Robert Tabaszewski, PhD*

Access to Health Care for Migrating Citizens in a Host State of the European Union

Abstract

The foundations of the European Union include free movement of persons, which is connected with the right of its every citizen to health care in the territory of another Member State. It follows from many regulations, including the Treaty on the Functioning of the European Union, the Charter of Fundamental Rights and the established case law of the Court of Justice of the European Union, which allow patients to freely choose a health care provider. The article analyses the migrating citizens' right of access to health care in a host state of the European Union under the provisions of the so-called Cross-border Directive, the scope of that right and its possible limitations. It also discusses practical problems of implementation of these provisions and their observance on the example of Poland.

Key words: the right to health, health systems, health care, civil rights, fundamental rights, health care in Member States, medical tourism.

* Department of Human Rights, Faculty of Law, Canon Law and Administration, the John Paul II Catholic University of Lublin
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1. Introductory notes

Progressing mobility of European Union citizens, i.e. travelling tourists, students, the unemployed, employees and members of their families, results in a growing significance of access of those people to health care facilities providing medical care in case of an undesired event: accident, disease or another emergency.[1] The key elements in health care provision are speed and accuracy. Therefore, it is vital for each and every citizen, i.e. a potential patient, to have a legal guarantee that in a given state they will receive a given service on the same or at least similar rules as in their home state. Given the above, European Union regulations in the scope of access to health care are one of the fundamental merits of the social security right, on which every European Union citizen can rely.[2]

The right of access to health care is inseparable with the freedom of service provision by employees, including medical personnel and public health professionals, guaranteeing that the quality of certain medical services provided will be adequate.[3] In addition to free movement of persons, free movement of resources and free movement of goods, free provision of services, including medical services, is one of the four fundamental principles of the European Union.[4] A positive aspect of that freedom is the right to free, unlimited access to health care for all European Union citizens in each Member State, regardless of their citizenship and their current location.

This article aims to examine the content of the right of access to health care understood as a human right as well as to verify whether the only normative criterion for possible differentiation of the place where health care is provided is the criterion of the citizen's free preference towards such a place or whether access to health care in another Member State is subject in practice to legal and factual limitations resulting from the specific character of mobility of potential patients.[5] In order to achieve that, the author analyses the right to health and the right of access to health care in a host state, confronts the existence of these rights against the system of fundamental rights of EU citizens and subsequently analyses the level of implementation of the provisions on availability of the right to health for migrating citizens transposed to the legal system of the state.

2. The citizen's right to health and universal access to health care in a Member State of the European Union

Before analysing the access enjoyed by the European Union citizens, let us first ponder the content protected by that right. It seems that its subject and the paramount aim are to protect and restore health as a value which is particularly precious to each European Union citizen.[6] As the EU legislation lacks a legal definition of health, European institutions make use of the definition provided in the Constitution of the World Health Organisation.[7] It states that health is not only the lack of disease and disability, but also a general physical, mental, social and spiritual condition defined as *well-being*.[8] Under the provisions of the Declaration of Alma-Ata, due access to health care has been recognised as a fundamental human right.[9] Therefore, what has been accepted in the literature is a division

1. Wolf Sauter, Harmonisation in healthcare: the EU patients rights Directive , Tilburg Law and Economics Center 6(2011): 2. DOI:http://dx.doi.org/10.2139/ssrn.1859251; Scott L. Greer, Tomislav Sokol, Rules for Rights: European Law, Health Care and Social Citizenship European Law Journal 1(2014): 70-71. DOI: http://10.1111/eulj.12036
2. Elizabeth Wicks, Human rights and healthcare , Oxford-Portland: Hart Publishing, 2007, 19; Anne Pieter van der Mei, Cross-Border Access to Health Care within the European Union: Recent Developments in Law and Policy , European Journal of Health Law 4(2003): 369-380. DOI: http://10.1163/157180903772757830
3. Jonathan Cylus, Irene Papanicolas, An analysis of perceived access to health care in Europe: How universal is universal coverage , Health Policy (119)2015: 1133 1144. DOI: http://dx.doi.org/10.1016/j
4. An Baeyens, Free movement of goods and services in health care: A comment on the Court cases Decker and Kholl from a Belgian point of view , European Journal of Health 4(1999): 373-383. https://doi.org/10.1093/hrlr/ngn036
5. Pieter Van der Mei, Free Movement of Persons within the European Community Cross-Border Access to Public Benefits , Oxford-Portland-Hart: Bloomsbury Publishing, 2003, 267; Piet Van Nuffel, Patients' Free Movement Rights and Cross-Border Access to Healthcare , Maastricht Journal of European and Comparative Law 12(2005): 253-254. DOI: http://10.1177/1023263X0501200304
6. John Tobin, The Right to Health in International Law , Oxford: OUP, 2012: 23, 130-131; Thérèse Murphy Health and Human Rights , Oxford-Portland-Oregon: Hart Publishing, 2013, 1; Eibe H. Riedel, The Human Right to Health: Conceptual Foundations , [in:] Realizing the Right to Health , Andrew Clapham, Mary Robinson (eds), Zurich: Rüfe&Rub, 2009, 28.
7. Constitution of the World Health Organization, New York, 22.07.1946 r. (U.N. Doc. E/772).
8. Robert Tabaszewski, „Prawo człowieka do zdrowia i jego definiowanie w systemie ochrony Światowej Organizacji Zdrowia", [in:] „Uniwersalne standardy ochrony praw człowieka a funkcjonowanie systemów politycznych w dobie wyzwań globalnych", Jerzy Jaskiernia, Kamil Spryszak (eds), Toruń: Wydawnictwo Adam Marszałek, 2016, 264-284.
9. Declaration of Alma-Ata. International Conference on Primary Health Care, Alma Ata, 6-12.09.1978, <http://www.un-documents.net/alma-ata.htm>; Brigit Toebes, The right to health as a human right in international right, Antwerpen-Groningen-Oxford: Springer, 1999, 251-252.

into the basic and specialised health care, which is provided universally and free of charge, yet not in all Member States. Sometimes Member State authorities decide that the right to protect health should be granted to its citizens only, and all external citizens, regardless of their European Union citizenship, should organise their health care on their own, particularly in the specialised area, and that the care provided by the state should only be auxiliary.[10]

Moreover, the right of access to health care, as a part of a broad social security right, should be distinguished from the right to health, which consists in the freedom of an individual from any health-influencing factors. In the continental system the right to health is a personal right that provides for "freedom from" any actions taken against human health in all its facets. This results in the maintenance of health *status quo*. The right to adequate health care is a positive right that can be implemented solely by public authorities through the social welfare system, taking into consideration other rights and needs of an individual.[11] In the case of the right to health, states have an obligation to actively implement that right, as individuals may take their claims to court.[12] As for the right of access to health care, an individual may seek only the part of rights which is guaranteed in the Constitution and in statutory law. However, in practice, it is difficult to imagine a patient's claim in the form of a court claim concerning an increase in health care financing.

The division into the right to health and the right of access to health care is not theoretical at all. It has an impact on the level of responsibility of Member States. In the case of freedom from actions taken against health, the state must only create normative space allowing for the use of adequate instruments for the maintenance of health. However, in the case of the right to health care, public authorities must be active, i.e. provide an "adequate" amount of resources and means that will guarantee proper functioning of the health care system. As in the state practice there are many various systems of financing and organisation of health care, the levels of provision of the right to health care will also vary.[13] As a result, the manner of asserting and enforcing that right in court will differ among Member States of the European Union.

10. Tamara Hervey, "The impacts of European Union law on the health care sector: Institutional overview", Eurohealth 4(2010): 5-7.
11. See: "Conclusions I", [in:] "Case Law on the European Social Charter", Strasbourg, 1982, 104
12. Robert Tabaszewski, "Prawo do zdrowia w systemach ochrony praw człowieka", Lublin: Wydawnictwo KUL, 2016, 73
13. See: Elke Jakubowski, Health care systems in the EU. A comparative study , [in:] Public Health and Consumer Protection Series , Luxembourg: European Parliament, 1998, 29-130.

Access to health care is a fundamental, albeit not the only, aspect of the social right, i.e. the right to health care. On the other hand, an EU citizen's right of access to health care cannot be considered exclusively in the context of social expenses and economic difficulties. This right falls outside the area of relations between a person and the social insurance system as a right of all citizens, regardless of their place of origin.[14] One can speak about exercising the citizen's right to health care if the said right meets the following requirements: availability, accessibility, acceptability and quality of service.[15] If a migrating citizen states that a given service does not meet the above requirements, that *lege artis* was not performed or they are denied the service in a given country, it is a serious infringement of the right of access to health care.

3. The scope of health protection for a migrating citizen in the light of EU regulations

The right to health protection appeared in the system of fundamental rights of the European Union relatively late.[16] Although references to human health can be found already in the founding treaties, the first express articulation of this right is provided in the Single European Act requiring the Member States to provide their citizens with "high level of health protection."[17] The instruments that were to facilitate the availability of health care services were guarantees regarding free flow of employees, goods and services. The extension of these obligations, consisting in cooperation between the countries within the scope of protection of human life, was provided in the form of provisions of the Maastricht Treaty[18], and then in the standards imposed by the Amsterdam treaty, turning the Member States into entities fully responsible for organising, financing and provision of health care services and medical care to their citizens.[19]

14. Opinion of Mr Advocate General Dioikitiko Protodikeio Athinon delivered on 30 December 2004 in the case Aikaterini Stamatelaki v. N.P.D.D., pt 40.
15. CESCR General Comment No. 14, General Comment 14, The right to the highest attainable standard of health, U.N. Doc. E/C.12/2000/4.
16. See: art. 69 of the Paris Treaty.
17. The Single European Act, Luxembourg, 17.02.1986 r. (O.J.E.C. L169, 29 June 1987).
18. Roscam Abbing, "Health Law & the European Union", European Journal of Health Law 1(1994): 123-126.
19. Art. 152 pt 5 of the Treaty of Amsterdam (O.J.E.C. C 340, 10 November 1997).

In the current legal situation, there are multiple regulations regarding the right of access to health care services, which makes it enforceable for the citizens who wish to use health care services in another Member State. In the light of TUE, when determining and implementing its policies, the European Union takes into consideration the requirements related to high level of protection of human life.[20] Article 168 of TUE divides the obligations within the scope of accessibility of health care services among the EU Member States, including: management of health care services, medical care and division of resources intended for this purpose. On the other hand, in certain situations TUE allows Member States to limit certain categories of rights and freedoms, including provision of health care services to persons outside of their country of origin due to the health premise.[21]

Access to health care services, treated as a separate human right, is guaranteed and explained in article 35 of the Charter of Fundamental Rights of the European Union as a component of the right to health protection.[22] It provided all citizens with the right of access to preventive health care, which means that citizens are entitled to benefit from treatment according to the conditions stipulated in national legislation and practice. When determining and implementing all Union policies and actions, the Union institutions are obligated to ensure high level of protection of human life.[23] Although the provision is programmatic in nature, since it determines the fundamental and minimum standard of the citizen's right of access to health care in given Member States, it also obligates the EU institutions and bodies to address the problem of health care system incompatibility, also through harmonisation of laws within the scope of coordination of social security systems.[24]

The above-mentioned laws, allowing to invoke the Union solidarity principles within the scope of access to health care in another Member State, are supported by the consistent judicial practice of the Court of Justice of the European Union which, while examining the cases related to the horizontal scope of governance of the social security law, recognises the primacy of freedom of an individual to obtain the service in a country other than their country of origin over the values related to the national economic security.[25] In 1998, in the case of Kohll[26] and later in the case of Decker[27], the citizens obtained the right to benefit from a health care service in another Member State without the need to previously obtain an administrative permit in their country of origin.[28] In the Stamaletaki's case, the provisions of national law that excluded any takeover of the treatment costs in a private health care centre in another Member State were deemed non-compliant with the principle of freedom of provision of services.[29] With the judgement passed in the Watts' case[30], beneficial to migrating citizens and confirming the obligation of the national authorities to refund the costs of hospital care in another Member State to the migrating citizen, the issues regarding the procedure of applying for consent and refund of costs by the migrating citizens were submitted to the Court many times.[31] The interpretation beneficial to migrating citizens as patients was confirmed and extended in the provisions of the so-called secondary written law.

Until 2011, the only laws allowing the migrating employee - a citizen of the European Union - to invoke the possibility of use of a medical service were the laws regarding the so-called coordination of systems of social security. However, these regulations, adopted at the beginning of the 1970's, did not correspond to the idea of four freedoms, since they only allowed for the use of the right of access to health care according to the principles applied in the country of origin for specific groups of entities: hired workers, persons pursuing economic activity and their family members.[32] Currently, migrating citizens can rely on more advantageous laws regarding coordination of social security systems, including regulation 883/2004 that replaced these regulations.[33]

20. Art. 9 of the Treaty on the Functioning of the European Union ([next as: TFUE], O.J.E.C. C 115/47, 9 May 2008).
21. Robert Tabaszewski, 2016, 148.
22. Charter of Fundamental Rights of the European Union, Paris, 7 Dec. 2000 (O.J.E.C. C 326/02, 26 October 2012).
23. Commentary on the Charter of Fundamental Rights of the European Union, Vienna, 2006, 306-311.
24. See: Tamara K. Hervey, Jean V. McHale, Article 35 , [in:] The EU Charter of Fundamental Rights. A Commentary , Steve Peers, Tamara Hervey, Jeff Kenner, Angela Ward (eds), Oxford: Hart-C.H. Beck-Nomos, 2014.
25. Case C-120/95 Nicolas Decker v. Caisse de Maladie des employés privés; Case C-368/98 Abdon Vanbraekel et al. v. Alliance nationale des mutualités chrétiennes (ANMC).
26. Case C-158/96 Raymond Kohll v. Union des caisses de maladie.
27. Case C-120/95 Nicolas Decker v. Caisse de maladie des employés privés.
28. This means that citizens are reimbursed according to the rates that apply in the country in which they are insured. Cf: Case C-157/99 B.S.M. Geraets-Smits v Stichting Ziekenfonds VGZ and H.T.M. Peerbooms v Stichting CZ Groep Zorgverzekeringen.
29. Opinion of Advocate General Dioikitiko Protodikeio Athinon delivered on 30 Dec. 2004 in the case Aikaterini Stamatelaki v. N.P.D.D.
30. Case C-372/04 Yvonne Watts v. Bedford Primary Care Trust i Secretary of State for Health; Gareth T. Davies, The effect of Mrs Watts trip to France on the National Health Service , King s Law Journal 1(2007): 163-166.
31. Case C-385/99 V.G. Müller-Fauré v. nderlinge Waarborgmaatschappij OZ Zorgverzekeringen UA i E.E.M. van Riet vs Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen; Case C-326/00 Idryma Koinonikon Asfaliseon (IKA) v Vasileios Ioannidis; Case C-56/01 Patricia Inizan v Caisse primaire d'assurance maladie des Hauts-de-Seine. For example, on Acereda Herrera, where the Court examined the scope of financing of the costs of travel, accommodation and meals of an accompanying person in the framework of the funds allocated for the provision: Case C-466/04 Manuel Acereda Herrera v. Servicio Cántabro de Salud.
32. Regulation (EEC) No 1408/71 of the Council of 14 June 1971 on the application of social security schemes to employed persons and their families moving within the Community (O.J.E.C. L28, 5 June 1971); Council Regulation (EEC) No 574/72 of 21 March 1972 fixing the procedure for implementing Regulation (EEC) No 1408/71 on the application of social security schemes to employed persons and their families moving within the Community (O.J.E.C. 74/1, 27 March 1972).
33. Regulation (EC) of the European Parliament and of the Council No 883/2004 on the coordination of social security systems (O.J.E.C. L166, 30 April, 2004); Regulation (EC) of the European Parliament and of the Council No 987/2009 laying down the procedure for implementing Regulation (EC) No 883/2004 on the coordination of social security systems (O.J.E.C. L 166, 30 October, 2009).

The coordination process is significant for migrating citizens, as it consists in consolidation of laws regulating the principles of receiving a health care service in another Member State.[34] It is based on the assumption that a citizen moving within the borders of the EU is entitled to equal access to specific health care services to the same or very similar extent as they could use such services in their country of origin, regardless of whether they wish to benefit from services at public or private health care institutions. The national authorities have an obligation to respect and implement the right of an individual to receive health care abroad, if they prove that this could provide them with more effective care or that it could be obtained within much shorter time.[35] However, practical imperfection of the laws on coordination manifested itself in the further European integration process, which showed differences arising from the extremely different health care organisation and financing models functioning in Member States.[36]

4. The content of the right of access to health care of a migrating citizen in the light of Cross-Border Directive

As long as the provisions of regulation 883/2004 put in order the so-far dispersed judgements of the Court of Justice that allowed for treating a migrating citizen as a person authorised to use medical services on terms similar to those which are offered to citizens of his or her home country, there was the necessity to regulate the situation of all, even potential, patients who, in the situation of free market, wanted to use the right to receive treatment in another country as well as to make it possible for them to obtain the refund of the costs of such treatment up to the level of the guaranteed benefit in the country in which they are insured.[37] Therefore, the crucial document is the directive on patients' rights in cross-border healthcare adopted by the European Parliament in January 2011 and confirmed by the Council in February 2011, as it regulates comprehensively the issues of free access to health care services in an EU Member State other than the place of the patients' insurance.[38]

34. By health care service one should understand the service provided by health care workers to patients in order to estimate, maintain or improve their health, including prescribing, dispensing and provision of medicinal and medical products.
35. Robert Tabaszewski, 2016, 157-158; Robert Tabaszewski, 2016, 157-158.
36. See: Council Conclusions on Common values and principles in European Union Health Systems (O.J.E.C. L 146, 22 June 2006).
37. Stephane de la Rosa, The Directive on cross-border healthcare or the art of codifying complex case law , Common Market Law Review (1)2012: 15-46.
38. 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, O.J.E.C. L 88/45, 4 April 2011, hereinafter: Directive.

It is worth noticing that this directive, in contrast to previous regulations, uses the term "patient" and not "insured person", and thus it supplements additional citizen guarantees included in the acts of the European Council concerning the health insurance and medical exchange between the Member States of the European Council.[39]

The personal scope of the authorisation was specified to a great extent. The directive grants the right of access to health care to these patients who decide to use health care in a Member State other than their home country (article 3 point a, h). In practice, the possibility to exercise this right was granted not only to employees, but also to all citizens of the EU who will use health care services for any reason. They are: patients referred for treatment abroad, patients temporarily staying abroad, retired patients living abroad, persons in border regions, persons looking for a health care service abroad on their own, persons sent abroad as part of coordination of social security systems.[40] The other group of authorised entities includes specialists performing medical professions of public trust who provide services to patients and are referred to in the directive (article 3 point f) as health care employees.

The personal scope is connected with the territorial scope of the law which is not limited to the Member States of the European Union, since patients can also receive health care service in the territory of the European Economic Area: Iceland, Norway, Lichtenstein and Switzerland (article 3 point c). Some health care services can also be received by EU citizens in Turkey as a candidate country.[41] These authorisations can be performed both in the public and private health care system. As for time limitations, the right of access to health care can be exercised since 25 October 2013 in the territory of any EU country, and since 1 January 2015 also in public and private medical centres in the territory of the EEA countries.[42] The period for which it is possible to obtain the return of the costs of the benefit obtained in the scope of cross-border health care is calculated from that moment.

39. Paul Schoukens, The right to access health care: health care according to European social security law instruments , Medicine and Law 3(2008): 501-533.
40. Katharine Footman, Cécile Knai, Rita Baeten, Ketevan Glonti, Martin McKee, Cross-border health care in Europe , European Observatory on Health Systems and Policies, London: World Health Organization, 2011, 2-5.
41. See: Perihan Elif Ekmekci, Patients Rights in Cross-border Healthcare (Directive 2011/24/EU) and How It Applies to Turkey as a Negotiating Candidate Country , European Journal of Health Law 1(2017).
42. Mathias Kifmann, Caroline Wagner, Implications of the EU Patients' Rights Directive , [in:] Health Care Provision and Patient Mobility: Health Integration in the European Union , Rosella Levaggi, Marcello Montefiori (eds), Milan-Heidelberg-New York-Dordrecht-London: Springer, 2014, 53-54.

However, the object of the benefit is not unlimited. The directive excludes the services that include supporting persons in need of aid in the scope of long-term care as well as the schemes of common vaccinations against contagious diseases.[43] The right of access to organs intended for transplantation and the right of access to transplantation programmes in other Member States has also been limited.[44] Migrating citizens can submit the application for the return of the costs of cross-border health care. This must only be limited to care to which a person insured is entitled under the regulations effective in a Member State where they are insured. This means that migrating patients do not have full factual freedom in the choice of the place where they would like to receive health care services, as they have to make price calculations, including the costs of stay, transport and potential company of third parties.

In order to make the authorisation of migrating employees possible, a range of obligations was imposed on Member States, yet the obligations of the countries in which health care services are performed differ from the obligations of the Member State in which the patient is insured.[45] In relation to the first group of countries, the directive imposes an obligation to ensure the quality of provided services which can be seen as an important exception to the principle included in Art. 168 TUE. The services performed for the migrating citizens must be of qualified nature, i.e. must be consistent with specific requirements under the principle of universality, access to high quality care, equality and solidarity. They must also correspond with the regulations of the Member State in which treatment is provided, under the standards and guidelines concerning the quality and safety specified by the Member State as well as EU regulations on safety standards.[46]

43. Art. 1 of the Directive.
44. Robert Tabaszewski, „Prawo do przeszczepu i jego ograniczenia w świetle Deklaracji Stambulskiej o obrocie narządami i turystyce transplantacyjnej", [in:] „Wybrane aspekty praw człowieka a bioetyka", Anna Białek, Mirosław Wróblewski (eds), Warszawa: Biuro Rzecznika Praw Obywatelskich, 2016, 127-142; Anne-Maree Farrell, „Adding Value? EU governance of organ donation and transplantation", European Journal of Health Policy 1(2010): 51-79.
45. As far as obligations of the state in which health service will be provided consist in guaranteeing equality in access to health care for both nationals and migrating citizens of the EU and EEA, the obligations of the state of origin of migrating citizens seeking health services in other states consist in organising their own health care system in a way that will make it synchronised and coherent with solutions applied in other Member States and will enable effective conduct of administrative procedures connected with granting permission for cross-border services and return of the money paid by the patient.
46. Art. 4 of the Directive.

The content of the right to access of the migrating patients is not only obtaining the health care service provided to patients by the employees of health care system with the purpose of evaluation, maintenance or improvement of health condition, including prescribing, releasing and making medicinal products and medicinal devices available, but also a range of other subject authorisations following *expressis verbis* from the directive[47]. They are: the right to information (Art. 4, 6), the right to make an informed choice, the freedom of access to medical services, the right to appropriate appeal procedures (Art. 5), the right to privacy, the right to confidentiality of processed data (Art. 4), the right to maintain treatment continuity (Art. 11), the right to use the health care service within the scope of health insurance, the right to cost return (Art. 7).[48]

The essential element of exercising the right of access to health care is the procedure of the return of the costs of health care services incurred by the migrating citizen as well as the right to information in this scope. For this purpose, the countries have an obligation to appoint national contact points for cross-border health care, which consult with the patient organisations, health care service providers and entities offering insurance.[49] The national contact points in the Member State where insurance entity is located provide patients and health care system employees with information on their rights and authorisations in a given Member State that follow from cross-border health care. A range of authorisations arise from the directive regulations, in particular, the patient's right to obtain information on the terms of cost return, to obtain access to these authorisations and their definition as well as appeal procedures and compensation in case when patients claim that their rights are not respected.[50] The range in which migrating citizens exercise their rights following from the directive will also result from the level of its implementation by the state government.

47. Art. 3 of the Directive.
48. Diana Delnoij, Wolf Sauter, Patient information under the EU patients rights Directive , European Journal of Public Health 2(2011): 271-272.
49. Art. 6 of the Directive.
50. Art. 9 of the Directive.

5. The implementation of the migrating citizen's right of access to health system on the example of Poland

Apart from showing obvious advantages for migrating patients connected with the harmonisation process of the EU legislation, it is necessary to draw attention to certain delays in some Member States in the implementation of its particular provisions.[51] They arise from the differences in the scope of organisation and methods of financing of health care systems as well as in policies adopted by countries. It is worth noting that the Directive became effective despite the lack of acceptance on the side of some Member States that did not obtain blocking minority: Poland, Romania, Slovakia and Portugal. In reference to the first country, arguments presented on 10 June 2010, during the debate in Luxembourg, concerned the fear that patients staying abroad might take advantage of their new citizen authorisation on a mass scale, which would cause financial instability of the public insurer (National Health Fund). Despite the above arguments, the directive was passed and the final date of its implementation was on 25 October 2013.[52]

The cross-border directive requires due implementation by state authorities and, in case of its undue or untimely implementation, the state authorities cannot impose the obligations on entities being the subjects of rights and duties specified in the directive: patients, medical centres and health care system employees.[53] In the author s opinion, it is necessary to assume that regardless of whether the state authorities have performed the implementation or undue implementation of the directive, upon the lapse of the deadline for implementation of the directive, the migrating citizens, as authorised entities, could refer to its provisions enabling them to exercise the right of access to the benefits of health care system in another Member State. In such situation it was necessary to assume that, on the grounds of given national legal regulations, the European Health Insurance Card is a physical and sufficient confirmation of having the right to use particular benefits in the situation of sudden threat to life and health and the cost return would be performed on the basis of receipts obtained by migrating citizens.[54]

The implementation of the directive is connected with significant expenditures for public health care incurred by Member States. Nevertheless, in the case of Poland, the consequences of failure to implement it would be much more serious. It would constitute violation of the essence of Art. 32 and 68 of the Constitution, consisting in departure from the constitutional principle of equality.[55] Poland, with over 12-month delay, adopted the directive by way of the amendment of 10 October 2014[56] to the act on health care benefits financed from public funds.[57] Contrary to appearances, the implemented regulations do not result in revolutionary changes in the scope of the use of health care benefits and the flows of patients between states covered with the directive are still limited. It also follows from the fact that the prior consent of state authorities is required for the use of some benefits by migrating citizens. It concerns the provisions connected with planning in order to ensure sufficient and continuous access to a balanced range of high quality treatment in a given Member State or one that concerns the necessity of cost control and, as far as possible, avoidance of wasting financial, technical and human resources as well as includes the stay of a given patient in hospital for at least one night or there is the need to use highly specialised and expensive medical equipment.[58]

It is worth noting that one of the factors influencing the popularity of a given Member State as the place of receiving a potential medical benefit is the price of medical services. In the case of popularity of health benefits among citizens arriving in countries of the so-called eastern EU expansion, including Poland, the Czech Republic or Slovakia, a decisive factor are low costs, relatively easy access to specialist treatment as well as personal contact of professional medical personnel with a patient.[59]

51. Por. Teresa Requejo, "Cross-border healthcare in Spain and the implementation of the Directive 2011/24/EU on the Application of Patient's Rights in Cross-border Healthcare", European Journal of Health Law 1(2014): 79-96.
52. Kancelaria Senatu RP, Sprawozdanie na temat praw pacjentów do opieki zdrowotnej w innym kraju, Bruksela, 25 października 2013 r.; Stanowisko 15/13/ VI Naczelnej Rady Lekarskiej w sprawie projektu ustawy o zmianie ustawy o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych oraz niektórych innych ustaw z dnia 25 października 2013 .
53. See: Herman Nys, "The transposition of the Directive on patients rights in cross-care healthcare in national law by the Member States: still a lot of effort to be made and questions to be answered", European Journal of Health Law, (1)2014: 1-14. DOI: http:10.1163/15718093-12341307
54. In the case of Polish citizens, if the National Health Fund refused to honour the evidence in the form of bills, the case should be referred to procedure before the court. Mattia Bossio, Pavia e Ansaldo, "Health Services and Patient Mobility", Journal of the International Institute for Law and Medicine 2015: 11.
55. Iwona Kowalska-Bobkoa, Anna Mokrzyckaa, Anna Sagan, W. Cezary Włodarczyk, Michał Zabdyr-Jamróz, "Implementation of the cross-border healthcare directive in Poland: How not to encourage patients to seek care abroad?", Health Policy" 120(2016): 1233–1239
56. Ustawa z dnia 10 października 2014 r. o zmianie ustawy o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych oraz niektórych innych ustaw (Dz.U. z 2014 r. Poz. 1491).
57. Ustawa z dnia 27 sierpnia 2004 r. o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych (Dz.U. z 2016 r. Poz. 1793 t.j.).
58. The requirement of consent also includes the treatment that poses a particular kind of threat to the patients or to the society; it is provided by the health care service provider who, in specified cases, may raise justified doubt connected with the quality or safety of the care provided. See. art. 8 of Directive.
59. Izabella Main, "Medical Travels of Polish Female Migrants in Europe", Czech Sociological Review 6(2014): 897-918.

On the other hand, in case of citizens of these countries, the premises deciding on the choice of cross-border benefit in other countries are: unavailability of a given benefit in their home country, possibility to obtain better health care in foreign centres, good reputation of a given specialist, speed of medical service obtained, service price, closeness of the centre providing care as well as opinion of persons who already used a given service.[60]

6. Summary

In the current normative conditions, on the basis of the EU law, the access to health care is still being formed, whereas its particular elements, such as: the right of access to preventive care, the right to obtain medical benefit of good quality as well as the right of access to regulated pharmaceutical products on the same terms as in the insuring country, are influenced by a range of regulations, both of primary and secondary nature.[61] The provisions of the Charter of Fundamental Rights concerning common access to health care and the provisions of the regulation on social security coordination are of high importance to citizens. However, the most important authorisations arise from the provisions of the cross-border directive. The content of this law is the realisation of the principle of universality of access to high quality health care with consideration of the principle of solidarity and equality.[62] In addition, the effect of the transposition of this directive to the national law and its application should not encourage patients to obtain treatment outside their insuring Member State.

This practice also indicates that the migrating citizens right of access to health care was a defective law, which is the result of complicated and unclear administrative procedures concerning the return of the already incurred costs. Hence, the exercise of this right becomes distant for persons who are not able to pay in advance the specified amount of money for the specialist benefit in another country. On the other hand, in the circumstances of uncertainty of the return of the already incurred costs, many people, especially those with less favourable financial situation, are still not willing to risk going to these EU countries where the costs of living

60. RafaB Riedel, "Baltic Journal of European Studies" 2(2016): 70.
61. See: art. 11 of Directive.
62. The consent requirement also includes treatments presenting a particular risk for the patient or the population; It is provided by a healthcare provider, which in individual cases may give rise to serious doubts about the quality or safety of care.. See: art. 8 of Directive.

and the level of medical services provided significantly exceed those in their home country.[63] An important aspect impeding the migrating citizen s right of access are limitations on the side of patients who, as a rule, prefer local centres equipped with medical personnel that takes into account local conditions and patient habits, as well as uses the same language. Also, the possibility of a patient s direct contact with their beloved ones and family is of great importance.

Regardless of the above mentioned arguments, it should be noted that the citizens authorisation arising from the directive offers migrating citizens a wide range of evident advantages, including the possibility of immediate use of the benefit in case of disease or accident (a negative aspect of the right to health protection) as well as to obtain preventive care (positive aspect).[64] Member States that, on one hand, take full responsibility for performance of secure, efficient, high quality and quantitatively sufficient health care system and, on the other hand, for the return of the costs incurred by their own citizens in other countries included in the scope of the directive, are the guarantor of the rights awarded to migrating citizens. It should also be noted that the aforementioned problems encountered by the migrating citizens fall within the general scope of the right of access to health care as the right which in order not to remain an indecisive and expectative right requires not only statutory measures, but also significant financial expenditures in the appropriate amount.

63. Izabella Main, "Medical Travels of Polish Female Migrants in Europe", Czech Sociological Review 6(2014): 897-918.
64. RafaB Riedel, "Baltic Journal of European Studies" 2(2016): 70.

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