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## Cross-Border Access to Health Care in the European Union as a Sustainable Development Policy

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### **Abstract:**

**Purpose:** A burgeoning body of research has described how the blockchain technology may affect the way firms operate within the recording industry which has undergone profound changes due to the dematerialisation of music and the emergence of new consumption habits. The purpose of the paper is to explore both the challenges and the opportunities related to the application of smart contracts and blockchain mechanisms to the recording industry.

**Approach/Methodology/Design:** Based on a review of contributions made to the literature in various fields, we discuss recent developments, relying on several examples and use cases which bring an updated perspective to a topical question. While the blockchain brings interesting solutions in favour of an improved management of copyright data and fees collection, several barriers impede their uptake and large-scale adoption.

**Findings:** We argue that the absence of both technological and regulatory standards, the resistance to change, and the necessary use of cryptocurrency, are all obstacles to a profound transformation of the sector.

**Practical Implications:** To overcome these limitations, we suggest three recommendations that deal with technological standards, cooperative agreements, and international regulation around blockchain.

**Originality/Value:** So far, the literature tends to focus either on blockchain technology or on smart contracts when discussing technological evolution within the recording industry. In this paper, we bring together these two elements which are definitely complementary to each other. Further research efforts are required to investigate in more details the feasibility and relevance of the recommendations we make.

**Keywords:** Recording industry, blockchain, smart contracts, copyright.

**JEL classification:** F5, K1.

**Paper Type:** Research study.

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## **1. Introduction**

The blurring of borders between individual European Union Member States stems directly from the principle of free movement of people and services. The lack of internal borders among the Member States of the Community has not only intensified migrations but also generated other problems, the consequences of which influence the development of the economy, on a broad sense, as well as the public-private sector as regards respect for fundamental rights within the concept of patients' rights. These issues relate to access to health services and thus to ensuring appropriate respect for the most crucial human rights and values. This issue also covers the set of obligations of the state and its bodies as the main guarantors and specific entities which redistribute goods and ensure the safety of citizens, i.e. patients in this case.

These issues are also part of a sustainable development policy, which aims to facilitate a dignified life for every human being, social inclusion, and environmental responsibility. In the new concept of sustainable development, the relations between the human being and the environment are based on a new framework (Fonseca, 2013). This concept is considered mainly in three depictions: the philosophical and social idea, which assumes the need for changes in the human value system; as a modern direction for economic development assuming new ways of organising and managing the economy; and as a newly emerging scientific discipline. Sustainable development should not be considered only as an abstract idea, as it is a collection of specific guidelines on the modelling of socio-economic development. The importance of this concept is underlined by the fact that it is commonly known, acceptable and implemented (McKee *et al.*, 2013).

It should be highlighted that sustainable development is a concept which focuses on the quality of life of a human being and their health. The desired state of affairs in this respect can be achieved through the proper management of five categories of capital: natural, economic, human, social, and capital integrating other types of capital. Managing those should take place under the principles of economic, social, institutional, and spatial governance. The concept of sustainable development can, therefore, be considered as a regulation of the new quality of those relations, as a specific ethical as well as legal, social and philosophical idea. This follows the idea of eco-humanism, which consists in the partnering of all people, transforming contemporary egoistic economics into a "social economy", using one's private value for the common good, and shaping ethical globalisation (Palm *et al.*, 2011).

The issues addressed in this article stem from the accession of Poland to the European Union and the implementation of Cross-Border Directive 2011/24/EU into Polish national law (OJ EU L 88, 2011). Access to health care in the European Union, the quality of such services, the appropriate standard of health care, and equal rights of every patient and respect for such rights, should all be analysed (Surówka, 2012, p. 9).

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EU policy based on the principles of free movement of persons and services means that patients can move within the EU to get the best possible care. Those principles are in line with the free movement of workers who are citizens of the Member States and are expressed in Council Regulation (EC) No. 1408/71 of 14 June 1971 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the Community. Those regulations should guarantee the right to social security benefits (also sickness benefits) based on the place of employment or residence. A draft Directive on safe, high quality, and efficient cross-border health care presented in 2008, which was ultimately renamed to Directive on the application of patients' rights in cross-border health care, refers to Article 114 and Article 168 (1) and (7), and is designed in particular to protect public health (Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare).

## 2. Cross-Border Directive

The implementation of the Directive into the Polish legal order aims to secure and realise the main principles of the Regulation within the coordination of social security, in particular the respect for and implementation of the principle of equality of patients, both residents and non-residents of a given Member State and the European Health Insurance Card.

The main goal of the Directive is to oblige all Member States to guarantee equal access to cross-border health care and to ensure the right to reimbursement of health care. At the same time, it realises patients' right to high-quality care and its safety.

In the analysed Directive 2011/24/EU of the European Parliament and of the Council, it was determined that in accordance with Article 168 (1) of the Treaty on the Functioning of the European Union, a high level of human health protection is to be ensured in the definition and implementation of all Union policies and activities. The wording of the Directive refers to the Council Conclusions on Common values and principles in European Union Health Systems. It also refers to the creation of universal standards, revolving around ensuring the safety of the recipients (in this case patients) and guaranteeing the high-quality of medical services. The implementation of these standards is linked to practical cooperation between the European Union Member States, which are to seek synergies in the interpretation and implementation of directive objectives, and which ultimately aim at coherence in the application and enforcement of health law.

The health care system constitutes an important part of the high level of social protection in Europe. Ensuring that patients have access to high-quality medical services is a sign of respect for human dignity and life protection, and greatly contributes to the sense of social cohesion and justice. This proposition is expressed in the Annex to the Conclusions, entitled *Statement on common values and*

*principles*. The values enumerated there – *universality, access to good quality care, equity, and solidarity* – at the same time comprise the axiological core of the health care system for the whole of Europe. *Universality* means that everyone has the right to health care; *solidarity* is related to the need to provide all patients access to health services covered by appropriate financial arrangements in national health systems; *equity*, related to equality, means access according to need, regardless of gender, race, age, religious convictions, social status or ability to pay. Thus, specific care manifests in EU health policy, which strives to facilitate a uniform level of patient care and to reduce the gap in health inequalities.

Considering patient safety policy, member states should foster cooperation between providers and payers, both at the local and international levels. The aim here is to achieve the best-possible effective cross-border care (Rosenmöller *et al.*, 2006).

### **3. Health Care Access Management: Myth vs. Reality**

When the premises of the Cross-Border Directive clashed with reality, it became visible that individual member states apply various and greatly diversified interpretations of the axiological rules. There are differences in respect of financing the costs of individual elements of health care, i.e. whether individuals should pay a personal contribution towards those costs, or whether there is a general contribution, and whether this is paid for from supplementary insurance (Wróblewski *et al.*, 2018).

Furthermore, the principle of *equity* was also subject to different regulations. Some member states have chosen to express it in terms of the rights of patients, others in terms of the obligations of health care providers. In terms of enforcement, there is no common ground as well. In some Member States, it is carried out through the courts, in others, ombudsmen are involved, etc.

What is also of importance, is that some Member States, including Poland, introduced the required prior authorisation of treatment. As per the provisions of the Cross-Border Directive, it is the Member States which are responsible for laying down rules as regards the management, requirements, quality and safety standards and organisation and delivery of health care. Since planning necessities differ from one Member State to another, it should, therefore, be for the Member States to decide whether there is a need to introduce a system of prior authorisation, and if so, to identify the health care requiring prior authorisation in the context of their system according to the criteria defined by the discussed Directive and in the light of the case-law of the Court of Justice. The procedure should be clear, transparent, and easily accessible, and guarantee that decisions are issued within a reasonable time.

It is also worth noting that in the light of the provisions of the Directive, the only grounds for refusing to grant prior authorisation is presented in Article 8 (6) (d), i.e. where health care can be provided by a Member State taking into account the current state of health and the probable course of the illness of a patient. On the other hand,

the Polish legislator interpreted this provision by pointing to health care services contracted in the country within a term which does not exceed a specific waiting time. Such an interpretation appears to be too formalistic.

#### 4. Interpretive Formalism

The Court of Justice of the European Union devised specific guidelines pertaining to the discussed research subject. Those guidelines refer to the formal issue of benefiting from cross-border care. In case *Leichtle v. Bundesanstalt für Arbeit ETS* (Judgement of the Court of 18 March 2004 in Case C8/02 *Ludwig Leichtle v. Bundesanstalt für Arbeit*), in its judgement of 18 March 2004, the Court of Justice adjudged that patients are free to choose the centre at which they receive treatment abroad, with no need for obtaining the consent of the national insurer, and provided for the rules for reimbursing medical costs incurred in another Member State (Bieńkowska, 2019).

CJEU Judgement C-173/09 of 5 October 2010 (*Elchinov v Natsionalna zdravnoosiguritelna kasa*, Judgment of the Court of 5 October 2010. C-173/09) was a breakthrough in the issue at hand. Therein, the Court stated that EU regulations “preclude a rule of a Member State which is interpreted as excluding, in all cases, payment for hospital treatment given in another Member State without prior authorisation” (Judgment of the Court of 5 October 2010. C-173/09). In their justification, the judges pointed to such rules restricting freedom to provide services. Therefore, the appropriateness of health care services being conditional on prior authorisation of, for example, the national insurance fund, was called into question. Furthermore, the court upheld all its previous judgements, wherein it explicitly stated that all national rules which make the provision of medical services subject to prior authorisation by the patient’s Member State, constitute a prohibited restriction on freedom to provide services and an unfair policy for the allocation of public funds in health care (Bosek, 2011).

#### 5. The Excessively Wide Interpretation of Service Reimbursement

After the Act of 15 November 2014 amending the Act on health care services financed from public funds and certain other acts (Journal of Laws of 2014, item 1491) went in force, its regulations implemented the provisions of the discussed Directive into the Polish legal system. Under these regulations, if certain criteria are met, a Polish patient can be reimbursed by the National Health Fund the costs of health care services included in the Polish catalogue of guaranteed benefits provided in another EU Member State against payment. Provisions which directly addressed the issue of reimbursement and set the definitions for the terminology used throughout the procedure went into force on 12 December 2015.

Thus, pursuant to Article 42b (1) of the Act on health care services: “The recipient is entitled to be reimbursed by the Fund for the costs of a health care service, which is

a guaranteed benefit, provided on the territory of a Member State of the European Union other than the Republic of Poland, hereinafter referred to as ‘reimbursement’”. On the other hand, Article 42d (2) (2) and Article 42d (2) (6) of the Act, which constitute the substantive basis for the issuance of administrative decisions to deny reimbursement, state that: “The director of a regional branch of the Fund determined pursuant to Section 1 shall issue an administrative decision to deny reimbursement, if ... the application for reimbursement concerns the services referred to in Article 42d (2) (2)”.

In the complaint brought by E. Ż against the National Health Fund (File Ref. No. VI SA/Wa 1323/17), the Regional Administrative Court (Wojewódzki Sąd Administracyjny) in Warsaw, having examined the case at a hearing on 27 September 2017 where E. Ż. files a complaint against the decision of the President of the National Health Fund of ... May 2017 No. ... on reimbursement for health care services, dismissed the complaint. In its justification of the judgement, the Court relied on the decision of the President of the National Health Fund. By virtue of Decision of ... May 2017, the President of the National Health Fund upheld the decision of of the ... National Health Fund Branch Director of ... September 2016 to deny reimbursement for health care services provided to E.Z. (the patient) in Germany, amounting to PLN 14,596.72.

The Court in the case discussed above stated that in accordance with the letter of the law, it is unquestionable that in a situation where a given health care service is not included in the range of guaranteed benefits covered by the regulation of the Minister of Health on this matter, relevant given the date of the case’s resolution, the authority must deny the reimbursement of the costs of treatment within the said procedure. It also pointed that the appeals authority was right in the contested decision to determine that the recipient, pursuant to Article 42b of the Act, had the right to reimbursement only for those services which were classified as guaranteed benefits. The findings made in the case gave a negative answer to the question of whether prosthetic restoration provided to the applicant as part of her treatment in Germany from ... 2014 to ... February 2015 was within the range of guaranteed benefits. The authority ascertained that the applicant failed to indicate a service for which she could effectively apply for reimbursement pursuant to the regulations on cross-border medical assistance.

In this case, as adjudged by the Court, the applicant was correctly informed about evidentiary proceedings and fully informed on the documents to be presented. One should, however, bear in mind that in reimbursement procedures provided for in Article 42b of the Act, the burden of proof as regards data from diagnostic or therapeutic processes, facilitating the identification of health care services to be reimbursed, lies on the party (The obligation to collect and consider the total body of evidence, stemming from Article 7 and Article 77 § 1 of the Code of Administrative Procedure, barring certain exclusions, is limited in the reimbursement procedures referred to in Article 42b of the Act to the comprehensive consideration of the total

body of evidence presented by a party. The Act of 14 June 1960 – the Code of Administrative Procedure, Journal of Laws of 1960, No. 30, item 168). This is explicitly pointed to in Article 42d (2) (b) of the Act, where: “The director of a regional branch of the Fund determined pursuant to Section 1 shall issue an administrative decision to deny reimbursement, if ... the recipient failed to produce documents presenting sufficient data on the diagnostic or therapeutic processes, facilitating the identification of health care services to be reimbursed” (Journal of Laws of 2016, item 1793, as amended).

The Court also stated that a comparison of the list of medical procedures in the documentary evidence presented by the applicant and the names of guaranteed dental benefits (Annex to the Regulation of the Minister of Health of 6 November 2013 - Journal of Laws, item 1462) explicitly points to those medical procedures not being the same.

The law clearly states that the benefits guaranteed in the aforementioned scope in accordance with the Regulation of the Minister of Health of 6 November 2013 are listed under items 36, 37 and 39 - made of acrylic - insertion of a complete denture in the toothless lower jaw, restoration of teeth with a partial denture with simple bent clasps for 5-8 missing teeth, restoration of teeth with a partial denture with simple bent clasps from more than 8 teeth. However, according to the submitted documentation concerning the benefits received by the applicant in the Federal Republic of Germany between 18 November 2014 and 26 February 2015, a number of procedures were carried out, considerably exceeding the range of guaranteed benefits. Based on the submitted documents, there were no grounds that would make it possible to conclude that there those included benefits that could be considered as publicly funded.

The implementation of the Cross-Border Directive does not apply to comprehensive health care in any of EU Member States. One must take into account a number of legal provisions that provide specific guidance on health care services that can be reimbursed. Furthermore, the Court determined that the issue of the applicant’s non-using domestic dental services would have been more relevant to the case, if the services provided in another EU Member State were included in the range of guaranteed benefits.

## **6. Conclusion**

The Directive on cross-border health care should be primarily construed as securing and respecting patients’ rights in terms of equality, equity, and respect for human dignity. It also perfectly matches the sustainable development policy which focuses not only on the individual but also has a broader dimension expressed in continuous efforts aimed at improving the quality of life of individuals, social groups and larger communities. The sustainability policy standards clearly correlate with the Cross-Border Directive. Indeed, they refer to meeting the most important needs of the

society, achieving optimal health protection and providing health services at a high level. The correct interpretation of the Directive's guidelines will help to develop standards for the implementation of sustainable development objectives, and thereby enhance health systems. This will be effected by coordinating an approach involving better health management and, more importantly, by focusing on appropriate legal policies, wherein the law has a key role in achieving health-related sustainable development objectives and understanding their interactions with other measures. This would be with an aim to influence the effectiveness of specific goals through the achievement of their objectives. Such an approach is much more conducive to raising the standards of health care in all Member States whose systems are based on respect for patients' rights as part of private law, but also to safeguarding rights already related to collective rights (Bieńkowska, 2016).

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