OPINION OF ADVOCATE GENERAL RUIZ-JARABO COLOMER

delivered on 22 October 2002 [1]

1. By the three questions which it has referred under Article 234 EC, the Centrale Raad van Beroep (Netherlands) seeks to ascertain, essentially, whether Articles 59 of the EC Treaty (now, after amendment, Article 49 EC) and 60 of the EC Treaty (now Article 50 EC) preclude legislation enacted by a Member State in the area of compulsory sickness insurance providing only benefits in kind which makes reimbursement of medical expenses in respect of treatment, where it is necessary, dispensed in another Member State by a medical practitioner or hospital with whom or which no agreement has been concluded subject to prior authorisation of the sickness insurance fund.

I — The facts of the two disputes in the main proceedings

A — *The proceedings relating to Ms Müller-Fauré*

2. Ms Müller-Fauré was dissatisfied with Netherlands dental surgeons, so she took advantage of a holiday in Germany to visit the dentist without having obtained the authorisation of her sickness insurance fund. Between 20 October and 18 November 1994, six crowns and a precision implant in the upper jaw were inserted. Her treatment included fillings, radiography and anaesthesia. On returning to the Netherlands, she applied to her sickness insurance fund, the mutual insurance company Onderlinge Waarborgmaatschappij OZ Zorgverzekeringen UA, (hereinafter 'OZ Zorverzerkeringen'), seeking reimbursement of the costs of the treatment, which amounted to DEM 7 444.59 (EUR 3 806.35). Since most of the treatment carried out in Germany is not covered by the compulsory sickness insurance and are therefore not eligible for reimbursement, the dispute concerns, in actual fact NLG 465.05 (EUR 211.03). On the basis of the opinion of its advisory dental surgeon, the fund rejected the application in May 1995.

3. The Appeals Committee of the Board responsible for supervision and administration of the sickness insurance funds (Commissie voor beroepszaken van de Ziekenfondsraad) considered, in February 1996, that the decision to reject the application was correct. It took the view that the

1 — Original language: Spanish.

compulsory sickness insurance fund is characterised by the provision of benefits in kind, which means that insured persons are entitled to receive treatment. It is only in exceptional cases that they may apply for reimbursement, but in the case of Ms Müller-Fauré that was not possible since the treatment was not urgent for the purpose of Article 22 of Regulation (EEC) No 1408/71. [2] Moreover, in order to obtain the treatment she sought, the patient had no need to resort to a dental surgeon who had no contractual arrangements with OZ Zorverzerkeringen.

4. The court before which proceedings were brought at first instance upheld that view and considered that the extent of the treatment performed and the fact that it spanned a period of several weeks clearly indicated that it was not urgent.

B — *The proceedings relating to Ms van Riet*

5. On 5 April 1993, Ms van Riet's doctor requested, on behalf of his patient, that the medical adviser of her sickness insurance company Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen ('ZAO Zorgverzekeringen') should authorise her to have an arthroscopy, chargeable to ZAO, in Belgium, where it could be performed much sooner than in the Netherlands. That request was rejected by letters of 24 June and 5 July 1993 on the ground that such treatment could be provided in the Netherlands.

Without waiting for the response, Ms van Riet had the arthroscopy and an ulnar reduction performed in a sports medicine clinic in Belgium. The insurance company refused to reimburse the cost, which amounted to BEF 93 792 (EUR 2 325.04)

6. On 23 September 1994, the Appeals Committee of the Board responsible for supervision of the management and administration of the sickness insurance funds upheld the decision to refuse reimbursement of the cost of the treatment. It found that the necessary and appropriate medical treatment was available in the Netherlands, within reasonable time, so that no emergency treatment for the purpose of Article 22 of Regulation (EEC) No 1408/71 was involved.

The Rechtbank declared the appellant's appeal unfounded on the ground that her

2 — Regulation (EEC) No 1408/71 of the Council 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 (OJ, English Special Edition 1971 (II), p. 416), as worded in Council Regulation (EEC) No 2001/83 of 2 June 1983 amending and updating Regulation (EEC) No 1408/71 and Regulation (EEC) No 574/72 (OJ 1983 L 230, p. 6).

complaint did not call to be treated in Belgium.

Furthermore, even if Ms Müller-Fauré had sought authorisation and Ms van Riet had awaited a response, the insurance funds would not have granted authorisation, since it is not evident that their treatment abroad was necessary. The lack of confidence in national medical practitioners is not sufficient reason, nor is the waiting time in the Netherlands for the arthroscopy unacceptably long.

II — The questions referred to the Court

7. In the order for reference, the Centrale Raad van Beroep states that the compulsory sickness insurance covers practically all of the medical care provided to Ms van Riet in Belgium. That statement is true only in respect of a limited portion of the dental work carried out on Ms Müller-Fauré in Germany, since the remainder is not eligible for reimbursement.

According to the case-law of the Centrale Raad van Beroep, the insured person must have obtained authorisation from the sickness insurance fund before treatment commences. The cost of the medical care provided abroad cannot be reimbursed unless, for particular reasons, refusal of the sickness insurance fund infringes a general principle of law. That was not the case with respect either to Ms Müller-Fauré, who took the opportunity to visit the dentist while she was on holiday, or to Ms van Riet, who did not wait until the fund replied to her request when there was no medical or other reason why she could not wait until her application was dealt with.

8. Finally, the Centrale Raad van Beroep wonders whether the contested decisions infringe Articles 49 EC and 50 EC. It therefore stayed proceedings in the two cases and referred the following three questions to the Court for a preliminary ruling:

'1. Are Articles 59 and 60 of the EC Treaty (now Articles 49 and 50 EC) to be interpreted as meaning that in principle a provision such as Article 9(4) of the Ziekenfondswet [Law on Health Insurance], read in conjunction with Article 1 of the Regeling hulp in het buitenland ziekenfondsverzekering [Regulation on health care abroad under the sickness insurance rules], is incompatible therewith in so far as it stipulates that in order to assert his entitlement to benefits a person insured with a health insurance fund requires the prior authorisation of that fund to seek treatment from a person or establishment outside the Netherlands with whom or which the health insurance fund has not concluded an agreement?

2. If the first question is to be answered in the affirmative, do the objectives of the Netherlands system of benefits in kind referred to above [to ensure balanced medical and hospital services open to all, the survival of the system of benefits in kind and control of the financial equilibrium by supervising the costs] constitute an overriding reason in the general interest capable of justifying a restriction on the fundamental principle of freedom to provide services?

3. Does the question whether the treatment as a whole or only a proportion thereof involved in-patient care affect the answers to these questions?'

III — National legal framework regarding compulsory sickness insurance [3]

9. In the Netherlands, workers and persons regarded as such whose income does not exceed a certain amount are covered by compulsory insurance under the Law on Sickness Funds which covers ordinary health care.

10. Under Article 8 of that Law, such funds are under an obligation to ensure that insured persons can exercise their right to obtain services. It is a system which provides only for health-care benefits in kind, so that beneficiaries are not entitled to the reimbursement of sickness costs which they may incur, but to the provision of free treatment. [4]

11. Under Article 3 of the Royal Decree on sickness insurance benefits in kind (Verstrekkingenbesluit Ziekenfondsverzekering) of 4 January 1966, 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 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 described as the appropriate professional procedure since,

3 — After giving a very brief description of the Netherlands compulsory sickness insurance scheme, the Centrale Raad van Beroep refers, for further information, to paragraph II.1 of the order of the Arrondissementsrechtbank te Roermond referring a number of questions for a preliminary ruling in Case C-157/99 *Smits and Peerbooms*, in which judgment was delivered on 12 July 2001 (ECR I-5473). For my part, I have taken, so far as relevant, the account of Netherlands legislation which I set out in Chapter I of the Opinion which I delivered in that case on 18 May 2000.

4 — During the hearing before the Court of Justice, both sickness funds laid great emphasis on the fact that the legislation does not confer on insured persons any right to reimbursement of medical costs which they may incur.

if it has a valid scientific basis, it is defined as a benefit within the meaning of the Law on Sickness Funds. [5]

As regards dental care, the benefits to which insured persons are entitled are governed by Article 7(2). In 1994, the Government decided to abolish almost in its entirety entitlement of persons over 18 years of age to dental treatment under the compulsory sickness insurance system. [6] It appears that, for the time being, only an annual screening check-up and any necessary radiography are covered.

12. Article 9 of the Law on Sickness Funds governs claims for entitlement to care and provides, so far as is relevant:

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

2. The insured person may choose from among the persons and establishments mentioned in paragraph 1, subject to the provisions of paragraph 5 and the provisions regarding conveyance by ambulance....

...

4. A sickness fund may, by way of derogation from paragraphs 1 and 2 hereof, authorise an insured person, for the purpose of claiming entitlement to a benefit, to apply to another person or establishment in the Netherlands where this is necessary for his health care. The Minister may determine the cases and circumstances in which an insured person may be granted authorisation, in claiming entitlement to a benefit, to apply to a person or an establishment outside the Netherlands.'

13. The requirement of obtaining such authorisation is contained in Article 1 of the Regulation on health care abroad under the sickness insurance rules of 30 June 1988, [7] which provides:

'A sickness insurance fund may authorise an insured person claiming entitlement to a benefit to apply to a person or establish-

5 — In *Smits and Peerbooms*, the Court laid down how that requirement was to be interpreted where an insured person applies for authorisation to obtain medical treatment in another Member State at a hospital with which no agreement has been concluded.

6 — A year later, the Government reintroduced partial financing for dentures because certain elderly persons could not afford them.

7 — *Staatscourant* 1988, No 123.

ment outside the Netherlands in those cases in which the sickness insurance fund determines that such action is necessary for the health care of the insured person.

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, so that they must obtain prior authorisation from their sickness fund in exactly the same way as they have to in order to be treated by a medical practitioner or health-care institution established in the Netherlands with whom or which the fund has not concluded a health-care agreement.' [8]

14. In order to offer benefits in kind to insured persons, sickness funds must, under Article 44(1) of the Law on Sickness Funds, conclude agreements with persons and establishments offering one or more forms of care. Article 44(3) thereof defines the content of such agreements, which are to include the nature and extent of the obligations and rights of the parties, the quality and effectiveness of the care, the 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.

8 — The Agent for the Netherlands Government confirmed that point at the hearing.

IV — The provisions of the Treaty on freedom to provide services

15. Article 49 EC provides:

'Within the framework of the provisions set out below, restrictions on freedom to provide services within the Community shall be prohibited 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.

...'

Under Article 50 EC:

'Services 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.

...'

V — Procedure before the Court

16. In the initial stages of these proceedings, written observations were submitted, within the period for the purpose by Article 20 of the EC Statute of the Court of Justice, by Ms Müller-Fauré, OZ Zorgverzekeringen, the Governments of Belgium, Denmark, Germany, Spain, Ireland, Italy, the Netherlands, Sweden, the United Kingdom, Iceland and Norway and by the Commission.

17. On 12 July 2001, the day on which judgment was delivered in *Smits and Peerbooms*, the Registry of the Court of Justice wrote to the Centrale Raad van Beroep asking it whether, in the light of the answers given in that case, it wished to continue with its reference for a preliminary ruling. After hearing the views of the parties in both cases, the latter replied, on 25 October 2001, that it did not wish to withdraw its questions.

18. After declaring the written procedure in the present case closed in February 2000, the Court decided in March 2002 to request the parties to the main proceedings, the Governments of the Member States, the Council, the Commission and any other interested parties to comment in writing on the conclusions to be drawn from the judgment in *Smits and Peerbooms*, in view of the views expressed by the Centrale Raad van Beroep in its letter of 25 October 2001.

Ms van Riet, OZ Zorgverzekeringen, ZAO Zorgverzekeringen, the Governments of Ireland, the Netherlands, Sweden, the United Kingdom and Norway and the Commission took the opportunity to do so. Notification to the Spanish Government not having been sent to its address for service, it was allowed to submit its observations after the time-limit, which it did on 1 August 2002.

19. The representatives of Onderlinge Waarborgmaatschappij OZ Zorgverzekeringen UA and of Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen and the Agents for Denmark, Spain, Ireland, Finland, Sweden, the United Kingdom and

the Commission presented oral argument at the hearing on 10 September 2002.

VI — The observations of the parties to these proceedings

20. The views of those parties which have submitted observations, other than those of the appellants in the two sets of main proceedings, Belgium and the Commission, are largely the same except in a number of distinct aspects which I shall discuss below.

21. Ms Müller-Fauré takes the view that the requirement of prior authorisation is contrary to Articles 49 EC and 50 EC and cannot be justified on the ground that the same services may be obtained in the Netherlands and Germany and that the costs and quality are the same. Ms van Riet states that, in order to confirm, by means of an arthroscopy, the diagnosis that an ulnar reduction was necessary, she would have to wait between 10 and 14 weeks. She would then have to wait a further 6 to 8 months for her operation. In order to avoid that inconvenience, she attended a clinic in Belgium, where she waited only four weeks for the exploratory examination and one week for the operation, and the total cost came to less than two-thirds of what it would have been in the Netherlands.

22. OZ Zorverzekeringen maintains that the requirement of prior authorisation before seeking the services of a non-contracted provider, whether in the Netherlands or abroad, is an inherent part of the system of benefits in kind. Should it be deemed a barrier to freedom to provide services, it would still be justified by the need to guarantee affordable, high-quality health care and by the equality of insured persons in respect of entitlement to benefits. It is not necessary to make a distinction as to whether it is a medical practitioner or a hospital providing those services.

23. The Belgian Government submits that the authorisation requirement is contrary to Articles 49 EC and 50 EC. Moreover, a finding that it is not necessary to seek treatment abroad because a medical practitioner with whom an agreement has been concluded is able to provide it within the country amounts to discrimination. The special nature of the system of sickness insurance, that is the fact that it only provides benefits in kind, is not an overriding reason in the general interest capable of justifying a barrier of that kind.

24. The views of the other 11 Member States may be classified into two groups. The first group, which comprises Denmark, Germany, Ireland, Sweden, United Kingdom, Norway and Iceland, is of the view that public health-care benefits provided free-of-charge to insured persons are not services within the meaning of Article 50 EC, either because they lack the element of remuneration [9] or because those concerned, the doctor and the patient, cannot influence either the content or the price of the benefit.

Those belonging to the second group, composed of Spain, Finland, Italy and the Netherlands, defend the view that the judgment in *Kohll*, [10] which concerned a sickness insurance system which reimburses part of the cost of treatment, cannot be applied to those which provide only benefits in kind, and there is no need, in that regard, to distinguish between care provided by a medical practitioner and that provided in a hospital.

Whether it is considered that those are services or that *Kohll* also applies to a sickness insurance system such as that of the Netherlands, all the above States, without exception, submit that the requirement of prior authorisation is not contrary to Articles 49 and 50 EC because it is justified.

25. In the first observations submitted by the Commission, it maintained that hospital and medical benefits are services within the meaning of the Treaty, including in those Member States which operate a public health system [11] which is totally separate on the one hand from medical practitioners who practise their profession privately and privately-funded hospitals on the other. Under the sickness insurance system of the Netherlands, the benefits in kind, the agreements and the requirement of prior authorisation are indissociable parts of a single scheme. However, to make the grant of authorisation subject to the condition that the patient requires a benefit which a contracted establishment cannot provide without undue delay constitutes

9 — A view which I share, as I made clear in the Opinion I delivered in Case C-157/99 *Smits and Peerbooms*. See, in particular, points 35 to 49 in which I examine in detail the characteristics of the Netherlands compulsory sickness insurance scheme and I state 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 50 EC.

10 — Case C-158/96 *Kohll* [1998] ECR I-1931.

11 — The Commission acknowledges that, in some Member States, there exist public health-care systems in which health-care providers are not members of a liberal profession, whose remuneration is not for medical care and hospitals do not pursue a commercial activity. At the hearing it gave as examples Denmark, Spain, Ireland and the United Kingdom.

direct discrimination on the basis of place of establishment inasmuch as it favours non-contracted Netherlands service-providers to the detriment of those based in the other Member States.

VII — The case-law of the Court of Justice on freedom to provide services in the context of prior authorisation required by the sickness insurance fund to receive treatment in another Member State

A — *Surgery visit to a medical practitioner and the prior authorisation requirement in a sickness insurance system which reimburses cost of treatment*

The Commission claims that neither protection of the quality of health-care nor keeping costs under control by the sickness funds is sufficient reason to justify the barrier to the freedom to provide services which prior authorisation constitutes. It differentiates, in the context of hospital care, between care provided on admission from those provided as outpatient care and assimilates the latter to the care dispensed by medical practitioners in their surgeries. It concludes that it is very unlikely that the phenomenon of patients travelling to other Member States in search of non-hospital treatment will become sufficiently significant to affect seriously a national social security system providing benefits in kind.

26. In the document submitted at the request of the Court following delivery of the judgment in *Smits and Peerbooms*, the Commission acknowledges that there are certain dental services the particular nature of which could cause them to be caught by the overriding reasons examined in the abovementioned judgment concerning treatment at hospital, so that it urges the Court to clarify its position in that regard.

27. On 28 April 1998, the Court of Justice delivered its judgment in *Kohll*. [12] 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.

28. With regard to the application of the freedom to provide services to treatment provided by an orthodontist established in another Member State, outwith any hospital infrastructure, the Court stated that, since the service was provided for remun-

12 — Cited above. The Court on the same day also delivered Case C-120/95 *Decker* [1998] ECR I-1831, on which I will not comment because the facts of the case concerned the purchase of spectacles and thus fell within the scope of the free movement of goods. See my Opinion of 18 May 2000 in *Smits and Peerbooms* for the views of the numerous authors who have commented on those two judgments.

eration, it was a service within the meaning of Article 50 EC.

29. As to restrictive effects, 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 subject to prior authorisation, while reimbursement of those incurred in the State of insurance was not subject to the same requirement. 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. [13]

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

31. With regard to the first ground, since the Luxembourg social security institution took on the same financial burden whether an insured person approached a Luxembourg orthodontist or one established in another Member State, the Court took the view that 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.

32. As regards the protection of public health, according to paragraphs 45 and 46 of *Kohll*, while Member States may fix limits to 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, from the scope of the fundamental principle of freedom of movement. [14] In any event, as the conditions for taking up and pursuing the profession of doctor and dentist have been the subject of several coordinating and harmonising directives, [15]

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

14 — Case 131/85 *Gül* [1986] ECR 1573, paragraph 17.

15 — 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).

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, so that rules such as those applicable in Luxembourg were not justified on grounds of public health in order to protect the quality of medical services provided in other Member States.

Next, it was accepted in the judgment 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 provided for in Article 46 EC, since it contributes to the attainment of a high level of health protection. In that regard, that article 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.

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

B — *Treatment provided in a hospital and the prior authorisation requirement in a sickness insurance system which provides exclusively benefits in kind*

33. On 12 July 2001, the Court delivered the judgment in *Smits and Peerbooms*, [16] in which it was called upon to consider, at the request of a Netherlands court, the Arrondissementsrechtbank ter Roermond, the same provision as is in issue in the present case, namely Article 9(4) of the Law on Sickness Funds, read in conjunction with Article 1 of the Regulation on health care abroad under the compulsory sickness insurance rules.

34. In one of the two cases before the Rechtbank, the sickness insurance fund had refused to reimburse Ms Smits, who was suffering from Parkinson's disease, the cost of specific, multidisciplinary treatment she had undergone, without authorisation, in a clinic in Germany. The reasons for the refusal consisted in the fact that the specific clinical method was not normal treatment within professional circles and was therefore not one of the benefits covered and that satisfactory and adequate treatment was available in the Netherlands at an establishment with which there were contractual arrangements, so that the treatment undergone in Germany was not necessary.

16 — Cited above.

In the other case, the sickness insurance fund refused Mr Peerbooms, who had fallen into a coma following a road accident, reimbursement for the treatment undergone in a clinic in Austria, consisting in special intensive therapy using neurostimulation, a technique which, in the Netherlands, is used only experimentally at two medical centres on patients under the age of 25 years, which Mr Peerbooms was not. The refusal was based, first, on the fact that, owing to the experimental nature of therapy using neurostimulation and the absence of scientific evidence of its effectiveness, that type of treatment was not regarded as normal within professional circles, so that it was not a treatment which was covered. Second, on the consideration that, since satisfactory and adequate treatment was available without undue delay in the Netherlands at an establishment with which the sickness insurance fund had contractual arrangements, the treatment undergone in Austria was not necessary.

35. The Court did not accept the view of the majority of the Member States which argued that sickness insurance systems providing exclusively benefits in kind did not fall within the scope of Articles 49 EC and 50 EC. It ruled that not even the fact that medical treatment provided at a hospital was financed directly by the sickness insurance funds on the basis of agreements and pre-set scales of fees could remove such treatment from the sphere of services.

36. Next, it held that the Netherlands rules deter insured persons from applying to providers of medical services established in a Member State other than that in which they are insured and thus constitute, both for insured persons and service providers, a barrier to freedom to provide services.

37. In paragraphs 76 et seq., the judgment examines the prior authorisation requirement to which the Netherlands legislation subjects the assumption of the costs of treatment provided in another Member State by a non-contracted hospital and finds the measure both necessary and reasonable for a number of reasons. First, because the number of hospitals, their geographical distribution, the mode of their organisation and the equipment with which they are provided, and even the nature of the medical services which they are able to offer, are all matters for which planning must be possible. Secondly, because such planning, in a contract-based system such as that of the Netherlands, seeks to achieve the aim of ensuring that there is sufficient and permanent access to a balanced range of high-quality hospital treatment within the State and to control costs and to prevent any wastage which would be all the more damaging inasmuch as the hospital sector generates considerable costs and must satisfy increasing needs, while the financial resources which may be made

available for health care are not unlimited, whatever the mode of funding applied. [17]

VIII — Examination of the questions referred to the Court

38. As has been pointed out above, the Court found in *Kohll* that, in the case of treatment carried out by a medical practitioner at his surgery, chargeable to a 'reimbursement' sickness insurance, the barrier to freedom to provide services which the prior authorisation from the sickness fund constitutes was not justified. However, in the judgment in *Smits and Peerbooms*, which concerned treatment provided in a hospital, chargeable to a system of benefits in kind, the Court found, without drawing a distinction between whether the system was one of reimbursement or provided only benefits in kind, that a restriction on one of the fundamental freedoms under the Treaty could be justified by overriding reasons in the general interest.

At this stage, it still remains to be ascertained whether such prior authorisation is permissible where what a person insured under a system of benefits in kind seeks is medical attention which does not require admission into hospital. [18]

39. The Centrale Raad van Beroep itself came to that conclusion in the letter it sent to the Court of Justice in which, first, it pointed out that *Smits and Peerbooms*, which concerned principally treatment offered after admission to hospital, did not enable it to reply to the questions arising in the case brought by Ms Müller-Fauré, where treatment had been dispensed in the specialist's surgery. However, although Ms Van Riet had shown herself in favour of maintaining the reference, the Netherlands court acknowledges that, in the light of the abovementioned judgment, there is no need to answer the questions but it nevertheless requests the Court of Justice to clarify the concept of 'without undue delay' employed in paragraph 103.

A — *Questions 1 and 2*

40. Those questions are practically identical to those referred by the Arrondissementsrechtbank te Roermond in *Smits and Peerbooms*, namely Questions 1(a) and

17 — Bonomo, A., 'Programmazione della spesa sanitaria e libertà di cura: un delicato dilemma', *Il Foro Amministrativo*, 2001, pp. 1870 to 1880, in particular, p. 1880: 'Equilibrio finanziario e programmazione della spesa sanitaria sembrano dunque prevalere sulla libertà di prestare servizi all'interno del territorio comunitario, e, quindi sulla libertà di scelta del luogo di cura'.

18 — Steyger, E., 'National Health Care Systems Under Fire (but not too heavily)', *Legal Issues of Economic Integration* 2002, 29(1), pp. 97 to 107, in particular p. 99: 'Since the Kohll and Decker cases concerned a system of reimbursement, the question remained whether the same approach should be applied to national health security schemes which offered benefits in kind'.

2. It is, none the less, appropriate to reformulate them in view of the fact that the Court has already dealt with the requirement of prior authorisation where care is provided in hospital.

Thus, the national court must be understood to be now seeking to ascertain whether Articles 49 EC and 50 EC preclude rules of a Member State setting up a system of benefits in kind requiring insured persons to obtain prior authorisation from their fund before travelling to another Member State if they wish to be seen by a medical practitioner with whom the fund does not have contractual arrangements, bearing in mind that authorisation is granted only if treatment is necessary for the insured person, which implies that appropriate treatment which may be provided without undue delay by a contracted medical practitioner is not available within the country.

41. The Court has already held, in *Smits and Peerbooms*, that the requirement that insured persons obtain authorisation from the sickness fund in order to exercise their entitlement to benefits, at a hospital in another Member State, constituted a barrier to freedom to provide services. I am of the view that the restriction on the insured person is of the same order of magnitude where what is involved is a consultation with a medical practitioner.

42. Indeed, Article 49 EC precludes the application of any national rules which have the effect of making the provision of services between Member States more difficult than the provision of services purely within one Member State. [19] Although the Netherlands legislation at issue does not deprive insured persons of the possibility of using a provider of services established in another Member State, in practice it makes assumption by the fund of the cost of the benefit subject to prior authorisation, which is moreover refused where the abovementioned requirement is not satisfied.

As was shown with regard to care provided in hospitals in paragraph 67 et seq. in *Smits and Peerbooms*, since only few medical practitioners established in other Member States are contracted to Netherlands sickness funds, in the majority of cases the assumption of the cost of consulting a medical practitioner established in another Member State is subject to prior authorisation, which would be refused if the abovementioned requirement is not satisfied. On the other hand, a visit to a contracted doctor established within the territory and responsible for dispensing most of the health care to insured persons under the Netherlands Law on sickness funds is not only free of charge to the

19 — Case C-381/93 *Commission* v *France* [1994] ECR I-5145, paragraph 17; *Kohll*, paragraph 33; and *Smits and Peerboom*, paragraph 61.

patient, it is also not subject to prior authorisation.

43. Therefore, as the Court held in the aforementioned judgment, the Netherlands rule at issue is not only a deterrent to insured persons, it also prevents them applying to medical practitioners established in the other Member State, so that it constitutes, for both the former and the latter, a barrier to freedom to provide services. [20]

44. The Court has already acknowledged, with regard to the provision of cross-border medical care, that there exists a number of overriding reasons in the general interest which, where they are fulfilled, are capable of justifying restrictions on the freedom to provide services irrespective of whether it is provided as outpatient care under a system of sickness insurance which reimburses part of the benefits [21] or provided in hospital under a system of benefits in kind. [22]

An analysis of the case-law reveals three reasons: one consists in avoiding the risk of seriously undermining the financial balance of the social security system; another is the objective of maintaining a balanced medical and hospital service open to all, which may also fall within the derogations on grounds of public health under Article 46 EC, in so far as it contributes to the attainment of a high level of health protection; and the final reason is maintenance of a treatment facility or medical service on national territory, which is essential for the public health and even the survival of the population.

45. It is therefore necessary to determine whether the barrier to freedom to provide health services which is constituted by the requirement, set by the Netherlands compulsory sickness insurance funds, to obtain prior authorisation before consulting a non-contracted medical practitioner is justified by any of those three reasons bearing in mind that it is settled case-law that national rules must not exceed what is objectively necessary for achieving the objective pursued and that such a result must not be achievable by less restrictive means. [23] Furthermore, discriminatory rules can only be justified on the general-interest grounds referred to in Article 46

20 — *Kohll* and *Smits and Peerbooms*, paragraphs 35 and 69 respectively.

21 — See paragraph 37 et seq. in the judgment in *Kohll*.

22 — See paragraphs 72 to 75 in *Smits and Peerbooms*.

23 — Case 205/84 *Commission* v *Germany* [1986] ECR 3755, paragraphs 27 and 29; Case C-180/89 *Commission* v *Italy* [1991] ECR I-709, paragraphs 17 and 18; Case C-106/91 *Ramrath* [1992] ECR I-3351, paragraphs 30 and 31; and *Smits and Peerbooms*, paragraph 75.

EC, to which Article 55 EC refers, and which do not include economic aims. [24]

The national court which has made the reference to the Court acknowledges that the system of benefits in kind, organised by the Netherlands sickness funds by means of agreements, serves to safeguard the quality of care for insured persons and to control costs.

46. As I said in the Opinion I submitted in *Smits and Peerbooms*, the Netherlands compulsory sickness system is characterised, first, by the fact that treatment is free for insured persons who, in order to obtain the health-care benefits they require, must use one of the medical practitioners or health-care institutions with whom or which their fund has concluded an agreement so that, if they decide to use non-contracted providers, they are required to pay any costs they incur, without entitlement to reimbursement; and, secondly, by the fact that sickness funds, which have a statutory duty to obtain for insured persons appropriate treatment, operate by concluding 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 medical 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 on each occasion.

47. As pointed out in paragraph 76 of *Smits and Peerbooms*, unlike the services provided by practitioners in their surgeries or at the patient's home, those provided in a hospital take place within an infrastructure with, undoubtedly, certain very distinct characteristics, since the number of hospitals, their geographical distribution, the mode of their organisation and the equipment with which they are provided, and the nature of the medical services which they are able to offer, must all be planned for.

I am nevertheless of the opinion that, with regard to a system of sickness insurance which is structurally organised to provide only benefits in kind, whether by providing itself with its own hospitals and contracted staff or, as in the Netherlands, by concluding agreements with medical practitioners and hospitals, the distinction between care provided by medical practitioners in their surgeries and those provided in hospital is blurred.

24 — Case C-288/89 *Collectieve Antennevoorrziening Gouda and Others* [1991] ECR I-4007, paragraph 11; Case C-353/89 *Commission* v *Netherlands* [1991] ECR I-4069, paragraph 15; Case C-484/93 *Svensson and Gustavsson* [1995] ECR I-3955, paragraph 15; and Case C-398/95 *SETTG* [1997] ECR I-3091, paragraph 23.

48. In the Netherlands, there are approximately 30 sickness funds, with defined territorial scope. Persons entitled to compulsory insurance must register with the fund operating in the municipal district in which they reside. The number of agreements which they regularly conclude with general practitioners and with medical practitioners with various specialisms varies according to the need for health care calculated by the area in which they operate and the number of patients registered in a given period.

49. Furthermore, the charges which funds agree each year with medical practitioners, which differ according to the specialism concerned, largely depend on the number of patients registered with them. The charges are calculated by means of an arithmetical formula whereby one amount,[25] representing average income, is added to another, representing the average cost of running a practice,[26] 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). In respect of 2000, that calculation produced the result that a general practitioner received from the sickness insurance fund with which he had concluded an agreement the amount of NLG 133, known as a subscription charge,[27] for every insured person who chose to be treated at his surgery, irrespective of the number of patients he actually saw, and regardless of the fact that some may have needed to be seen more often than others and some may not have needed to be seen at all at any time during the year.[28] It would appear that contracted dentists also receive from the sickness fund payment at a flat rate per patient.[29]

Provision is thus made in advance for the financing of all the health care patients may need in the course of a year, as out-patients for general practitioners, specialists and dentists, in order to ensure that the funds do not in principle have to bear any additional expenditure. In those circumstances, the use by insured persons of non-contracted providers can have a significant impact on the funding of the system, since it represents an additional financial burden for the fund in every case, and consequently risks seriously undermining the financial balance of the system.

25 — This includes salary, holiday pay, insurance, bonuses, premia and pension plans. Salaries are based on civil service salary scales and are reviewed annually.

26 — There are guidelines for calculating the cost of running each profession's establishments. Account is taken of the costs of accommodation, transport, assistant staff, telephone, area covered, instruments and so forth. They are adjusted in accordance with new requirements, such as, for example, installing computers in surgeries.

27 — That charge amounts to NLG 157 per insured person over 64 years of age.

28 — The system of remunerations for contracted practitioners who provide their services within the context of the compulsory sickness insurance system is markedly different from the system governing private practice, where there is no system of subscription charges, there being a charge for each visit instead.

29 — See Chapter 5 of the publication produced by the Ministerie van Volksgezondheid, Welzijn en Sport-NL, May 2001, entitled *Health Care, Health Policies and Health Care reforms in the Netherlands:* 'General practitioners and dentists receive capitation payments for their sickness fund insured, but usually fee for services from their private insured clients'.

50. The fact is that, if there are only a few patients every year who follow the course of action taken by Ms Müller-Fauré, it is difficult to prove that reimbursing their costs has a significant impact on the management of the budget of the sickness funds.

Indeed, the Commission argues that there is no question of a risk of seriously undermining the financial balance of the social security system inasmuch as, because of the language barrier or difficulties in travelling, in the final analysis the number of patients going to other Member States to see a doctor are very few. [30]

51. I cannot agree. The Commission knows very well that there is a relatively large number of doctors benefiting from freedom of establishment in order to practise in Member States other than their own. If a patient visits such a doctor who speaks the patient's language, there is no longer a language barrier. Likewise, language borders in Europe are far from being coterminous with the territorial limits of the States and, across broad border areas, people often use the language of the neighbouring country. I would point out as examples Belgium and the Netherlands, Luxembourg and Germany, Italy and Austria, Sweden and Finland, Spain and Portugal, or countries which share a language, such as Ireland and the United Kingdom or Austria and Germany.

Neither is distance a deterrent factor, in particular, in view of the progress in communications within Europe, the trend in second-home ownership in another Member State and the ease and frequency with which a sizeable proportion of the population travels to other countries on holiday.

52. There is another reason why I believe there would be a relatively high number of patients who, if they could be certain of being reimbursed, would choose to travel to another Member State in order to see a specialist. They would be those who, having the means to afford it, would not wish to wait a relatively long time before being seen by a doctor. The patient seeks, with legitimate eagerness, to do everything in his power to look after himself. Let us bear in mind that, as far back as the eighteenth century, Molière was aware of that human tendency since Argan, the main character in his comedy *Le malade imaginaire*, sought to marry his daughter Angélique, irrespective of her wishes, to a doctor

30 — At the hearing, the Netherlands Government informed the Court that, even all the disadvantages listed by the Commission and despite the mandatory nature of the prior authorisation requirement, some 14 000 insured persons received treatment abroad in 2001.

in order to ensure for himself treatment for any complaint from which he might ail. [31]

53. It must be borne in mind, when maintaining the financial balance of the system, that the functioning of a system of benefits in kind is characterised also by the important role played by general practitioners, who are responsible for providing patients with primary care, referring them, where necessary, to the relevant specialist, whom patients cannot consult directly. If insured persons were able to sidestep that prior stage and go on their own initiative to a specialist in another Member State, while the sickness fund remained obliged to reimburse them, a large part would be lost of the efficiency brought to the system by that method of controlling unnecessary use of medical services, in particular in preventing specialists' waiting rooms being filled with patients who prescribe such a consultation for themselves without even knowing which specialist should deal with their complaint. Thus, that aspect of the general practitioner's work, intended to contain costs and monitor the proper matching of means to needs, fulfils, within the system of contracted services, a function similar to that of the prior authorisation from the fund prior to consulting a non-contracted practitioner.

54. Furthermore, so far as concerns the desire to maintain a broad range of medical care which is balanced and open to all, it is clear that the interest of practitioners in concluding agreements with the sickness funds is in direct relation to the number of patients which they might be allocated and in respect of whom they collect charges every year. If insured persons, instead of going to contracted practitioners, were to go to non-contracted doctors, whether within the country or abroad, the funds would be unable to guarantee a number of insured persons per doctor. There would be a risk that many such practitioners would lose interest in undertaking to make themselves available to a definite extent and guarantee the quality and price of their services by concluding agreements with the funds which manage the compulsory sickness insurance, preferring instead to treat private patients, who would certainly be fewer but from whom they receive higher fees. Thus, despite the efforts of the funds to make plans for the provision of health care, staffing and funding, it would not be possible to guarantee insured persons stable and open access to medical practitioners, including a wide range of specialists, at affordable cost, so that the continuity of the system of benefits in kind, in its present form, would be seriously jeopardised. It must be borne in mind that, as the Court has consistently held, Community law does not detract from the powers of the Member

31 — See Molière, *Le malade imaginaire*, in particular Act I, Scene 5, Ed. Larousse, petits classiques, Paris, 1998, p. 61. It is interesting to note that, in scene 10 of Act III, Toinette, the servant, pretends to her employer to be a doctor and, foreshadowing the question of crossborder medical care, claims to be an itinerant doctor, going from town to town, from province to province, from kingdom to kingdom, p. 167.

States to organise their social security systems, [32] so that in the absence of harmonisation at Community level, it is for national legislation to determine the conditions for entitlement to benefits. [33]

55. It is true that social security systems of benefits in kind are burdened with the problem of waiting lists, arising from the ever-widening discrepancy between supply and demand in health care, both with regard to admission to hospital and to seeing a doctor. [34] Faced with that situation, prior authorisation from funds before seeking treatment from non-contracted sources is a mechanism which enables them to establish priorities for various forms of treatment, manage the available resources and ensure, in practice, health care in accordance with the needs which may arise at any time. If patients on doctors' waiting lists had free access to the non-contracted services market and were entitled to reimbursement, it would destroy the fundamental principle of equality, between insured persons, of access to health care to the detriment of those who, because they lack the means or because they trust in the fairness of the system, await their turn, with the result that the essence of a system of sickness insurance of benefits in kind would be lost, becoming a *de facto* reimbursement system.

In that context, the fact that it turns out that the cost of the actual treatment which an insured persons such as Ms Van Riet has obtained in another Member State was less than that which the fund would have had to pay in the State of membership is irrelevant, since the adverse consequences of such a course of action for the system cannot be assessed on the basis of just one isolated case. [35]

56. Likewise, where patients travel regularly and systematically to other Member States in search of medical treatment, the risk arises, in particular, for smaller countries, that funds stop managing to maintain an acceptable level of professional competence in the treatment of rare or very complex conditions.

32 — Case 238/82 *Duphar and Others* [1984] ECR 523, paragraph 16; Case C-70/95 *Sodemare and Others* [1997] ECR I-3395, paragraph 27; *Kohll*, paragraph 17; and *Smits and Peerbooms*, paragraph 44.

33 — Joined Cases C-4/95 and C-5/95 *Stöber and Piosa Pereira* [1997] ECR I-511, paragraph 36; *Kohll*, paragraph 18; and *Smits and Peerbooms*, paragraph 45.

34 — This is not a problem which affects only sickness insurance systems providing benefits in kind: one need only note the number of days patients are made to wait in Luxembourg, a State which provides only for reimbursement of part of the costs of treatment incurred by insured persons, before seeing a general practitioner or the number of weeks before managing to see a specialist.

35 — Dubouis, L., 'La libre circulation des patients hospitaliers, une liberté sous conditions', *Revue de droit sanitaire et social*, 37(4) 2001, pp. 721 to 726, in particular p. 726: '... on peut se demander s'il est pleinement légitime d'accorder au patient qui se déplace le droit de choisir entre le régime de son État d'origine et celui de l'État dans lequel il se fait soigner les éléments qui lui sont les plus favorables'.

57. Moreover, by being indissociably linked to the system of sickness benefits in kind, prior authorisation is an ideal means for allowing insured persons to know, sufficiently in advance, whether the treatment they seek is covered, enabling the fund to keep control over costs and the use of resources.

If Ms Müller-Fauré had sought prior authorisation, she would have learnt that, of the services which she was going to seek from the dentist in Germany, only an infinitesimal part was covered by her social security system in the Netherlands. At the same time, the fund could have determined whether the state of the patient's dentition required treatment from a non-contracted dentist or whether it was preferable that the patient should see a contracted dentist, bearing in mind that covered dental treatment is provided on the basis of capitation payments.

58. Belgium, where the sickness insurance reimburses part of the costs of treatment, objects to prior authorisation of funds, ruled out under *Kohll*, being justified where systems of benefits in kind are concerned, inasmuch as the freedom to provide services cannot depend on the special nature of the social security system.

I understand that point of view but I do not share it. I am aware of the difficulty of reconciling that fundamental freedom under the Treaty with the idiosyncrasies of the sickness insurance systems of 15 countries, most of which grant benefits in kind. However, it must be borne in mind that the Member States have never had the intention of harmonising their laws in this field and have confined themselves to coordinating them by means of Regulation No 1408/71 in order to achieve the objectives required under Article 42 EC. Although it is true that, when organising their social security systems, the Member States must comply with Community law, [36] that obligation cannot require them to abandon the principles and philosophy which has traditionally governed their sickness insurance, nor require them to undergo restructuring on a scale such as to enable them to reimburse those of their insured persons who choose to go to the doctor in another Member State. [37]

59. Finally, the necessity of the treatment which the patient proposes to follow, by going to a non-contracted provider, as a condition for the granting of prior authorisation by the sickness insurance fund, was examined in detail in paragraphs 103 to 107 of the judgment in *Smits and*

36 — *Kohll* and *Smits and Peerbooms*, paragraphs 19 and 46 respectively.

37 — We have yet to see how insured persons would react since, instead of enjoying free health care, they would have to pay for it in advance and wait for a time before being reimbursed part of the actual cost.

Peerbooms. In my opinion, the same reasoning applies in the present case, and should be declared justified in accordance with Article 49 EC, provided that the condition is construed to the effect that authorisation may be refused on that ground only if the same or equally effective treatment for the patient can be obtained without undue delay from a medical practitioner with which the insured person's sickness insurance fund has contractual arrangements. [38]

Interpreted thus, such a condition results, in the context of prior authorisation, in an adequate, balanced and permanent supply of high-quality outpatient treatment being maintained within the national territory and provides financial stability to the sickness insurance system.

60. Just as with treatment in hospital, were many persons insured under a system of benefits in kind decide to travel to other Member States to see a medical practitioner, when there is sufficient supply in the country under contractual arrangements providing adequate identical or equivalent services, the outflow of patients would put at risk the very principle of having contractual arrangements, all the planning and rationalisation carried out by the funds, the balance in the supply of medical care and the management of resources in accordance with priorities. [39]

However, once it is clear that the benefits covered by the national insurance system cannot be provided by a contracted practitioner, it is not acceptable that national practitioners not having any contractual arrangements with the insured person's sickness insurance fund be given priority over doctors established in other Member States since, once such benefits are ex hypothesi provided outside the planning framework established by national legislation, such priority would exceed what is necessary for meeting the overriding

38 — That is the view taken in respect of hospital treatment by the Arrondissementsrechtbank te Rotterdam, which had referred the question in that case, when it ruled on the merits of the main proceedings, on 3 October 2001, just two and a half months after receiving the Court's answer. It dismissed Ms Geraets-Smits' application on the ground that it had not been proven either clinically or scientifically that the specific, multidisciplinary treatment provided in Germany was any better than the care available in the Netherlands and because the patient could have been seen in her own country at a hospital having contractual arrangements with her sickness fund. Mr Peerboom's application suffered the same fate, the court having found that the special intensive therapy by means of neurostimulation cannot be regarded as normal within professional circles, inasmuch as it has not been sufficiently researched or recognised by international medical science. In coming to that conclusion, the court relied on an expert opinion of 1994 on stimulation programmes, the report by a committee of the Health Authority and a pilot study. See the judgments in the 'National Decisions' database of the Court, reference QP/03935-P1-A and QP/03935-P1-B.

39 — Dubouis, L., op. cit., p. 726 states, with regard to health care provided in hospitals: 'Il reste que les incidences pratiques à moyen ou long terme de cette jurisprudence paraissent difficiles à évaluer. Ne risque-t-elle pas d'induire un afflux excessif de candidats à l'admission dans les établissements "en pointe", d'aggraver les difficultés des systèmes de soins moins performants? Il apparait souhaitable que nos systèmes hospitaliers s'ouvrent aux vents de l'Europe. Pour autant, on ne saurait oublier combien ils diffèrent les uns des autres, combien chacun est complexe et repose sur des fragiles équilibres, financiers notamment.'

requirements capable of justifying a barrier to the principle of freedom to provide services.

61. I am fully aware that the interpretation which I am proposing not only runs counter to the view of States whose sickness insurance systems reimburse part of the costs incurred by insured persons, the only one of which to have submitted its views being Belgium, but also has the drawback that it challenges the views of extreme supporters of the liberalisation of health services in the Member States. It does, however, at least have the advantage of offering a clear and unambiguous solution to the problem raised, avoiding dilemmas such as that faced by the Commission, which acknowledges that the special nature of certain dental services would justify invoking the general-interest reasons considered in *Smits and Peerbooms*.

In answer to the question I put to it in that respect, the Commission explained that it meant very expensive dental treatment which required the services of highly specialised practitioners, since the availability of such services requires planning. It further acknowledged that there are no absolute means of differentiating between hospital and outpatient care: where a patient is admitted, the authorisation requirement is justified, whereas if the service is provided at a surgery, that requirement must be considered on a case-by-case basis.

I am not alone in thinking that the Commission's proposal, however adequate it may appear in the light of the principle of proportionality, would not work in practice [40] since, first, it would introduce an element of uncertainty for the users of the system contrary to the principle of legal certainty and, secondly, if prior authorisation is justifiable on the ground that insurance funds need to plan for the supply of medical services, I think it is obvious that the most expensive or complex services should not be the only services which must be planned for. [41] That is not to take account of the fact that the funds ought to consider beforehand, in respect of each outpatient service, whether it is such as to require prior authorisation, thus introducing an additional obstacle into the procedure for obtaining health care.

62. In view of all the foregoing considerations, I am of opinion that Articles 49 EC and 50 EC do not preclude legislation of a Member State, setting up a social security system which provides for sickness benefits

40 — The Member States which attended the hearing, in exercise of their right of reply, showed themselves to be against that possibility.

41 — The possibility is not restricted to dental treatment. There are services such as scanning or magnetic resonance imaging, which are usually provided by radiologists, which do not require admission to hospital and the availability of which is limited and undoubtedly requires planning by the bodies which manage the sickness insurance fund.

in kind, requiring insured persons to obtain prior authorisation from their sickness insurance fund in order to travel to another Member State, if they wish to be treated by a non-contracted practitioner, and making the grant of such authorisation subject to the condition that the treatment is necessary for the person concerned, provided it is understood that it can be refused only if the same or equally effective treatment can be obtained without undue delay from a practitioner having a contractual arrangement with the insured person's sickness insurance fund.

B — *The third question*

63. The judgment in *Smits and Peerbooms* already analysed exhaustively the requirement of prior authorisation to obtain, in another Member State, services provided in hospitals. There is therefore no need to answer the third question referred to the Court which sought to ascertain whether in order to answer the two preceding questions, it was necessary to make a distinction according to whether the care was provided, in whole or in part, at hospital.

C — *The clarification sought by the Centrale Raad van Beroep regarding the meaning of 'without undue delay' used in paragraph 103 in the judgment in Smits and Peerbooms*

64. In the letter of 25 October 2001, the national court asked the Court of Justice the meaning of that expression, which it did not find clear, in the following terms:

'Is the term "without undue delay" [tijdig] in paragraph 103 of the judgment in *Smits and Peerbooms* to be interpreted as meaning that there can be no question of any undue delay if medical treatment is not urgent or necessary on medical grounds, irrespective of the length of the waiting time for such treatment?'

65. In that regard, I agree with the Commission, which pointed out that the term derives from Netherlands law, specifically from the order by which the Arrondissementsrechtbank te Roermond made its reference in *Smits and Peerbooms*. The word 'tijdig' appears in the last line of the penultimate paragraph of Chapter II(1) of the order.

It is a condition linked to one of the two requirements laid down by the sickness funds when granting prior authorisation, namely that the planned treatment is necessary for the patient.

66. Furthermore, in *Smits and Peerbooms* the Court explained, in paragraph 104, the way in which to determine whether equally effective treatment could be obtained without undue delay from an establishment having contractual arrangements with the insured person's fund, stating that the national authorities are required to have regard to all the circumstances of each specific case, not only of the patient's medical condition at the time when authorisation is sought but also of his past record.

As may be seen, the Court made no mention of grounds other than medical.

67. I am of the opinion that it must be explained to the national court that determination of the condition as to 'without undue delay' (tijdig) must be carried out from a strictly medical point of view, irrespective of the length of the waiting time for the treatment sought.

IX — Conclusion

68. In view of the foregoing, I propose that the Court's reply to the questions referred to it by the Centrale Raad van Beroep should be as follows:

(1) Articles 49 EC and 50 EC do not preclude legislation of a Member State, setting up a social security system which provides for sickness benefits in

kind, requiring insured persons to obtain prior authorisation from their sickness insurance fund in order to travel to another Member State, if they wish to be treated by a non-contracted practitioner, and making the grant of such authorisation subject to the condition that the treatment is necessary for the person concerned, provided it is understood that it can be refused only if the same or equally effective treatment can be obtained without undue delay from a practitioner having a contractual arrangement with the insured person's sickness insurance fund.

(2) Determination of the condition as to 'without undue delay' (tijdig) must be carried out from a strictly medical point of view, irrespective of the length of the waiting time for the treatment sought.