The National Judiciary – Sword of or Shield from ECJ Rulings?
The Instructive Example of the Kohll/Decker Jurisprudence

by
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Abstract: The role of the national judiciary in enforcing EC law in general and ECJ rulings in particular has been largely neglected by empirical legal and political science research. Existing research has categorized the role of the national judiciary as either shielding national legislation from the ECJ or as serving as a ‘sword’ to foster integration and to force change on reluctant governments. This paper sides with the second assumption and tries to empirically assess it using the example of the patient mobility jurisprudence by the ECJ, the so-called Kohll/Decker jurisprudence. The three case studies on France, the UK and Germany show that national courts played an important role in overcoming the resistance against this jurisprudence through forcing the legislator to end judicial uncertainty with a multiplication of national court cases that contradicted domestic legislation.

I Introduction

The role of the national judiciary in enforcing European Community (EC) law in general and European Court of Justice (ECJ) rulings in particular has been largely neglected by empirical legal and political science research. Existing research has categorized the role of the national judiciary as either shielding national legislation from the ECJ primarily by withholding references or as serving as its ‘sword’ to foster integration and to force change on reluctant governments. These contradicting views, however, have not been assessed empirically to a satisfying degree. Partly, this reluctance stems from the methodological difficulties to find a direct link between national court cases and the (legal) implementation of ECJ cases. The example of the ECJ patient mobility jurisprudence provides an instructive opportunity to assess the role of the national judiciary. First, Member States fiercely rejected the implementation of this jurisprudence. Finally, a number of Member States conceded and implemented the rulings. National court cases played an important role in this shift.

The Kohll and Decker rulings challenged Article 22 – health care entitlements abroad – of one of the oldest EEC regulations, Regulation 1408/71 on the application of social security schemes to employed persons and their families moving within the Community. Also, the ECJ applied the passive free movement of services, i.e. the freedom to receive a service, and the free movement of goods to patients moving within the Community and thus provoked a totally new challenge for the Member States. Although the legal profession anticipated Kohll and Decker for many years, these rulings were considered an ‘explosive issue’ (Gobrecht 1999: 17). Kohll and Decker were so important that according to an anecdote from the German Ministry of Health, the very day of the pronouncement of the rulings a high ranking official drove to Luxembourg by car in the middle of the night to come into possession of the written version of the rulings which was only available in English at the time. In the following weeks, months, and years, these ECJ decisions were intensely discussed and contested in the political and academic arenas, as well as in the media. A huge amount of articles and books was written on Kohll and Decker and their potential impact (e.g. Eichenhofer 1999; Jorens 2004; Leibfried 2005; Sieveking 2007). In some accounts, the possible destruction of the domestic social security systems was evoked (Ferrera 2003), while others reacted much more reserved (Becker 1998). However, Kohll and Decker were only the beginning, forthcoming rulings fine-tuned these cases, i.e. extended and limited their

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1 The argument of this paper is one part of my doctoral thesis at the Graduate School of Social Sciences, University of Bremen. I have submitted the doctoral thesis in July, I have received the scientific opinions in September, and I will defend the doctoral thesis November 2007.


scope simultaneously. The so-called Kohll/Decker jurisprudence that has emerged comprises a dozen of rulings which were delivered between 1998 and the present. The consequences of this jurisprudence for the principle of territoriarity enshrined in the national social security systems were deemed to be of high importance. In addition, the financial and structural costs of the implementation of the Kohll/Decker jurisprudence were considered to be extremely high. Therefore, this stream of cases was contested by most of the EU Member States, its impact on the individual social security systems was denied and implementation refused. Despite this fierce resistance by governments/administrations and the majority of health care actors, the ECJ jurisprudence was fully incorporated into domestic legislation in France and Germany and partially in the UK. Why could the opposition against the Kohll/Decker jurisprudence be overcome? What, if any, role did national court cases play in the implementation processes?

The role of national court cases in the legal transposition of EC law has been neglected because it is considered extremely difficult to link specific court rulings to national implementation processes. Through careful process-tracing (see e.g. George/Bennett 2005) I will be able to attribute a specific policy response to a specific ruling. I paid special attention to the time sequencing of national changes and was thus able to separate the impact of court rulings from other possible factors. I gathered and analysed an amplitude of documents at the national level: rulings by national courts, legal texts dealing with legislative or administrative changes as a response to ECJ and national court cases, legal text drafts, ministerial circulars, parliamentary debates, newspaper articles, press releases, documents from the domestic insurance funds, and documents from other concerned actors. Having analysed these various documents I then tried to evaluate my findings with the help of 25 problem-centred expert interviews. On the one hand, I conducted interviews with actors on the supranational level: members of the legal staff of the DG Internal Market who were engaged in monitoring and promoting the implementation of EU Member States, staff members of the DG Employment, Social Affairs and Equal Opportunities who were monitoring the correct implementation of Regulation 1408/71, staff members of the DG Health and Consumer Protection who were keeping a watch on health being incorporated into all Community policies, and members of European interest groups, such as the Association Internationale de la Mutualité and the European Social Insurance Platform. On the other hand, more importantly, on the Member State level, in Germany, France, and the UK, I interviewed ministerial officials who were concerned with the implementation of ECJ rulings, officials of compulsory health insurance funds who were dealing with European law, and independent academic experts who followed the respective internal and European processes.

The paper proceeds in the following way: Using the example of the Kohll/Decker jurisprudence I will first elaborate the different conceptualisations of the role of the national judiciary. Then, I will assess the explanatory value of national court rulings to explain the implementation of the Kohll/Decker jurisprudence in France, Germany and the UK. Hereby, I will also consider alternative explanations: Thus, I will be able to determine whether and to what extent national court rulings were decisive in incorporating the principles elaborated in the selected rulings into the social security legislation of the three EU Member States. Finally, I will conclude my paper with a short summary of the role of the national judiciary in implementing the Kohll/Decker jurisprudence and a short discussion of the further implications of my results.
II National Judicial Systems

Tanja Börzel and Thomas Risse noticed that the sheer willingness of national courts to engage in a legal discourse on a given subject does not necessarily lead to compliance (2002: 164). However, in alliance with the ECJ the national judicial branch is considered to be a crucial element for explaining the implementation of ECJ jurisprudence. Links between the ECJ and national courts seem to be a key mechanism in fostering compliance. Joseph Weiler, Karen Alter and others developed distinctive branches of this basic explanation. They explored the motives of national courts for engaging in such linkages, found cross-national variation and variation among different types and levels of courts in one country.

According to Weiler, the national judicial branch is the most interesting and consequential interlocutor of the ECJ (1994b: 518). The national judiciary has been a two-fold partner of the Court of Justice: First, it accepted, by and by, the so called constitutionalisation of the legal and political order of the European Community – the structural key doctrines of direct effect, supremacy, pre-emption, implied powers, state liability and so forth (see Weiler 1991; Lenaerts 1992; Slaughter/Stone Sweet/Weiler 1998; Weiler 1999). Weiler observed in 1994 that, ‘in all member states, in practically all matters likely to be the subject of litigation, which judges must uphold, and that, within the field of application of Community law, in cases of conflict between a Community norm and a member state norm, the former not the latter, must be applied’ (1994b: 518). Weiler also looked beyond the doctrinal content of the ECJ jurisprudence and found that, second, the national judiciary got increasingly involved in ‘administering’ the law of the European Community (1994a: 135). The interpretative claims made by the ECJ exerted a considerable ‘compliance pull’ on the Member States. More precisely, the piecemeal acceptance of the ECJ doctrines of direct effect and supremacy was willingly transformed by the national courts into procedural and social reality (Weiler 1994b: 512-518). National courts have become ‘the principle vehicle for imposition of judicially driven Community discipline’ (Weiler 1994a: 135-136). According to Weiler, the compliance and enforcement mechanisms in the relationship between the ECJ and the national judicial branch work as follows:

‘When a national court seeks the Reference it is, with few exceptions, acknowledging that, at least at face value, Community norms are necessary and govern the dispute. This very issue may be of huge political significance and the subject of controversy among governments or between the Member States as a whole and, say, the Commission. But, the very fact that ‘their own’ national courts make a Preliminary Reference to the European Court of Justice, forces governments to ‘juridify’ their argument and shift to the judicial arena in which the Court of Justice is pre-eminent (so long as it can carry with it the national judiciary). When a national court accepts the ruling, the compliance pull of Community law becomes formidable. When European Community law is spoken through the mouths of the national judiciary it will also have the teeth that can be found in such a mouth and will usually enjoy whatever enforcement value that national law will have on that occasion’ (ibid: 136).

Karen Alter (1998) also took the view that the legal doctrines of EC law supremacy and direct effect were essential to the increasing political power of the ECJ. The support by national courts was critical, made ECJ rulings enforceable, emboldened the ECJ, and made the political threat of non-compliance fade. According to her, the real ‘linchpins’ of the EU legal system were the national courts, whereas the ECJ’s docket with the Commission and the Member States stayed rather empty (Alter 1998: 227).
Jonathan Golub (1996) revised the ‘traditional model’ of judicial cooperation. National judges may use preliminary references as a ‘sword’ to foster integration or to force policy change on a reluctant national government. Or, by withholding references ‘strategically’, they may shield national policy from ECJ interference. Golub concluded from empirical evidence for Great Britain – especially for environmental policy – that there are domestic political factors, such as a prevailing political climate of Euro-pessimism, which create strong disincentives for national judges to make preliminary references (1996: 377-381).

Lisa Conant (2003) postulated that the ‘overwhelming’ majority of national court rulings on European law take place outside the preliminary reference structure. She claimed that ‘(n)ational courts are most often applying European law (…) without any formal interaction with the ECJ’ (2003: 81). However, Conant held that ‘(e)vidence on national judicial behavior suggests that opportunities to generate pressure [on administration, AJO] through persistent litigation remain limited’ (ibid: 74). According to her, EC law is generally applied case by case without causing major changes in legislation or policy (ibid: 80).

All four authors generally agree that the application of EC law by national courts can in principle lead to its legal implementation. Indeed, the behaviour of national courts as a bridge between the EU and the citizens of the Member States is a central variable in explaining the implementation of ECJ rulings. National courts refer preliminary cases to the Court of Justice. The ensuing rulings have to be accepted by the national courts to solve the case at hand. If the national courts do not refer cases to the ECJ, the latter cannot develop its dogmatic principles. If the national courts do not accept the ECJ doctrines and do not apply them in a proper way, implementation cannot take place. But if national courts refer cases and apply the ECJ rulings, other domestic actors, such as the administration and the legislator, may – with a multiplication of cases and increasing judicial uncertainty – be forced to consider implementing the rulings.

What role did the national courts play regarding the Kohll/Decker jurisprudence in the three Member States France, the UK and Germany, and beyond? Were they able to influence the implementation of the ECJ decisions? And, if yes, to what extent? My working hypothesis here is the following:

If national courts in an EU Member State accept and apply the doctrines elaborated by the ECJ, the implementation of the rulings will take place quicker and smoother than in Member States where court activism is absent.

III ECJ Jurisprudence on Patient Mobility

Now, I will briefly examine the series of important cases about the exportability of health care benefits that will be used to answer the posited hypothesis. This line of rulings started with Kohll and Decker in 1998 and was followed chronologically by Vanbraekel and Geraets-Smits/Peerbooms in 2001, Müller-Fauré/van Riet and Inizan in 2003, Leichtle in 2004, Keller in 2005, and most recently Watts and Acereda Herrera in 2006. These rulings taken together will be referred to in short as the ‘Kohll/Decker jurisprudence’.

Kohll and Decker had been expected for a long time and redrew the borders between national and European social security law. In Kohll, a Luxembourg citizen was refused authorization by his Luxembourg health insurance for an orthodontist out-patient treatment in Germany for his daughter. His request was rejected because the treatment was not deemed urgent and could have been carried out in Luxembourg. In Decker, Nicolas Decker was refused
reimbursement by his Luxembourg health insurance for a pair of spectacles he had bought in Belgium using a prescription from a Luxembourg ophthalmologist. The justification here was that Decker had not sought prior authorization as demanded by the Health Insurance Code of Luxembourg at that time. In its Kohll ruling, the Court of Justice observed, first, that, ‘according to settled case-law, Community law does not detract from the powers of the Member States to organise their social security systems’ (para. 17). At the same time EU Member States ‘must nevertheless comply with Community law when exercising those powers’ (ibid: para. 19). Second, the ECJ determined that a prior authorization procedure for out-patient care, as in Luxembourg, violated the (passive) free movement of services Articles 49 (ex-59) and 50 (ex-60) EC, and were neither justified by the control of health expenditures nor by the balancing of the budget of the social security systems (ibid: paras 35, 37, 42). In its preliminary Decker ruling, the Court of Justice held that requiring prior authorization for the purchase of medical products violated the free movement of goods guaranteed in Articles 28 and 30 EC Treaty (para. 36).

Kohll and Decker created a second avenue of cross-border care in addition to Regulation 1408/71 (see Jorens 2002: 110): patients could now seek medical treatment in another EU Member State without depending on the discretion of their domestic insurance institutions. These two cases were only a first step. They threw up more questions than they could answer and led to considerable administrative, political and legal uncertainty. The two rulings aimed at Luxembourg’s health insurance that provides health care through cash reimbursement. The consequences of Kohll and Decker for similar systems were quite clear. The ones for health insurance systems based on delivering in-kind benefits and for national health care systems, and for other types of benefits, mainly in-patient care, were unclear. The legal uncertainty created by Kohll and Decker was (partly) relieved in subsequent rulings.

Vanbraekel4 and Geraets-Smits/Peerbooms5 brought the first nuances to Kohll and Decker. Vanbraekel added two elements: First, Articles 49 and 50 EC precluded national legislation which inhibited the reimbursement of costs incurred in a hospital if an authorization was made ex post. Second, Article 22 of Regulation 1408/71 was interpreted as granting to patients – who had first been refused authorization which was then granted ex post – a reimbursement of costs up to the (higher) level of the home state. Geraets-Smits/Peerbooms added another two important elements to the Kohll/Decker jurisprudence: First, a system of prior authorization was not per se violating European law; treatment in a hospital, a sector where planning is required, may justify such a procedure (paras 76-81). Second, such authorization may not be refused if an identical or equally effective treatment cannot be obtained without ‘undue delay’ from an institution under contract with the competent sickness fund (ibid: paras 103-104). Here, the ECJ ‘unquestionably determined that systems based on the benefits in kind principle do fundamentally fall within the ambit of freedom to provide services’ (Fuchs 2002: 541) and are thus also affected by the developing exportability of domestic health benefits.

With Vanbraekel and Geraets-Smits/Peerbooms it became clear that prior authorization could be justified for medical provision in hospitals. Prior authorization for in-patient care did not necessarily violate Articles 49 and 50 EC, if specific conditions obtained. Geraets-Smits/Peerbooms referred primarily to the Dutch system although the ECJ stated that, ‘(i)t must be accepted that a medical service provided in one Member State and paid for by the

patient should not cease to fall within the scope of the freedom to provide services guaranteed by the Treaty merely because reimbursement of the costs of the treatment involved is applied for under another Member State’s sickness insurance legislation which is essentially of the type which provides for benefits in kind (para. 55). Therefore, some countries, like the UK, wondered how the decision would impact on their health care system. Geraets-Smits/Peerbooms concerned in-patient care and theoretically left open whether outpatient care in EU Member States with in-kind benefit systems had to be treated like those operating with cash benefits.

Müller-Fauré/van Riet confirmed the view that health care systems based on in-kind delivery were affected by the Kohll/Decker jurisprudence. In Müller-Fauré/van Riet, the ECJ confirmed that cross-border out-patient care did not require prior authorization. For in-patient care the Court allowed prior authorization. In addition, the ECJ gave guidance to the insurance institutions what ‘without undue delay’ meant. To satisfy this condition ‘the national authorities are required to have regard to all the circumstances of each specific case and to take due account not only of the patient’s medical condition at the time when authorisation is sought and, where appropriate, of the degree of pain or the nature of the patient’s disability which might, for example, make it impossible or extremely difficult for him to carry out a professional activity, but also of his medical history’ (para. 90). In this case the ECJ referred to systems of other EU Member States and stated generally that ‘a medical service does not cease to be a provision of services because it is paid for by a national health service or by a system providing benefits in kind’ (ibid: para. 103).

In Inizan, the Court of Justice stated: national systems that rely on prior authorization for allowing the reimbursement of medical costs incurred in another Member State are violating Article 49 EC (para. 18). Referring to Geraets-Smits/Peerbooms and Müller-Fauré/van Riet the ECJ affirmed that prior authorization for in-patient health care was necessary, reasonable and justified (ibid: para. 56).

In Leichtle, the ECJ added two new elements to the previous jurisprudence: First, health care costs, like transportation and lodging costs, which are not directly part of a health benefit, may still be reimbursed (para. 51). Second, a social insurance fund cannot refuse reimbursement with the argument that a preliminary authorization had not been given before the treatment (ibid: para. 55).

In Keller, the ECJ decided, first, that insurance institutions were bound by the findings and decisions of those in other Member States in case of a referral abroad. Second, the Court of Justice held that ‘the cost of the treatment provided in that State must be borne by the institution of the Member State of stay in accordance with the legislation administered by that institution, under the same conditions as those applicable to insured persons covered by that legislation’ (para. 72).

Watts added one essential element to the Kohll/Decker jurisprudence: For the first time the ECJ explicitly ruled on a national health service and found that national provisions in such a

7 Case C-56/01, Patricia Inizan v Caisse primaire d’assurance maladie des Hauts-de-Seine [2003] ECR I-12403.
8 Case C-08/02, Ludwig Leichtle v Bundesanstalt für Arbeit [2004] ECR I-2641.
10 Case C-372/04, The Queen on the application of Yvonne Watts v 1) Bedford Primary Care Trust 2) Secretary of State for Health [2006] ECR I-4325.
system which inhibited patients to travel abroad were violating the fundamental principle of the passive free movement of services.

Finally, Acereda Herrera\textsuperscript{11} clarified that costs of travel, accommodation and subsistence did not have to be granted.

Each of the cases making up the Kohll/Decker jurisprudence discussed in this part reaffirmed, refined and amplified the preceding cases. Each case clarified some aspects and at the same time raised new ones. This is why I consider them a ‘stream’ of cases.

\textbf{IV The Three Case Studies}

In the following part I will elaborate three case studies on France, the UK and Germany, which had to implement the Kohll/Decker jurisprudence. In the final part of this section I will also consider empirical evidence for some other EU Member States.

\textbf{A France}

The French Social Security Code (\textit{Code de la Sécurité Sociale}, CSS) was not in line with the Kohll/Decker jurisprudence regarding two elements: First, it rested upon the strict territorial principle enshrined in Article L.332-3 CSS. The rights of patients who received health care treatment abroad were suspended. And second, France was too restrictive in authorizing patients to travel abroad for treatment (see Palm/Nickless/Lewalle/Coheur 2000: 53-54). The expected financial costs were supposed to be low, because of the low incentives for French patients to travel abroad for treatment in the absence of waiting lists.

The French government represented by the Ministry of Foreign Affairs argued in the proceedings before the ECJ: unrestricted patient mobility would result in ‘de mettre gravement en cause les possibilités de survie des régimes de sécurité sociale sur le principe de solidarité’ (ECJ, Rapport d’audience, Kohll: para. 17). France was particularly concerned with the expected outcome of the decision, i.e. with a gradual abolishment of the principle of territoriality. Therefore, the immediate political reaction was that on June 29, 1998, two months after Kohll and Decker, the French Ministère de l’Emploi et de la Solidarité issued a letter in which it explained its position on these decisions. The French Ministry instructed the insurance funds to strictly apply the national rules until a national decision was made to implement the jurisprudence in an appropriate and concerted manner. The insurance funds respected this ministerial instruction. The French administration perceived the rulings to be a potential danger for the entire French social security system. It believed that the ‘\textit{conventionnements}’ (contracts) with French doctors could not be easily extended to foreign providers (Interview F3). The ‘\textit{conventionnement}’ was an internal instrument for the government to limit the health expenditures by sanctioning health care professionals. Doctors from abroad without a contract, so it was feared, could have endangered this steering instrument. In addition, technical application problems were expected, for example with the reimbursement of products that were unknown in France (Interview F3).

Despite this initial obstruction, the French government implemented the Kohll/Decker jurisprudence. Through a number of circulars and decrees, the French Ministry invalidated the initial ministerial letter and moved slowly but gradually towards compliance. Finally, in

\textsuperscript{11} Case C-466/04, Manuel Acereda Herrera v Servicio Cántabro de Salud [2006] ECR I-5341.
April 2005 the French government modified the *Code de la Sécurité Sociale* concerning the reimbursement of costs incurred for health care outside France. Most importantly four new articles (R.332-3 to 6) were inserted into the new Section 2 in the part of the legislation entitled ‘Health care treatment received outside of France’. Ambulatory health care costs incurred in another EU/EEA country according to R.332-3 now had to be reimbursed under the same conditions as if the treatment had been received in France except that a reimbursement must not exceed the actual costs incurred by the patient. R.332-4 still required an authorization for in-patient health care. This authorization could be refused under two circumstances only: the treatment is not listed in French regulations as reimbursable; an identical or equally efficient treatment can be provided in France ‘*en temps opportun*’ (without undue delay) considering the condition of the patient and the evolution of the condition. In addition, the French government determined in 2006 in Articles L.6211-2-1 and R.6211-46 to 56 of the *Code de la Santé Publique* that EU/EEA bio-medical analysis laboratories could offer their services to French patients under the same conditions as French providers.

Why did France finally comply with the *Kohll/Decker* jurisprudence? The two main reasons were the combined and enduring pressure exerted by the European Commission through its infringement proceedings and by national courts through their rulings. *First*, the period of governmental and administrative non-activity in 1998 was broken by several European Commission interventions. The Commission started an infringement procedure against France in October 1999, because the French practice of not reimbursing the costs of spectacles, which had been bought abroad, directly contradicted *Decker*. In March 2001, the French *Ministère de l’Emploi et de la Solidarité* finally succumbed to the pressure from the Commission. The *Direction de la Sécurité Sociale/Division des Affaires Communautaires et Internationales* issued a circular in which it first invalidated the initial ministerial letter from 1998. Although the success of this first infringement proceeding was only a minor concession, the French position began to crumble more and more as the pressure continued. In 2000 and 2001, the European Commission started additional infringements against France regarding medicinal products and bio-medical analysis laboratories. After the condemnation by the ECJ the government modified the *Code de la Santé Publique* (CSP) accordingly in 2004/06.

*Second*, more importantly for the argument of this paper, national court cases contributed considerably to the change in position of the French government. In 2000, the first national court cases started to trouble the administration and the government. Several French first instance tribunals laid down decisions against individual *Caisses Primaires d’Assurance Maladie* (CPAM). For example, the *Tribunal des Affaires de Sécurité Sociale* in Strasbourg delivered three rulings against the *CPAM de Strasbourg* in June 2000: *Pfrimmer*, *Thébaud*, and *Vaquin*. In *Pfrimmer* it based its ruling on *Decker* and decided that the CPAM’s refusal to reimburse the costs for spectacles purchased in Germany was incorrect. The *Tribunal* concluded:

‘La norme supranationale telle que dégagée par la Cour de Justice des Communautés Européennes doit bénéficier à Madame Pfrimmer nonobstant la résistance des caisses françaises, juridiquement infondée’.

The *Tribunal* decided similarly in two other cases: *Thébaud* and *Vaquin*. Here, it based its decision on *Kohll* and *Decker* and ruled that optical products and dental prostheses purchased in another EU country had to be reimbursed by the *Caisse Primaire*. The CPAM appealed against these decisions before the *Cour d’Appel de Colmar*. However, this court rejected the
appeals and confirmed all three rulings. The Cour d’Appel declared that neither the financing of the social security system nor public health considerations provided sufficient reasons to refuse the reimbursement (Cour d’Appel de Colmar, Thébaud and Vaquin, 17 October 2002; Pfrimmer, 19 June 2003). In addition, in Pfrimmer the appeals court found that the original ministerial letter that instructed the insurance funds to ignore Kohll and Decker was wrong.

In March 2002, the French Cour de Cassation, referring explicitly to Vanbraekel, ruled in Robert Magnan v CPAM Hauts-de-Seine: Immediately necessary health care received in a UK private hospital outside the structure of the national health system had to be covered by the French insurance fund in charge. The Cour de Cassation could have referred the case to the ECJ. It refrained, though, because it was convinced to know the European requirements and obliged the CPAM Hauts-de-Seine to reimburse the health care costs of Robert Magnan based on Article 22 of Regulation 1408/71. Two years later, in May 2004, the Cour de Cassation used almost identical formulations as in Magnan in CPAM de Montpellier v Gérona. It decided that the Caisse Primaire had to reimburse a patient who had received urgent hospital treatment in Spain (Cour de Cassation, 25 May 2004). Having in mind these national court cases Jean-Philippe Lhernould generally referred to the ‘volonté des tribunaux français d’intégrer la jurisprudence communautaire’ (2003: 3). Although according to Francis Kessler some French courts such as the Cour d’Appel de Paris still remained reluctant in following the Cour de Cassation (2003: 18), the extensive Magnan ruling was a quantum leap pushing for the implementation of the Kohll/Decker jurisprudence. The Ministry in reaction to Magnan issued a letter to the insurance funds approving the ruling (Interview F3). In the French case, the multiplication of court cases put more and more pressure on the administration and the government to come up with an instrument to end judicial uncertainty relating to patient mobility, which it finally did.

B The United Kingdom

The United Kingdom’s Beveridge model of a National Health Service (NHS) was incompatible with the Kohll/Decker jurisprudence in three ways: First, reimbursing health care costs to its patients was alien to the NHS tradition. It provided in-kind benefits, had no financial reimbursement mechanism and no fund out of which treatment abroad could be paid for. Second, its strict territorial principle prevented the NHS from sending patients abroad. Third, patient referral under the European coordination Regulation 1408/71 with its E112 scheme was handled restrictively in the UK. The version of Article 22(2)(c) of Regulation 1408/71 valid in 1998 could be seen as violated by the UK practice. The policy of the Department of Health (DoH) was to refer patients abroad only if the waiting time was being excessive according to UK standards. The logic of rationing health care was overriding the health and the probable course of the disease of a patient, attention to which was demanded by the ECJ decisions. The expected financial costs for the UK NHS resulting from the implementation of the Kohll/Decker jurisprudence were estimated to be high, because of its structural underfunding and the consequential long waiting times for UK patients.

In the proceedings of Kohll, the UK government stated that Articles 49 and 50 EC ‘ne s’appliquent pas à la fourniture de prestations de services de santé publique par un organisme de sécurité sociale qui constitue une entité à but non lucratif, dont les frais sont financés en tout ou en partie à l’aide de fonds publics’ (ECJ, Rapport d’audience, Kohll, para. 85). According to its opinion, to maintain prior authorization schemes was justified for the financial stability of the domestic social security regimes (ibid: para. 87). The UK government denied that the rulings were transferable to its NHS immediately after Kohll and
Decker were decided (see Palm/Nickless/Lewalle/Coheur 2000: 86-87). The main argument was that the UK NHS was not comparable to a reimbursement-style system like Luxembourg’s. If patients obtained health services privately they had to pay them from their own resources, because the NHS also did not refund the costs of treatment provided privately within the UK. Services obtained privately outside the UK should be treated similarly (Interview UK2). In response to the subsequent rulings, the UK government consistently maintained that the principles elaborated by the ECJ in the Kohll/Decker jurisprudence could not be applied to the NHS. The government feared two aspects of the ECJ jurisprudence particularly: First, in more general terms, it was afraid that the ECJ would push the boundaries of applying the EU basic principles to health care systems further and further (Interview UK2). Second, more specifically, the main rationing instrument of the UK NHS, the waiting list, was potentially creating incentives for patients to travel abroad for treatment. A massive outflow of patients in connection with the reimbursement of their costs would have distorted this integral part of the functioning of the NHS. The DoH argued that with the outflow of patients it would indirectly finance health care systems of other EU Member States and ultimately deprive the NHS of much needed financial resources.

Despite the resistance, the UK government made important legislative and administrative changes in response to the Kohll/Decker jurisprudence. First, two important legislative changes were implemented. In 2001, the UK government amended the English NHS regulation on travel expenses and extended them to patients going abroad to receive treatment. In addition, in 2002 the government removed the strict territorial restriction from the 1977 NHS Act. Section 5(2)(b) was repealed and after Section 3(1) the UK government inserted that the Secretary of State may provide or secure the provision of health care outside England and Wales (The National Health Service Act 1977 and National Health Service and Community Care Act 1990). In addition, the NHS and Community Care Act from 1990 was amended. Paragraph 15(A) now determined that ‘(a)n NHS Trust may arrange for the provision of accommodation and services outside England and Wales’. These amendments created the explicit power for the NHS to purchase health care from outside the UK without having to ask the DoH for approval. Primary health care trusts could now buy services from the private sector abroad. Second, the UK government adopted a ‘contractual approach’ to patient mobility in 2001/2002. It introduced a pilot scheme to relieve imminent pressure from the NHS and to give patients on a waiting list the choice to be treated in health care centres in other EU Member States, but only if these foreign centres were under contract with the NHS. After this centralised pilot scheme was phased out, the local health authorities continued the referral mechanism. And third, the DoH altered the relevant guidance to the public several times.

How can the administrative and legislative changes in the UK be explained? First, an aggressive press campaign, which was initiated by the Sunday Times and fuelled by patients and medical associations and which revealed major problems within the NHS, caused considerable public and political pressure on the UK government in summer 2001. The government immediately reacted by announcing the insertion of a pilot scheme to treat patients overseas and by announcing major legislative changes. Second, this strategic move fitted perfectly into the agenda of the Labour party to restructure the NHS in a market-oriented manner with ‘elements of both modernisation and marketisation’ (Allsop/Baggott 2004: 29). Three elements of the broader governmental plan, the patient choice agenda, the involvement of the private sector, and the overall agenda to reduce waiting times and lists, fed into the implementation of the Kohll/Decker jurisprudence.
And third, most importantly for this paper, the Watts decision by the Administrative Court thwarted the strategy of the government to pre-empt court cases. The DoH unquestionably had relieved much of the public pressure with the help of its practice to refer patients abroad. However, by the end of 2002, it became clear that the problem for the government was not solved. The next urgent problem for the DoH arose with Müller-Fauré/van Riet that was decided by the ECJ in May 2003. The DoH especially disliked the distinction made by this ruling between out-patient and in-patient services, because according to its view both required the same amount of planning and financing (Interview UK2). The UK Administrative Court had explicitly awaited Müller-Fauré/van Riet to be able to lay down its own decision in Watts in October 2003. This UK case had caused considerable (media) attention. In March 2003, Yvonne Watts, a United Kingdom resident, had her hips replaced in France. The competent British Bedford Primary Care Trust refused to reimburse her costs with the argument that she had not accepted the required waiting time. After Müller-Fauré/van Riet was handed down, the responsible judge of the first instance Administrative Court, Mr Munby, ruled that the passive free movement of services applied to the NHS also. According to him ‘the fundamental principles articulated by the ECJ (…) in Müller-Fauré (sic!) and van Riet (…) were intended to be, and are, as applicable in the case of the NHS as in the case of the Dutch ZFW [Dutch public Health Insurance Act, AJO]’ (Watts, para. 108).

In detail, judge Munby found the then existing waiting time of the NHS for in-patient treatment of 15 months intolerable. According to him it had to be much less than a year. Though, he did not set a specific time figure. In addition, the judge found fault the official public guidance by the DoH and said that it should be altered in order to make UK patients aware of their rights under Article 49 EC (Administrative Court, Watts, paras 196 and 199).

However, the DoH thought that the Administrative Court read too much into the ECJ rulings (Interview UK1). Watts explicitly contradicted the Secretary of State for Health, John Reid, who claimed that people who were on a waiting list for less than a year could not receive reimbursement. Since this ruling, in principle, patients who suffer ‘undue delay’ waiting for an operation in the NHS could go to another EU Member State to get treatment and then will be reimbursed by the NHS. However, in official statements the DoH claimed that Watts was complex and needed to be considered in detail (The Independent, 2 October 2003). Both parties, Mrs Watts and the DoH appealed the national court decision. Therefore, it went on to the Court of Appeal that referred it in July 2004 in seven questions to the ECJ. Mrs Watts’ lawyers opposed the referral and claimed that the court of first instance had already answered the questions raised by the Secretary of State in the light of the ECJ jurisprudence (Financial Times, 21 February 2004). In the first most important question, the Court of Appeal asked whether in the light of the ECJ jurisprudence Geraets-Smits, Müller-Fauré and Inizan, in principle UK nationals were entitled to receive hospital treatment in other EU Member States. The Court of Appeal specifically wanted to know whether the state-funded UK NHS had to be distinguished from the health care system of the Netherlands. The UK government proposed to answer this question with ‘yes’ (ECJ, Report for the Hearing for Watts, paras 46 and 67). The ECJ stated in its preliminary ruling that the obligation to reimburse the cost of a hospital treatment provided in another Member State also applied to the UK NHS. A prior authorization scheme like the one in the UK had to prove that the waiting time did not exceed a medically acceptable period of time considering the condition of the patient and her clinical needs. Accordingly, the DoH changed its guidance to the public. However, these interim guidelines of the DoH were rather unclear about what would happen if patients travelled abroad outside the established structures.
C Germany

Two elements of the German Bismarck model of a statutory health care system were incompatible with the Kohll/Decker jurisprudence: First, the strict principle of territoriality and, second, the general principle that health care services are provided through in-kind benefits. The expected financial costs for Germany were low, because of the low incentives for patients to travel abroad.

In the ECJ proceedings on Kohll and Decker, the German government articulated the expectation that an uncoordinated opening of the markets for pharmaceuticals, medical equipment, and medical care would seriously endanger the structure of the national system of social security.\footnote{ECJ, Rapport d’audience, Kohll, paras 55 and 60; and Rapport d’audience, Decker, para. 34.} Therefore, when the ECJ adjudicated Kohll and Decker in 1998, the immediate political reaction was the strict refusal of its transferability to the German in-kind benefit system. According to the Federal Ministry of Health, the Federal Insurance Authority and the competent Länder ministries there was no binding effect for Germany. The legal position in Germany remained unaffected. The instruction to take a stand against Kohll and Decker came from the highest political level, minister Seehofer, who was openly opposed to the ECJ interfering in national health care systems. The main fear of the Ministry of Health was that the ECJ jurisprudence would cause intense political and legal pressure and, would ultimately lead to structural changes for the domestic provision of health care. Already a few people claiming reimbursement of their costs incurred abroad were seen as causing major changes in the entire system. The major health care actors, the care providers, patients’ organisations and health insurance funds were split in their evaluation. Some saw chances to attract new foreign patients, a stronger competition among care providers and ultimately financial relief, while others pointed to the dangers emanating from Kohll and Decker for social security systems.

Despite the resistance, the German government transposed the ECJ rulings Kohll and Decker, Geraets-Smits/Peerbooms and Müller-Fauré/van Riet in 2003 (Deutscher Bundestag, 15/1525: 80-82). It changed Paragraph 13 and inserted Paragraph 140(e) of ‘Book’ 5 of the Social Code with the help of a Statutory Health Insurance Modernization Act. There, it relaxed the territorial restriction of the demand for benefits. It determined as a matter of principle that insured persons were entitled to care providers in other Member States of the EU and EEA and to choose cash instead of in-kind benefits. However, the German government limited cash reimbursement to out-patient care and left hospital care abroad still dependent on prior authorization by the competent insurance fund. Following the ECJ jurisprudence, prior authorization may only be refused if an equal or an equally effective treatment can be obtained in due time from a contractor of the insurance fund. The reimbursement of health care costs was not limited to foreign care. In fact, all insured could choose cash benefits instead of in-kind benefits. Prior to the Statutory Health Insurance Modernization Act, in German law the importance of the in-kind benefit principle was already occasionally undermined. Nevertheless, the amendment of Paragraph 13 of Book 5 of the Social Code was a substantial strengthening of the cash reimbursement principle in the German health care system. In addition, Paragraph 140(e) extended the in-kind benefit principle to foreign cases. Insurance funds may now provide their insured with health care abroad through contracts with foreign providers.

Why did the Ministry of Health and the Central Associations of Statutory Health Insurance Funds change their views on this jurisprudence? There is a number of factors which were decisive to change the German position: First, the fear of the Ministry of Health and the
insurance funds that the implementation of the ECJ jurisprudence would create considerable political and legal pressure for an opening for foreign cases of its health care system based on in-kind benefits and that this disruption would affect the entire system could be overcome. No decisive health care actor argued that the in-kind principle should be completely abolished and that the principle of cash reimbursement should be introduced as a general principle instead. And the predominant principle of providing in-kind benefits for foreign cases could be relaxed without major repercussions: Voluntarily and compulsorily insured persons got the opportunity to opt for cash reimbursement only under quite restrictive conditions. A second important factor driving the prompt implementation was the fine-tuning of the ECJ jurisprudence. The Ministry of Health and the insurance funds had feared that not only out-patient but also unlimited in-patient mobility would be triggered by the ECJ decisions. In this case the political and – more importantly – financial costs would have been considerable. Therefore, as a matter of principle they fiercely rejected the entire jurisprudence on patient mobility. However, the ECJ excluded in-patient cases in general from benefit exports and handled permission very restrictively. Consequently, the skepticism towards the ECJ and its decisions – which was widespread among insurance funds and in the Ministry – decreased substantially. The self-restrained ECJ approach paved the way for the smooth transposition of the jurisprudence. Third, from 1998 onwards several working groups among the Central Associations of Statutory Health Insurance Funds and a broader Common Working Committee which consisted of many different actors started to discuss the implications of the Kohll/Decker jurisprudence. In these working groups the fears were cooled out or dissipated and even hopes for cost saving effects were expressed. Fourth, domestic party political preferences played a role: CDU/CSU consent to the Statutory Health Insurance Modernization Act was required. The first draft of this law was not far-reaching enough for the CDU/CSU on whose political agenda patient sovereignty and patient choice was a high priority. Therefore, it pressed successfully for a more ambitious implementation. It was the de facto grand coalition between the red-green government and the CDU/CSU that extended the conditional choice of cash reimbursement to all insured persons and to health care received abroad. Fifth, the fact that some insurance funds had already started to apply (parts of) the jurisprudence and others had not was an additional impetus for the Ministry of Health. It wanted to put an end to the legal uncertainty created by the ECJ and national court decisions and it wanted to end the considerable discretion that insurance funds had in implementing the jurisprudence.

And last but not least, the role of the national judiciary was important. In 2001, a phase in which the outright rejection of the Kohll/Decker jurisprudence began to crumble, the first national court cases arose. The Verwaltungsgericht Sigmaringen, an administrative court of the first instance, claimed that there was no settled national case law yet and referred its case to the ECJ with two questions on health cures. In 2002, two German social courts each referred a case to the ECJ. In March, the Social Court Augsburg referred Weller and asked here whether Paragraphs 16 and 18 of Book 5 of the Social Code of that time conflicted with Articles 49 and 50 EC. With this preliminary reference the Social Court wanted to find out whether the German statutory sickness insurance scheme had to be treated like a system based on reimbursement. In October 2002, the German Federal Social Court (BSG) referred Bautz to the ECJ for a preliminary ruling. The BSG wanted to know whether German provisions were violating European law that allowed insured persons to consult a doctor abroad only in the exceptional case and that demanded prior authorization from the insurance

13 Case C-322/02, Eva-Maria Weller v Deutsche Angestellten-Krankenkasse, removed from the register by order of 17 May 2004.
14 Case C-454/02, Karin Bautz v AOK Baden-Württemberg, removed from the register by order of 8 June 2004.
In 2003, the ECJ under consideration of Müller-Fauré/van Riet asked the German court to reconsider its request. According to the BSG, with Müller-Fauré/van Riet there was no more a need to clarify European law. The BSG’s preliminary question was withdrawn – together with Weller – in May 2004 and the case was referred back to the Landessozialgericht. The German legislator had not waited for the court decisions, and had, to the regret of the insurance funds (Interview G2), anticipated the rulings and changed its legislation in 2003. There is strong evidence that the national court cases were not instrumental for the implementation of the Kohll/Decker jurisprudence in Germany. Nonetheless, they were an additional factor for the administration and government that had to be borne in mind.

D Evidence from the other Member States

There is some scattered evidence that in a number of other Member States national court rulings also played an important role. In Luxembourg for instance the impact of the Kohll/Decker jurisprudence seems to have been predominantly court-driven (see Kerschen 2003: 7). Because Italy did not make any changes in legislation or administrative practice in its National Health Service, its Corte di Cassazione became active and stated in several cases that treatment received abroad without authorization had to be reimbursed under specific circumstances. The Swedish Supreme Administrative Court found in 2004 in three rulings that persons who had received medical services abroad and demanded reimbursement from Sweden ‘should be reimbursed, to the extent that the medical service would have been covered by the Swedish national health system’ (Jorens/Hajdú 2006: 91).

V Conclusion: National Courts – Accelerating Implementation

The three case studies on France, the UK and Germany showed that national courts considerably influenced the implementation of the Kohll/Decker jurisprudence. French courts applied autonomously the material doctrines elaborated by the Court of Justice and forced the legislator – with a multiplication of cases decided in line with the ECJ jurisprudence – to end judicial uncertainty and to. The UK Administrative Court with an important ruling forced the government to move towards the implementation of the jurisprudence. In Germany, the legislator anticipated such national court rulings and incorporated the jurisprudence into its social law.

In France, courts at all levels, including the Cour de Cassation, accepted and applied the ECJ doctrines in the Kohll/Decker jurisprudence. As early as 2000, the Tribunal des Affaires de Sécurité Sociale du Bas Rhin applied Kohll and Decker. The Cour d’Appel de Colmar affirmed these rulings in 2002/03. In addition, the Cour de Cassation set important precedents for the French government and administration in decisions such as Magnan in 2002 and Gérona in 2004. The government faced further court cases. In order to decrease the legal uncertainty caused by the judicial activism of the national courts, and to remedy the resulting nonuniform application of the law, it therefore implemented the jurisprudence and changed the relevant legal provisions in the Code de la Sécurité Sociale and the Code de la Santé Publique in 2005/06.

The nonofficial policy of the UK government consisted in preventing domestic court cases on patient mobility. It deliberately preempted upcoming cases by using its wide discretionary power to reimburse patients who had received health care abroad. Nevertheless, this
preventive strategy towards national court cases did not work out entirely. The Administrative Court of first instance in Watts explicitly used the Kohll/Decker jurisprudence, notably Geraets-Smits/Peerbooms and Müller-Fauré/van Riet, without referring the case to the ECJ, and challenged the legislative provisions in the UK. The government appealed against this first instance decision and ‘achieved’ a referral to the ECJ by the Court of Appeal in the hope that the Kohll/Decker jurisprudence would be declared inapplicable to the UK NHS. However, the government ultimately lost the judicial battle and then faced a situation, in which it could not perpetuate its overall obstructive attitude. Even before the ECJ decision in Watts, the UK government had been forced by the Administrative Court ruling to move towards implementing the jurisprudence.

In Germany, the Siemens Betriebskrankenkasse (SBK) and the Techniker Krankenkasse (TK) both initiated legal proceedings to prevent the government from blocking the implementation of the jurisprudence. The SBK explicitly wanted to bring its case of a refused statute change to the ECJ. However, the Social Court Munich denied this request in 2003 since a similar German case, namely Bautz, was already pending before the Court and, therefore, suspended the SBK case to await the results of the ECJ ruling. The two German cases, Weller and Bautz, were referred to the ECJ in March and October 2002. The first was referred by the first instance Sozialgericht Augsburg and the second by the highest social court in Germany, the Bundessozialgericht. Both cases were withdrawn in May and June 2004 with the reasoning that the ECJ had given sufficient indications on how to interpret Article 49 EC and Regulation 1408/71. None of these national court cases were decided before the Kohll/Decker jurisprudence was transposed. However, there is sufficient evidence that these pending domestic cases did contribute to convince the government to include the Kohll/Decker jurisprudence in the Statutory Health Insurance Modernization Act in 2003.

To sum up, in the case of the implementation of the Kohll/Decker jurisprudence, the national judiciary behaved like the sword of the ECJ. This paper clearly indicates that national courts are a key variable for understanding and explaining national implementation. National courts are able to accelerate implementation. As soon as national courts accept and apply the doctrines elaborated by the ECJ, governments face accomplished facts. Such national rulings in interaction with contradicting legislative provisions created judicial uncertainty in the Member States. The domestic legislator was, therefore, forced to implement the ECJ rulings and to change the law on the books in order to decrease the judicial uncertainty. Therefore, the behaviour of national courts has to be at the very centre of investigation when looking at compliance with EC law in general and ECJ rulings in particular. If governments/administrations hamper implementation, if domestic political considerations are incompatible with the ECJ jurisprudence, if ECJ requirements are incompatible with existing domestic structures and policies, then national courts can resolve non-compliance through forcing the legislator to end judicial uncertainty with a multiplication of national court cases that contradict domestic legislation.
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