OPINION OF ADVOCATE GENERAL RUIZ-JARABO COLOMER

delivered on 18 May 2000 [1]

1. The Arrondissementsrechtbank (District Court), Roermond (Netherlands), has on this occasion referred two questions to the Court of Justice for a preliminary ruling under Article 177 of the EC Treaty (now Article 234 EC) in order to resolve two disputes pending before it. It asks, essentially, whether Articles 59 (now, after amendment, Article 49 EC) and 60 (now Article 50 EC) of the EC Treaty preclude legislation enacted by a Member State in the area of compulsory sickness insurance which requires persons insured under it to obtain authorisation from their insurance fund in order to claim entitlement to benefits from a medical practitioner or health-care institution, situated in the same Member State or abroad, with whom or which the fund has not entered into an agreement, or, otherwise, to pay the costs incurred without entitlement to reimbursement.

I. The national legislation on compulsory sickness insurance

2. The documents before the Court show that, in the Netherlands, workers and persons regarded as such whose income does not exceed a certain amount [2] are compulsorily insured under the Ziekenfondswet (Law on sickness funds) ('ZFW'), which covers ordinary health care. [3]

3. Under Article 5(1) of the ZFW, persons falling within its scope must register with a sickness insurance fund active in the municipality in which they are resident; [4] the fund is required to register such persons as insured persons. It is a system which provides only for health-care benefits in kind. Insured persons are therefore entitled not to the reimbursement of whatever sickness costs they may incur, but to the provision of free health care.

4. Under Article 3 of the Verstrekkingenbesluit (Royal Decree) of 4 January 1966 on benefits, as amended by the Royal Decree of 16 December 1997, health care is to include, *inter alia*, assistance by a general medical practitioner and a specialist 'to such extent as is regarded as normal

1 — Original language: Spanish.

2 — The Netherlands Government states that, for 1997, the ceiling was NLG 60 750

3 — Care considered to be extraordinary because, for example, of its long duration or high cost, and which cannot be paid for by individuals or satisfactorily provided for by private insurance companies, is governed by the Algemene Wet Bijzondere Ziektekosten (General law on special costs in connection with sickness).

4 — According to the information provided by the Netherlands Government at the hearing, there is a total of 30 insurance funds in the Netherlands.

within professional circles'. The decisive factor for present purposes is what the medical profession in the Netherlands regards as normal. In general, treatment is not recognised as normal where it is not provided or recommended because it has not been sufficiently endorsed by international or national scientific research. What matters is the extent to which a particular treatment is regarded as the appropriate professional procedure; if it has a valid scientific basis, it is recognised as a benefit within the meaning of the ZFW.

5. *Article 9* of the ZFW governs claims for entitlement to care and provides, so far as is relevant:

'1. An insured person who wishes to claim entitlement to a benefit shall [...] apply to a person or establishment with whom or which the sickness insurance fund with which he is registered has for that purpose entered into an agreement [...].

2. The insured person may choose from among the persons and establishments mentioned in Article 8(1), without prejudice to the provisions of Article 9(5), with regard to conveyance by ambulance, as provided for in the relevant legislation [...].

[...]

4. A sickness insurance fund may, by way of derogation from paragraphs 1 and 2 hereof, authorise an insured person, in order to claim entitlement to a benefit, to apply to another person or establishment in the Netherlands where it is necessary to do so in order to ensure proper care. The Minister may determine the cases and circumstances in which an insured person may be granted authorisation to claim entitlement to a benefit from a person or establishment outside Netherlands territory.'

6. The requirement of obtaining such authorisation is contained in Article 1 of the Regeling hulp in het buitenland ziekenfondsverzekering (Regulation on health care abroad under the sickness insurance rules) of 30 June 1988, [5] which provides:

'A sickness insurance fund may authorise an insured person claiming entitlement to a benefit to apply to a person or establishment outside the Netherlands in those cases in which the sickness insurance fund shall

5 — *Staatscourant* 1988, No 123.

determine that such action is necessary for the health care of the insured person'. [6]

7. In order to be able to offer benefits in kind to insured persons, sickness funds must, under Article 44(1) of the ZFW, enter into agreements with persons and establishments offering one or more forms of care. Article 44(3) thereof goes some way towards defining the content of such agreements, which are to include the nature and extent of the obligations and rights of the parties, the category of care to be provided, the quality and effectiveness of the care, its cost, and supervision of compliance with the terms of the agreement. The insurance fund may terminate the agreement if the person or establishment concerned fails to comply with its terms.

Such agreements do not, however, provide for the financing of health care, which, in the case of treatment provided in the Netherlands, is governed by the Wet tarieven gezondheidszorg (Law on the financing of health care); in the case of treatment provided abroad, sickness funds are free to negotiate with medical practitioners and health-care institutions.

Sickness funds have extensive freedom in concluding agreements with both medical practitioners and health-care institutions. They are, nonetheless, subject to two restrictions: a fund must, if so requested by a health-care institution situated in the region in which the fund is active or regularly used by the local population, enter into an agreement with that institution; and funds must conclude agreements only with medical practitioners qualified to administer the treatment in question and with authorised health-care institutions.

8. As the national court explains in its order, according to settled case-law of the Centrale Raad van Beroep (Central Court of Appeal), where authorisation for an insured person to undergo treatment abroad at the expense of the sickness fund is denied, it must first be established whether the treatment may be regarded as a benefit under national law, the criterion to determine which being whether it is 'normal in the professional circles concerned'. [7]

6 — No special conditions have been laid down for insured persons who wish to be treated by medical practitioners or health-care institutions established abroad with whom or which their funds have not entered into an agreement for the provision of health care. An insured person seeking such treatment must obtain prior authorisation from his sickness fund in exactly the same way as he has to when seeking treatment by a medical practitioner or health-care institution established in the Netherlands with whom or which his fund has not entered into a health-care agreement.

7 — In a judgment of 23 May 1995, the Centrale Raad van Beroep held that authorisation to receive treatment abroad under Article 9(4) of the ZFW is not to be given where such treatment cannot be regarded as a benefit within the meaning of the aforementioned provisions. In that case, treatment in New York was not classified as a benefit because it was experimental in nature and could not be deemed 'normal within professional circles'. In another judgment, of 19 December 1997, the same court upheld the view of the sickness fund which was a party in the proceedings to the effect that the treatment at issue, which was provided in Germany, did not (yet) have a sufficient scientific basis and was still regarded in the Netherlands as experimental.

Provided that the normality criterion is satisfied, it must then be considered whether the authorisation can be granted pursuant to Article 9(4) of the ZFW in conjunction with Article 1 of the regulation on medical care abroad under the compulsory sickness insurance scheme. The criterion in that respect is whether the medical treatment is 'necessary for the health care of the person concerned', regard being had to whether, in view of the treatment methods available in the Netherlands, the treatment provided abroad is necessary from a medical point of view.

II. The facts of the dispute between Mrs Geraets-Smits and Stichting Ziekenfonds

9. On 5 September 1996, Mrs Geraets-Smits (the plaintiff in the first case), who was born on 6 June 1928 and has suffered from Parkinson's disease for many years, applied to Stichting Ziekenfonds (the defendant institution) for reimbursement of a payment she had made to the Elena Clinic in Kassel (Germany), which specialises in the specific and multi-disciplinary treatment of Parkinson's disease. Patients are admitted for between three and six weeks, during which time they are examined and treated with a view to achieving the optimal administration of medication. At the clinic, patients also receive physiotherapy and ergotherapy treatments, together with socio-psychological care.

10. By decision of 30 September 1996, reaffirmed by decision of 28 October 1996, the defendant institution informed the plaintiff that she could not be reimbursed under the ZFW. The reason for the refusal was that adequate and appropriate treatment for her illness was available in the Netherlands and it was not therefore necessary to seek specific clinical treatment at the Elena Clinic.

11. The plaintiff did not agree with that decision and sought the opinion of the Ziekenfondsraad (Sickness Funds Council). The Council's appeals committee delivered its opinion on 7 April 1997. It found that both the defendant's decision and the reasoning underlying it were correct. The plaintiff appealed against that decision to the Arrondissementsrechtbank, claiming that the specific clinical treatment in Germany was indeed more effective than the fragmented approach in the Netherlands.

12. When the first hearing in the case was held on 25 September 1997, there was produced in court a letter from the consulting neurologist, dated 11 September 1997, in which he stated that there were sufficient grounds to authorise the plaintiff's treatment at the German clinic. Thereupon, the court appointed a neurologist as an expert witness. He submitted his report in February of the following year, stating that it was neither clinically nor scientifically established that the specific approach

was better, and that there was no reason on objective medical grounds for the plaintiff to be treated at the German clinic.

III. The facts of the dispute between Mr Peerbooms and Stichting CZ Groep Zorgverzekeringen

13. Mr Peerbooms (the plaintiff in the second case), who was born on 8 April 1961, fell into a coma following a road-traffic accident on 10 December 1996. On 24 February 1997, his neurologist requested Stichting CZ Groep Zorgverzekeringen, the defendant institution, to bear the costs of the plaintiff's treatment at the University Clinic in Innsbruck (Austria).

That clinic offers a special intensive neurostimulation therapy which, in the Netherlands, is used only experimentally at one rehabilitation centre in Tilburg and at another in Utrecht. The plaintiff was not admitted to either clinic because, for the purposes of that experiment, the two centres do not accept patients over twenty-five years of age. He was therefore due to be transferred to the rehabilitation centre in Hoensbroeck, where the therapy in question is not used. He was in fact admitted to the clinic in Innsbruck on 22 February 1997,[8] in a vegetative state. After undergoing the special therapy, he emerged from the coma and regained full consciousness. On 20 June 1997, he was discharged and transferred to the rehabilitation clinic in Hoensbroeck in order to continue his convalescence.

14. By decision of 26 February 1997, the neurologist's request was refused — on the advice of the medical adviser — on the ground that the appropriate treatment for the patient could be obtained from a health-care institution having an agreement with the patient's sickness fund or, failing that, from a non-contracted institution in the Netherlands. The neurologist submitted a further, more detailed, request which was again refused on 5 March 1997. A complaint was lodged but was dismissed as being unfounded. In line with the opinion of the appeals committee, and after hearing the views of the medical adviser once again, the sickness fund remained of the view that, on current medical thinking, the treatment of comatose patients in Innsbruck was not more effective than the facilities available in the Netherlands and that it was not therefore necessary to go to Austria to receive care.

15. The plaintiff appealed against that decision. The Arrondissementsrechtbank appointed an expert witness in this case

8 — That is to say, two days before his neurologist sought authorisation from the sickness fund for him to receive care at that centre.

too, who submitted his report on 12 May 1998. He took the view that no specific and appropriate treatment of the kind offered in Innsbruck was available to the plaintiff in the Netherlands, except at the centres in Tilburg and Utrecht, where he had not been admitted because he exceeded the maximum age limit, and that the therapy at the Hoensbroeck rehabilitation centre would not have been appropriate. The sickness fund's neurologist responded to that report by emphasising the experimental nature of the treatment and the fact that it was still not accepted by the scientific community. After being questioned on this point, the first expert witness submitted a supplementary report, on 31 August 1998, in which he maintained his original conclusions.

IV. The questions referred to the Court

16. In order to resolve the two disputes, the Arrondissementsrechtbank, Roermond, referred the following questions to the Court of Justice for a preliminary ruling:

'1. (a) Must Articles 59 and 60 of the EC Treaty be interpreted as meaning that a provision such as Article 9(4) of the ZFW in conjunction with Article 1 of the rules on health care abroad under the sickness insurance scheme is inconsistent with those Treaty provisions where the national rules cited provide that a person insured under the sickness insurance fund requires prior authorisation from the sickness insurance fund in order to seek his entitlement to benefits from a person or establishment outside the Netherlands?

(b) What is the answer to Question 1(a) where the authorisation referred to therein is refused, or does not apply, because the relevant treatment in the other Member State is not regarded "as normal in professional circles" and thus is deemed not to constitute a benefit within the meaning of Article 8 of the legislation on sickness insurance funds (ZFW)? Does it make any difference in that connection whether regard is had solely to the conceptions of Netherlands professional circles and whether national or international scientific yardsticks are applied and, if so, in what respect? Is it also relevant whether the relevant treatment is reimbursed under the social security system provided for under the law of that other Member State?

(c) What is the answer to Question 1(a) where the treatment abroad is deemed to be normal and therefore to constitute a benefit but the requisite authorisation is refused on the ground that timely and adequate care can be obtained from a contracted Netherlands

care provider and treatment abroad is therefore not necessary for the health care of the person concerned?

2. If the requirement to obtain authorisation constitutes a barrier to the freedom to provide services enshrined in Articles 59 and 60 of the EC Treaty, are the overriding reasons in the general interest relied on by the defendants (*inter alia*, in the letter cited above of 14 July 1998) sufficient in order for the barrier to be regarded as justified?'

V. The Community legislation

17. Article 59 of the EC Treaty provides: '[w]ithin the framework of the provisions set out below, restrictions on freedom to provide services within the Community shall be progressively abolished during the transitional period in respect of nationals of Member States who are established in a State of the Community other than that of the person for whom the services are intended.

[...]'.

18. Article 60 of the EC Treaty provides: '[s]ervices shall be considered to be "services" within the meaning of this Treaty where they are normally provided for remuneration, in so far as they are not governed by the provisions relating to freedom of movement for goods, capital and persons.

"Services" shall in particular include:

[...]

(d) activities of the professions.

[...]'.

19. Article 22 of Regulation No 1408/71, [9] which governs, *inter alia*, the need for an employed or self-employed person, or a member of his family, to go to another Member State in order to receive appro-

9 — Regulation (EEC) No 1408/71 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community, as amended and updated by Council Regulation (EC) No 118/97 of 2 December 1996 (OJ 1997 L 28, p. 1).

priate treatment, provides, so far as is relevant here:

'1. An employed or self-employed person who satisfies the conditions of the legislation of the competent State for entitlement to benefits, taking account where appropriate of the provisions of Article 18, and:

[...]

(c) who is authorised by the competent institution to go to the territory of another Member State to receive there the treatment appropriate to his condition,

shall be entitled:

(i) to benefits in kind provided on behalf of the competent institution by the institution of the place of stay or residence in accordance with the provisions of the legislation which it administers, as though he were insured with it; the length of the period during which benefits are provided shall be governed, however, by the legislation of the competent State;

2. [...]

The authorisation required under paragraph 1(c) may not be refused where the treatment in question is among the benefits provided for by the legislation of the Member State on whose territory the person concerned resided and where he cannot be given such treatment within the time normally necessary for obtaining the treatment in question in the Member State of residence taking account of his current state of health and the probable course of the disease.

[...]'.

VI. The recent case-law of the Court of Justice on freedom to provide services in the context of reimbursement of medical costs incurred in another Member State

20. On 28 April 1998, the Court of Justice gave judgment in the *Decker* [10] and *Kohll* [11] cases. Both judgments have been the subject of abundant academic legal commentary [12] and gave rise to fears, when delivered, that they would cause incalculable

10 — C-120/95 [1998] ECR I-1831.

11 — C-158/96 [1998] ECR I-1931.

12 — The number of commentators who have written about those two judgments, to date, is in excess of 40.

financial damage to national social security systems. [13] I do not intend to look at the judgment in *Decker* in great detail: the facts of that case related to the purchase of spectacles and therefore fell within the framework of the free movement of goods. [14]

21. The judgment in *Kohll*, on the other hand, concerned the provision of cross-border services. The questions had been referred by the Cour de Cassation (Court of Cassation), Luxembourg, in the course of proceedings brought by Mr Kohll against the decision of his sickness fund refusing to give authorisation for his daughter to be treated by an orthodontist in Germany, on the ground that the treatment was not urgent and could be provided in Luxembourg.

22. With regard to the application of the freedom to provide services to treatment provided by an orthodontist established in another Member State, outside any hospital infrastructure, the Court held that, since that service was provided for remuneration, it was a service within the meaning of Article 60 of the Treaty, which expressly refers to activities of the professions.

23. As to restrictive effects, the Court held that, while the Luxembourg rules did not deprive insured persons of the possibility of approaching a provider of services established in another Member State, they did make reimbursement of the costs incurred in that State subject to prior authorisation, while reimbursement of those incurred in the State of insurance was not subject to authorisation. It therefore decided that such rules deterred insured persons from approaching providers of medical services established in another Member State and therefore constituted for them and their patients a barrier to freedom to provide services. [15]

24. Several grounds were put forward by way of justification for the rules in question, namely maintenance of the financial balance of the social security system and protection of public health, which included

13 — C. Nourissat, in 'Quand Panacée rejoint Europe ou comment la Cour de justice consacre la liberté des soins dans la communauté' [When Panacea joins Europe or how the Court of Justice is establishing freedom of health care in the Community], published in *La Semaine Juridique*, edition générale 1999 II 10002, expresses the view: 'Nicolas Decker's pair of spectacles and Aline Kohll's dental treatment are destined to enter Community judicial mythology alongside Mr Costa's electricity bill and Dijon's blackcurrant liqueur'; Ph. Gosseries, in *Journal des Tribunaux du Travail*, 1999, pp. 446 to 449, in particular p. 446, states: 'the Court's two judgments of 28 April 1998 [...] have driven a coach and horses through the organisation of health-care insurance schemes in the Member States of the European Union. Some have claimed that, through those two judgments, the Court has created a state of real panic among managers of social security institutions across the entire Union [...]'.

14 — In that judgment, the Court held that Articles 30 and 36 of the EC Treaty preclude national rules under which a social security institution of a Member State refuses to reimburse to an insured person on a flat-rate basis the cost of a pair of spectacles with corrective lenses purchased from an optician established in another Member State, on the ground that prior authorisation is required for the purchase of any medical product abroad.

15 — Joined Cases 286/82 and 26/83 *Luisi and Carbone* [1984] ECR 377, paragraph 16, and Case C-204/90 *Bachmann* v *Belgium* [1992] ECR I-249, paragraph 31.

the need to guarantee the quality of medical services and the aim of providing a balanced medical and hospital service open to everyone.

25. With regard to the first ground, the Court held that, since the financial burden on the Luxembourg social security institution was the same whether an insured person approached a Luxembourg orthodontist or one established in another Member State, reimbursement of the costs of dental treatment provided in other Member States at the rate applied in the State of insurance had no significant effect on the financing of the social security system.

26. As regards the protection of public health, the Court pointed out in paragraphs 45 and 46 of its judgment that, while Member States may limit freedom to provide services on grounds of public health, that right does not permit them to exclude the public health sector, as a sector of economic activity and from the point of view of freedom to provide services, from the scope of the fundamental principle of freedom of movement. [16] In any event, since the conditions for taking up and pursuing the profession of doctor and dentist have been the subject of several coordinating and harmonising directives, [17] the Court held that doctors and dentists established in other Member States must be afforded all guarantees equivalent to those accorded to doctors and dentists established on national territory, for the purposes of freedom to provide services, and that rules such as those applicable in Luxembourg could not be justified on grounds of public health in order to protect the quality of medical services provided in other Member States.

The Court went on to accept that the objective of maintaining a balanced medical and hospital service open to all, while intrinsically linked to the method of financing the social security system, may also fall within the derogations on grounds of public health under Article 56 of the EC Treaty (now, after amendment, Article 46 EC), since it contributes to the attainment of a high level of health protection. It stated in this respect that Article 56 permits Member States to restrict the freedom to provide medical and hospital services in so far as the maintenance of a treatment facility or medical service on national territory is essential for the public health and even the survival of the population.

16 — Judgment in Case 131/85 *Gul* v *Regierungsprasident Düsseldorf* [1986] ECR 1573, paragraph 17.

17 — The Court cites Council Directive 78/686/EEC of 25 July 1978 concerning the mutual recognition of diplomas, certificates and other evidence of formal qualifications of practitioners of dentistry, including measures to facilitate the effective exercise of the right of establishment and freedom to provide services (OJ 1978 L 233, p. 1); Council Directive 78/687/EEC of 25 July 1978 concerning the coordination of provisions laid down by law, regulation or administrative action in respect of the activities of dental practitioners (OJ 1978 L 233, p. 10); and Council Directive 93/16/EEC of 5 April 1993 to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications (OJ 1993 L 165, p. 1).

As it had not been shown that the rules were necessary in order to attain those two objectives, the Court held that they were not justified on grounds of public health.

VII. The proceedings before the Court of Justice

27. Most of the commentators who have written about the judgments in *Decker* and *Kohll* have given a positive assessment of the Court's findings, [18] which are consistent with the reasoning underpinning its case-law in relation to the free movement of goods and services. [19] However, those two judgments have left many questions unanswered, since they did not determine whether or not that case-law is also applicable to health care provided in hospitals, [20] or whether its scope is confined to social security systems, like that in Luxembourg, under which the cost of hospital and medical care received by a patient is either paid on his behalf or reimbursed to him in full or in part, [21] or, on the other hand, extends to systems which, like that in the Netherlands, are organised in such a way as to provide insured persons with health care in kind. [22] That is the very question which the Court must answer when it gives judgment in the present case. [23]

18 — The dissenting voice would appear to come from L González Vaqué in 'Aplicación del principio fundamental de la libre circulación al ámbito de la seguridad social: la sentencia Decker' [Application of the fundamental principle of freedom of movement to the field of social security: the judgment in *Decker*], published in *Revista de Derecho Comunitario Europeo*, 1999, pp. 129 to 139, in particular p. 139, although he does state that there are sufficient elements within that case-law to make it possible to limit any (adverse) effects it might have in the short and medium term on the economy of the sensitive health-care sector.

19 — P. Mavridis, in 'Libéralisation des soins de santé: un premier diagnostic' [Liberalisation of health care: an initial diagnosis], published in *Revue du Marché Unique Européen*, 1998, No 3, pp. 145 to 196, in particular p. 195, states '[...] today's decision was already embodied in yesterday's case-law on Articles 30 and 59 to 60. The judgments in *Kohll* and *Decker* do not therefore represent a "big bang", revolution, explosion or any other natural disaster. They had long been in the pipeline'. J. Ph. Lhernould, in 'Une caisse de sécurité est-elle tenue de rembourser les frais médicaux engagés par un assuré dans un autre Etat membre?' [Is a social-security fund required to reimburse the medical costs incurred by an insured person in another Member State?], published in *Revue de droit sanitaire et social*, 1998, pp. 616 to 623, in particular p. 622, regards it as a positive development that those two judgments have triggered a movement of resistance to the practice whereby Member States almost automatically refuse to give authorisation for insured persons to receive health care in another Member State at the expense of their insurance fund. R. Giesen, in *Common Market Law Review*, 1999, pp. 841 to 850, in particular p. 850, states that both judgments deserve his approval, despite the surprise they caused when they were delivered, especially in Germany.

20 — P. Cabral, in 'Cross-border medical care in the European Union — bringing down a first wall', published in *European Law Review*, 1999, pp. 387 to 395, in particular p. 395, takes the view that that extension is implicit in the judgments in question.

21 — A. Bosscher, in 'La seguridad social de los trabajadores migrantes en la perspectiva del establecimiento del mercado' [Social security for migrant workers from the point of view of the establishment of the internal market], published in *Los sistemas de seguridad social y el Mercado único europeo*, Madrid, 1993, pp. 23 to 33, in particular p. 32, considers that the unrestricted right to go to another Member State in order to receive health care at the expense of the competent State would be disproportionate to the financial capabilities of the Member States' social security institutions.

22 — These doubts are expressed by A. P. van der Mei in 'Cross-border access to medical care within the European Union — Some reflections on the judgments in *Decker* and Kohll', published in *Maastricht Journal of European and Comparative Law*, 1998, pp. 277 to 297, in particular p. 293: 'But what are the implications of the judgments? For which types of "foreign" treatment are patients entitled to be reimbursed? In which cases can Member States refuse to pay the "medical bill"? Do Member States have the right to protect themselves against a possible large influx of patients coming from abroad?' Some commentators, such as A. Bonomo, in *Giustizia Civile*, 1998, I, pp. 2391 to 2401, in particular p. 2401, take the view that implementation of the single market is incompatible with such restrictive State rules which require prior authorisation to be obtained for the reimbursement of medical costs incurred in another Member State and unjustifiably hinder the free movement of patients within the Community.

23 — As anticipated by M Thill in '*Decker* et *Kohll* ou la libre circulation des patients à l'intérieur de l'Union européenne et ses limites' [*Decker* and *Kohll* or the free movement of patients within the European Union and its limits], published in *Feuillet de Liaison de la Conférence Saint-Yves*, 1999, No 92/93, pp. 57 to 89, in particular p. 84.

28. In addition to Stichting CZ Groep Zorgverzekeringen, the sickness fund against which Mr Peerbooms brought proceedings before the Arrondissementsrechtbank, Roermond, and the Commission, 10 of the 15 Member States have submitted written observations in these proceedings,[24] within the time-limit laid down for that purpose in Article 20 of the EC Statute of the Court of Justice: Belgium, Denmark, Germany, France, Ireland, Netherlands, Portugal, Finland, Sweden and the United Kingdom. To these must be added two States belonging to the European Economic Area: Iceland and Norway. This is clear proof of the expectations which have been raised by this case and the interest with which the Court's decision is awaited.

29. At the hearing on 4 April 2000, the representatives of the two sickness funds which are defendants in the main proceedings, the agents for the Governments of Denmark, Germany, France, Ireland, the Netherlands, Austria, Finland, Sweden, the United Kingdom, and Iceland respectively, and the agent for the Commission presented oral argument.

30. Stichting Ziekenfonds VGZ, the fund against which Mrs Geraets-Smits brought proceedings, considers that Member States are free to organise their social security systems and that the provisions of the Treaty cannot prevent such a system from operating on the basis of agreements concluded by sickness funds with medical practitioners and health-care institutions entitling them alone to provide health care to insured persons. On that premiss, the restrictions inherent in a system such as the Netherlands compulsory sickness insurance scheme, which provides only benefits in kind, are likewise incapable of being incompatible with the Treaty.

In the event that the Court finds otherwise, it submits that the conditions for granting authorisation to consult a non-contracted health-care provider are not discriminatory, and points to the differences between the compulsory sickness insurance scheme in the Netherlands and that in Luxembourg as support for the assertion that *Kohll* cannot be applied to the Netherlands scheme.

31. The sickness fund against which Mr Peerbooms has brought proceedings submits that health care under the Netherlands legislation is organised in the form of a range of benefits comprising only those considered normal in professional circles

24 — It is not surprising that there has been such concern, given the views expressed by commentators such as P. Mavridis in 'Libéralisation des soins de santé: un premier diagnostic' [Liberalisation of health care: an initial diagnosis], published in *Revue du Marché Unique Européen*, 1998, No 3, pp. 145-196, in particular p. 171, where he states that the merit of the judgments in *Decker* and *Kohll* lies in the fact that insured persons have been granted a direct right, irrespective of national law and Regulation No 1408/71, which means that they can now go to another Member State in order to obtain medical products, receive the treatment necessary for their condition, and have the costs reimbursed at the rate applied in the State of insurance. Should the sickness funds refuse to reimburse the costs, he reminds his readers of the principle established in *Brasserie du Pêcheur* and *Factortame* that the State must make good any damage caused to individuals as a result of failure to comply with Community law.

and based on treatments of proven scientific benefit, and that it is irrelevant for present purposes whether or not a benefit not considered normal in the Netherlands is covered by sickness insurance in another Member State. The agreements which sickness funds conclude with medical practitioners and health-care institutions govern the cost and quality of the care and ensure that the financial balance of the system is maintained by fixing a budgetary framework, limiting facilities and providing financing, which is governed by law. It states that the decisive factor in authorising an insured person to go abroad to receive treatment is no longer whether that treatment can be provided in good time in the Netherlands, but whether it can be provided by a medical practitioner or health-care institution with whom or which the fund has entered into an agreement, irrespective of the State in which they are established. Health care from a provider not having an agreement with the sickness fund, on the other hand, is still subject to prior authorisation.

The defendant institution points out that several experiments of cross-border health care involving both hospital and outpatient treatment have been launched in the Euregio Rhin/Waal and Euregio Meuse/Rhin regions, without any great flow of patients into Belgium or Germany having been observed. [25]

25 — Those same experiments are cited by A. P. van der Mei, op. cit., pp. 278 and 279: '[...] in a number of border regions, health insurers and health providers have concluded agreements which are aimed at giving patients the right to obtain care "on the other side of the border"'.

32. I am not going to set out the views expressed by each Member State in its observations separately; I shall merely summarise them, since they are largely the same.

Judging from their observations, the Member States appear to fall into two major groups in terms of their views. Those in the first group, namely Belgium, France and Austria, consider that the health care provided under a public social security scheme is a service within the meaning of Article 60 of the Treaty. Those in the second group, however, which comprises Germany, Ireland, the Netherlands, the United Kingdom, Denmark, Sweden, Finland and Iceland, take the view that health care under a social security system organised in the form of benefits in kind does not constitute a service within the meaning of Article 60. Portugal and Norway have expressed no views on this point.

The division of opinion among the Member States ends here, since they all agree that the requirement of prior authorisation from the institution of the State of insurance in order to receive care in another Member State, although constituting a barrier to freedom to provide services, is justified.

33. At the end of the written procedure, the Court asked the Netherlands Government whether it had amended its national legislation in order to bring it into line with the case-law established in the aforementioned judgments in *Decker* and *Kohll*. It states in its reply that that case-law does not require any reform of the ZFW as regards the conclusion of agreements between funds, on the one hand, and medical practitioners and health-care institutions on the other. It adds that several projects had been introduced to develop the provision of cross-border health-care before the events material to *Geraets-Smits* and *Peerbooms* took place, although the judgments cited have been instrumental in increasing the number of agreements concluded with health-care institutions established in other Member States.

At the hearing, Stichting Ziekenfonds VGZ informed the Court that it had begun negotiations with medical practitioners and health-care institutions in other Member States with a view to concluding agreements on the provision of health care for those insured with it. Stichting CZ Groep Zorgverzekeringen stated, for its part, that it had already concluded similar agreements with both medical practitioners and health-care institutions situated in Belgium and Germany.

34. The Commission submits that, in principle, the criteria of what is normal in professional circles and whether the treatment is necessary, as employed by the Netherlands legislation, are both consistent with Article 22 of Regulation No 1408/71, and that, when applying the first, a Member State has a broad discretion in deciding which benefits are covered by a particular social security scheme. In practice, however, those two criteria must be applied in a manner compatible with Community law.

In its view, there is some evidence in the Netherlands legislation that the conditions for granting authorisation to receive health care abroad differ from those laid down for treatment in the Netherlands, and that the requirement of authorisation could therefore constitute a specific barrier to the freedom to provide services.

VIII. Analysis of the questions referred to the Court

A. *The health care provided for under the compulsory sickness insurance scheme in the Netherlands and the concept of services within the meaning of Article 60 of the Treaty*

35. By the questions referred, which, in my opinion, must be examined together, the Netherlands court wishes to ascertain whe-

ther Articles 59 and 60 of the EC Treaty preclude social security legislation such as that at issue in the main proceedings which, by way of agreements concluded by sickness insurance funds with medical practitioners and health-care institutions, organises a system of benefits in kind which requires insured persons who need to consult a non-contracted practitioner or institution, whether situated on national territory or abroad, to obtain authorisation from their fund before they can receive the benefits to which they are entitled.

36. In order to answer the question thus recast, it is appropriate, first of all, to determine whether the medical and hospital care available under the Netherlands sickness insurance scheme falls within the scope of the freedom to provide services. Put simply, the issue is whether the benefits to which insured persons are entitled under the ZFW are services for the purposes of Article 60.

In paragraph II.3 of its order for reference, the Arrondissementsrechtbank says that it is proceeding from the premiss that the treatments which the plaintiffs in the main proceedings received in Germany and Austria are services within the meaning of Article 60 of the Treaty. I do not have sufficient information to form an opinion on this point. However, I do not consider this to be a decisive factor in answering the questions raised. If those treatments are services within the meaning of Article 60, the freedom of both patients to go to another Member State as recipients of services and to receive them has not been restricted. Nor, indeed, do they complain of having received worse treatment than the nationals of those States. [26] None the less, in so far as they rely on Article 60 of the Treaty in order to request that their insurer bear the costs incurred, I consider it essential to ascertain whether their legal relationship with the insurer entitles them to receive services within the meaning of the Treaty.

37. I should like to make it clear that the analysis that follows relates specifically to health care provided solely in the form of benefits in kind by a social security scheme such as that at issue, under which insured persons have no entitlement to reimbursement of the costs incurred in obtaining care. I consider it necessary to make this preliminary clarification in order to avoid any confusion, since the Court of Justice has on several occasions firmly held that certain medical benefits are to be regarded as services for the purposes of Article 60 of the Treaty, and that persons who move to

26 — It has emerged from the proceedings pending before the Court of Justice in Case C-411/98 *Ferlini* v *Centre Hospitalier de Luxembourg* (OJ 1999 C 20, p. 18) that, in Luxembourg, persons requiring treatment who are not insured under the national social security scheme have to pay considerably more than those who are insured. The Report for the Hearing in that case states that, at the material time (1989), persons insured under the Luxembourg social security scheme were charged LUF 36 859 for childbirth, while those not insured had to pay LUF 59 306 (that is to say 71.43% more) for the same benefit in the same hospital. Advocate General Cosmas, in the Opinion he delivered in that case on 21 September 1999, considered that difference in treatment to be contrary to Article 7(2) of Council Regulation No 1612/68 on freedom of movement for workers within the Community (OJ, English Special Edition 1968 (II), p. 475).

another Member State in order to receive medical care are recipients of services.

Examples of that rule can be found, moreover, in paragraph 29 of the judgment in *Kohll*, which concerned treatment provided by an orthodontist, in the judgment in *Society for the Protection of Unborn Children Ireland*,[27] where it was held that medical termination of pregnancy, performed in accordance with the law of the State in which it is carried out, constitutes a service within the meaning of Article 60 of the Treaty, and in the judgment in *Luisi and Carbone*,[28] where it was held that freedom to provide services includes the freedom, for the recipients of services, to go to another Member State in order to receive a service there, without being obstructed by restrictions, even in relation to payments, and that persons receiving medical treatment are to be regarded as recipients of services.

In all those examples, the Court was at pains to point out either that the benefit had been provided for remuneration, as in the first case cited, or, as in the second, that termination of pregnancy is a medical activity which is normally provided for remuneration and may be carried out as part of a professional activity. In the third case, an Italian national had been fined for having exported currency in excess of the amount authorised by the national foreign-exchange-control legislation in order, *inter alia*, to receive medical treatment in Germany.

38. Under Article 60 of the Treaty, services are to be regarded as 'services' where they are normally provided for remuneration, in so far as they are not governed by the provisions relating to freedom of movement for goods, capital and persons. Such 'services' are to include, in particular, the activities of independent professionals, and, as the Court has held, the special nature of certain of those services is not capable of removing them from the ambit of the rules on freedom of movement[29]

There is no doubt that medicine has traditionally been practised by independent professionals, although nowadays this is not always the case since, in some Member States, many doctors are employed by the national social security system, while others combine such employment with private medical practice.

39. The Court has consistently held that Community law does not detract from the powers of the Member States to organise their social security systems.[30]

27 — Case C-159/90 *Society for the Protection of Unborn Children Ireland* v *Grogan* [1991] ECR I-4685, paragraph 21.

28 — Cited in footnote 15 above, paragraph 16.

29 — Case 279/80 *Webb* [1981] ECR 3305, paragraphs 8 and 10, and *Kohll*, cited in footnote 11 above, paragraph 20.

30 — Case 238/82 *Duphar* v *Netherlands* [1984] ECR 523, paragraph 16, Case C-70/95 *Sodemare and Others* v *Regione Lombardia* [1997] ECR I-3395, paragraph 27, and *Kohll*, cited in footnote 11 above, paragraph 17.

40. In exercising those powers, the Netherlands has organised a compulsory sickness insurance scheme which covers all persons whose income does not exceed a certain amount and which is managed by sickness funds with separate legal personality. It is financed from the contributions paid by insured persons and employers, and an annual payment made by the State, from the public purse, to the general sickness insurance fund. The sickness insurance funds are responsible for concluding with medical practitioners and specialist institutions agreements for the provision of health care to the persons registered with them.

41. Unlike the situation in *Kohll* with respect to the social security scheme in Luxembourg, where insured persons have complete freedom to choose their general practitioner and specialist, but are required to pay the cost of the service they receive, after which the sickness fund reimburses part of that cost to them or, in the case of hospital care, pays the institution directly on their behalf, health care under the Netherlands compulsory sickness scheme is free for insured persons. [31] In order to obtain the health-care benefits they require, however, insured persons must use one of the medical practitioners or health-care institutions with whom or which their fund has concluded an agreement because, if they decide to use non-contracted providers, they are required to pay any costs they incur, without entitlement to reimbursement.

42. That fundamental difference causes me to question whether the treatment provided by medical practitioners and health-care institutions in such circumstances may be regarded as a service within the meaning of Article 60 of the Treaty, in view of the fact that the person for whom the service is provided does not receive it in return for remuneration.

43. The Court of Justice has of course made it clear, in its judgment in *Bond van Adverteerders*, [32] that Article 60 of the Treaty does not require the service to be paid for by those for whom it is performed.

I think, however, that, in the case of the social security scheme under consideration, it is not simply the case that what an insured person does not pay for a medical procedure is paid to the medical practitioner or health-care institution in question by a third party (in this instance, the sickness fund).

44. In practice, [33] it seems that, in order to calculate how much sickness funds contri-

31 — It would be true to say that it is free in virtually all cases, even though certain benefits may be subject to the payment of a contribution by the person concerned. The legislation does provide, however, that the persons receiving the benefits do not all have to make the same contribution.

32 — Case 352/85 *Bond van Adverteerders* v *Netherlands* [1988] ECR 2085, paragraph 16.

33 — Details of how the charges are calculated have been taken from the leaflet 'Wat is het CTG (College Tarieven Gezondheidszorg)?' [What is the Health-care Tariffs Authority?], Utrecht, January 2000, and in particular from paragraph 5, entitled 'Hoe komen budgetten en tarieven tot stand (Rekenvoorbeeld A: ziekenhuisbudget) (Rekenvoorbeeld B: Tarief voor huisartsbezoek)' [How are budgets and tariffs set? Calculation example A: hospital budget; Calculation example B: Tariff for home visits by GPs]. Part of that leaflet has been published in English (by COTG, Utrecht, 1995) under the title 'What is the National Health Tariffs Authority?'.

bute to hospitals, it is necessary first of all to determine the budget for each hospital in order to establish the permissible costs, [34] and then to ascertain the supplementary charges [35] and the attendance charge, [36] that is to say the charge for each day a patient is accommodated in hospital, although that charge does not reflect the real cost of accommodation. The charges are intended to finance the budget of each health-care institution; the budget is adjusted year on year, so that, if income exceeds expenditure, the attendance charge for the following year will be reduced and, if expenditure has exceeded income, it will be increased.

45. The charges which sickness funds agree each year with medical practitioners differ according to the specialism concerned and do not consist of a separate payment per medical procedure. They are calculated by means of an arithmetical formula whereby amount A, representing average income, [37] is added to amount B, representing the average cost of running a practice, [38] the sum of which is divided by a factor representing the workload (on the basis, for example, of 2 350 patients a year, in the case of a general practitioner, and however many deliveries a year, in the case of a midwife). That calculation means that, for the year 2000, a general practitioner will receive from the sickness insurance fund with which he has concluded a health-care agreement the amount — known as a subscription charge [39] — of NLG 133 for every insured person who has chosen to be treated at his surgery, irrespective of the number of patients he actually sees, and regardless of the fact that some may need to be seen more often than others and some may not need to be seen at all at any time during the year. [40]

46. Under that system of compulsory sickness insurance, the funds operate by con-

34 — The budget is calculated on the basis of four elements: infrastructure costs; operating costs, which remain fixed irrespective of the level of occupation of the facilities; semi-fixed costs, which are based on capacity, beds and specialist units, and variable costs, which depend on the volume of activity in each hospital.

35 — These are nation-wide charges for certain activities performed by the hospital. There are approximately 1,600 such charges for every type of treatment: operations, diagnoses, tests etc.

36 — This is different for each hospital and varies considerably from one to the other. It is obtained from the hospital's budget as follows: receipts from supplementary charges are deducted from the budget and the figure arrived at is divided by the estimated number of days of hospital accommodation, that is to say the period for which a patient occupies a bed. It does not reflect the real cost of a day's hospital accommodation, but is used to balance the financing of each hospital. In the example given in the aforementioned leaflet, the estimated number of days of hospital accommodation for hospital x was 115 000, which, applied to a budget of NLG 104 940 000, and estimated receipts by way of supplementary charges of NLG 36 355 000, gives an attendance charge of NLG 596.

37 — This includes salary, holiday pay, insurance, bonuses, premiums and pension plans. The salary is determined on the basis of the pay scales applicable to public servants and is adjusted annually.

38 — There are general gudelines for calculating the cost of running the facilities necessary for each profession. Account is taken of the cost of accommodation, transport, support staff, telephones, catchment area, instruments etc. Costs are adjusted as and when the need arises, for example to provide for the computerisation of practices.

39 — That charge rises to NLG 157 for each insured person over the age of 64.

40 — The system of remuneration for contracted practitioners providing health care under the compulsory sickness insurance scheme is clearly different from the system applicable to private patients, where consultations are paid for individually rather than on the basis of a subscription charge.

cluding with health-care institutions and independent medical practitioners agreements in which they determine in advance the extent and quality of the benefits to be provided, and the financial contribution the fund will make, which, for practitioners, consists in the payment of a fixed flat-rate amount, and, for each hospital, in the payment of an attendance charge, which is intended to finance the institution rather than to cover the real cost of hospital accommodation.

Viewed from that angle, it is very much like the systems operated in certain Member States where the social security institutions have their own resources and staff which they engage directly [41] for a pre-set number of hours and a given salary. To my mind, it is clearly different from other systems, such as that in Luxembourg, [42] the subject-matter of *Kohll*, which I have already described. Under the Luxembourg system, as indeed the Court confirmed, the relationship between the insured person and the practitioner is characterised by a provision of 'services' within the meaning of Article 60 of the Treaty, [43] but I am also convinced that there is no such provision of 'services' under the system I am considering here, since the element of remuneration required by Article 60 of the Treaty is lacking. [44]

47. The position is similar in the case of national education systems, in connection with which the Court has had occasion to express its views on the principle of freedom to provide services. In *Humbel* [45], for example, the Court held that, under the first paragraph of Article 60 of the EEC Treaty, only services 'normally provided for remuneration' are to be services within the meaning of the Treaty, and that, even though the concept of remuneration is not expressly defined in Articles 59 et seq. of the Treaty, its legal scope may be deduced from the provisions of the second paragraph of Article 60 of the Treaty, the essential characteristic of remuneration being the fact that it constitutes consideration for the service in question, the amount of which is agreed upon between the provider and the recipient of the service. The Court pointed out that that characteristic is absent in the case of courses provided under the national education system, since, first of all, the State, in establishing and maintaining such a system, is not seeking to engage in gainful activity but is fulfilling its duties towards its own population in the social, cultural and

41 — Such staff have the status of civil servants or quasi civil servants whose relationship with the social security institutions is governed in certain Member States by public law.

42 — The French and Belgian systems operate according to the same principles.

43 — This also applies to health care provided in hospital, since, although treatment is paid for by the sickness fund rather than the insured person, there is a charge for each medical procedure based on the cost of the benefits involved.

44 — For a detailed examination of the statutory social security systems in force in the Member States, see R. Langer: 'Grenzüberschreitende Behandlungsleistungen — Reformbedarf für die Verordnung 1408/71?' [Cross-border provision of treatment — What reform for Regulation No 1408/71?], in *Neue Zeitschrift für Sozialrecht*, 11/1999, pp. 537 to 542, in particular pp. 537 to 539. The author differentiates between 'sogenannte reine Versicherungsmodelle' [so-called pure insurance models], in which category she includes the Luxembourg, Belgian and French systems, 'staatliche Gesundheitssysteme' [State health-care systems], in which category she includes the systems of the majority of the Member States, and 'sogenannten Mischsysteme' [so-called mixed systems], in which category she includes the German, Austrian and Netherlands systems.

45 — Case 263/86 *Belgian State* v *Humbel* [1988] ECR 5365, paragraphs 15 to 19.

educational fields, and, secondly, the system in question is, as a general rule, funded from the public purse and not by pupils or their parents.

In *Wirth*,[46] it held those findings to be equally applicable to courses provided in establishments of higher education financed largely from public funds. It emphasised, however, that, whilst most higher education establishments are financed in this way, some are nevertheless financed essentially out of private funds, in particular by students or their parents, and seek to be commercially profitable. When courses are given in such establishments, they become services within the meaning of Article 60 of the Treaty since they offer a service in return for remuneration.

48. The Court had occasion to express its views on the classification of social security institutions in the context of competition law in its judgment in *Poucet and Pistre*[47], where, after reiterating that, in that context, the concept of an undertaking encompasses every entity engaged in an economic activity, regardless of the legal status of the entity and the way in which it is financed,[48] it held that sickness insurance funds and the organisations involved in the management of the public social security system fulfil an exclusively social function, since that activity is based on the principle of national solidarity and is entirely non-profit-making, and the benefits paid are statutory benefits bearing no relation to the amount of the contributions.

49. In the light of the characteristics of the Netherlands compulsory sickness insurance scheme which I have described, I take the view that the health-care benefits in kind which it provides to insured persons lack the element of remuneration and are not therefore services within the meaning of Article 60 of the EC Treaty.

If those benefits do not constitute services, the answer to be given to the Arrondissementsrechtbank, Roermond, would have to be that Article 59 of the Treaty does not preclude the sickness funds of a Member State from requiring persons registered with them to seek authorisation in order to be able to receive health-care benefits from an institution with which they have not concluded an agreement, whether or not that institution is situated in that or another Member State.

46 — Case C-109/92 *S. M. Wirth* v *Landeshauptstadt Hannover* [1993] ECR I-6447, paragraphs 16 and 17.

47 — Case C-159/91 and C-160/91 *Poucet and Pistre* v *Assurances Générales* [1993] ECR I-637, paragraphs 17 and 18.

48 — Case C-41/90 *Höfner and Elser* v *Macrotron* [1991] ECR I-1979, paragraph 21.

50. None the less, in case the Court should not share my views, and considers that the benefits in question are services within the meaning of Article 60 of the Treaty, I shall now examine the restrictive effects which the requirement to obtain prior authorisation from the sickness fund may have on the freedom to provide services.

B. *The restrictive effects of the provisions of the compulsory sickness insurance scheme on freedom to provide services*

51. Does the fact that Article 9(4) of the ZFW, in conjunction with Article 1 of the regulation on health care abroad, makes the possibility of approaching a non-contracted medical practitioner or health-care institution situated abroad subject to prior authorisation from the insurer constitute a restriction on the freedom to provide services?

I shall take account in my reasoning of the doubts raised by the Arrondissementsrechtbank in Question 1(b) and (c), that is to say whether the criterion of what is regarded as 'normal in professional circles' has any bearing in deciding whether a particular health-care benefit is covered by the insurance scheme in question, whether it makes any difference that the same benefit is covered by a social security scheme in another Member State, and whether the criterion of the necessity of the treatment applies where the benefit is covered by the scheme but authorisation to go abroad in order to receive health care is denied because adequate care can be provided by a medical practitioner or health care institution in the Netherlands.

52. It is my view that, worded thus, the question must be answered in the affirmative. After all, in practice, the obligation to request and obtain such authorisation constitutes a restriction on the freedom to provide services, since it makes it more difficult and less attractive for insured persons to go to another Member State to receive health care.

53. The Court has held in that respect that, with a view to the achievement of a single market and in order to permit the attainment of its objectives, Article 59 of the Treaty precludes the application of any national legislation which has the effect of making the provision of services between Member States more difficult than the provision of services purely within one Member State. [49] Although the Netherlands legislation at issue does not deprive insured

49 — Case C-381/93 *Commission* v *France* [1994] ECR I-5145, paragraph 17, and *Kohll*, cited in footnote 11 above, paragraph 33.

persons of their entitlement to benefits in another Member State, it does require authorisation, which is subject to very restrictive conditions. It may therefore deter them from approaching providers of medical services established in another Member State and constitutes for them and their patients a barrier to the freedom to provide services. [50]

54. The question is whether or not that barrier is justified in the light of the Court's case-law.

C. *Whether the requirement of prior authorisation in order to claim entitlement to benefits in another Member State is justified*

55. The obligation to abolish restrictions on freedom to provide services was interpreted by the Court of Justice as prohibiting all discrimination against the person providing the service by reason of his nationality or the fact that he is established in a Member State other than that in which the service is to be provided. [51] The principle of equal treatment, of which Article 59 of the Treaty is a specific expression, prohibits not only overt discrimination by reason of nationality but also all covert forms of discrimination which, by the application of other criteria of differentiation, lead in fact to the same result. [52]

56. The Court of Justice has held in this regard that national rules which are not applicable to services without distinction as regards their origin and which are therefore discriminatory are compatible with Community law only if they can be brought within the scope of an express derogation. [53] Article 66 of the EC Treaty (now Article 55 EC) provides that Articles 55 to 58, which appear in the chapter on the right of establishment, are to apply to freedom to provide services. Article 56 lays down as exceptions to both those freedoms measures contained in provisions of national law prescribing special treatment for foreign nationals on grounds of public policy, public security and public health. Economic aims cannot constitute grounds

50 — *Luisi and Carbone* and *Bachmann*, cited in footnote 15 above, paragraphs 16 and 31 respectively, and *Kohll*, cited in footnote 11 above, paragraph 35.

51 — Case 33/74 *Van Binsbergen* v *Bestuur van de Bedrijfsvereniging voor de Metaalnijverheid* [1974] ECR 1299, paragraph 25. See also the judgments in Joined Cases 110/78 and 111/78 *Ministère Public* v *Van Wesemael and Others* [1979] ECR 35, paragraph 27, and *Webb*, cited in footnote 29 above, paragraph 14.

52 — Case C-3/88 *Commission* v *Italy* [1989] ECR 4035, paragraph 8, and Case C-360/89 *Commission* v *Italy* [1992] ECR I-3401, paragraph 11.

53 — *Bond van Adverteerders and Others* v *Netherlands*, cited in footnote 32 above, paragraph 32, and Case C-260/89 *ERT* v *Dimotiki* [1991] ECR I-2925, paragraph 24.

of public policy within the meaning of Article 56 of the Treaty. [54]

57. The wording of the order from the Arrondissementsrechtbank suggests to me that it regards the application of the criteria of what is 'normal in professional circles' and the 'necessity of the treatment' both by the Netherlands sickness funds, when processing applications for health care abroad, and by the case-law of the Centrale Raad van Beroep, as discriminatory by reason of the place where the provider of services is established.

58. The Commission, for its part, submits that the first criterion favours medical practitioners and health-care institutions established in the Netherlands in that it takes into account only national medical opinion. It is a neutral criterion which is applied to national and foreign providers of services without distinction but which, in practice, is prejudicial to those in other Member States. The second criterion, it contends, is applied differently depending on whether the non-contracted health-care provider to be consulted is situated in the Netherlands or abroad, since, under the national legislation, before a non-contracted institution abroad is used, a check must be made to see whether any non-contracted institution in the Netherlands can offer the care in question. For that reason, it constitutes technical discrimination by reason of the place of establishment.

In the Commission's view, the requirement of prior authorisation combines both those criteria but is characterised predominantly by the technical discrimination inherent in the second. It therefore proposes that the prior authorisation requirement should be regarded as a technically discriminatory measure which can be justified only as a derogation under Article 56 of the EC Treaty, namely on grounds of public policy, public security or public health.

59. I do not agree with that assessment. The criterion of what is 'normal in professional circles', which is determined on objective medical grounds and without regard to the place where the treatment is provided, is used to decide which benefits are covered by the compulsory sickness insurance scheme. Although that decision is taken with reference only to national medical opinion, the impact of foreign expertise, as imparted through the contributions to medical science made by specialists from other States at international conferences and in specialist literature, must not be underestimated.

Furthermore, in deciding which benefits are to be covered by the sickness insurance

54 — *Bond van Adverteerders and Others* v *Netherlands*, cited in footnote 32 above, paragraph 34.

scheme, regard is had not only to what is technically possible in medicine, but also to what is financially viable. Accordingly, the benefits covered, what they include and the treatments available for certain conditions differ considerably from one Member State to another, as the two cases pending before the Arrondissementsrechtbank have shown. [55] The decentralisation of national social security institutions which previously operated at national level also leads to variations dictated by the funds available to one regional body as compared with another. [56] For those reasons, a particular treatment which is not covered by a sickness insurance scheme cannot become one of the benefits available under it simply because someone has managed to obtain it from a non-contracted provider, whether locally or abroad. [57]

60. The Court has held that Community law does not detract from the powers of the Member States to organise their social security systems, [58] and that, in the absence of harmonisation at Community level, it is for the legislation of each Member State to determine, first, the conditions governing the right or duty to be insured with a social security scheme [59] and, second, the conditions for entitlement to benefits, [60] provided that there is no discrimination in that regard between nationals of the host State and nationals of the other Member States. [61]

I consider that the criterion of what is 'normal in professional circles' used by sickness funds in deciding which benefits are covered by compulsory sickness insurance is not discriminatory, since it does not mean that only benefits available in the Netherlands are included, and it is not prejudicial, either to a greater extent or in all cases, to providers of services established in other Member States. In any event, Community law as it stands at present cannot oblige a Member State to include in the cover provided by a compul-

55 — As an example of such differences, I can cite the Spanish general social security scheme, under which health care in the fields of stomatology and odontology does not include the cost of or procedure for fillings (except for persons under the age of fourteen), endodontics, dental prostheses, osteo-integrated implants and orthodontics.

56 — In Spain, for example, it appears that the Servicio Andaluz de Salud [Andalucian Health Service] was the first public-health institution to include sex changes among its benefits.

57 — To give an example of such differences in cover, Miss Kohll could have obtained her orthodontic treatment from a private specialist in Spain and claimed reimbursement in Luxembourg, but a person insured under the Spanish social security scheme cannot obtain such treatment anywhere without bearing the full cost himself.

58 — *Duphar and Others* and *Sodemare and Others*, cited in footnote 30 above, paragraphs 16 and 27 respectively.

59 — Case 110/79 *Coonan* v *Insurance Officer* [1980] ECR 1445, paragraph 12, Case C-349/98 *Paraschi* [1991] ECR I-4501, paragraph 15, and *Kohll*, cited in footnote 11 above, paragraph 17.

60 — Joined Cases C-4/95 and C-5/95 *Stöber* and *Piosa Pereira* v *Bundesanstalt für Arbeit* [1997] ECR I-511, paragraph 36, and *Kohll*, cited in footnote 11 above, paragraph 18.

61 — *Coonan*, cited in footnote 59 above, paragraph 12, Case 368/87 *Hartman Troiani* v *Landesversicherungsanstalt Rheinprovinz* [1989] ECR 1333, paragraph 21, Case C-245/88 *Daalmeyer* [1991] ECR I-555, paragraph 15, Case C-297/92 INPS v *Baglieri* [1993] ECR I-5211, paragraph 13, and Case C-340/94 *De Jaeck* v *Staatssecretaris van Financiën* [1997] ECR I-461, paragraph 36.

sory sickness insurance scheme all the benefits and treatments covered by the sickness insurance schemes of the other Member States.

For the same reasons, I consider it irrelevant for present purposes that a benefit is covered by the sickness insurance scheme in one Member State but excluded from cover in another.

61. As regards the criterion of 'the necessity of the treatment' for the insured person, I do not infer from Article 9(4) of the ZFW, read in conjunction with Article 1 of the regulation on medical care abroad under the compulsory sickness insurance scheme, as the Commission does, that it is applied differently depending on whether a course of treatment regarded as a benefit is to be followed in a non-contracted establishment in the Netherlands or abroad. In both cases, the sole condition is that such treatment be authorised by the sickness fund.

It should be emphasised, however, that the national court's uncertainty concerns a different situation, namely that of an insured person who is not authorised to go abroad for treatment regarded as a benefit because there is a contracted medical practitioner capable of administering that treatment in time in the Netherlands. That uncertainty will cease to apply if the Court finds that health care under the compulsory sickness insurance scheme in the Netherlands does not constitute a service within the meaning of Article 60 of the Treaty. However, in case it should find otherwise, I shall address this question in the context of my thoughts on the justification for the requirement of prior authorisation.

62. As I see it, in requiring that an insured person obtain authorisation from his fund, the Netherlands legislation on compulsory sickness insurance does not discriminate between recipients of services on grounds of nationality, since it applies to all persons wishing to go to another Member State; furthermore, in differentiating only between contracted and non-contracted providers, regardless of whether they are established in the Netherlands or abroad, it does not discriminate between insured persons by reason of the origin of the benefit either. [62]

62 — This situation is clearly different from that in Case C-353/89 *Commission* v *Netherlands* [1991] ECR I-4069, where the Court held that it was not necessary for all undertakings in a Member State to be placed at an advantage in comparison with foreign undertakings, it being sufficient that the preferential system set up should benefit a national provider of services. In that case, the Commission criticised the Netherlands for requiring national broadcasters established in its territory to entrust the making of all or part of its programmes to a Netherlands undertaking.

63. The national court seems unconvinced that there is no discrimination inasmuch as it finds that the agreements in question are largely concluded with institutions established in the Netherlands.

It should be added that, in the light of Council Directive 93/16/EEC of 5 April 1993 to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications, [63] and of the fact that the Netherlands Government states in paragraph 56 of its written observations that a health-care institution authorised to operate in another Member State is automatically authorised to enter into an agreement with sickness funds in the Netherlands, there appears to be no statutory bar precluding funds from concluding such agreements with medical practitioners and health-care institutions in other Member States. The fact that, for reasons of common sense and in order to make it easier for persons registered with them to receive care when they are ill, sickness funds seek to conclude such agreements with providers whose facilities are closest at hand is a separate issue. Indeed, the conclusion of agreements with medical practitioners and health-care institutions situated in regions of Belgium and Germany bordering on the Netherlands has been prompted by that very concern, without causing any major linguistic problems.

64. To resume my examination of the authorisation requirement, in relation to which the rules do not formally draw any distinction regarding medical practitioners from other Member States, I should point out that, according to the Court, Article 59 requires not only the elimination of all discrimination against a person providing services on the ground of his nationality but also the abolition of any restriction, even if it applies without distinction to nationals providing services and to those of other Member States, when it is liable to prohibit or otherwise impede the activities of a provider of services established in another Member State where he lawfully provides similar services. [64]

65. The Court thus considers that freedom to provide services, as one of the fundamental principles of the Treaty, may be restricted only by provisions which:

(1) are justified by overriding reasons relating to the general interest and are applied to all persons or undertakings pursuing those activities in the territory of the State in question, in so far as that interest is not safeguarded by the provisions to which the Community national is subject in the Member State where he is established;

63 — OJ 1993 L 165, p. 1.

64 — Case C-76/90 *Säger* v *Dennemeyer* [1991] ECR I-4221, paragraph 12, and Case C-398/95 *SETTG* v *Ypourgos Ergasias* [1997] ECR I-3091, paragraph 16.

(2) are necessary to ensure that the objective they pursue is attained; and

(3) do not go beyond what is necessary to attain that objective. [65]

66. The Arrondissementsrechtbank wishes to ascertain whether the overriding reasons in the general interest relied on by the defendant institutions are sufficient to justify the barrier to freedom to provide services.

67. Over the years, the Court has developed case-law relating specifically to overriding reasons in the general interest. I can state, by way of examples which are not intended to be exhaustive, that it has recognised as such: the protection of intellectual property; [66] the need to protect recipients of services, which may justify providers of services being subject to the professional rules of conduct of the host Member State; [67] the social protection of workers; [68] consumer protection; [69] fair trading; [70] a cultural policy consisting in the maintenance of a national radio and television system which secures pluralism; [71] safeguarding the sound administration of justice; [72] safeguarding the cohesion of a tax system; [73] maintaining the good reputation of the national financial sector; [74] conservation of the national historical and artistic heritage; [75] proper appreciation of a country's archaeological, historical and artistic assets and the widest possible dissemination of knowledge of the artistic and cultural heritage of a country; [76] and the risk of serious impairment of the financial equilibrium of the social security system. [77]

65 — Case 205/84 *Commission* v *Italy* [1986] ECR 3755, paragraph 27, Case C-180/89 *Commission* v *Italy* [1991] ECR I-709, paragraphs 17 and 18, and Case C-106/91 *Ramrath* v *Ministre de la Justice* [1992] ECR I-3351, paragraphs 29 to 31.

66 — Case 62/79 *Coditel* v *Ciné Vog* [1980] ECR 881, paragraph 18.

67 — *Van Wesemael*, cited in footnote 51 above, paragraph 28.

68 — *Webb*, cited in footnote 29 above, Joined Cases 62/81 and 63/81 *Seco* v *EVI* [1982] ECR 223, paragraph 14, Case C-113/89 *Rush Portuguesa* v *Office National d'Immigration* [1990] ECR I-1417, paragraph 18, Case C-43/93 *Van der Elst* v *Office des Migrations Internationales* [1994] ECR I-3803, paragraph 23, and Case C-272/94 *Guiot* [1996] ECR I-1905, paragraph 16.

69 — Case 220/83 *Commission* v *France* [1986] ECR 3663, paragraph 20, Case 252/83 *Commission* v *Denmark* [1986] ECR 3713, paragraph 20, *Commission* v *Germany*, cited in footnote 65 above, paragraph 30, Case 206/84 *Commission* v *Ireland* [1986] ECR 3817, paragraph 20, Case C-198/89 *Commission* v *Greece* [1991] ECR I-727, paragraph 21, and Case C-222/95 *Parodi* [1997] ECR I-3899, paragraph 32.

70 — Joined Cases C-34/95, C-35/95 and C-36/95 *Konsumentombudsmannen De Agostini Forlog AB and TV-Shop* v *Banque H. Albert de Bary* [1997] ECR I-3843, paragraph 53.

71 — Case C-288/89 *Collectieve Antennevoorziening Gouda* [1991] ECR I-4007, paragraphs 23 and 25, Case C-353/89 *Commission* v *Netherlands* [1991] ECR I-4069, paragraph 30, and Case C-148/91 *Vereniging Veronica* v *Commissariaat voor de Media* [1993] ECR I-487, paragraph 15.

72 — Case C-3/95 *Reisebüro Broede* v *Sandker* [1996] ECR I-6511, paragraph 36.

73 — Case C-300/90 *Commission* v *Belgium* [1992] ECR I-305, paragraph 21, *Bachmann*, cited in footnote 15 above, paragraph 28, and Case C-484/93 *Svensson and Gustavsson* v *Ministre du Logement et de L'Urbanisme* [1995] ECR I-3955, paragraph 16.

74 — Case C-384/93 *Alpine Investments* [1995] ECR I-1141, paragraph 44.

75 — Case C-180/89 *Commission* v *France* [1991] ECR I-659, paragraph 17, and Case C-198/89 *Commission* v *Greece* [1991] ECR I-727, paragraph 21.

76 — Case C-154/89 *Commission* v *France* [1991] ECR I-659, paragraph 17, and Case C-198/89 *Commission* v *Greece* [1991] ECR I-727, paragraph 21.

77 — *Kohll*, cited in footnote 11 above, paragraph 41.

68. The overriding reasons in the general interest relied on by the defendant institutions are, in summary, as follows:

— maintaining the infrastructure and the financial equilibrium of the system of agreements in such a way as to keep the costs, volume and quality of care under control;

— making health care accessible to everyone;

— ensuring an adequate number of doctors, facilities and hospital beds by striking a balance which avoids both waiting lists (which result in a restriction on access to health care) and the wasting of financial resources (which are very limited in the health sector), the achievement of which requires the regulation of access to hospitals;

— limiting the number of patients who go abroad for treatment and to avoid a large influx of foreign patients, on account of the disruption this would create in the use of hospital facilities.

The Member States which have intervened in these proceedings cite, as overriding reasons in the general interest justifying maintenance of the authorisation requirement, in addition to those already referred to, the need for insurance funds to be able to control costs; respect for the power of each State to establish health-care priorities on the basis of the resources available to it and the needs of its population; and respect for the principle of equality among insured persons, a breach of which would be detrimental to more disadvantaged patients, for whom travel to another Member State would inevitably involve cost concerns.

69. All the foregoing reasons can be reduced to three, namely, maintaining the financial equilibrium of the compulsory sickness insurance scheme, providing a balanced medical and hospital service open to everyone without distinction, and ensuring the availability of the requisite health care and medical skills within national territory.

70. Those three reasons have already been examined by the Court in *Kohll*, where it held that the risk of seriously undermining the financial balance of the social security system may constitute an overriding reason in the general interest capable of justifying the requirement that an insured person obtain authorisation to receive care abroad. [78] As regards the need to provide a balanced medical and hospital service

78 — Cited in footnote 11 above, paragraph 41.

open to all insured persons without distinction, and the purpose of ensuring an adequate treatment facilities and medical service on national territory, the Court held that they could be linked to the derogations on grounds of public health under Article 56 of the Treaty, which permit Member States to restrict the freedom to provide medical and hospital services. [79]

71. What is in dispute is not, therefore, whether those three reasons are valid justifications for a barrier to freedom to provide services such as the authorisation requirement at issue, where, as in this case, it is applied without distinction to national providers and to providers established abroad, but whether that requirement is necessary in order to ensure that the objectives it pursues are attained and whether it complies with the principle of proportionality.

72. I shall attempt to dispel those doubts. Under schemes such as that in this case, which provide insured persons with benefits in kind, the sickness funds manage their budget by concluding with medical practitioners and health-care institutions agreements which lay down the benefits contracted for, the services that will be available and the financial contribution which the funds undertake to make. Provision is thus made in advance for the financing of all the health care insured persons may need in the course of a year, whether as outpatients or in hospital, in order to ensure that the funds do not in principle have to bear any additional expenditure.

It is my view that, in those circumstances, the requirement of authorisation constitutes not only a necessary and proportionate means of attaining the objective of maintaining the financial equilibrium of the system, but also the only means available to sickness funds for controlling payments to a non-contracted provider for health care which they have already paid the contracted providers to dispense, since this represents an additional financial burden. It seems clear to me that, under a social security system where health-care resources, practitioners and institutions are pre-established, sickness funds must be able to expect that, barring rare exceptions subject to their consent, any health care which insured persons require will actually be provided by the practitioners and institutions contracted, regardless of whether they are situated on national territory or abroad.

79 — Ibid., paragraphs 50 and 51.

73. I should like to add that, under a system of benefits in kind such as that at issue, the distinction drawn by Advocate General Tesauro in point 59 of his Opinion in *Decker*[80] and *Kohll*[81] between benefits provided by independent practitioners and those provided in hospitals, does not apply. As I see it, the use by insured persons of non-contracted providers represents an additional financial burden for the fund in every case. I therefore consider that the requirement of prior authorisation is justified.

74. I believe that both the objective of providing a balanced medical and hospital service open to everyone and the objective of maintaining essential treatment facilities and medical service on national territory, apart from being intrinsically linked to the method of financing the system, can be brought within the ambit of the public health grounds which, under Article 56, are capable of justifying a restriction on freedom to provide services, as the Court held in paragraphs 50 and 51 of its judgment in *Kohll*. In contrast to *Kohll*,[82] however, in the present case it has been demonstrated that, because of the structure of the Netherlands compulsory sickness insurance scheme, which is based on prior comprehensive agreements with medical practitioners and health-care institutions regarding technical resources, hospital facilities and manpower, the authorisation requirement is justified for the purpose of ensuring that funds are alerted to any additional health-care needs that arise, so that the imbalances detected can be corrected.

75. The foregoing considerations support the inference that a sickness fund can legitimately deny an insured person authorisation to receive non-contracted health care abroad, on the ground that the care necessary can be afforded to him by a practitioner or an institution on national territory with whom or which it has entered into an agreement.

D. *The application of Article 22 of Regulation No 1408/71*

76. Despite the fact that the national court has not raised the matter of the interpretation of Article 22(1)(c)(i) and the second paragraph of Article 22(2) of Regulation No 1408/71, it nonetheless merits a few lines. As will be recalled, that provision confers on a worker insured in one Member State who is authorised by the competent institution to go to another Member State to receive health care the right to enjoy the

80 — Cited in footnote 10 above.
81 — Cited in footnote 11 above.
82 — *Ibidem*

benefits he requires at the expense of the competent institution, in accordance with the provisions of the legislation of the State in which the benefits are provided. Authorisation may not be denied where the treatment is among the benefits provided for by the legislation of the Member State on whose territory the person concerned resides and where he cannot be given such treatment in that State within the time normally necessary because of his current state of health and the probable course of the disease.

77. The provision regulates the specific case of an insured person who goes to another Member State to receive, in accordance with the legislation of that State, treatment paid for by the competent institution. This situation is clearly different from that at issue in *Kohll*, where the insured person received treatment in another Member State but was reimbursed by the competent institution only at the rate applied in the State of insurance.

78. The conditions which sickness funds in the Netherlands lay down for granting authorisation for treatment by a non-contracted medical practitioner or hospital, namely that the treatment should be regarded as a benefit covered by compulsory sickness insurance, and that it should be impossible for the treatment required by the patient's state of health to be given to him within a reasonable period under the agreement, are the same as those contained in Article 22 of Regulation No 1408/72 for authorising treatment abroad. I also note that under the proposal which the Commission submitted to the Council with a view to simplifying Regulation No 1408/71 [83], Article 22 would become Article 18 and the present negative wording 'the authorisation may not be refused' would be replaced by the more positive formula 'the authorisation shall be granted', although the existing conditions, namely that the treatment should be a benefit covered by insurance and should be urgently required, would be maintained. [84]

79. In my opinion, that provision is still valid and should be applied [85] in parallel

83 — Proposal for a Council Regulation (EC) on coordination of social security systems — COM/98/0779 final (OJ 1999 C 38, p. 10).

84 — The proposed text is as follows: 'Authorisation to receive appropriate treatment outside the competent State. A person who is authorised by the competent institution to go to the territory of another Member State to receive there the treatment appropriate to his condition shall receive the benefits in kind provided, on behalf of the competent institution, by the institution of the place of stay, in accordance with the provisions of the legislation it administers, as though he were insured pursuant to the said legislation. The authorisation must be accorded where the treatment in question is among the benefits provided for by the legislation of the competent State in whose territory the person involved resides and if he cannot, taking account of his current state of health and the probable course of the illness, be given such treatment within the necessary time.'

85 — See, in the same connection, R. Cornelissen: 'The principle of territoriality and the Community regulations on social security (Regulations 1408/71 and 574/72)', *Common Market Law Review*, 1996, 33, pp. 439 to 471, in particular pp. 465 and 466.

with the rules laid down by the Court in its judgments in *Decker*[86] and *Kohll*[87] in relation to a social security scheme such as that in Luxembourg, which cannot be transposed to all the other schemes operated in the Member States because of their inherent diversity.

I should like to add in this respect that I find it regrettable that the competent institutions of the Member States apply that provision so restrictively and grant so few authorisations each year, when it could, under their control, provide an invaluable means of reducing the long waiting lists with which patients in some Member States have to contend. Patients could thus obtain health care in another Member State by invoking Article 22 of Regulation No 1408/71, or by relying directly on *Decker* and *Kohll*, without having to run the risk, on return to their State of residence, of being denied reimbursement.[88]

80. The practice of 'clinico-social tourism', whereby patients, usually of sound financial means, seek better medical treatment abroad, is an age-old phenomenon which pre-dates the creation of the European Union. In 1911, the German writer Thomas Mann and his wife, who was ill, booked themselves into a sanatorium in Davos, Switzerland. Contact with the patients who had come from all over the world to find a cure in this remote mountain-top establishment provided the inspiration for his masterpiece 'Der Zauberberg' (The Magic Mountain) (1924), which centres around the fraught search for ideal health care.[89] This 'clinico-social tourism' is a further reason why the competent institutions should be more flexible when authorising persons insured with them to go to another Member State for treatment, in such a way that the principle of equal treatment for insured persons as regards access to the highest possible level of medical care can be maintained without the financial equilibrium of the respective systems being jeopardised.[90]

86 — Cited in footnote 10 above.

87 — Cited in footnote 11 above.

88 — A. P. van der Mei, op. cit., pp. 286 and 287, states in this regard: 'in all other cases authorisation may be refused. The Regulation thus leaves it largely to the Member States to decide whether or not authorisation is given and, in practice, authorisation is indeed usually refused. National laws and regulations limit the number of circumstances in which the health (insurance) institutions may grant authorisation, and within these limits the relevant institutions appear to follow rather strict authorisation policies'.

89 — Es waren da Liegehallendamen verschiedener Nationalität untermischt mit (...) einem bebrillten jungen Holländer mit rosigem Gesicht und monomanischer Leidenschaft für den Briefmarkentausch; verschiedenen Griechen, pomadisiert (...) Der Bucklige Mexikaner, dem Nichtkenntnis der hier vertretenen Sprachen den Gesichtsausdruck eines Tauben verlieh (...). T. Mann: Der Zauberberg, S. Fischer Verlag GmbH 1974, p. 324. ('New figures turned up on the terrace: ladies of various nationalities from the general rest-halls [...] monocled youths of seventeen, a spectacled, rosy-faced young Dutchman with a mania for collecting postage stamps; certain Greeks, with pomaded hair [...] the hump-backed Mexican, whose ignorance of any language save his own lent him the facial expression of a deaf person [...]' T. Mann: 'The Magic Mountain', Vintage (Random House), London 1999, p. 232, translated from the German by H. T. Lowe-Porter.)

90 — According to J. Le Grand: 'La asistencia sanitaria y la construcción del mercado único: perspectiva y problemática' [Health care and construction of the single market: outlook and problems], *Mercado único europeo y seguridad social*, Madrid, 1993, pp. 332 and 333, social tourism can prompt States which are losing patients to other health systems to improve their own medical services. He points out, however, that whether or not this will happen in practice will depend on the system of remuneration for medical services: if it is based on fees for the services provided, the incentive will be to treat as many patients as possible; if remuneration depends on the number of persons health systems have on their lists, the incentive will be to keep relatively healthy patients on those lists and to send patients requiring expensive treatments to social security systems in other countries; if, finally, remuneration takes the form of a salary, the incentive will be to try to have the least number of patients possible. In his opinion, the latter two situations may give rise to social tourism prompted by the service providers, who will seek to persuade their patients to look elsewhere, including in other Member States, to receive treatment.

IX. Conclusion

81. In view of the foregoing, I propose that the Court's reply to the questions referred to it by the Arrondissementsrechtbank, Roermond (Netherlands), should be as follows:

(1) The health-care benefits in kind which a compulsory sickness insurance scheme such as that in the Netherlands grants to the persons insured with it do not incorporate any remunerative element and do not therefore constitute services within the meaning of Article 60 of the EC Treaty (now Article 50 EC). Accordingly, Articles 59 (now, after amendment, Article 49 EC) and 60 of the Treaty do not preclude sickness funds from requiring persons registered with them to seek authorisation in order to be able to receive benefits from a practitioner or an institution with whom or which they have not entered into a health-care agreement.

(2) If, on the other hand, the proposition is accepted that such benefits are services within the meaning of Article 60 of the Treaty, the requirement of authorisation would, in practice, constitute a barrier to freedom to provide services, but would have to be regarded as a necessary and proportionate means of maintaining the financial equilibrium of the system in order to provide a balanced medical and hospital service open to everyone, and to ensure the availability of the necessary treatment facilities and medical service within national territory.