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A Judicialisation of Healthcare Policies in Denmark and Spain? The Universalist Healthcare Model Meets the European Union¹

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Abstract

This paper examines the impact of judicialisation on the right to cross-border healthcare in Denmark and Spain, i.e., the national impact of legal integration as spurred by the Court of Justice of the European Union (CJEU). We expect the national impact of judicialisation to be conditioned by the ex-post judicial, administrative and political responses, particularly the national courts' activation of EU law. By using new data, a compilation of national court cases, quasi-judicial proceedings and research interviews with key respondents, we examine the process of judicialisation in the two member states. The findings demonstrate that the national courts hardly played a role in Denmark and that although the courts were more active in Spain, the rulings remained largely unobserved by the political and administrative elite and the courts were thus unable to push for change. The administrative and political responses were found to be quite similar in the two member states, adapting to EU-induced changes in a protectionist and defensive manner. We conclude that the two universalistic healthcare models have so far proved resistant to judicialisation and that the discrepancy between what emerges de jure at the supranational level and the de facto rights produced at the national level is still a wide one.

Keywords

Health policy, Judicialisation, EU patient mobility, Universalist health care model, Impact

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Introduction

It is increasingly held that European politics has become judicialised, a process through which courts are becoming more involved in settling political disputes and come to propel political change. Although identified as a global trend, the judicialisation of politics should be particularly strong in the European Union (Kelemen 2013, 295). In European integration, judicialisation may occur at both the supranational and national levels. It involves both the Court of Justice of the European Union (CJEU), which produces change by means of legal integration, and the national courts, as decentralised enforcers of European law. The CJEU is famous for its ability to take European integration forward, and its judicial interpretations – if they are fully taken on board – would undoubtedly transform a large set of national policies and politics. However, such court-driven change could hardly occur uncontested. Central questions of theoretical and empirical importance remain open. To what extent does judicialisation produce national impact? How may ex-post judicial, administrative and political responses and interactions condition the impact of judicialisation, i.e., reactions after a supranational judicial decision has been rendered (Ginsburg 2014, 490-494)?

In this paper, we examine the impact of legal integration on cross border healthcare in Denmark and Spain. Until the late 1990s, the right to receive healthcare services in another member state was limited by the Treaty, which set out that the delivery and organisation of healthcare was the responsibility of the member states. Additionally, regulation 1408/71 (now regulation 883/2004) on the coordination of social security for migrant workers stated that planned healthcare treatment could only be sought in other member states and reimbursed in the home state if it had been authorised beforehand by the relevant national authority. The division of competences between the EU and the national level was thus fairly clearly set out (Carrascosa 2014; 2014b).

The high degree of national control has subsequently been challenged by two sequences of EU-invoked change (see also the introduction to this special issue, Vollaard and Martinsen 2016). First, the established regulatory status quo was challenged by a line of CJEU case law that specified that healthcare was not exempted from single market principles.² Second, as a response to this line of CJEU jurisprudence, a Patient

² See in particular the following cases; C-120/95 Decker [1998] ECR I-01831; C-158/96 Kohll [1998] ECR I-01931; C-368/98 Vanbraekel [2001] ECR I-5363; C-157/99 Geraets-Smits and Peerbooms [2001] ECR I-05473; C-326/00 Ioannidis [2003] ECR I-1703; C-385/99 Müller-Fauré and Van Riet [2003] ECR I-04509; C-56/01 Inizan [2003] ECR I-12403; C-8/02 Leichtle [2004] ECR I-2641; C-372/04 Watts [2006] ECR I-4325; C-466/04 Acereda Herrera [2006] ECR I-5431; C-444/05 Stamatelaki, [2007], ECR I-3185; C-211/08 Commission v Spain [2010] ECR I-5267; C-512/08 Commission v France [2010] ECR I-8857; C-490/09 Commission v Luxembourg [2011] ECR I-249; C-255/09 Commission v Portuguese Republic [2011] ECR I-10547; C-173/09 Elchinov [2010] ECR I-8889.

Rights Directive (PRD) has been adopted, which has subsequently been transposed in the member states.³ The PRD is the collective political response to previous legal integration. In the course of legal integration, the CJEU has established that healthcare is a service within the meaning of the treaty. In its line of case-law, it has clarified that internal market principles also apply to hospital care, but it draws a distinction between hospital care and non-hospital care. Hospital care may, under certain conditions, justify prior authorisation. The Court, however, found that for non-hospital care, prior authorisation was an unjustified barrier to the free circulation of services. Jurisprudence had established a situation of legal uncertainty, and member states requested that the European Commission come up with a proposal to clarify matters. It took the Commission ten years to present a proposal that separately dealt with cross border healthcare. On 2 July 2008, the Commission presented its proposal on a Patients' Rights Directive (COM (2008) 414). The European Parliament and the Council of Ministers engaged in turf negotiations for 2.5 years but, in March 2011, managed to agree on a compromise during the second reading. The Patient Rights Directive became a reality. The output of political negotiations had, however, modified what the Court had initiated (Martinsen 2015). Considerably more national control was put in place during the negotiations. As stated in article 8 of the PRD, prior authorisation can be permitted for hospital care but also for highly specialised and cost-intensive care, and member states can themselves define what is classified as highly specialised and cost-intensive care, provided that such a classification is objective, proportionate and transparent. The European Commission was far from satisfied with the final result and found that it constituted a very restrictive interpretation of the case-law of the Court (COM (2010) 503, 7). However, as a response to political negotiations, the Court itself has become more cautious in its interpretation, taking a more 'tempered approach' (Hatzopoulos and Hervey 2013). It now acknowledges that prior authorisation is also justifiable for highly specialised and costly healthcare⁴, thus allowing more national control for access to healthcare in another member state.

This paper first sets out the theoretical framework for examining the judicialisation of politics, followed by an empirical analysis of judicialisation and transposition in Denmark and Spain. The analysis draws on a new data set where we compiled national court cases and quasi-judicial proceedings that had based their decisions on the relevant CJEU jurisprudence. Furthermore, research interviews were held with key respondents in the two member states, including civil servants in charge of the transposition from the relevant ministries and regional authorities, representatives from patient organisations, boards for patient complaints, and representatives from the involved healthcare agencies, among others. A total of 22 semi-structured interviews were conducted for the present study from August 2012 to October 2014.

³ Directive 2011/24/EU on the application of patients' rights in cross-border healthcare.

⁴ For this turn in legal interpretations, see in particular C-512/08 Commission v France [2010] ECR I-8857.

A Judicialisation of Politics – From Legal Integration to National Change

In general, judicialisation marks a process where court rulings impact both politics and policy-making. The term has a dynamic connotation that suggests a broadened judicial impact at the expense of the parliament, the government and the executive (Rothmayr 2001, 77). Judicialisation is noted as a global trend, but one that reaches 'its apotheosis in the European Union' (Kelemen 2013, 295).

Whereas scholars of European integration generally agree on the Court as an important actor for European integration, they tend to disagree on what the broader impact of legal integration is, particularly when it runs counter to the political preferences of the governing majority. One group of scholars sees the political power of the Court as considerable indeed, with fundamental implications for politics (Kelemen 2013; Alter 2009; Stone Sweet 2000). According to this view, politics is inexorably placed in the 'shadow' of constitutional review (Stone Sweet 2000, 202). Parliamentary sovereignty, understood as majoritarian rule, has lost 'its grip' and has been 'steadily undermined' by the counter-ideology of modern constitutionalism (Stone Sweet 2000, 196). The relationship between law and politics is one where judicial activity conditions politics, rather than the other way around.

"... Governments and parliaments have developed new practices designed to accommodate the constitutional law, as it is progressively elaborated by the court. Judicialisation provokes the emergence and institutionalisation of a new kind of legislative politics" (Stone Sweet 2000, 202-203).

In this view, a 'judicialisation of politics' has gained traction in the European Union (Stone Sweet 2010, 7). Kelemen terms this highly judicialised mode of governance as Eurolegalism (Kelemen 2011). Political decision-making and national responses have become judicialised, which means that non-judicial actors are guided by court-developed rules. Judicialisation creates a new type of legislative politics, in which legislators carry out the following:

'routinely take decisions that they would not have taken in the absence of review, and governing majorities anticipate likely decisions of the court and constrain their behavior accordingly' (Stone Sweet 2000, 202).

Other scholars note that although judicialisation is a growing trend, the impact of the judiciary on public policy outcomes depends on the subsequent political reactions (Hirschl 2008). The political sphere needs to support judicial interventions for these to generate policy reforms. If litigation introduces a unwelcome development to the political elites, the political elites have many ways to 'quell unfavorable judgments' (Hirschl 2009b, 827; Fisher 1988, ff.) Courts and their jurisprudence cannot be understood in isolation but are instead integral parts of the larger political and societal setting (Hirschl 2008, 97; Börzel 2006). According to Hirschl, bureaucratic disregard or reluctant implementation of unwelcome jurisprudence constitutes a 'lethal' political response to judicialisation (Hirschl 2008, 110; see also Rosenberg 2008;

Garrett, Kelemen, and Schulz 1998). At the level of the European Union, scholars have disputed the extent to which legal integration spurs more general change in the EU member states and have criticised the assumption that CJEU “rulings are automatic catalysts for policy change and that innovative legal interpretation prompts wide-ranging reforms” (Conant 2002, 15). Courts have neither purse nor sword and rely on third-party enforcement for their decisions to have more general impact (Conant 2002, 202; Greer and Martín de Almagro Iniesta 2014, 363). For CJEU decisions to have a national impact, they depend on domestic judicial, administrative and political institutions, which are unlikely to adapt without dispute to supranational judicialisation that contradicts national, political and legal cultures (Kagan 2008, 25; Börzel 2006).

The CJEU rulings on cross border healthcare constitutes our case for examining the extent to which supranational judicialisation produce concrete change at the national level. Cross border healthcare is likely to be a strong case for judicialisation because the CJEU, for many years, had extended the right de jure and because a large set of actors obviously have an interest in developing these rights; patients, patient organisations and providers, particularly private providers. At the same time, it is a policy area of strong national institutions with their own organisational logics and legacies. Therefore, the strength of judicialisation as a driver of de facto change is at test here.

By de facto change, we understand the outcome of judicialisation; i.e., an extension of the right to healthcare treatments across borders, found in national court decisions, in changed administrative practices or in changes of national law as well as in de facto patient mobility. It is important to note that concerning the right to cross border healthcare, there are two sequences of change: the first sequence runs from approximately 1998-2011 and concerns the national impact of legal integration as stemming from the case-law of the Court. The second sequence covers the subsequent years 2011-2015 and concerns the national impact of political integration in cases where the PRD is implemented in the member states. Here, we examine the transposition of PRD article 8, which specifically lays down when prior authorisation is justified in the light of EU law. The authorisation procedure constitutes the means of national control that is challenged by EU law.

National Courts and Mode of Democracy as Pivotal to Judicialisation

To examine the national impact of judicialisation within the healthcare area, we analyse national responses in two Beveridge tax-financed healthcare models with universal coverage: Denmark and Spain. These two healthcare systems face the same set of systemic challenges from an extended choice of healthcare treatment across borders. Both systems rely on a high degree of public control on the provision and

consumption of healthcare. Healthcare has traditionally been tied to the region of residence, free choice has been limited and the general practitioner (GP) has been the gatekeeper of assessing specialised and hospital care. However, the two EU member states differ in their modes of democracy and judicial culture, which may matter for the national impact of judicialisation. Informed by previous studies, we expect national courts to be pivotal to the national impact of judicialisation because they may guide or instruct the implementing behaviour of national bureaucrats and politicians (Alter 2001; Golub 1996; Obermaier 2009). We expect the national courts' activation of EU law to be important for impact. The scholarly literature on law and politics has primarily focused on the role of the national judiciary when sending preliminary references to the CJEU, thereby propelling European integration while potentially challenging national legal hierarchies and politics. Few studies have looked into how national courts carry out their role as decentralised enforcers of EU law. On a more theoretical account, Tallberg points to decentralised enforcement as a particular strength of the EU, making non-compliance a merely temporal phenomenon (Tallberg 2002, 610). Studying the implementation of the CJEU case-law on cross border health-care in France, Germany and the UK, Obermaier found national court activism to be key to national political and administrative responses (Obermaier 2009). The national judiciary was capable of pushing national politics into compliance. Along these lines, we thus expect national courts to adjudicate their own cases in accordance with the CJEU jurisprudence and thereby force the legislators to act and comply. We however also note other scholars' reservations against regarding decentralised enforcement strategies as the 'panacea' for compliance; these scholars have noted that litigants often lack the necessary resources and time to carry out legal proceedings and that national courts may not have the capacity to or be willing to act as the decentralised enforcer of EU law (Slepcevic 2009; Davies 2012; Conant 2001; Börzel 2006). Furthermore, different forms of democracy around which the relationship between court, legislator and executive is institutionalised may condition the national courts' ability or willingness to activate EU law in the national arena.

Denmark belongs to the tradition of majoritarian democracy, where parliamentary supremacy has traditionally defined the relationship between the courts and the legislator. Parliamentary majorities represent the 'will of the people', and in principle, such majorities should not be subject to judicial review (Wind, Martinsen, and Rotger 2009; Dworkin 1996; Ginsburg 2003; Wind 2010). A judicial review in which courts can strike down legislation adopted by the political majority is considered counter-majoritarian and an unacceptable limit on democracy. It has been argued that belonging to the tradition of majoritarian democracy has made Danish courts more reluctant in sending preliminary references to the CJEU in the attempt to avoid supranational judicial review (Wind 2010; Wind, Martinsen, and Rotger 2009). Furthermore, Denmark has no social courts; instead, complaints for the violations of rights can be

submitted to quasi-judicial court bodies: the Social Appeals Board and since 2011 the National Agency for Patients' Rights and Complaints. The Social Appeals Board has traditionally appeared reluctant to consider EU law in its cases for appeal (Martinsen 2005). We expect to find the same reluctance in regard to judicial Europeanisation, thus making Danish courts less active decentralised enforcers of CJEU case-law.

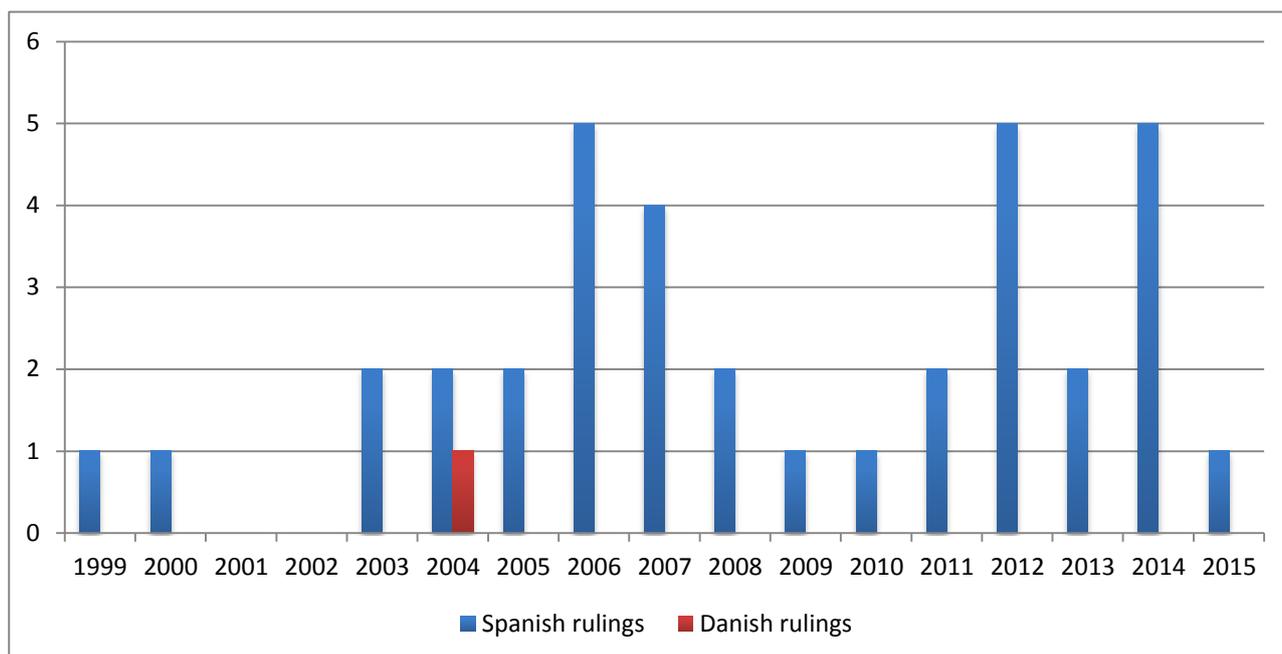
Our expectations differ with regards to Spain. Spain belongs to the tradition of constitutional democracy. After the Spanish transition to democracy in 1978, a European model of constitutional democracy was adopted, where courts were to exercise centralised judicial review by referring cases to the Constitutional Court to protect constitutional rights. The constitution supported strong regionalism and an enforceable body of fundamental rights and liberties (Sweet 2002, 83). Similarly, national judges who are entitled to challenge the constitutionality of the laws enacted by the parliament may feel less reluctant than their Danish counterparts to review the compatibility of national law with EU law. In Spain, the right to healthcare is constitutionally settled as article 43 of the constitution. Moreover, the Spanish judicial Council has institutionalised a network of national judges expert on EU law (RED-UE) that traces the latest developments in the field of European law, provides information on the most relevant jurisprudence of the CJEU to their peers and assists Spanish judges with the use of preliminary references (Mayoral et al., 2013), thus helping national judges integrate the jurisprudence of the CJEU in their rulings. We therefore expect Spanish courts to be active enforcers of the CJEU case law.

Decentralised Judicialisation in Denmark and Spain

To account for the decentralised judicialisation of the right to cross border healthcare, we gathered national rulings that quoted the relevant CJEU rulings between their accession to the EU until January 2015.⁵ De-centralised judicialisation was found to vary in Denmark and Spain. Figure 1 demonstrates that compared with Denmark, the Spanish courts have been more active in the consideration of the Court's jurisprudence concerning health care across borders. For this reason, we expect a stronger national legal push for compliance in Spain than in Denmark.

⁵ The search was done in national case-law databases (Spain: <http://www.poderjudicial.es/search/indexAN.jsp> and Denmark: jura.karnovgroup.dk) compiling national courts' ruling basing decisions on any of the CJEU cases on Patient Mobility specified in footnote 1 above. The data covers litigation from supreme and higher regional courts. Lower court cases are not exhaustively covered because they are underrepresented in these databases. Interviews with key-respondents, however, confirmed that lower courts were not active in enforcing EU cross border healthcare law.

Figure 1: National court rulings based on CJEU cross border healthcare case law:



Judicialisation in the Case of Denmark

Providing public healthcare in Denmark is a shared responsibility primarily between the state and the five regions (Martinsen and Vrangbæk 2008, 173). These five Danish regions are the main planners and providers of healthcare, whereas the state influences the sector through the budget and the overall regulatory framework.

Planning is an integral part of the Danish healthcare system. The ‘family doctor’, i.e., the General Practitioner (GP), serves as an important gatekeeper for healthcare treatment and has been considered important for the quality of care, bridging patients’ demands and system supply. The GP thus has a very important control function in the Danish system, referring patients to specialist treatment and hospital care. A patient, once referred by the GP, has an extended free choice of hospital care if s/he cannot be treated within two months in his/her own region. In that case, the patient can choose healthcare at a public hospital in another region or at a private or foreign healthcare provider with which the Danish regions established an agreement beforehand.

Judicialisation of Danish Healthcare: Defensive Absorption

The Danish implementation of the CJEU case law can be characterised as defensive absorption, mirroring a very sceptical position to the application of internal market principles on healthcare. As observed in figure

1, Danish courts have only made reference to the CJEU jurisprudence in one case, which was ruled by the Danish Supreme Court but did not grant the plaintiff the right to reimbursement of the costs of cross border care.⁶ We have thus been unable to confirm the key role for national courts that Obermaier found for France, Germany and the UK (Obermaier 2009). Instead, the patient venue for claiming EU rights seems to be the quasi-judicial body of the National Agency for Patients' Rights and Complaints (Patientombuddet), which was formed in January 2011. The agency is the highest administrative authority that considers patient complaints and evaluates regions' decisions on applications for cross border care, among other issues concerning patients' rights. We compiled all of the decisions from the National Agency for Patients' Rights from January 2011 to January 2015.⁷ In that period, 16 cases considered EU law and the right to have healthcare treatment in another EU member state. In 9 cases, the agency supported the region's refusal to reimburse the costs of cross border care. In 7 cases, the agency went against the region's decision and the right to cross border healthcare was granted.

Table 1: Treatment of EU cross-border healthcare law cases by the Danish Agency for Patients' Rights

Demands on cross-border healthcare granted	7
Demands on cross-border healthcare not granted	9
Total	16

Source: the database of the Danish Agency for Patients' Rights on decisions

On further examination of administrative and political responses, the Danish executive has taken a defensive approach to legal integration. The Danish government, i.e., the Danish Healthcare Ministry, responded to the initial case-law of the CJEU by reinterpreting the definition of what constitutes a 'service' within the meaning of the Treaty. The government took the stance that a 'service' within the internal market needed to involve an element of private pay and profit. Thus narrowing down the definition of 'service', it could keep the large majority of Danish healthcare services outside the definition because healthcare is generally provided as benefits in kind, free of charge and thus with no direct remuneration. The early jurisprudence by the Court resulted in a smaller amendment of Danish healthcare policy, implemented by executive order.⁸ The change implied that patients who were insured in group 1⁹ could purchase in other member states the type of non-hospital healthcare where there was an element of

⁶ Case U.2004.1126H.

⁷ The compilation of cases has excluded the cases dealing with dental care.

⁸ The policy reform entered into force by executive order, BEK no. 536 of 15 June 2000.

⁹ Patients insured in Denmark must choose between group 1 or group 2 coverage. Care from the GP and specialists in Group 1 is free of charge; a specific GP is chosen who then refers for further treatment. Patients in group 2 are not assigned a specific GP but enjoy access to any GP or specialist on request. However, only a part of the costs for treatment in Group 2 is reimbursed. Roughly 98% of Danish residents are insured in Group 1.

private pay, i.e., dental care, physiotherapy, and chiropractic treatments with subsequent fixed-price reimbursement from the relevant Danish institutions. Especially the purchase of dental care became popular among Danish healthcare insured. Here the patient would pay more than half of the costs of care and thus have a private incentive to buy cheaper dental treatment in another member state, while maintaining the Danish public subsidy.

Table 2: Number of reimbursement for dental treatments purchased in another member state

2009	2010	2011	2012	2013	2014
16648	18592	20483	21984	42547	38526

Source: Data provided by the five Danish regions. Two regions were unable to provide figures for 2009-2013. One region was unable to provide figures for 2014.

The Danish government maintained the narrow definition of ‘service’ for a considerable time. However, an internal departmental note from 2004¹⁰ from the Ministry of Health demonstrates that internally, the responsible civil servants did not all share the conviction that status quo could be maintained in light of the CJEU jurisprudence. The note proves that the sufficiency of Danish implementation was disputed inside the Ministry. Although the public administration externally agreed in consensus, it internally acted less as a unitary actor. The note stated explicitly that the Danish understanding of a service within the meaning of the Treaty could no longer be sustained and that in light of the recent case-law, the Danish implementation of EU law was too narrow. The Minister, at that time Lars Løkke Rasmussen, had thus been informed by his bureaucracy, but no change occurred externally. In later answers to parliamentary questions, the narrow definition of ‘service’ was even restated to the Danish Parliament on various occasions (see answers to parliamentary questions no. 4965, 4967 and 4969, 17 May 2006). The insufficient compliance with litigation was thus a deliberate political choice, i.e., for a long period, domestic politics hindered compliance.

Internal dispute and critique inside the civil service did not suffice as pressure to adapt. Instead, quasi-judicial proceedings were activated. In 2003, a case before the Danish Social Appeals Board (‘Ankestyrelsen’) commenced.¹¹ One of the Danish regions had refused to reimburse a patient his cost for outpatient care provided in Germany. When the case was first raised, the Board supported the refusal, reasoning that the cost of care provided by a specialist doctor in Germany could not be reimbursed because a service within the meaning of the Treaty required an element of private pay and one of profit. The Board

¹⁰ Internal unofficial departmental note from the Ministry of Interior and Health, 22. March 2004.

¹¹ Case before the National Social Appeals Board, 31 October 2003.

thus accepted the definition of the Ministry without considering it any further. The patient, however, complained to the Danish Ombudsman. The Ombudsman entered the case and exchanged viewpoints with both the Ministry and the Social Appeals Board. Against this background, the Board decided to take the case up again. This resulted in a revised decision 3 years later, in which the Social Appeals Board found that specialist treatment constituted a service within the meaning of the Treaty.¹² It thus contradicted the maintained definition of the Ministry of Health, based on the reasoning that the CJEU had a broader view on what defined an EU related service than the Danish re-definition from 2000 and onwards. However, in the concrete case, the plaintiff was not supported in having his costs of care reimbursed because he had not acquired a referral beforehand from his GP, as is the requirement in the Danish law. Again, the de facto right to cross border healthcare was granted.

The new statement by the Board did not, however, lead to the Ministry reconsidering its implementation practice, i.e., enforcement by the quasi-judicial board of appeal did not impact on administrative behaviour or cause change of legislation. In May 2007, the Danish Ombudsman proceeded with his inquiries and asked the Ministry why it had not changed its executive order of June 2000 to include a broader view on access to healthcare services in another EU member state. The Ombudsman also reminded the Ministry that the National Social Appeals Board ranked as the highest national administrative instance in interpreting and laying down the definition of service within the meaning of the Treaty. The Ministry finally responded and changed the executive order as of 1 December 2008 to also cover non-hospital specialist treatment in another member state for group 1 insured in Denmark.¹³

With a time lag of more than 8 years, Danish application in law and practice stands out as mirroring strong preferences for status quo, according to which the rights to cross-border health care remain limited. The position appears as self-reliant, defensive and for a considerable time period rather immune to internal and external criticism. In regard to the judicialisation through national courts, Danish courts practically took no role at all. Quasi-judicial proceedings instead pushed for a certain extension of de facto rights; however, in a numerical sense, it was a right granted to the very few.

Transposing the patients' rights directive in Denmark

In Denmark, the Ministry of Health was responsible for the transposition of the Directive, whereas the regions and healthcare providers were responsible for the practical implementation of the Directive. The

¹² Case before the National Social Appeals Board, 29 September 2006, SM S-2-06.

¹³ The policy reform entered into force by executive order, BEK no. 1098 19 November 2008.

Danish law entered into force 1 January 2014, which meant that Denmark did not meet the transposition deadline of 25th October 2013.

Concerning the outcome of the PRD, the implementation of article 8 is central. The Danish transposition of this article does not, however, facilitate patients' outflow but instead maintains the prior authorisation policy. For both hospital care and highly specialised and high-cost care that does not require hospitalisation, authorisation must be issued (Danish law proposal, L 33 as adopted 20. December 2013; § 89). The law obliges the Danish Health and Medicines Authority to issue a list setting out which treatments require prior authorisation. The issued list sets out that all treatments that require at least one night of hospitalisation plus all treatments listed in the 'plan for specialisation', 'specialeplanen', as a 'regional' or 'highly specialised' function require authorisation. The list simply links to the 'plan for specialisation', where a somewhat overwhelming range of treatments appears. According to the directive's article 8.5, the national authority is obliged to grant authorisation if the patient is entitled to the healthcare in question but it cannot be provided 'within a time limit which is medically justifiable'. What constitutes a 'medically justifiable time limit' is decided on a case-by-case basis by the responsible civil servant upon consulting the relevant medical expertise. The room for discretion available here makes it likely that the decision will favour national healthcare providers.

In sum, Denmark has been slow to adapt to the sequences of EU-induced change. National courts did not act as catalysts for domestic change but were instead reluctant to act as decentralised enforcers of CJEU jurisprudence. Quasi-judicial agencies were somewhat more active, but their decisions did not result in major political or administrative change. The transposition of the directive implies yet other gradual steps of change to allow for EU cross-border healthcare but does so without bringing Denmark outside its comfort zone of a nationally controlled healthcare system.

Judicialisation in the Case of Spain

The basic Spanish health care model belongs to the NHS. The citizens' right to healthcare was inserted in the Spanish constitution of 1978, and universalism was later articulated in the general health bill of 1986 (Lopez-Casasnovas et al. 2005: 221-222).

At the same time that Spain developed into a tax financed model with universal coverage, welfare governance has devolved. During a lengthy process from approximately 1979-2002, the autonomous communities consolidated these competences to provide healthcare (Greer 2009, 143). The process of devolution of health competences carried with it legislative attempts to balance the tension between

regional autonomy and equal rights for the Spaniards, regardless of their region of residence (García-Armesto et al., 2010: 233). Against this background, a new national benefit basket was introduced by the national cohesion and quality act, enforced by 2006. The national benefit basket defines the basic rights, and regions may add to these. Considerable regional differences exist in the access to and the quality, safety and efficiency of the healthcare sector (García-Armesto et al., 2010). Furthermore, the regional autonomy implies that patients cannot choose healthcare in another region. Thus, free choice is not a part of patient rights in Spain.

As in Denmark, the general practitioner is – across regions – the important gatekeeper of the system. The GP is always the first point of contact, except for emergencies. The patient will visit the family doctor with whom the patient is registered, and the doctor will then refer for specialised or hospital care (García-Armesto et al., 2010: 191-192).

Judicial Europeanisation of healthcare in Spain: Unobserved courts

Compared with the Danish case, Spanish courts have been more active in considering EU law in national jurisprudence. Furthermore, Spanish practices have been considered before the CJEU in two cases.¹⁴ In the first case, a social court from Madrid¹⁵ sent a preliminary reference to the CJEU about the obligation to reimburse the costs of healthcare in a non-member country (Switzerland) due to the diagnosis and recommendations made by a GP established in Germany. The CJEU laid down that the Spanish competent institution is bound by the diagnosis and choice of treatment of the doctors that were authorised in another member state. In the second case, the Commission issued an infringement procedure against Spain.¹⁶ The CJEU, however, supported the Spanish government's position, laying down that in the event of non-planned treatment, Spain, as the competent member state, did not have to reimburse the total cost of the health service provided in another member state if the coverage of the service provided was, according to the national legislation, inferior to the one that would have been provided in Spain.

With regard to national court cases, Spanish courts have based their decisions on CJEU jurisprudence in 35 cases and have thus been more active enforcers of EU law than Danish courts. In 19 of these cases, national courts granted cross border healthcare to the Spanish patients. A closer look into the decisions shows how in 15 occasions, the courts implemented CJEU jurisprudence to allow access to specialised treatment in another Member State or in countries of the European Economic Area (e.g., Switzerland). In the rest of the

¹⁴ A third case C-466/04 *Acereda Herrera* considered reimbursement of authorization based on regulation 1408/71.

¹⁵ C-145/03 *Keller*.

¹⁶ C-211/08 *Commission v Spain*.

cases, EU law was not part of the main rationale of the ruling but was cited in support of granting access to 1) the Spanish private system and 2) to non-EU member states, such as Panamá.

Table 3: Treatment of EU cross-border healthcare law cases by Spanish courts

Demands on cross-border healthcare fully or partially granted	15
Demands on access to private or non-EU healthcare granted	4
Demands on cross-border healthcare not granted	16
Total	35

Source: CENDOJ database

Turning to the national executive, the Spanish implementation of the CJEU case-law can be characterised as defensive – or even neglected. The administrative and legislative responses of Spain simply ignored the rulings to keep or protect national legislation that limited the configuration of cross-border care to the well-known, but more restrictive, rules of Regulation 883/2004. This position was complemented by a litigation strategy at the national and EU levels that defended the compatibility of national law or administrative decisions with EU regulation. At the same time, any necessity to adapt to the Court's jurisprudence was discarded by the national authorities (Feria Basilio 2011: 258-59).

This resistance to judicial Europeanisation is based on deference from the administration to the parliament and the legislative process (Greer and Martín de Almagro Iniesta 2014, 377-378). This deference is also present during national litigation processes, where the institutional position of the State lawyer appears to pay considerable attention to the governmental position. A State lawyer is likely to hesitate to allege the incompatibility of national law with EU law, even if there are legal grounds for such actions, because this can affect future career opportunities (Mayoral, 2013: 130-131). Furthermore, the regional governments neglected the rulings:

"regional health ministries, who are the core of the health system, are more interested in running health services than in tracking, understanding, or implementing ECJ rulings" (Greer and Martín de Almagro Iniesta 2014, 377).

This neglect was possible because regional authorities rely primarily on the health ministry in Madrid for an impact analysis of the Court's rulings and do not take any action by themselves. Nevertheless, despite its competence in EU health policies, the Health Ministry in Madrid did not adopt any measure or elaborated policies for regional authorities to follow in relation to the implementation of the CJEU health care jurisprudence (Interviews, 6. September 2013 and 9. September 2013).

Transposing the patient rights directive in Spain

Through the Council negotiations of the patient rights directive, Spain was one of the major voices against the proposal of the Commission (interviews, December 2009; July 2010). Spain led the blocking majority

that in December 2009 vetoed against the compromise text of the Swedish presidency, but when it took over the chair of the presidency in January 2010, it managed to establish a compromise between the member states, which allowed for the final adoption of the directive (Martinsen 2015, 169-170).

The transposition of the directive has been marked by different tensions. First, the division of labour that the directive implies collides with the devolved healthcare governance of Spain. As a directive, the Health Ministry in Madrid is in charge, which normally has very little competence in the policy area. Representatives from the autonomous regions argue that it has been difficult for them to influence both the negotiations of the directive and its transposition. In light of the lengthy process of devolution, the leeway that the directive gives to the national ministry is regarded as problematic from a regional point of view (Interviews, November 2012; September 2013). The Ministry of Health has transposed the directive, whereas the regional governments have had the possibility to give input in the Inter-territorial Council that settles issues between regions and the central government.

As emphasised above, the high degree of regional autonomy implies that key dimensions of the provision of healthcare differ across Spain. The transposition of the patient rights directive amplifies such differences, thus de facto reinforcing inequalities. First, the regions operate with different prices for healthcare (interview, September 2013). Regional tariffs comprise the level at which the patient will be reimbursed if he/she is treated in another member state. A Spanish patient from Andalusia will thus be reimbursed according to a different tariff than a resident in Extremadura. Second, benefit packages differ across regions. A patient from a region with a broader coverage will thus in principle be able to access a broader cross border supply. Third, because some regions operate with their own waiting time guarantees, the definition of 'undue delay' must also differ across regions.

Transposition in Spain has been marked by other important misfits between the national model and the directive. Spanish patients are tied to their regions and cannot access healthcare in other regions. Recently, 'choice' has been introduced across national borders. Furthermore, public healthcare does not allow Spanish patients to be treated by non-contracted providers. The NHS system in Spain owns the providers, which the system considers to be a means of quality and safety assurance (interview, December 2009). This makes the Spanish system differ from other NHS systems in the EU, including Denmark, where the state contracts providers to whom patients can then be referred. This underlines the stark incompatibility between a directive that makes it possible to access private, non-contracted, providers across borders and a national model with publicly owned providers. Choice disturbs the Spanish model. Finally, as in the Danish model, the role of the 'family doctor' as the gatekeeper ensuring the quality of care is challenged by allowing patients to look for and consult doctors in other member states.

With regard to the outcome of article 8 of the PRD, national change is, however, de facto limited. Spanish Autonomous Communities (AC) managed to coordinate their interests and work together in the inter-territorial Council to allow for a broad use of the prior authorisation procedure. The AC pushed together to add as many criteria as possible as a way to extend their control over the process of authorising services and their expenditures (Interview, 6. September 2013). Thus, as in Denmark, prior authorisation for cross border healthcare is required both for hospital treatment and for “techniques, technologies or procedures included in the National Health System's common portfolio of services which have been selected because they require the use of highly specialized medical procedures or equipment, the need to provide care to patients suffering complex problems or due to their cost-intensiveness” (see detailed list on <http://www.msssi.gob.es/en/pnc/ciudadanoEsp/SSAutrPrev.htm> as well as the Spanish implementing law Royal Decree 81/2014 of 7. February 2014).

To summarise, similar to Denmark, Spain has been reluctant to adapt to the sequences of EU-induced change. Although national courts managed to extend cross-border healthcare rights of Spanish patients in 15 cases by means of the CJEU jurisprudence, these court cases did not change the administrative practices or national law. CJEU case-law was not devoted political or administrative attention, and national courts did not have the power or the sword to instigate broader national change (Conant 2002).

Conclusion

This paper has examined the impact of judicialisation on the right to cross border healthcare in Denmark and Spain. We expected ex-post national judicial, administrative and political responses and, in particular, courts' activation of EU law to be important for the de facto change that EU legal integration may cause. We found different judicial responses in the two member states. In Denmark, national courts did not activate EU law. It is remarkable that only one court case considered EU law for its decision but that it ultimately did not grant the right to cross border care. Quasi-judicial proceedings proved to be the more accessible venue for patients to demand their EU rights. Sixteen cases considered the right to cross border healthcare between 2011-2015; in 7 of these cases, the right to the reimbursement of cross-border healthcare costs were granted, thereby de facto extending rights. However, in general, courts have been weak players in the push for judicialised rights in Denmark, and the 'quasi-judicialisation' identified has not been able to push for notable administrative or political change. In Spain, national courts did take CJEU jurisprudence into national courtrooms, and in 15 of these 35 cases, Spanish patients became entitled to EU cross border healthcare paid by the public purse. Although Spain had more court cases than Denmark,

only 15 cases produced de facto rights, which demonstrates that court rulings – even in a constitutional democracy such as Spain – are hardly sufficient as leverage for general rights. Neither CJEU rulings nor the national court cases were able to instigate more general political or administrative change in Spain. Political and administrative actors largely ignored the case-law of the European court, and the infringement procedure that the Commission pushed forward did not correct the legislative or administrative practices in Spain. In addition, national court cases remained unobserved by the political and administrative elite, thus quelling a broader judicial impact by means of bureaucratic and political disregard.

Administrative and political responses were found to be quite similar in Denmark and Spain. The two universalistic NHS models have long resisted EU impact on their healthcare systems, finding that their models are fundamentally unfit for patient-driven free choice across borders. Such protectionist positions are motivated by the overall healthcare legacies embedded in the national models but also reasoned in budgetary and governance justification. An EU free choice model constitutes a financial threat to fragile publicly financed models with equality as the basic legitimising norm, and the centralisation implied in EU governance disturb models with a high degree of decentralisation. The directive has been transposed in lawful texts in both member states, but the ability for patients to make actual use of their newly gained rights is low. The ex-post responses to in the two member states is summarised in table 3 below:

Table 4: Ex-post Responses to Judicialisation in Denmark and Spain

	Denmark	Spain
Judicial Responses	National courts not acting as decentralised enforcers of EU law, but quasi-judicial proceedings to some extent. Quasi-judicialisation, however, unable to be leverage for considerable administrative or political changes.	National courts acting as decentralised enforcers of EU law. National judicialisation, however, unable to be leverage for administrative or political changes.
Administrative and Political Responses	<i>To legal integration</i> ; defensive absorption. Limited change of administrative practices and national law. <i>Transposition of PRD</i> ; PA maintained for hospital care as well as for highly specialised and costly care; national control maintained de facto limiting patient outflow.	<i>To legal integration</i> ; ignoring CJEU jurisprudence and not observing national rulings. No change of administrative practices and national law. <i>Transposition of PRD</i> ; PA maintained for hospital care as well as for highly specialised and costly care; national control maintained de facto limiting patient outflow.

Such defensive - or even neglecting - ex-post responses matter to the de facto outcome in terms of actual patient mobility. Apart from Danish healthcare insured purchasing dental care in other member states, the de facto extension of cross border healthcare for Danish and Spanish patients remains limited indeed as demonstrated in table 4 below¹⁷.

Table 5: Outflow of patients in Denmark and Spain in accordance with the Patients' Rights Directive in 2014¹⁸

	Denmark	Spain
Inquiries ¹⁹ regarding cross-border healthcare since 1/1-2014	900	553
Applications for reimbursement for treatments that do not require prior authorisation since 1/1-2014	64	4
Reimbursement for treatments that do not require prior authorisation since 1/1-2014	21	3
Applications for prior authorisation since 1/1-2014	61	23
Prior authorisation granted since 1/1-2014	14	8

¹⁷ The "Commission report on the operation of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare" (COM(2015) 421 final) places Denmark in top with 31032 reimbursements of healthcare across border which do not require prior authorization. However, the large majority of treatment in another member state concerned dental treatment. In a response to the Danish parliament, the Danish Healthcare Minister noted that for the 3 regions which were able to give detailed information on cross border healthcare, 98% of all applications concerned dental care amounting to 78% of all costs reimbursed for healthcare in another member state as according to the patient rights' directive (see parliamentary question 752 of 24. April 2015. Also confirmed by the Danish contact point for cross border healthcare through mail correspondence, 6. October 2015).

¹⁸ Data for Denmark covers the period 1/1-2014 to 20/10-2014. Data for Spain covers the period 1/1-2014 to 1/1-2015.

¹⁹ Inquiries not limited to the directive, but concerns the right to cross border healthcare more generally.

Source: Data provided by the five Danish regions and the Spanish Citizens' Advice and Information Office, Ministry of Health, Social services and Equality. The treatments that do not require reimbursement do not include dental care. For these figures see table 1 above.

In 2014 thirty-five patients have been reimbursed for cross border healthcare from the Danish authorities, but only 11 in Spain. We consider this a low outcome of judicialisation and its subsequent EU law - litigated, designed and negotiated in great detail and for long time to facilitate access to cross-border healthcare in the EU. However, de facto rights are so far for the very few. Especially when taking the much larger population in Spain compared to Denmark into account, the outcome is extremely low in the Southern peninsula. The de jure rights stemming from the EU impact little in a member state where domestic politics, institutional legacies and administrative behaviour contradict the idea of mobility and free choice, and where patients appear weakly informed²⁰ of their European rights.

However, the rather minimal change found in both member states may change over time. Patients may find successful ways to push for their rights. In this regard, patients may team up with private providers, envisioning new opportunities to open up national or foreign markets by means of the EU patients' rights directive. The Commission may start a new round of infringements. Domestic politics may come to see an emerging opportunity structure in EU law. However, judicialisation has not yet been able to produce national impact to any notable extent. Despite their different democratic models, national courts have not been able to push for broader change in both member states or challenge the established institutional status quo. The impact of judicialisation appears to be highly conditioned by administrative and political responses, which so far have discarded the European way. The discrepancy between what emerges de jure at the supranational level and national de facto rights is wide indeed.

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²⁰ Eurobarometer on Patients' rights in cross-border healthcare in the European Union: http://ec.europa.eu/public_opinion/archives/ebs/ebs_425_en.pdf

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