinger & Schmucker, 2009).

The implementation of the NHS can be interpreted as a part of the general welfare state expansion and transformation into a social democratic welfare regime in the post war economic boom. The NHS reflects social democratic values of universal coverage, equal access to services and beliefs in the efficiency of public services. The Social Health Insurance type that is in Germany represents a dominant role of societal actors in healthcare regulation and financing, whereas private for-profit providers mainly deliver services (Landwehr, 2013).

The Norwegian health system is characterised mainly by the predominance of tax-financed public provision of health services, as is the case in the rest of the Nordic countries area and the United Kingdom. This system differs from German system as well as from other OECD countries where privately provided health services are being funded by a mix of social and private insurance. The health system in Norway has succeeded in securing universal coverage and high quality service (van den Noord, Hagen & Iversen, 1998). Inter-sector

cooperation across government has become increasingly important over the past few years, especially as a means for addressing social inequalities in health. More attention has also been paid to improving resource allocation (through priority setting and an increased use of health technology assessment), quality issues and patient safety. Strengthening the position of patients and next-of-kin has been a policy priority since the turn of the millennium, for example, through a comprehensive patient rights law regulating issues such as patient choice and complaint procedures (Ringard et al., 2013).

3.2.1. Financing

Sources of revenue and financial flows - Germany

Social Health Insurance is dominant in Germany. The public share of total health expenditure in 2012 was some 73%. Private insurance accounted for the remaining 27% of total expenditure. The proportion of health care financed from taxes has decreased throughout the last decades, falling from 10.8% in 1996 to 4.8% in 2012. The most significant decrease of public expenditure was recorded for long-term care (over 50%) with the introduction of mandatory long-term care insurance in 1993 shifting financing away from means-tested social assistance (Busse & Blümel, 2014: 113).

The SHI system contributions are divided into payments from employees and their employers unless members are self-employed. The contribution rate is automatically deducted from monthly salaries. There has been a uniform contribution rate: 14.6% of income shared evenly between the members and employers. Total contributions of all members are collected in a central fund and distributed to sickness funds in form of risk-adjusted capitations (Ziller, Eaton, & Widström, 2015). Sickness funds collect contributions and transfer these to the Central Reallocation Pool. Contributions increase proportionally with income to an upper threshold (a monthly income of €4050 in 2014). Resources are then redistributed to the sickness funds according to a morbidity-based risk-adjustment scheme, and funds have to make up any shortfall by charging a supplementary premium (Busse & Blümel, 2014).

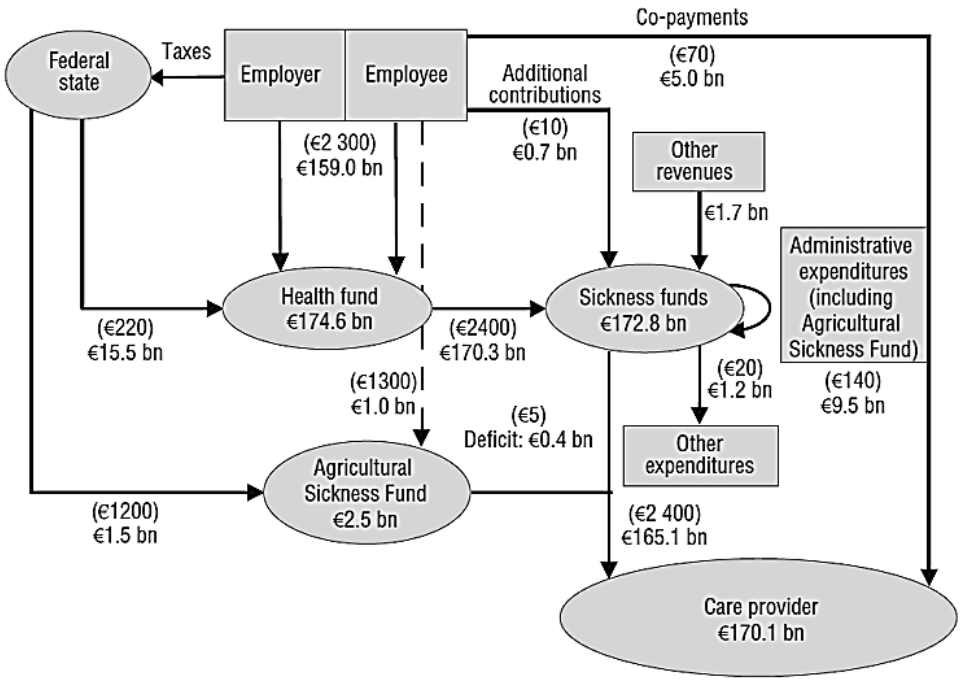

Figure 1. Financial flows in the German SHI system (1–4 quarters 2010, preliminary results) from Bundesministerium für Gesundheit (2011)

Note: bn means Billion

Fig. 1 shows detailed illustration of financial flows within the SHI system including the rounded total health expenditure and the expenditure per insured for 2010. This diagram also emphasizes that the share of tax-financed health expenditure is much higher than the recognized share of 5% (Busse & Blümel, 2014).

Sickness funds pay health care providers, hospitals and physicians in ambulatory care that represent the main expenditure blocks just ahead of pharmaceuticals. Hospitals are financed through dual financing, with financing of capital investments through the federal states and running costs through the sickness funds, private health insurers and self-pay patients – although the sickness funds finance the majority of operating costs (including all costs for medical goods and personnel). Financing of running costs is negotiated between individual hospitals and federal states' associations of sickness funds, and primarily takes place through diagnosis-related groups (DRGs) (Busse & Blümel, 2014). The remuneration of the health service providers is negotiated in complex corporatist social bargaining processes between SHI funds and provider organizations mainly on the common state level, in German called Bundesländer. For outpatient care, sickness funds pay a capitation to physicians' associations to cover most expenses. The German risk-adjustment scheme differentiates capitations according to 40 age groups, gender groups, six reduced earning capacity groups and 155 hierarchic morbidity groups that are based on 80 diseases.

Physicians' associations distribute their total revenue to physicians according to a complex catalogue that specifies fees for cases as well as for specific services. Physicians face a reduction in their fees once they have treated more than a predefined number of cases in a quarter. Hospital reimbursement is mainly based on Diagnostic Related Groups (DRGs). Similar to physicians' reimbursement, target budgets limit total expenditure. If a hospital treats more cases than agreed upon in negotiations, it faces reductions in its DRG payments for additional patients (Kifmann & Wagner, 2014). Payment for private services is on a fee-for-service basis using the private fee scale, although individual practitioners typically charge multiples of the fees indicated (Busse & Blümel, 2014).

SHI members can obtain treatment from physicians that belong to a physicians' association. Access to medical care is mainly free. Co-payments exist for prescription drugs and for inpatient care. They cannot exceed two per cent of household income. Traditionally, general practitioners have no gatekeeping role (Chambers et al., 2010) and patients are free to go directly to a SHI-affiliated specialist doctor of their choice. Importantly, members generally receive benefits in kind, implying that they are not billed for services (Kifmann & Wagner, 2014).

Sources of revenues and financial flows - Norway

In Norway, health-care services are mainly financed through the general tax system, with patients' out-of-pocket (OOP) payments as supplementary source. Collected taxes flow to the state budget, counties and municipalities is illustrated in the Fig. 2.

Public financial resources flow mostly from the central and regional governments and from the National Insurance Scheme (NIS). It accounts for over 85% of total health expenditure. The rest of 15% is privately financed health expenditure (OECD, 2013). Voluntary health insurance in health care financing is low but increasing. Some five per cent of the Norwegian population is holding private health insurance (Ringard et al., 2013).

Financing of primary care is coming from municipal taxes, the central government block grants and earmarked grants for specific purposes. General Practitioners' (GP) income is divided between capitation payments (amount to around 30% of GPs' income) and a fee-for-service basis. Majority of specialist care is financed through block grants, 60% and Diagnosis Related Groups distributed by the Regional Health Authorities (RHAs), 40% (Ringard et al., 2013).

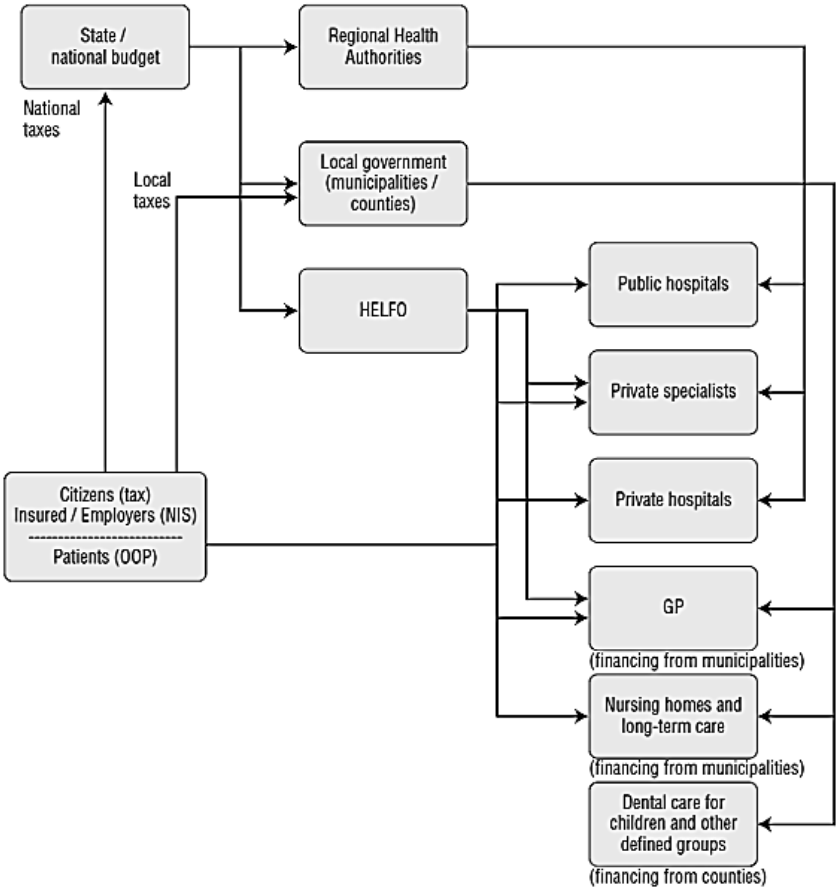

Figure 2. Financial flows in the Norwegian health system from Ringard et al. (2013, p. 57)

Overview of the statutory financing system - Germany

The SHI is managed based on regional division and operated by sickness funds. There were 132 sickness funds in 2014 in comparison to 960 in 1995. In addition, there are a few special insurance funds for certain companies or guilds as well as for certain groups of professional groups, such as farmers. Sickness funds are corporations under public law and have historically the right to self-government. The key principles are solidarity (everyone is covered and pays a contribution unrelated to the health status) and subsidiarity (local decision-making and personal responsibility). Sickness funds compete for SHI members with their services and with their cost management (Kifmann & Wagner, 2014). With minor exceptions, all funds provide similar benefits. Services are supplied on a contractual basis (Ziller, Eaton, & Widström, 2015).

Overview of the statutory financing system - Norway

In Norway, it is the parliament that determines the scope of the statutory coverage, the criteria for co-payments and the safety net. No major changes were introduced in the scope of

coverage in recent years and the discussions have been focused instead on the level of co-payments and the safety net (Ringard et al., 2013). Currently, there is more focus set on priority setting, which may involve exclusion from coverage or increasing the level of co-payment for some treatments (e.g. coverage of in vitro fertilization has been changed several times) (Lindahl & Squires, 2011).

Coverage - Germany

Health insurance has been mandatory since 2009 for all citizens and permanent residents, either through statutory insurance (SI) or private health insurance (PHI). The SI covers 85% of the population – either mandatorily or voluntarily. Insurance cover through PHI is mandatory for certain professional groups (e.g. civil servants). Under certain conditions, PHI can be an alternative to SHI (e.g. the self-employed and employees above a certain income threshold) (Busse & Blümel, 2014). In 2012, about 11% of the working population whose yearly gross income exceeds €53,550 are members of a private insurance scheme that is based on Social Security Code V (i.e. the Social Code, In German, "Sozialgesetzbuch, SGB V") from 1988. It can provide complementary cover for people with SI, such as dental care. Additionally, 4% of the population is covered by sector-specific governmental schemes (e.g. for the military). People covered by SI have free choice of sickness funds, and are all entitled to a comprehensive range of benefits. Private healthcare schemes can either provide a complete health service for those who opt out of the SI, or top-up cover for those who remain within it. The premium for private insurance is lower and private insurance schemes offer more flexible packages of care. However coverage applies only to the insured persons. Family members like spouses and/ or children are excluded thus they need to be insured separately (Ziller, Eaton, & Widström, 2015).

Coverage – Norway

Everybody who is legally residing in Norway is entitled to publicly funded health-care services (Ringard et al., 2013). This entitlement is included in health-care legislation: the Municipal Health and Care Act of 2011 (Ministry of Health and Care Services, 2011), the Specialist Care Act of 1999 (Ministry of Health and Care Services, 1999) and the National Insurance Act of 1997 (Lovdata, 1997).

Residents from the EEA and EU have in principle the same entitlement to health services as Norwegians, and are reimbursed according to EEA regulations and bilateral agreements. If there is no bilateral agreement, foreigners outside the EEA normally have to

pay the full cost for services received. All pregnant women and children (regardless of their citizenship and residency status) have access to immunization and primary healthcare. Acute emergency care is accessible to anybody including undocumented immigrants (Ringard et al., 2013).

3.2.2. Organization and governance

Organization and governance - Germany

In the Federal Republic of Germany, responsibility for the healthcare system is divided between central government, the 16 federal states and self-governing bodies of physicians, hospitals, dentists, psychotherapists, and public sick funds. Health insurance is separated between statutory and private schemes. As described previously, the statutory health insurance occupies a central position in the healthcare system in Germany. The SI system requires mandatory membership of a state-approved sick fund. The vast majority of the German population (85%) are members of such fund that reimburses legally prescribed standard packages of healthcare including oral healthcare. The highest national decision-making institution for the SHI scheme is the Federal Joint Committee. This authority was established in 2004 at a federal level. It includes representatives of the public, sickness funds, the professional organisations and is responsible for defining and redefining the benefit packages for the SHI (Jakubowski & Saltman, 2013).

Organization and governance - Norway

Organization of health services is semi-decentralized. Primary care is under the responsibility of some 450 municipalities, except provision of dental care that is kept with the 19 counties. Since 2002, the specialist care is under the state's responsibility and is administrated by four RHAs. The Ministry of Health is in charge of regulation and supervision of the health system. In the same time operative tasks are delegated to various subordinate agencies. These are the Directorate of Health and the Norwegian Medicines Agency (NoMA). Some 15 compulsory national health registers collect various types of health data, e.g. on cancer and cardiovascular disease. In additions there are around 200 voluntary medical registries. The National Board of Health Supervision provides overall supervision and monitoring of health services (Directorate of Health, 2012).

3.2.3. Comparison

The health systems of both countries have in principle universal coverage. National health insurance in Norway and statutory health insurance in Germany are legally enforced schemes that make sure that everybody receives health care when needed. The major difference between the German and the Norwegian health system is that in Norway it is financed and organised by the public sector and in Germany by a combination of the public and private sector. Firstly, collection of revenue differs. In Germany, it is salary based. Revenue is collected from employers and employees and distributed by a pool of multiple insurance funds. However, it is the federal government that regulates the insurance funds revenue and risk pooling. In Norway, contributions to the system are made via general taxation. In practice, regulation, financing and provision are governed by the state (Adolph et al., 2012).

3.2.4. New trends and possible developments

There is an increasing amount of private health insurance. In Germany, private sources accounted for 27.1% of total expenditure in 2012 (Busse & Blümel, 2014). In Norway, voluntary health insurance in health care financing is still low (5%) but increasing (Ringard et al., 2013). Provision of health services by private practices is more common in Germany and still rare in Norway. The existence of private actors in the health systems of both countries has positive and negative sides. In Norway, private providers are linked to contracting by public health authorities in order to deal with one of the most critical limitations of the national health system, the waiting times. Increased treatment capacity was introduced through contracting with private for-profit hospitals. Despite the many efforts, public hospitals still operate at their capacity limits and there are many Norwegian patients waiting to receive elective hospital treatment (Ringard et al., 2013). In Germany, system division into SHI and PHI remains one of the largest challenges for the German health care system – as risk pools and financing differ, access and provision lead to inequalities (Busse & Blümel, 2014). Those who have above-average health and above-average incomes usually prefer to be a member of PHI. Therefore the financial viability of SHI is in risk (Mielck & Helmert, 2006).

With respect to EU patient mobility rules, patients that are prone to seek more possibilities in provision of health services may find many opportunities in cross border health care. For example in Denmark, there were observed two trends of Europeanization that

have had a significant impact on Danish health system. The first trend is the introduction of market elements, particularly patient choice relevant for free movement of goods, services and persons in the EU. The second trend is centralization in policy-making and administration (Salomonsen, 2005, Vrangbaek and Martinsen, 2005, Vrangbaek and Martinsen, 2008). The Social Security Regulation represents for patients seeking health treatment abroad a statutory health insurance where by law you are entitled for health services when needed in public hospitals. This regulation represents social rights meaning that health care is provided not only to people in acute need but also cross border workers and patients that are authorized by their insurer. The private market based Patients' Rights Directive provides patients with more choices. The patient may seek health treatments in public hospitals and also in private hospitals. Those patients that are facing a medically unjustifiable waiting time for treatment at home are entitled for authorized treatment abroad with a higher level of coverage for health care costs. This law strengthens not only patients' position in receiving health care abroad. It also favours private health care providers that shall be more active in attracting patients/customers from abroad. Their motivations shall be based on filling up their free capacities and increasing their profits.

4. ANALYSING IMPLEMENTATION AND IMPACT OF PATIENT MOBILITY RULES

After presenting the background of EU rules on patient mobility and description of the health systems of Germany and Norway, part two of this thesis is devoted to the impact of these rules on health systems in both countries. The analytical part is divided into four chapters. In the first chapter, we present process of the transposition of the Patients' Rights Directive into the legislation of the two countries. Subsequently, the second chapter sets focus on how the rules are implemented in the area of financing and organisation. The third chapter presents factors affecting impact on the countries' health systems. And the last chapter is focusing on convergent and divergent impact of the rules and their challenges for health systems in both countries.

Over the last decades, governments across the EU have undertaken reforms to improve the performance of health systems (Cutler, 2002). Performance objectives often concern waiting times. Delays that became politically disturbing can prompt free choice as capacity is sought outside the public system. One strategy has been for governments to officially commit to reducing waiting lists. In Norway, legislation grants patients maximum waiting time guarantees. With public dissatisfaction mounting and electoral retribution lurking, extra capacity has been imported to fulfil promises of improvement, expecting to diminish demand pressures and push public providers to perform (Glinos et al., 2010b). In Bismarckian health systems like in Germany, market-oriented reforms have replaced passive forms of purchasing with selective contracting and introduced competition among insurers. Selecting which services to buy from which hospitals can give new incentives to encourage providers, increasingly remunerated according to activity, to become more responsive and efficient as they compete for contracts (Robinson, Jakubowski, Figueras, 2005). Such developments have led to wider scope of health care provision over national borders. European legislation such as Social Security Regulation puts pressures to territorially unlock national health systems (Ferrera, 2005) and encourage patients to seek health care treatments abroad.

In the autumn of 2014, the Special Eurobarometer (a survey) took place in the 28 EU member states. Some 27,868 respondents from different social and demographic groups were interviewed face-to-face at home in their mother tongue on behalf of the Directorate-General

for Health and Consumers (SANCO) (European Commission, 2015c, p. 8). The result of the survey showed that "Receiving treatment that is not available in your country" was indicated as the most common reason to seek treatment abroad (91% of respondents in Denmark and 87% of respondents in Sweden).[8]

Table 1: *Reasons to seek treatments abroad (multiple answers possible)*

Reasons	**EU28**	**Denmark**	**Germany**	**Sweden**
To receive treatment that is not available in (OUR COUNTRY)	**71%**	**91%**	67%	**87%**
To receive better quality treatment	53%	66%	50%	56%
To receive treatment from a renowned specialist	38%	43%	52%	62%
To receive treatment more quickly	34%	66%	24%	67%
To receive cheaper treatment	23%	20%	50%	16%
To receive treatment from a provider that is closer to your home	6%	7%	9%	7%
Other (SPONTA-NEOUS)	2%	1%	2%	0%
Don't know	2%	0%	2%	0%

Source: European Commission (2015c), p. 16.

According to result of this survey, those EU countries where people are more likely to travel abroad to receive medical treatment are relatively small in population size. On the other hand, Germany was one of those countries where respondents were the least willing to receive treatment abroad (11%). This is probably because Germany has in general a good capacity of health services. Yet "receiving treatment that is not available in your country" (67%) was the most common answer of German respondents. Other reasons to seek medical services abroad were: cheaper treatment (50%), better quality treatment (50%) and treatment from renowned specialist (52%) as it is illustrated in the Table 1 (European Commission, 2015c, p. 15).

Even if Norway is not a member of EU, it is for most practical purposes subject to EU law that is covered by the Agreement on the EEA. The European Free Trade Association (EFTA) states as Norway, Iceland and Liechtenstein are equal partners at the EU internal market, on the same terms as the EU member states.[9] This includes having access to the internal market's four freedoms: the free movement of goods, persons, services and capital (Norwegian Mission to the EU, 2015). The freedom to provide services implies that once a

[8] NB: Scandinavian countries like Denmark and Sweden have similar health systems and challenges in the health sector as Norway.

[9] The EEA Agreement does not cover the following EU policies: common agriculture and fisheries policies (although the EEA Agreement contains provisions on trade in agricultural and fish products); customs union; common trade policy; common foreign and security policy; justice and home affairs (the EEA / EFTA States are however part of the Schengen area); direct and indirect taxation; or economic and monetary union (http://www.efta.int/eea/eea-agreement/eea-basic-features, accessed 28th October 2015)

public system opens up to non-statutory providers, no discrimination may be made between a hospital located within the national territory or elsewhere in the EU (Martinsen, 2005). Selective contracting has made national systems more susceptible to these EU rules. Giving a greater role to the for-profit sector opens the door to cross-border contracting. Furthermore, a series of rulings by the ECJ on the freedom of EU citizens to seek health services entail that if care is not available within medically justifiable time limits in their home system, patients are entitled to go to other EU countries (Palm, Glinos, 2010). The Patients' Rights Directive that was recently transposed into legislation of Germany and Norway clarifies the rules on access to healthcare in another EU country.

4.1. Transposition of the Patients' Rights Directive

4.1.1. Germany

Germany was one of the first EU member states to implement the decisions of the European Court of Justice on patient mobility into national law by passing the Statutory Health Insurance Modernization Act of 2004 (Bundesgesetzblatt, 2003, p. 2190). It explicitly allows SHI members to claim inpatient and outpatient treatment in all 28 EU member states and in the additional four member states of the EFTA, i.e. Iceland, Liechtenstein, Norway and Switzerland. Furthermore, the legislation allows sickness funds to directly enter into contracts with healthcare providers in the EEA and Switzerland (Social Code Book V, Sect. 140e).

The following principles on EU cross-border care are legally implemented according to the Social Code Book V, Sect. 13 para. 4–6:

- All SHI members can claim *outpatient* treatment to which they would be entitled in Germany in any other EU member state without prior permission.
- All SHI members can claim *inpatient* treatment to which they would be entitled in Germany in any other EU member state subject to prior permission. This permission must be granted if the German healthcare system cannot provide the treatment within the medically necessary period.
- In both cases, the costs must generally be reimbursed up to the amount which would be reimbursed in Germany if the domestic preconditions for treatment are fulfilled.
- Another significant point of the Patients' Rights Directive is the Article 11(1): Recognition of prescriptions issued in another member state. Prescriptions issued by medical staff in one country should be recognised in other EU states.

- Name(s) of the patient
- Forename(s) (written out, i.e. not only initials)
- Date of birth
- Date issued
- Name(s) of the prescribing doctor or dentist
- Forename(s) (written out)
- Professional qualification
- Direct contact information (e-mail and telephone or fax number, in each case with the international dialling code)
- Office address (including the name of the Member State in question)
- Signature (handwritten or digital, depending on the medium on which the prescription is issued)

Identity of the medicinal product prescribed where necessary

- The "common name" of the medicinal product in accordance with European directives (2001/83/EC) (International Non-proprietary Name). The brand name is only used in exceptional cases.
- Form of administration (tablet, solution, etc.)
- Amount
- Strength
- Dosage

N.B.

Please make sure that your doctor or dentist does not prescribe the package size designation when it comes to the quantity of the medicinal product to be stated. The package size designation in Germany is a standardised size for three package sizes with different numbers of tablets, capsules, suppositories, etc. It is abbreviated on the prescription to N1, N2 or N3. This standard size is unknown in other Member States. A doctor or dentist or pharmacist in another Member State cannot comprehend this quantity information, so that the prescription must state the precise quantity (e.g. 20 pieces).

Figure 3. Obligatory information to be provided in case of medicinal products from National Contact Point for cross-border healthcare (2015)

As we may see, the illustration above shows conditional information of prescriptions that can be recognised in other EU states that is rather exhaustive. In reality the prescription that is issued by the medical professional may lack one of presented data like the "common name" and therefore may cause difficulties in its recognition.

An important step in implementation of the new EU law was the legal establishment of a national contact point for cross-border healthcare. It was the only change in German law that was necessary to meet the Patients' Rights Directive.

On the level of German states (in German called länder) the law was implemented individually and transposed on different dates in each federal state (the European Commission representative, personal communication, 24th April 2015). For example in the Bremen State, it was transposed into "Bremen Patients Mobility implementing law" regulating the definitions of Article 3 ("Definitions"), some aspects of Article 4 (2d[10] – "Responsibilities of the Member State of treatment") and Article 6 (3[11] – "National contact points for cross-border healthcare") of the Directive (Parliament of Bremen, 2013). The State of Brandenburg adopted a legal act on the implementation of EU law in the field of health professions where it regulates the definitions of Article 3 ("Definitions"), some aspects of Article 4(2) (b[12]), (d) ("Responsibilities of the Member State of treatment") and Article 6 (3 - "National contact points for cross-border healthcare") of the Directive (Parliament of Bremen, 2013). The new law in Bremen entered into force on 1 April 2014 and the new law in Brandenburg entered into force on 11 July 2014 (European Commission, 2015f).

The Patients' Rights Directive complements the existing Social Security Regulation on the coordination of social security systems. The Directive differs from the Regulation in three aspects: only planned cross-border care treatments are affected: there is no need for an approval for outpatient care prior to the planned treatment, costs of the planned EU cross-border treatment are only borne up to the amount a comparable treatment would have cost in

[10] The Member State of treatment shall ensure that: systems of professional liability insurance, or a guarantee or similar arrangement that is equivalent or essentially comparable as regards its purpose and which is appropriate to the nature and the extent of the risk, are in place for treatment provided on its territory;

[11] In order to enable patients to make use of their rights in relation to cross-border healthcare, national contact points in the Member State of treatment shall provide them with information concerning healthcare providers, including, on request, information on a specific provider's right to provide services or any restrictions on its practice, information referred to in Article 4(2)(a) - the cost of cross-border healthcare is reimbursed in accordance with Chapter III - REIMBURSEMENT OF COSTS OF CROSS-BORDER HEALTHCARE, as well as information on patients' rights, complaints procedures and mechanisms for seeking remedies, according to the legislation of that Member State, as well as the legal and administrative options available to settle disputes, including in the event of harm arising from cross-border healthcare.

[12] The Member State of treatment shall ensure that: healthcare providers provide relevant information to help individual patients to make an informed choice, including on treatment options, on the availability, quality and safety of the healthcare they provide in the Member State of treatment and that they also provide clear invoices and clear information on prices, as well as on their authorisation or registration status, their insurance cover or other means of personal or collective protection with regard to professional liability. To the extent that healthcare providers already provide patients resident in the Member State of treatment with relevant information on these subjects, this Directive does not oblige healthcare providers to provide more extensive information to patients from other Member States;

the home country less a deduction for administration. The Social Security Regulation, by contrast, stipulates that cross-border patients obtain healthcare as if they would be insured in the country they visit or work. If this coverage is more generous than in Germany, sickness funds must therefore reimburse it. On the other hand, if co-payments or other out-of-pocket-payments apply to patients in that country, the SHI member would have to pay them as well. The German SHI members are allowed to choose between reimbursement according to the Directive and the Regulation that improves the situation for SHI members for planned cross-border care treatments (Kifmann & Wagner, 2014).

4.1.2. Norway

Norway is a member state of the EFTA. According to the principle of unanimity applied in the EEA Joint Committee, all the EFTA states must agree in order for new EU legislation to be integrated into the EEA Agreement and for it to apply to cooperation between the EFTA states and the EU. If one EFTA state opposes integration, this also affects the other EFTA states in that the rules will not apply to them either, neither in the individual states nor between the EFTA states themselves nor in their relations with the EU. This possibility that each EFTA state has to object to new rules that lie within the scope of the EEA Agreement becoming applicable to the EFTA pillar is often referred to as these parties' right of veto. So far, this right has not been exercised. This is partly because when EU legislation is to be integrated into the EEA Agreement it is submitted to the EEA Joint Committee at the final stage of an extensive process of information and consultation between the contracting parties (Regjeringen, 2015). Norway did not apply the right for veto with regards to the Patients' Rights Directive and therefore was expected to transpose it into its legislation.

Before the Directive was transposed, Norway was criticised by the ESA (EFTA Surveillance Authority) for not complying with the EEA Agreement (the Norwegian Ministry of Health representative, personal communication, 10th April 2015) in the form of a formal notice sent to Norway on 14th May 2014 (ESA, 2014). The Authority found that certain provisions in the Norwegian legislation are not in line with the EEA Agreement, in particular with Article 20 of Regulation 883/2004[13] on social security coordination and Article 36 EEA[14] on free provision of services. The letter of formal notice only concerned medical

[13] Travel with the purpose of receiving benefits in kind - Authorization to receive appropriate treatment outside the Member State of residence.

[14] Within the framework of the provisions of this Agreement, there shall be no restrictions on freedom to provide services within the territory of the Contracting Parties in respect of nationals of EC Member States and

treatment that requires hospitalisation (in-patient treatment), not outpatient treatment. The Authority also noted that whereas a system of prior authorization for access to in-patient treatment is as such permissible under EEA law, EEA law requires that any such system must be easily accessible and capable of ensuring that a request for authorization will be dealt with within a reasonable time – and in any case within a time limit that is medically justifiable for the patient in question (ESA, 2014).

ESA claimed that certain provisions in the Norwegian legislation were not in line with EU rules, and as such represented an infringement of the EEA Agreement (ESA, 2014). ESA's objections were based on the following arguments:

- *...that the rules prohibiting patients from returning directly to a medical service provider in another EEA State to receive the treatment and being reimbursed for it to which they are entitled upon the expiry of the deadline for treatment under the national legislation.*
- *... that Norway has failed to ensure that a patient who cannot be given the medical treatment to which he is entitled under the national legislation within a medically justifiable time,*
- *...the criteria determining whether adequate medical services exist in Norway in relation to applications for authorizations/reimbursement of hospital treatment in other EEA States. ESA states that Norwegian legislation was not in line with the obligations required under EEA law and can end up by referring the case to the EFTA Court* (Veggeland and Time, 2014: 26).

Such arguments were also raised in Sweden as well as in other cases involving the regulation of cross-border care (Mossialos and Palm 2003; Palm and Glinos 2010; van de Gronden et al. 2011; Wismar et al. 2011). In reaction to this, on 9 July 2014, the EFTA States and the European Union adopted seven Joint Committee Decisions by written procedure incorporating 26 EU legal acts into the EEA Agreement. Among these was the Patients' Rights Directive (EFTA, 2014). On 15th August 2014, the Norwegian Ministry of Health responded to the formal letter where it addressed all the comments (Royal Norwegian Ministry of Health and Care Services, 2014).

On 16th December 2014, Parliament agreed to the Directive to be incorporated into the EEA Agreement (Stortinget, 2014). The resolution was passed with the votes of the Conservative Party, Progress Party and the Liberals. From the consultation procedure minutes

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EFTA States who are established in an EC Member State or an EFTA State other than that of the person for whom the services are intended.

(Ministry of Health, 2014b) that were circulated on 27 June 2014 we learnt that the national act from 22nd November 2010 No.1466 about benefits to receive healthcare in another EEA country fully respects the Directive. However there were some changes made:

- hospital treatment should be included;
- prior authorization:
    - the Directive allows member states to require pre-authorization. The Ministry has legal basis for doing so in Folketrygdloven (The National Insurance Act).

"The Ministry has concluded that it is currently *not necessary to require pre-authorization*. It will monitor the developments of patient mobility closely and consider at a later stage if there will be a need to restrict the flow of patients. "

The reasoning for such conclusions was as follows:

- *The prior-authorization entails a restriction in the free movement of services.*
- *Without it, patients will be able to travel freely to receive treatment and then claim refunding. This right is limited to treatments that are covered in the home country, and the amount reimbursed is limited to what it would cost in the home country.*
- *The previous Government (Stoltenbeg II) proposed to establish a mechanism for prior-authorization (Prop 118 L). The current government (Solberg) wishes to put the patient in focus, give him options and reduce waiting time. The Ministry has balanced two concerns: its own needs to plan and control, and the patient's needs. From the patient's perspective pre-authorization would mean limiting his possibility to receive treatment in other countries. In Norway there is insufficient capacity for some kinds of hospital treatments. For some patients the possibility to receive treatments abroad will mean shorter waiting time. In some cases there is a limited knowledge/experience in Norway, and then the patient will benefit from accessing expertise in other countries.*
- *Establishing a prior-authorization mechanism would require a lot of resources. Statistics from Sweden show that in 2013 there were 5500 patients reimbursed for a total cost of 124 million Swedish crowns. This was considered to be a low number. Data from Norway show that few patients choose to go elsewhere than their local hospital.*
- *Norway's own experience with the current legal act for non-hospital care shows the same: 8200 patients were reimbursed in 2013 for a total cost of 28 million NOK (300 patients for specialist services, 6000 for physiotherapy).*

- *It is hard to predict how many will go abroad with an open solution, but reason to believe it will be limited. The current government is very devoted to reducing queues. Therefore it does not want to introduce prior-authorization. However, it will monitor the situation very closely* (Ministry of Health, 2014a).

Eventually, the Directive was transposed into Norwegian legislation on 1st March 2015 (Lovdata, 2015). It is amending the national legal act from 22nd November 2010 No. 1466 on benefits for healthcare received in another EEA country. The amended paragraph 3 says what types of health care benefits are paid. The new paragraph 9a indicates that, *"a patient is considered to have the right to necessary medical care from the specialist"* and *"the patient is entitled to an allowance for expenses for such medical care as patient considering receiving in another EEA country, and the highest benefit that will be paid for this health care"* (Lovdata, 2015).

In Norway, the transposition of the Patients' Rights Directive was partly a result of EU pressure, but once it was fully transposed, it got a more liberal application than in many EU member states. Particularly, it is not introducing prior authorization mechanism. The motives for this choice were however political (the Norwegian Directorate of Health representative, personal communication, 7th October). This adjustment was done as a political bargain between political parties in the parliament (Stortinget, 2014). Their motivation for more liberal application was based on populistic approach not pro-European approach. In the report issued by European Commission (2015e), we learnt that the prior authorization mechanism was not introduced in Norway because of limiting administrative burden linked to its managing. The argument not to apply the prior authorization was statistics from Sweden indicating that the extent of cross-border health care use will be too small to justify the bureaucracy needed for such a system (Ministry of Health, 2014a).

4.2. The implementation of EU patient mobility rules in the area of financing and organisation

4.2.1. Germany

Currently there are two standard ways of financing a planned treatment abroad. They differ in terms of the legal basis, prerequisites for your entitlement to treatment, payment methods of the healthcare provider, reimbursement possibilities, and co-payments and in some other aspects.

1. The first one refers to the Social Security Regulation that is directly applicable EU law. In this way, assumption of costs if the person is treated as if he/she had statutory health insurance using standardized forms. It is necessary to obtain prior authorization for the treatment from health insurance fund where the person is insured and the fund issues standardized forms for this purpose. This enables the patient to show in the state of treatment that he/she wishes to be treated as a patient who has statutory health insurance in that country and that patient's health insurance fund will pay the bill.
2. The second way of financing refers to the Patient Rights Directive that was applicable after it was transposed into German legislation: Assumption of costs if a patient is treated as if he/she had private health insurance. The patient decides to undergo treatment that his/her health insurance fund would also pay for in Germany under the same conditions in another EU country. Patients initially pay the costs incurred by them and subsequently apply for a reimbursement. In many cases, prior authorization is not necessary. However if the invoice was not issued in German, it has to be translated at patient's expense. With regards to reimbursement of prescribed medicine products, first the patient has to pay the cost of the medicinal products or medicinal devices as were treated as a private patient. After returning to the country of residence, healthcare insurer as a rule reimburses the costs up to the price that would be paid in the country where he is insured/residing (National Contact Point for cross-border healthcare, 2015).

4.2.2. Norway

Since 1 March 2015, adoption of the Directive in Norway, Norwegian patients referred for a specialist treatment can choose to seek it individually in any EU/EEA country (Lovdata, 2015). Expenses can be reimbursed up to the cost of the equivalent treatment in Norway. If there are any additional treatments and travel expenses, it may not be covered. The HELFO shall be treating applications for reimbursement and will decide on the reimbursement on a case-by-case basis. By 29th April 2015, there were only three requests for reimbursement (the Oslo University Hospital representative, personal communication, 29th April 2015). However the number of requests increased to 62 by 7th October 2015 (the Norwegian Directorate of Health representative, personal communication, 7th October 2015). In order to be eligible for reimbursement of out of pocket expenses, the health treatment must be equivalent to the one that would have been covered in Norway.

According to the Norwegian Health Economics Administration (HELFO, 2015) patients are free to choose treatments in any EEA country with no need of prior authorization under the Patients' Rights Directive. Travel expenses are covered with strict limitations. Patients are normally not reimbursed for more than travelling to the nearest healthcare provider in Norway. Priority-right patients (in Norwegian: "Rettighetspasienter") who are assessed as entitled to necessary healthcare from the specialist health service within a certain time limit can opt to apply for prior authorization before travelling abroad for treatment. This only applies to treatment or investigation provided by a hospital, outpatients' clinic, radiology department, laboratory, specialist, physicians, and to medication. (HELFO, 2015). Transposition of the Patients' Rights Directive has impact on the national prioritization regime, it takes into account changes in awarding the right for treatment for patient as a part of the national legislation related to patients' rights (the Norwegian Directorate of Health representative, personal communication, 7th October 2015). If there is a need for a special treatment that is not possible to receive in Norway (e.g. proton therapy), there is a special procedure (managed by Regional Health Authorities, in Norwegian: "helseforetak") outside application of the EU rules (the Norwegian Ministry of Health representative, personal communication, 17th April 2015). The Directive is also solving the problem with long waiting lists. Patients who have had their waiting-time guarantee breached have the right to receive assistance from the National Contact Point (HELFO) in selecting a foreign provider and to extended cost coverage. In order to get the specialist health service, the health system requires everyone to have a referral from a medical professional that is in line with countries' health system rules. With regards to the private health service in Norway, there are different terms and conditions to receive treatment (HELFO, 2015).

The new legislation (Lovdata, 2015) includes rights for citizens from other EEA countries that would seek treatment in Norway. These patients must check respective procedures with the National Contact Point in their country of residence. All EEA citizens have the right to receive healthcare within the specialist health service in Norway. The treatment is paid out of pocket and is to be reimbursed by their health insurer (HELFO, 2015).

The core differences in implementation of EU patient mobility rules in Germany and Norway are represented by different political structure, organisation and financing of health systems. First of all transposition of the Patients' Rights Directive in Germany was carried out on the level of each federal state and was relatively faster than in the centrally organised

Norwegian administration. In Norway, the Directive was transposed on 1st March 2015. In Germany, financing of planned treatment abroad gives patients two options: financing based on Social Security Regulation where patients need to obtain prior authorization for planned health care and the new Patient Rights Directive where patients initially pay the costs incurred by them and subsequently apply for reimbursement at their health insurance (National Contact Point for cross-border healthcare, 2015). In both countries, financing of planned treatment abroad is similar though authorities dealing with reimbursement differ. After adoption of the Patient Rights Directive, Norwegian patients referred for a specialist treatment can choose to seek it individually in any medical centre and any EEC/EU country (Lovdata, 2015). After coming back home, expenses can be reimbursed up to the cost of the equivalent treatment in Norway. Reimbursement is carried out by national administration represented by HELFO. As it is observed, German patients follow the same procedure. However reimbursement of cost is organised on different level, with a separate private health insurance whereas in Norway, patients are referred to HELFO, the public administration.

4.3. Factors affecting impact

4.3.1. Different health system institutions

Germany

Germany is a Federal Republic consisting of 16 Länder (states). Each state has its own constitution, parliament and government. Nevertheless, the highest government authority lies with the federal institutions. In addition to the German Bundestag (federal parliament), the Bundesrat (federal council) of delegates from Länder governments also participates in the legislative process at the federal level (Germany at a Glance, 2015). This political structure makes decision-making and implementation of EU policies more challenging and time consuming.

According to Greer & Rauscher (2011), German state authorities reacted to the Kohll/Decker cases slowly and with limitations.[15] German politicians argued that owing to

[15] In 2003, over five years after the ECJ announced its judgment in the Kohll/Decker cases, the German government changed the German social code book to reflect the rulings. As part of the 2003 Statutory Health Insurance Modernization Act, Germany amended Article 13 of the Social Code Book V with paragraphs 4 to 6 and included a new Article 140e. The former specifies that publicly insured patients are entitled to receive outpatient healthcare services in those countries in which Regulation 1408/71/EEC (social security mobility) is applicable and be reimbursed by their fund for the costs they incur. The latter allows the health insurance funds to enter into direct contracts with healthcare providers in those countries in which Regulation 1408/71/EEC is applicable to offer their insured easier access to services in those countries (Greer & Rauscher, 2011).

the lack of established prices for healthcare services cost reimbursement for services rendered in other EU member states would not be feasible. Subsequently the ECJ rulings as it was with Müller-Fauré and van Riet (European Court of Justice, 2003) reassured that earlier jurisprudence concerning cross-border patient mobility was not limited to cost reimbursement systems but also applied to benefits-in-kind systems, such as Germany. The decision of ECJ stresses that the principle of freedom to provide services precludes Netherlands legislation requiring prior authorization for non-hospital care provided in another member state by a non-contracted provider. By contrast, in the case of hospital care, the requirement for prior authorization may be justified. The Court confirms that the way in which health care systems are organised does not affect individuals' rights in respect of the meeting of costs. As a matter of fact, Mrs Van Riet visited a Belgian hospital for arthroscopy without prior authorization to avoid the waiting lists in the Netherlands. Mrs Müller-Faure, another Dutch citizen, had requested dental care (hospital and non-hospital treatment) during her vacation in Germany. Their home insurance funds refused authorization on the ground that adequate care could have been obtained in the home member state, and that no medical urgency was present justifying the crossing of borders. The ECJ determined that prior authorization should not be required for reimbursement of medical expenses for outpatient treatment incurred in another member state. Prior authorization would only be required for inpatient hospital treatment. Crucially, the ECJ also did not distinguish between different reimbursement systems i.e. a system based on refunds (e.g. Kohll) or benefits in kind (e.g. Müller-Faure/ van Riet) (Greer & Rauscher, 2011, p. 227).

With respect to the German health system, the core element of the Bismarckian model is that the funding is primarily based on income-related contributions, not by taxes, and the management of healthcare is run by self-governing corporatist bodies (Gerlinger & Schmucker, 2009). This very important factor ensured different impact of EU patient rules on German health system than in Norway. Even if federal government of Germany was reluctant to accept EU patient mobility rules and limiting, German insurance funds identified in these rules a promising business opportunity. Such situation puts into focus patients as a possible market tool in order to increase revenues of German sickness funds. Solidarity and equal treatment in provision of health care services are more likely put the on side-line. In fact, German insurance funds were slightly faster than the German state to apply EU patient mobility rules in the form of contracting health care services in other European countries. Based on the statement provided by a representative of the European Social Observatory (personal communication, 30th April 2015), Kohll/Decker cases were the crucial point. Many

people and politicians in Europe were very surprised by the ECJ rulings. Looking at previous ECJ rulings, it was already possible to recognize a certain tendency. There were some less well-known ECJ rulings that were delivered at a time when patient mobility did not attract much interest (Greer & Rauscher, 2011, p. 228). Even if the German government officially denied the applicability of Kohll and Decker to the German healthcare system, the health system organizations' head offices started to issue guidance to patients and some social insurance funds started to make changes to their organization's internal policies and procedures (Greer & Rauscher, 2011, p. 228). Some German health insurance funds changed their rules to allow their clients to seek and be reimbursed for outpatient healthcare services in other EU member states. Others like Sickness fund Munich (AOK) focused on improving access to health-care services for those clients living in border regions (Greer & Rauscher, 2011, p. 228). The organisational structure of the German health system lead to a more dynamic impact of EU patient mobility rules mostly after publicity of ECJ rulings. Information about the new possibilities was spread among relevant users and stakeholders. Socializing and mimicry among patients and representatives of the German insurance funds are possibly those driving forces of convergence that led to such development.

Norway

The organisation of the Norwegian health system is divided into two levels: the national level (state owned regional health enterprises) and the local level (municipalities). Both have found opportunities in contracting health services abroad. This was not however reaction to ECJ rulings but in order to deal with the long waiting lists in the Norwegian health system and to explore possibilities for cost saving. The paper from Wismar et al. (2011) describes how cross-border cooperation started in January 2001 as a national three-year project. The Medical Treatment Abroad Project was set up for waiting-list patients requiring elective surgery. In November 2000, the Norwegian Parliament had granted NOK 1 billion for the purchase of care abroad in order to reduce waiting lists (Nesse, 2001). There were some 10,000 treatments carried out abroad over the first two years of the project. The most popular countries were Sweden to which 48% of patients travelled, and then followed Denmark (33%) and Germany (17%). The other destinations were France, Finland, Spain, England and Austria. In terms of hospitals, the top three destinations were: private hospital Hamlet in Denmark, which received around a third of the Norwegian patients, Axess Elisabeth hospital and Dalsland hospital, both in Sweden, with 13% and 12% of the patients. In total, Norwegian health authorities had an agreement with 55 foreign hospitals (Wismar et

al., 2011). The most common reasons to go abroad were linked to the musculoskeletal system, the circulatory system, or the urogenital system (HELTEF, 2003).

Contracting with foreign providers is an alternative for countries with no or few providers outside the statutory sector as it is the case of Norway. Purchasers send patients abroad in various numbers through either experimental or enduring arrangements. Since 2001, Norwegian municipalities send patients to southern Spain for rehabilitation, rheumatology and long-term care in facilities owned by Norwegian health organizations or by municipalities themselves (Fuchs, 2007). Here we may see a difference with regard to the German health system. It was not state authorities that took the initiative to contract health services abroad, but private German sickness funds that represent independent corporatist bodies. German sickness funds attracted German patients with more choices of health care treatments. This may lead to increased demand for health services abroad. From this we may already assume increasing power of the private insurance market and decreasing control of the German state over its health system financing and organisation.

The annual report for 2014 issued by the Norwegian Directorate of Health (in Norwegian: Helsedirektoratet) presents data about reimbursement of treatments outside hospital in line with the Social Security Regulation. Out of 9730 cases, there were 8165 case reimbursed that makes in total NOK 34 514 087.00. The top countries on the list were Spain, Hungary, Poland, Sweden and Germany. The most popular treatments were physiotherapy, dental treatment, medicines and general practitioner consultations. Based on these data, we can assume that popularity of seeking treatment abroad in the EU/EEA countries may further develop after the implementation of the Patients' Rights Directive. According to the most recent data from the Norwegian Directorate of Health (personal communication, 7th October 2015), till 7th October 2015 there were 81 cases under the new EU Directive. These were divided into requests for prior authorization: 19 cases and reimbursement: 62 cases.

Cross-border care contracting – Norway & Germany

The mechanism of providing planned health care abroad by the Norwegian national insurance scheme started long before the Patients' Rights Directive was transposed into the national legislation. The purpose was to resolve deficiencies of the health system (waiting lists, cost savings) not reacting to ECJ rulings, as was the case in Germany. The first planned health treatments started in late 1990's in the form of contracting by Norwegian municipalities. As an example serves the Bærum municipality that since 2002 owns and runs health centre 'Centro Asistencial Noruego' in Spain. The municipality contracted provision

of long-term care, rheumatology and rehabilitation. Favourable price differences lead to attractive contractual conditions between foreign purchasers and local providers. Mostly, it was the case when local providers were allowed to charge more for foreign patients. Comparisons are however complex due to variations in calculation methods and cost components of medical prices (Glinos, 2010b). Nevertheless an important advantage of contracting is that invoices are processed directly between contractual parties. Contracts ensure paying for services faster and give clarity as tariffs and sometimes volumes are agreed. There are also savings on the side of administrative costs where are no extra cost for issuing hospital bills. Funding sources can be earmarked (Nesse, 2001). Alternatively, funding may come from individual insurers or the region of residence. Middlemen are mostly responsible for verifying hospital invoices, and sometimes for transferring payments (Nebling & Schemken, 2006).

In the publication from Glinos (2010b), two approaches are described in setting prices and funding as illustrated in the table below (Table 2.).

Table 2: *Pricing and funding*

	National Insurance Authority (Norway)	**Norwegian municipalities (Norway)**	**HEK (Germany)**
Prices negotiated according to practice applicable in purchaser's system	Yes	Distinction less relevant as purchaser and provider belong to same system	*No data*
Prices according to health system of provider	Norwegian Parliament allocated EUR 140 MILL to the project in 2000	Region of residence	Yes
Funding source	National Insurance Authority	Norwegian municipalities	Health insurer

Source: Glinos et al. / Health Policy 95 (2010): 108

The first sets prices according to the purchaser's requirements. In the National Insurance Administration (NIA) contracts, prices differed widely between foreign providers suggesting tariffs that were not fixed. For example, prices charged for "deviation of the nasal septum/nasal septoplasty ranged from 5042 NOK in one hospital to 26,390 NOK in another (Botten, Grepperud & Nerland, 2004). From the perspective of the German sickness fund, Hanseatische Krankenkasse (HEK) paid Czech spas according to levels below those in Germany presumably because it made significant savings. No data were found on whether foreign facilities have charged more for treating German and Norwegian patients than for treating their national patients. Once the pricing and funding was agreed, health authorities decided on selection of treatments. Health care contracted abroad is invariable part

of national benefit packages. Most treatments concern non-life-threatening surgery where long waiting lists have developed in local hospitals or lower price is stimulating. It also has to be medically feasible to send patients abroad via clear pathways. Even where savings are not the key motivation, it must be financially justifiable to purchase the specific treatments abroad considering medical costs as well as possibly included travel expenses (Botten, Grepperud & Nerland, 2004).

Next step in the provision of heath care abroad is selecting patients and providers (Table 3.). Where waiting lists exist, patients having experienced the longest delays are generally offered the possibility to travel. Only patients that are fit and willing to travel are sent abroad, though mechanisms vary.

Table 3: *Selection processes*

	National Insurance Authority (Norway)	**Norwegian municipalities (Norway)**	**HEK (Germany)**
Selection of foreign providers	Restricted enquiry sent to ca. 20 hospitals. 15 selected after inspection	Norwegian-owned and/or accredited facilities in Spain	According to recommendations of Deutsches Medizinisches Zentrum, management organisation specialised in rehabilitation.
Basis for selecting what care to purchase abroad	Waiting lists	Possibility for cost savings. Medically beneficial climate Patients can apply for care in Spain. Selection based on entitlement and medical condition	Possibility for cost savings. Reputation of foreign providers Based on entitlement and referral for contracted care
Selection of patients/access to cross-border care	Public hospitals decided whether to send waiting list patients abroad, and how to prioritize	Norwegian municipalities	HEK

Source: Glinos et al. from Health Policy 95 (2010), p. 109

In the Norwegian projects, cross-border access was decided by participating local hospitals. Some hospitals chose not to take part or were reluctant to refer patients (Botten, Grepperud & Nerland, 2004). While comparing with German insurers contracts, these allow greater flexibility. Since it is affiliated with a doctor's referral and can choose contracted providers independently of location (Nebling & Schemken, 2006).

Selection of health care providers can be more or less formalised. The Norwegian NIA did a restricted inquiry among foreign interested or recommended hospitals (Nesse, 2001). Purchasers follow numerous criteria to pick potential providers. Most importantly, medical quality of care is assessed and compared against the standards of the home country.

Experience and qualifications of treating doctors and clinical records may have to be proven. Providers must be able to supply the exact treatments needed. Considerations of travel comfort and communication favour the least distant, most accessible hospitals where medical staff has adequate language skills. Other criteria may include providers' reputation, price levels, previous patient experiences and past cooperation. As a part of the contract negotiations, purchasers inspect facilities to check clinical pathways, quality, hygiene and safety standards; and the managerial, logistic and financial aspects of foreign hospitals.
(Glinos et al., 2010b)

Cross-border pathways generally start with a doctor's referral prescribing treatment covered by a contract abroad. Purchasers from NHS systems arrange travelling, hospital rooms, and medical appointments (such as pre- and post-treatment consultations, surgery and rehabilitation), and usually pay for travel costs. The Norwegian NHS sometimes covered an accompanying person. NHS purchasers also take care of transferring medical files to foreign providers. By contrast, German insurers do not make medical or travel arrangements nor usually cover travel costs. The same rules apply whether a patient goes to a contracted domestic or foreign hospital. Similarly, Norwegians going for long-term care or rehabilitation in Spain pay the travel and a nominal day-fare as when treatment takes place in Norway (Fuchs, 2007). While actual treatment for example surgery may be carried out abroad, diagnostics and follow-up care mostly take place in the home system.

4.3.2. Patients' choice

Weaknesses of the national health system may have a pushing effect on patient willingness to travel abroad for treatment. Long waiting times due to lack of capacity and deficiencies in technology or competence are the most usual reasons for patients to actively seek healthcare services in other countries (Hem, et al., 2011). Differences in co-payment from patients can in some cases also act as an incentive to go abroad for treatment. In line with most western countries, Norway has experienced substantial increase in costs related to the healthcare sector (Kittelsen, et al., 2009). Health itself is a special good and it is generally assumed that patients want to be treated as close to home as possible, served by health personnel speaking their language, surrounded by relatives and in a familiar system. The distance of a health facility from home plays important role in patient's decision making. The more it is distant from his home, less attractive it appears to him/her (Luft et al., 1990). Burns and Wholey calls it the 'distance-decay' hypothesis (1992). On the other hand there are

still patients who are willing or may prefer to be treated abroad. This must give certain advantages that attract him/her to travel. Normally, patients decide to seek planned health services abroad deliberately, and more or less voluntarily. It starts by comparing health services in the country of residence with health services elsewhere where patients decide to be treated (Brouwer et al., 2003). Usually there is difference between motivational factors. Glinos et al. (2010a) have identified four of them:

1. ***Availability***: in terms of quantity of services and in terms of types of services. Mobility happens due to unavailable treatment that cannot be obtained in the home system.
2. ***Affordability***: is relevant when care is a part of the insurance package but subject to co-payments, and where health insurers charge lower premiums for policies stipulating care that is delivered abroad.
3. ***Familiarity*****:** it is applicable in border-regions, health facilities across the border may be geographically and culturally closer and the patient may feel most familiar with when providers speak their language/dialect.
4. ***Perceived quality of health care:*** patients may travel because they perceive the quality of services delivered home as inferior to that available abroad.

Even if patients consider several aspects when deciding to travel for care, mobility is usually triggered by one of the four motivational factors. Another aspect that triggers seeking a health treatment abroad is a lack of trust in a local health care provider (the Oslo University Hospital representative, personal communication, 29th April 2015). If patient loses trust in a local hospital after the unsuccessful treatment, the whole picture of the health care provider may become very negative. Also from other perspective when in case of urgency a patient is treated in a foreign hospital. In worse cases, the hospital itself may be accused of inadequate treatment. This was the case in 2010 when the Norwegian patient advocacy organisation found that Austrian alpine skier Lanzinger had not received adequate treatment for his serious injuries during a competition in Norway (his leg was amputated), and was entitled to monetary compensation from Ullevål University Hospital (Vespestad, 2010).

In reality there are low numbers of patients seeking treatments abroad. The special Eurobarometer from 2014 revealed (Fig. 4), that only 2% of Germans received treatment in another EU country in the last 12 months. In Scandinavian countries, there were 4% of Danes and 3% of Swedes who received any medical treatment in another EU country (European Commission, 2015c, p. 15).

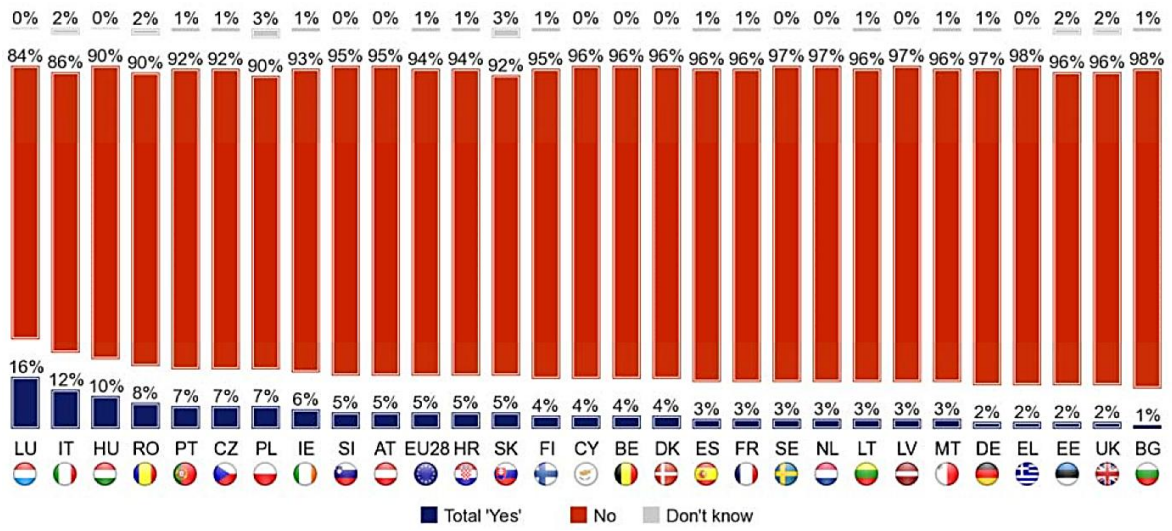


Figure 4. Question: Have you receive any medical treatment in another EU country in the last 12 months? (European Commission, 2015c, p. 11)

NB: Multiple answer possible

With regards to willingness to have treatment in another EU country (Fig. 5), the highest enthusiasm was found in Malta, where almost 8 out of 10 people would consider doing so (78%).

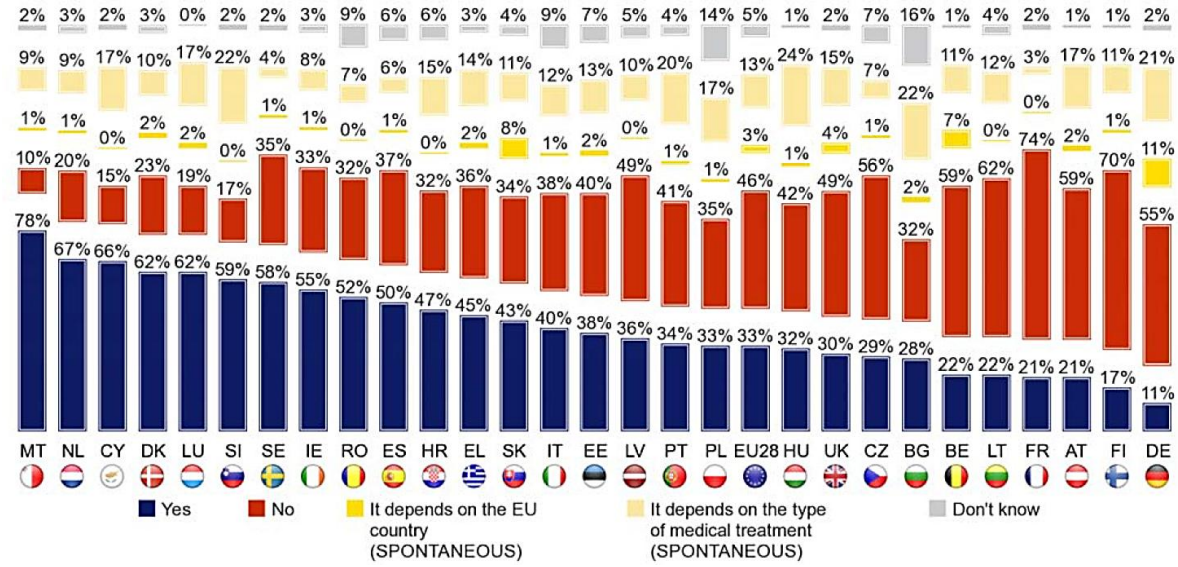


Figure 5. Question: Would you be willing to travel to another EU country to receive medical treatment? (European Commission, 2015c, p. 12.)

NB: blue means yes, red means no, yellow means: it depends on the EU country (spontaneous), light yellow: it depends on the type of medical treatment (spontaneous), grey means: don't know

There was also higher interest of Scandinavian countries: Denmark (62%) and Sweden (58%). On the other hand, the lowest number of respondents willing to have treatment abroad was in Germany (11%). Comparing these results with the 2007 findings, it appears that the

highest scores at that time were recorded in the same countries. In seven EU member states, at least three quarters of respondents said they were willing to travel to another country for treatment; these were Cyprus (88%, highest score), Malta (82%), Ireland (79%) and Denmark (78%). Interestingly, respondents in Finland (26%) and Estonia (29%) were least likely to be prepared to do so (European Commission, 2015c, p. 12).

4.3.3. Context: Geography

Geographical factors can play very important role in deciding whether to be treated home or abroad. As an example we can use a case of cross-border healthcare on the border of Austria and Germany described by Glinos & Wismar (2013). Cross-border cooperation between the general public hospital of St Josef Braunau in Upper Austria and the district hospital at Simbach in Bavaria[16] developed gradually and out of necessity. The first phase of cross-border activities started with a request from Germany by 12 Bavarian sickness funds. Austrian hospital was addressed to cover the local population in the cross-border region. The German health care system allowed health insurance companies to purchase foreign ambulatory medical services in Austria. Another important step in the cross-border cooperation was the creation of a joint coronary angiography unit in July 2008, initiated by the Braunau hospital but located at the Simbach hospital because of a lack of available space at the Austrian hospital. The initiation of this diagnostic service aimed to guarantee long-term cross-border care of high quality for a region with about 130,000 citizens. The lack of a cardiological centre before its creation in 2008 meant that the local Austrian rural population had been severely underdiagnosed. The risk of mortality due to heart attack in the region had been before up to 30% higher than in more central parts of Austria (Glinos & Wismar, 2013). Later in 2009 the Braunau–Simbach coronary angiography unit became a GmbH[17] operated jointly by an Austrian GmbH (a subsidiary of the Franciscan nuns of Vöcklabruck) and the municipality of Simbach (with a 4.9% share). This cooperation had some drawbacks that showed complications in financing of health care services. The insurance-based health care system in both countries provides benefits-in-kind services to patients. Sickness funds pay providers directly for medical treatment. However the major difference is in the way how these costs are calculated. Austrian providers charged Austrian sickness funds only for the

[16] Centrally located in a geographic triangle formed by Linz, Salzburg and Munich separated by the River Inn.
[17] The acronym GmbH, which is written after the name of the company, designates a company as private in Germany. The letters stand for Gesellschaft mit beschränkter Haftung which, translated literally, means a company with limited liability.

costs of the treatment itself based on a modified diagnosis-related group system. The charges did not include costs of operating the infrastructure or possible budget deficits because these were covered by a regional Austrian health fund that is financed by taxation. When German patients received treatment in Austria, the Austrian hospital charged the German sickness funds via an official tariff that covers both the treatment and the cost that would have been covered by taxes in Austria. This meant double cost for German sickness funds that for Austrian (Glinos & Wismar, 2013). Since the Austrian and German regional health authorities changed their policy priorities, collaboration between these two hospitals suffered and ended in 2011 (Kostera and Burger, 2013).

Border-region actors do not escape the national logic of health systems. If they collaborate across the border it is very often to serve a domestic agenda and strengthen their position within the domestic system. Moreover, if other regional or national actors deem that collaborating partners go too far they are likely to rein in the cross border care activities. In case of Austrian-German cooperation, partners were forced to give up the otherwise well-functioning cross border care due to the decisions of health authorities (Glinos & Baeten, 2015). Cross-border health care responds to needs in border-regions but obeys the priorities, rules and incentives of domestic health systems. As one scholar puts it, cross-border health care tends to leave health systems and their borders largely intact (Kostera, 2011, 2013). It is due to this reality that "cross-border hospitals" are likely to remain a dream (Glinos & Baeten, 2015). Similar motivations have led the German sickness funds to contract services of rehabilitation centres in Czech Republic and Hungary. With foreign curative spas being renowned and tariffs up to 30–40% cheaper than in Germany, both the insurer and its members take advantage (Nebling, Schemken, 2006). Purchasing abroad is possible since 2004 when new legislation was implemented allowing contracts with foreign providers (Glinos, Baeten, & Maarse, 2010).

4.4. Discussion

The founding fathers of European unifying project were looking for convergence in their policy making. The EU motto, "United in diversity" signifies how Europeans have come together forming the EU, to work for peace and prosperity, while at the same time kept being enriched by the continent's many different cultures, traditions and languages (European Union, 2015). Is it also applicable with regards to the health care provision? Do EU patient mobility rules have harmonizing effect on health systems of the member states? Or do their

different health systems and political structure lead to diverging impact? In Bismarckian Germany, EU patient mobility rules lead to further divergence where 16 state parliaments were empowered to filter EU rules in the form of Patients' Rights Directive. Beveridgean Norway filtered the Patients' Rights Directive in a more liberal way than needed. Domestic political bargains played more important role than the external pressure. From previous experience, some Norwegian political parties are typically sceptical of solutions made at the EU level and a more restrictive approach would be rather expected. However the motive for decision-making in more liberal style was not based on pro-European motives but a result of political bargaining (the Norwegian Directorate of Health representative, personal communication, 7th October 2015 and Stortinget, 2014)

The convergent effect of EU rules on patient mobility is present in both countries when it comes to application of the Social Security Regulation. As explained previously, the nature of EU regulation is similar to a national law with the difference that it is applicable in all EU countries without any necessity to transpose it to national legislation. In practice, it was application of the EU competition law that made members states to acknowledge that the prior authorization to receive health care services abroad is seen as an obstacle to the free movement of services. It was coercive power of the EU law after a series of ECJ rulings that made members states to accept common rules.

On the other hand EU directives set out general rules to be transposed into national legislation by each country, as they deem appropriate. In the case of the Patients' Rights Directive, both Germany and Norway transposed the Directive according to its different national legislative processes. However application of these rules of both countries is very similar with respect to establishment of National Contact Points that should facilitate information and guidance to its citizens with respect to these rules.

In the process of the EU policy cycle, Germany is one of the EU states whose governmental representatives use coercion and will make considerable effort to weaken the legitimacy of competing standards. According to Drezner (2005), because all greater powers have an incentive to engage in these tactics, the rest of the actors in the system will be asked – or forced – to choose which set of standards to endorse earlier than they otherwise would have. In such description we can observe Germany as a great power and Norway as the state that usually accepts and adopts EU rules under the coercive effect.

4.4.1. Convergent effect

Following the framework of convergence, coercion is present with regards to EU hard laws where this law is fully applicable in all EU/EEA member states (the Social Security Regulation) or transposed in the member states' legislation (the Patients' Rights Directive). However the convergent effect of directives is of course weaker than those of regulations because the former have to be transposed into national law. With regards to the other two driving forces of convergence, mimicry and socializing, they are also present in implementation of the EU patient mobility rules. Mimicry is occurring during active exchange of information and reports between Nordic health administrations (Denmark, Finland, Norway and Sweden) and countries' National Contact Points. As mentioned earlier, a good example of mimicry was proven in the consultation paper from the Ministry of Health of 27 June 2014 that proposes not to apply prior authorization under the Patients' Rights Directive. The argument not to apply the prior authorization was statistics from Sweden indicating that the extent of cross-border health care use will be too small to justify the bureaucracy needed for such a system (Ministry of Health, 2014a). Socializing is present during the annual meetings of Nordic health administrations but also during meetings in Brussels on the governmental level where Norway has its own representative taking care of health and food agenda (the Norwegian Directorate of Health representative, personal communication, 7th October 2015). In addition to this, socializing among patients may lead to spreading word about possible health care services abroad and lead to higher export of patients abroad. Such situation can help with lowering waiting lists in some hospitals but also cause closing of certain practices of hospitals where number of patients becomes insufficient to run them. However this is unlikely to happen.

Socializing makes patients well informed about their rights and mimicry makes them to act and use them. In practise it is when patients share their own experience with health care abroad with friends and acquaintances. Consequently, those who get inspired may find in others' experiences encouragement to seek health care abroad and copy what others have already done. However, we may also assume that German sickness funds interacted with insurance companies of other countries or used their lobbyists in Brussels to receive sufficient knowhow to expand their services abroad. They may have been inspired to use EU rules by a practical example: In 2013, when Techniker Krankenkasse (TK) had become second largest German statutory health insurance fund, with approximately 8.3 million members. TK took advantage of new markets with health care and initiated a pro-active

strategy towards cross-border healthcare. TK monitors quality of contractual partners and requires care by physicians and nurses who speak German fluently. Payment for services is undertaken between the contractual partners and TK. Therefore SHI members do not have to pay cash in advance and TK does not have to check bills from unknown providers (Kifmann & Wagner, 2014). Currently, the TK European Service for Clinics comprises around 135 clinics in eight member states (Austria, Belgium, Czech Republic, Italy, Netherlands, Poland, Portugal and Spain). This service was originally initiated in co-operation with another sickness fund (The sickness fund ‘‘AOK Rheinland Hamburg’’) in regions in which a large number of unplanned acute and emergency EU cross-border treatments of TK members occurred such as ski injuries in Austria. Furthermore, there are other additional single contracts between TK and EU cross-border healthcare service providers (Kifmann & Wagner, 2014). In all TK partner clinics, it is possible to receive planned inpatient and outpatient cross-border care. Moreover, TK has lately entered contracts with four dental clinics in Hungary and Poland. Finally, TK has contracted with nearly forty spa and rehabilitation facilities that are located in six EU member states, predominantly in Central Europe (Austria, Czech Republic, Hungary, Italy, Poland and Slovakia). TK reimburses all the contractually declared therapy costs. On top wellness treatments like e.g. additional massages have to be borne out-of-pocket by the members. These additional treatments tend to be less expensive than in Germany. Furthermore, TK pays a one-time extra payment of 100 Euro for a cure or rehabilitation treatment that lasts for at least two weeks (Kifmann & Wagner, 2014). German sickness funds found in patient mobility rules an opportunity to further expand their business activities and send more patients for health treatments abroad. This may lead to undermining of fundamental principles of the German statutory health insurance system: solidarity and equal treatment. In the same time this also puts financial stability into danger because of decreased control of finances based on the target budget. This is explained more in detail in the following subchapter. Here we may see consequences that are based on fundamental differences of the countries’ health systems. In Norway, the organisation of health care provision is centralised. Contracting health care services abroad were managed by public authorities not private sector. If Norwegian patients get better informed about their rights with regards to patient mobility, this may also lead to higher demand for health care services abroad as well as higher supply with respect to private providers establishing their practices over borders. Since reimbursement of health care services is managed by only one authority (HELFO) the control over the flow of patients is monitored better.

Martinsen and Vrabaek (2008) also point to a rather complicated process of Europeanization. In their view, Europeanization takes place as a result of multiple influences not simply as a top-down EU-imposed or induced process of change. The ECJ rulings are a good example of existing pressures on countries' public authorities to comply with EU patient mobility rules. These were coming from the bottom up not the other way around. This is in-line with the assumption that coercion as well as mimicry and socializing function as converging forces.

4.4.2. Divergent effect

On the other hand whereas Norway seems to be more liberal in implementation of EU rules in order to give more rights to its patients, German legislative process allowed higher filtration of EU rules, specifically the Patients' Rights Directive through 16 federal states. This was only possible with the Directive that is a law open for national adaptation. As pointed out before, German sickness funds were more in favour of EU patient mobility rules establishment than German governmental bodies. However the possibility of relatively free application of the Patients' Rights Directive also raised problems for financing of the German health system. The reason is that the Directive de facto stipulates fee-for-service reimbursement for cross-border treatment. While inside Germany, reimbursement is limited by target budgets. Official fees are therefore overestimates of actual payments. This implies that the current system that uses official fees for cross-border care is potentially too generous. If cross-border care becomes more widespread, then sickness funds can face considerable expenditure increases. The fee-for-service reimbursement for cross-border care is also problematic for equity reasons. It puts those at an advantage who are able to seek cross-border care because they are mobile and possess the means for travelling (Kifmann & Wagner, 2014). According to a representative of the National Contact Point in Germany, there was no positive impact on the national health system since the Patients' Rights Directive was transposed into the national legislation (email received 10th March 2015 from Head of EU-PATIENTEN.DE, National Contact Point for Cross-border healthcare).

To avoid the adverse effects on expenditure and equity, an important step is to correct the official fees for treatment in Germany for the effects of expenditure control measures. A useful approach is to calculate what is actually paid for treatment in Germany considering that some treatments are reimbursed only partially because they have been provided when the target budget was already exhausted. Since this is known only retrospectively, data from

previous years can be used to calculate a reduction due to budgeting restrictions. A problem of this approach is that it may be regarded as a way of limiting patient mobility in the EU. However, it is in line with the requirement that reimbursement for treatment abroad is up to the amount that would be paid in the home country. Cross-border care also requires adjustments within the German sickness fund system. One problem is that sickness funds now pay twice for a patient who seeks outpatient care abroad because they continue to pay the capitation to the regional physicians' association. Payments for cross-border care should therefore be deducted from the associations' budget. At the moment, however, this is difficult because the fees paid for cross-border care can be larger than the fees received by a physician when treating the patient at home. Again, this calls for a recalculation of the remuneration of cross-border care (Kifmann & Wagner, 2014).

In Norway the open application of the EU rules also causes divergent effect with respect to public financing and principles of solidarity and equal treatment. The Patients' Rights Directive mechanism is following private health insurance market rules where adverse selection[18] and moral hazard[19] may occur. In Norway, patients who have had their waiting-time guarantee breached have the right to receive the specialist health service abroad and get reimbursed according to rules set by the Norwegian health system. This creates an opportunity for Norwegian private health care providers to open medical centres over the borders in vicinity of more populated areas (e.g. Oslo). Such situation may not only lead to differentiation caused by adverse selection (only patients fit to travel receive offer for health treatments) but also financial unsustainability for public health system (the Norwegian Directorate of Health representative, personal communication, 7th October 2015). Theoretically, if the number of patients in specific groups, e.g. cardiovascular diseases decrease significantly in certain regions, local doctors may not be able to maintain their skills (with less frequent treatments) thereby compromising necessary quality standards.

[18] Adverse selection can lead consumers who are healthier to eschew high-cost, complete health insurance coverage or eschew coverage altogether, leaving the market to individuals at higher risk for adverse health outcomes (Sloan, 2012, p. 12). Patients may be attracted by the fact that their treatment abroad may be reimbursed and they shall demand higher quantity of persona health services (Sloan, 2012, p. 11).

[19] When people become insured, insurance pays for their care. In economists' view, insurance is reducing the price of care to zero. When the price is reduced in this way, consumers purchase more health care than they would have purchased at the normal market prices—this is the moral hazard (Nyman, 2004).

Even if EU rules aim to have harmonizing effect, providing possibility to reimburse legitimate cost for health services carried out abroad contradicts rules of public health systems in both countries. The coexistence of one sector of care that relies on expenditure control mechanisms and implicit rationing as it is in Norway and Germany (domestic health system/public) and an alternative sector of care that is reimbursed fee-for-service (Patients' Rights Directive/private) is conflicting. If such a choice would exist within a country, the expenditure-controlled sector (national/public) would likely suffer at the expensive of the fee-for-service sector (abroad under the Patients' Rights Directive/private). However fee-for-service raises its own problems. In particular, it is vulnerable to both moral hazard by patients and supplier-induced demand by physicians[20]. To counter these effects, co-payments may have to be increased. It remains to be seen whether cross-border care will create such problems (Kifmann & Wagner, 2014). Up to now, its impact has been limited (a professor from the University of Hamburg, personal communication, 1st October 2015).

Colombo & Tapay (2004) also confirm that private health insurance presents risks for the attainment of health system performance goals but also point to opportunities. It can be credited with having injected resources into health systems, added to consumer choice, and helped make the systems more responsive. Nevertheless, it may give rise to considerable equity challenges and health care expenditure. In order to access for high-risk groups, possible market failures need to be addressed (Colombo & Tapay, 2004).

In order to conclude this analysis of convergent versus divergent impact of EU rules on health systems of Germany and Norway, Rometsch and Wessels (1996: 357) claim that there is a causal link between Europeanization and convergence, but also between nationalization and divergence. However in the case of Patients' Rights Directive, we can observe contradictory effect. The nature of EU patient rules are in conflict with current health system rules of Germany and Norway where both countries try to keep health services organisation and financing sustainable. The Directive clarifies rules in the cross-border health care though its nature opens up questions about equity and financial sustainability that can negatively affect health systems based on solidarity and equity principles.

[20] According to the Physician-induced demand (Suppliers induced demand) hypothesis, information between physicians and patients is so asymmetric that a physician can shift out the demand curve for his or her services when it is in the physician's self-interest to do so. Shifting involves recommending a service such as a revisit or a surgical procedure whether or not the recommended care is of potential benefit to the patient. Eventually demand is shifted in the physician's interest not in the consumer's (Sloan, 2012, p. 200).

4.4.3. Challenges

Quality and standards

Health care actors are bound by the rules, regulations and standards of the domestic health system covering everything from how medicine is practised, how health professionals are trained and remunerated, the scope of benefit packages, how health services are paid for, to the safety and hygiene criteria which hospitals must adhere to (Glinos & Baeten, 2015). Opening borders for patients facilitates increased choice of treatments but does not ensure the same standards as patient may get home. Even if treatments are comparable, they are not identical. In addition to difficulties with standardisation, Norwegian health authorities see a great risk in the Methicillin-resistant Staphylococcus aureus (MRSA) contamination if patients receive treatments in hospitals abroad. The MRSA is the most common resistant bacterium in European countries. Norway is a low-prevalence country (the Norwegian Directorate of Health representative, personal communication, 7th October 2015). Quality and continuity of cross-border care is therefore a concern that needs to be addressed. Anecdotal evidence suggests that cross-border care sometimes falls outside of the mechanisms designed to ensure the quality of care provided, particularly when the mobile patient does not speak the language of the health system or understand how the foreign health system works (Rosenmöller, McKee & Baeten, 2006). As it was confirmed by the representative of the Directorate of Health (7th October 2015), it is very difficult to evaluate quality standards of health care providers abroad. Therefore it is very challenging for National Contact Points to recommend suitable medical facilities. So far, there is no common control mechanism and shared information about successful experience of patients receiving health care abroad. This may be developed in the future and lead to different dynamics of cross-border health care.

Prioritization versus inequality

EU rules on patients' mobility give opportunity for patients to seek health treatments abroad. Norway has a system of individual waiting-time guarantees for patients who have been granted priority status. Patients in Norway have the additional right to travel to another country for treatment, if waiting-time guarantees are breached. It is when treatment cannot be provided within a given timeframe home, a patient is entitled to receive the treatment abroad paid by the state (Hem, Kalseth & Wilson, 2011: 14). Naturally, the patient needs to be willing and fit to travel. In such case, we can assume that priority for treatment abroad get

patients with less serious health problems and those who are informed about such choice from their physician. In Norway, prioritization of health care services is primarily related to specialist services. With regards to hospital treatments, the prioritization regulates placement of patients based on criteria such as severity, expected benefit and cost effectiveness. These assessments aim to facilitate the distribution of health care services according to principles of equality and justice. Medical assistance should be provided for prioritised patients within medically justifiable time limit, and patients are entitled to receive services from private health care providers or outside the realm if the deadline is not observed. The functioning of this statutory basis may be disrupted by application of the new Patients' Rights Directive where Norway chose to take more liberal approach than needed by not requiring prior authorization (Helsedirektoratet, 2012). As mentioned before, the decision not to introduce the prior authorization was based on political bargaining in order to put Norwegian patients into focus and not based on the prioritisation principles of equality and justice (the Norwegian Directorate of Health representative, personal communication, 7th October 2015)

In Germany, according to survey carried out in 2012 (Wagner, 2013), TK members who travelled abroad in 2010 for planned cross-border treatment were in majority retirees from older generations (see Fig. 6).

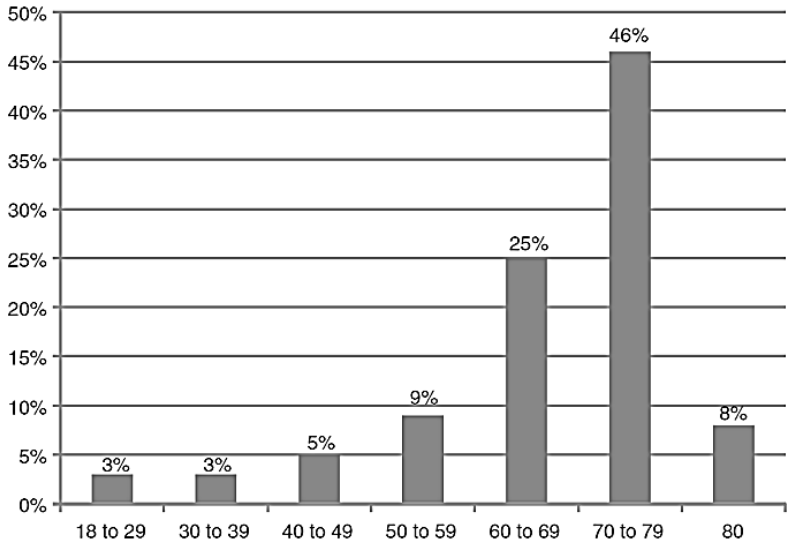


Figure 6. Age distribution of TK members with planned cross-border treatment from Wagner et al. (2013)

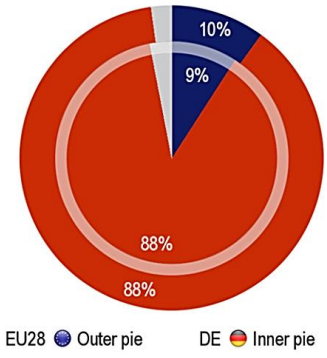
Nearly 80 % were over 60 years, out of which half were aged 70–79 years, and another 8 % were older than 80 years. Accordingly, the majority are retirees (70 %). The remaining members are employees (16 %), housewives and househusbands (10 %), and self-employed persons (4 %). Both genders are equally represented with 50 %. The level of education of planned cross-border care consumers at TK is high with a share of 54 % having passed their A-levels (''Abitur''), out of which 32 % are university graduates and another 3

% have a doctorate in addition. Since most cross-border care users are retired, the income level is comparatively low: 50 % had a gross income of 1,000–2,500 Euros, another 10 % of 750–1,000 Euros. With regards to types of treatments, rehabilitation was most popular treatment covering 51%, inpatient treatments (treatments in hospitals) significantly increased from 4% (survey held in 2010) to 16%. The third largest medical treatment group (11%) was represented by treatments carried out by dentists and orthodontists. Patients also received help from specialists (6%) and general practitioners (6%). Following these results, most of patients that seek treatment abroad are older than 60 years, pensioners and with higher education looking for rehabilitation. Based on this, we can assume that such group represents well informed patients who have time and physical conditions to travel abroad.

The Patients' Rights Directive is strengthening patients' rights, by providing possibility to have treatment (abroad) reimbursed at home. The new law may reinforce the legal position of German and Norwegian patients who wish to obtain medical care abroad, in particular healthcare that is prioritized at home but not provided early enough due to waiting times. The option of seeking treatment abroad will mainly be utilized by certain groups of patients, thus changing the "patient profile" of those being treated at home.

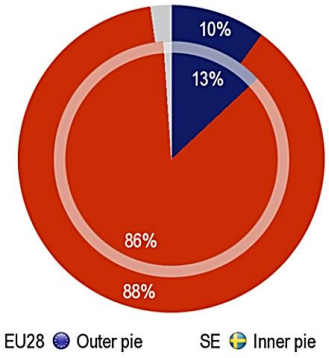
Lack of transparency

According to Eurobarometer, EU citizens are not conscious about many aspects of cross-border healthcare. First of all, they do not know where to receive information on EU patient rules. As it is illustrated below (Fig. 7), there were only 10% of asked respondents (EU 28) that knew about existence of National Contact Point. In Germany (Fig. 7), there were only 9% who were aware of it and in Sweden, there were slightly more respondents familiar with existence of the National Contact Point with 13% (Fig. 8).



	EU28	DE
Yes	10%	9%
No	88%	88%
Don't know	2%	3%

Figure 7. Question: In each EU Member State, there is a National Contact Point that provides information about cross-border health care inside the EU. Did you know that it existed? (Germany) (European Commission, 2015c)

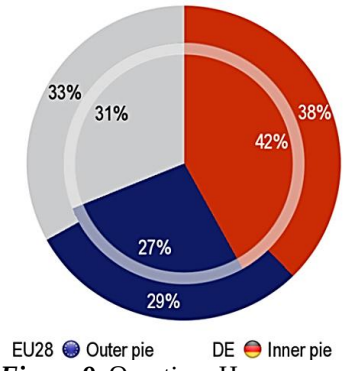


	EU28	SE
Yes	10%	13%
No	88%	86%
Don't know	2%	1%

Figure 8. Question: In each EU Member State, there is a National Contact Point that provides information about cross-border health care inside the EU. Did you know that it existed? (Sweden) (European Commission, 2015c)

Even if there are low numbers of respondents aware of a National Contact Point in Germany, the German National Contact Point received most of requests for information in comparison to other EU member states in 2014 (except Luxembourg and Sweden). According to the recently issued EC report on the operation of Patients' Rights Directive (4th September 2015), a total of 109 223 requests for information were recorded in 2014. Germany was one of three EU member states that between them accounted for nearly 75% of the requests recorded: Germany (36 602), Finland (25 207) and Austria (15 536). These larger figures are probably due to website visits being recorded as information requests in these three EU member states (European Commission, 2015d, 16).

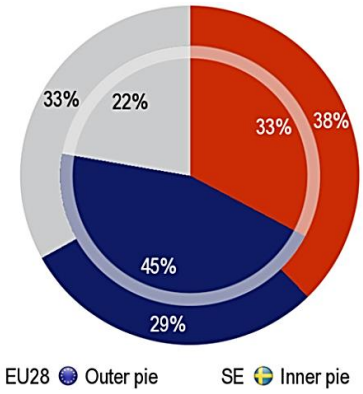
With respect to right to get prescription from doctor in home country to be used in another EU country, there were 29% of EU28 respondents and 27% of respondents in Germany (Fig. 9) aware of this right. On the other hand, there were 45% of respondents in Sweden that knew about the rule (Fig. 10).



	EU28	DE
True	38%	42%
False	29%	27%
Don't know	33%	31%

Figure 9. Question: Here are some statements related to healthcare received in another EU country. For each of the following, could you please tell me whether you think it is true or false? – You cannot get a prescription from your doctor to use in another EU country (Germany) (European Commission, 2015c)

NB: Correct answer: False



	EU28	SE
True	38%	33%
False	29%	45%
Don't know	33%	22%

Figure 10. Question: Here are some statements related to healthcare received in another EU country. For each of the following, could you please tell me whether you think it is true or false? – You cannot get a prescription from your doctor to use in another EU country (Sweden) (European Commission, 2015c)

NB: Correct answer: False

This challenge can also explain why so few people seek medical treatments abroad. Knowing these rights could positively affect deficiencies of health systems in Germany as well as in Scandinavian countries.

For Norway, the number of treatments abroad for Norwegian residents has so far been low and it is not expected to have much impact on the national budget (the Ministry of Health representative, personal communication, 17th April 2015). However we must remember that the new rules were adopted only in March 2015 and this may change in the years to come. According to a representative of Oslo University Hospital (29th April 2015), practice shows that even if Norwegian patients are informed of other possibilities elsewhere they still prefer to be treated in their local hospital. In general they are reluctant to travel to other hospitals in the same region that may have lower waiting times. Patients are usually triggered to seek heath care elsewhere when they lose trust in their health care provider near home. Therefore feelings of familiarity play an important role. In general Norwegian patients still prefer seeking treatment locally and keep on waiting to get treated near their homes (the Oslo University Hospital representative, personal communication, 29th April 2015).

In the analytical part of the thesis we learnt that the Patients' Rights Directive was transposed into German and Norwegian legislation in different way according to their specific political and organisational structure. Since the financing and organisation of health systems is different in both countries, the impact brings different impact and challenges. This is also caused by factors affecting impact as well as driving forces of convergence and divergence.

5. CONCLUDING REMARKS

Good health is one of the most important objectives of public policy. One of the most valuable assets a person possesses is to be and to stay healthy (Barak-Erez & Gross, 2007). Healthy populations are not only economically more productive, but also socially more cohesive. And this is basically because health enables individuals to lead a socially and economically productive life (International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978). Considering that health care services contribute to improvements in health, (Ruger, 2004) the access and quality of health care provision are key topics of political discussions within EU/EEA member states but are also a part of common policies on the EU level.

Even if various EU/EEA states represent different health systems whether they rely on market mechanisms and competitive pressures to strategically manage their health systems or not, the commitment in providing everyone with full access to an adequate range of health care services, based on the material principle of equal access according to need, still prevails as a strong value in all member states' health systems (Borges, 2011). The principle of solidarity remains at the heart of the European social model that works not only as a founding principle but also as a moral premise that encompasses the idea of mutual responsibility of citizens for each other's health care and that of equitable access to care (Kaczorowska, 2006).

The establishment of EU patient mobility rules was a complex process with years of negotiations between the EU member states, the Commission and the European Parliament, as well as following important signals expressed in the ECJ rulings. All this indicates the extent of the conflict and uncertainty facing policy-making in this area (Palm et al., 2011). This process has both converging and diverging impacts on countries' health systems. In our case studies, we identified converging effect of the Social Security Regulation that is applied in Germany and Norway thanks to its coercive power in the form of direct applicability. In addition the ECJ rulings made member states to acknowledge that the prior authorization to receive health care services abroad may be seen as an obstacle to the principle of free movement of services, one of the basic elements of European integration. More intense socialization and mimicry not only on the level of public institutions but among patients themselves led to increased use of their rights. Eventually, it was the individuals themselves those who brought this to courts. The pressure to comply with EU patient mobility rules was therefore bottom up process, not only top down. The use of health care abroad caused challenges to health systems financing of the member states as well as frustration to patients

that did not get reimbursed for it. If the voices of some dissatisfied patients (e.g. a legal case of German citizen, Leichtle) were not listened by national courts they went further and got positive response from the ECJ. In this respect, ECJ rulings on patients receiving treatments abroad initiated calls for better coordination of health systems and policies across Europe. This led to adoption of the Directive that was to a large extent a codification of court rulings. The adoption of the Directive was a way of making the rules clearer; reduce unpredictability caused by a series of court rulings and giving member states a way to "control" how the rules should be implemented. However, the adoption and implementation of the Directive have also had divergent effect. First of all, EU directives represent a type of law that needs be transposed into countries' legislation and is open for national adaptation. The Patients' Rights Directive was differently transposed in each Germany länder as well as in Norway. This is partly due to different political organizational structure. Secondly, we can observe empowerment of national institutions that can filter EU rules. Germany is a federal republic that is already divided into more of less autonomous states where empowerment of länders' parliaments led to divergent adoption of the Patients' Rights Directive. In Norway, the national parliament filtered EU law resulting in more liberal rule. Not introducing the prior authorization may result in lowering waiting list by increased use of health care abroad. Thirdly, there is different level of national sovereignty according to the rational choice theory. In other words we may assume that EU member states are motivated by self-interests, utility maximization, or goal fulfilment while implementing EU patient mobility rules. Their motivation is limited by how much power has respective EU member state in regulating its internal affairs without foreign interference. We can use an example of Norway who decided to transpose the Directive in more liberal way where interests of political parties played important role. By not introducing prior-authorization mechanism, it shows that Norway decided independently and above the expectations of the EU.

In Germany, as well as in all EU countries, patients may choose which type of rule they wish to follow in planning treatments abroad: Social Security Regulation or Patients' Rights Directive. Unlike in Norway where patients still need a referral from his/her GP for all specialist treatment, this is not the case in the German health system.

Besides convergent and divergent impact of EU patient mobility rules, we identified several challenges that need to be tackled in the future. German experts call for different calculation of treatments abroad than home in order to keep financial sustainability of the health care systems. This is because experts are speculative about higher use of health care abroad that leads to challenging public expenditure control of health services in Germany.

Well informed patients may find in the Patients' Rights Directive an opportunity to demand more health care abroad thanks to the possibility to receive health care treatment from private providers not only in public hospitals. According to new law, they do not need to wait for prior authorization and can seek health care treatment in both public but also private hospitals. Such rules reinforce position of private health providers and potentially lead to limited control of financing based on target budgets. However, it is not expected that there will be many patients seeking health care abroad though it may have some evident impact on expenditure control mechanism (the European Commission representative, personal communication, 24th April 2015). A more acute worry is the public health risks linked to different quality standards of hospitals abroad. Since it is very difficult to evaluate quality standards of health care providers abroad, National Contact Points find it very challenging to recommend suitable medical facilities. Till now, there is no common control mechanism and limited information about successful experience of patients receiving health care abroad. In addition Norwegian health authorities are very concerned about prioritization where EU patient mobility rights are seen as a threat of the system that aims to facilitate the distribution of health care services according to principles of equality and justice. Yet another important concern is the lack of transparency. According to the recent Eurobarometer, there are still many citizens that are not fully aware of their rights or about the existence of National Contact Points that can provide them with information and guidance.

The Patients' Rights Directive gives more clarity on ECJ rulings and strengthens patients' rights while opening up new ways of receiving treatment abroad. The new law is reinforcing the legal position of German and Norwegian patients who are willing to obtain medical care abroad or are in acute need to obtain health while not in danger of life. This fact is important to remember. The possibility to seek healthcare in another member state, and have the costs reimbursed back home, is a right that many EU nationals are still not conscious of. The member states are still not favourable in making its citizens aware of it (the European Commission representative, personal communication, 24th April 2015). With more transparent communication of such rights, health care mobility may rise in the coming years. Such situation is not in favour of the national authorities that may lose some of their control over expenditures, as well as keeping certain quality standards of health treatments.

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