EU-TRHeaDS

EU Citizens' Transnational Rights and Health-related Deservingness at the Street-level

Freedom of movement and healthcare rights in the European Union

EU framework and daily challenges

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Introduction

The recognition of transnational healthcare rights of mobile EU citizens is a precondition for the exercise of free movement within the Union, the cornerstone of EU citizenship. Since the creation of the European Economic Community by the Treaty of Rome in 1957, different coordination mechanisms and procedures have been developed and refined to regulate access to sickness benefits for mobile EU citizens moving across Member States (MSs) (Cornelissen and De Wispelaere, 2020; Martinsen & Vollaard, 2014). Although the EU framework was initially designed to protect male, migrant workers employed in full-time and regular occupations, over time many social entitlements linked to working status have been extended to include (almost) all Union citizens (Cornelissen, 2009; Verschueren, 2020).

Broadly speaking, it is possible to distinguish between two sets of rules. On the one hand, the rules that apply in the case of EU citizens who move to another MS for healthcare purposes ('planned healthcare'), mainly set by Directive 2011/24/EU on the application of patients' rights in cross-border healthcare and Regulation 883/2004/EC on the coordination of social security systems.[1] On the other hand, the rules that regulate access to healthcare for EU citizens who move for other purposes - either temporarily or not – which originate from the interplay of Regulation 883/2004/EC on the coordination of social security systems, its Implementing Regulation 987/2009 and following amendments (hereafter: 'the Regulations'), and Directive 2004/38/EC on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States (hereafter: 'the Citizenship Directive').

Moreover, healthcare has come to represent a strategic issue for the European Commission, even more so after the outbreak of the COVID19 pandemic. While respecting MSs' exclusive competences on healthcare, the Commission has actively invited governments to guarantee accessible healthcare and full healthcare coverage, to a large extent via the Open Method of Coordination (European Commission, 2013a, 2017) and the more recent declaration of the European Pillar of Social Rights (European Parliament, Council of the European Union, & European Commission, 2017).

Yet, significant obstacles in accessing healthcare for mobile EU citizens have been frequently reported, revealing the existence of bureaucratic and administrative barriers that affect the realisation of this right at the everyday level (ECAS, 2016, 2019, 2021; Strban et al., 2016; European Union, 2017; European Court of Auditors, 2019). This descriptive report provides an overview of the EU rules regulating access to healthcare for EU citizens who move to another MS, delving in their content and main challenges. As this document will highlight, addressing the complex equilibrium between mobile EU citizens' cross-border entitlements and MSs' bounded healthcare systems appears critical, particularly in times of renewed debates on 'Social Europe' and the challenges posed by COVID-19 to intra-EU mobility and healthcare systems.

[1] Mobility for healthcare purposes it not the object of this study.

1. Access to healthcare during a temporary stay in another MS: the European Health Insurance Card

EU citizens have the right to enter and stay in the territory of another MS for up to three months without any visa or equivalent formality, although the MS of stay may require them to report their presence 'within a reasonable and non-discriminatory period of time' (Directive 2004/38/EC, Article 5). While the MS of stay is not obliged to grant them entitlement to social assistance during this period (Directive 2004/38/EC, Article 25), EU citizens who temporarily stay in another MS are covered against the risk of sickness by their country of residence.

Since the early 1970s, the Regulations have progressively harmonised the criteria to guarantee access to 'unplanned healthcare' for mobile EU citizens during 'a stay' in another MS, extending it to 'medically' - rather than only 'immediately necessary' - care, and to 'all persons insured' in a MS rather than solely workers (Cornelissen, 2009; Fillon, 2009; Vollaard, van de Bovenkamp & Martinsen, 2016). On this respect, it should be noted that the Regulations 'only' coordinate – rather than harmonise - the national healthcare systems of MSs. Accordingly, the way in which 'healthcare in particular is organised by a Member State is a rather fiercely guarded national competence in the EU' (De Wispelaere & Berki, 2021, p. 426).

To facilitate coordination between MSs, the 2002 Barcelona European Council set the basis for the introduction of the European Health Insurance Card (EHIC; Administrative Commission for the Coordination of Social Security Systems, 2003/751/EC, 2009/S1), which certifies the entitlement of an 'insured person' 'staying' in a Member State other than the competent Member State to 'benefits in kind which become necessary on medical ground.' (Administrative Commission for the Coordination of Social Security Systems, 2009/S1, Article 1). In the words of the then President of the European Commission, Romano Prodi, the EHIC represented 'another piece of Europe in your pocket' (European Commission, 2004), a 'a visual symbol of the social dimension of the European Union' (De Wispelaere & Backi, 2021, p. 429). Yet, as it will be discussed below, each of the legal concepts defined by the Regulations, as well as the different procedures set by MSs to both issue and recognise it, frequently turn into daily challenges for mobile EU citizens, affecting the full realisation of their cross-border healthcare rights.

Three main phases can be distinguished in the functioning of the EHIC and, more generally, of cross-border unplanned healthcare. An 'ex-ante' phase, which concerns the rules and procedures regulating the entitlement to and issuing of the EHIC to a EU citizen by the competent MS. Secondly, an 'in itinere' phase, which deals with the rules regulating the access to unplanned care for EU citizens during a stay in another MS. Finally, an 'ex-post' phase, which comprises the mechanisms regulating the reimbursement of the treatments provided to mobile EU citizens, either between citizens and their competent institutions or between institutions.

To further facilitate and speed up exchanges between MSs' social security institutions (on sickness benefits and all other social security domains covered by the Regulations), the 'Electronic Exchange of Social Security Information' (EESSI) system was launched in 2017. With the first exchange of information within this system taking place in 2019, it is expected that EESSI should be in full

production for all 32 participating countries (EU Member States plus Iceland, Liechtenstein, Norway, Switzerland and the United Kingdom) by June 2022. The EESSI system is expected to allow a quicker and more efficient processing of social security benefits for mobile EU citizens, as well as a more efficient implementation of social security coordination rules for MSs thanks to the use of standard electronic forms and procedures (European Commission, 2021).[2] However, as explained by a research participant,

> we sometimes receive requests by e-mail or telephone from French or German hospitals, who ask: 'we have a Belgian citizen without a EHIC, this is his name, his registration number, can you send us his EHIC or replacement certificate?'. These are practices that exist and that will continue to exist… In principle, only the EESSI should be used, but it is necessary to remain practical, eh? We are not going to change practices that have existed for years. In addition, we are in a transitional phase in this system. It is gradually, since 2019, that the Member States have begun to use it. (IN_BE01).

Hence, the ability of the EESSI to achieve these results ultimately depends on MSs' willingness to engage with it. As a research participant commented, '*the EESSI. … it should be easy, it should work. But, if one of the two countries is not willing to make the effort, it will not work*.' (IN_CS001).

1.1. Ex-ante: rules and procedures regulating the issuing of the EHIC

In 2020, an estimated number of 240 million EHIC were in circulation, compared to approximately 200 million in 2013 (De Wispelaere, De Smedt & Pacolet, 2022; Pacolet & De Wispelaere, 2014).[3] This means that more than a half of the population in the EU held a EHIC. Although the numbers are undoubtedly increasing over time, the gap between the actual and potential number of EHIC in circulation largely depends on the rules and procedures regulating the issuing of the card by MSs.[4]

To start with, the Regulations explicitly refer to 'insured persons', that is, 'any person satisfying the conditions required under the legislation of the [competent] Member State […] to have the right to benefits'. This means that, while the Regulations define the mechanisms for coordinating social security systems and set the principles of equal treatment and non-discrimination of EU citizens, MSs continue to define healthcare rights and associated entitlement criteria domestically. Therefore, who an 'insured person' is still depends on - and thus reflect the varieties of - health systems within the Union (Wendt, 2009).

Accordingly, Cyprus, Denmark, Finland, Ireland, Italy, Latvia, Malta, Portugal, Spain and Sweden are characterised by National Health Systems (NHS), which entitle citizens and those residing legally in the country to almost free-of-charge healthcare, to be financed through general taxation. On the contrary, Austria, Belgium, Bulgaria, Czech Republic, Croatia, Estonia, France, Germany, Greece, Hungary, Lithuania, Luxembourg, the Netherlands, Poland, Romania, Slovakia and Slovenia have opted for Social Health Insurance (SHI) schemes, which usually differentiate healthcare entitlements according to professional status, and where healthcare provision is mainly financed by social security

[2] Another digital tool, the European Social Security Pass, is currently being piloted, and the first results are expected to be delivered during the first half of 2022.
[3] The annual publication on cross-border healthcare and the EHIC are openly accessible via the Publications Office of the European Union (https://tinyurl.com/6u68xrnz).
[4] For an in-depth assessment of the EHIC, see the annual reports of the EU Commission on "Cross-border healthcare in the EU under social security coordination", available here: https://ec.europa.eu/social/main.jsp?catId=22&langId=en

contributions. As in SHI systems healthcare entitlement is contributory-based, the share of population insured against illness via social health insurance schemes varies (Table 1). In countries such as Germany, Poland or Slovakia, more than 5 per cent of the resident population has not compulsory healthcare insurance. Consequently, these people cannot export any public health coverage from home in case they temporarily move to another MS under the Regulations.

Table 1. Resident population and population with compulsory healthcare insurance by country (EU and EEA)

	2013		2019		2020	
	resident pop.	% insured persons	resident pop.	% insured persons	resident pop.	% insured persons
AT	8.451.860	99.9	8.858.775	99.9	8.901.064	99.9
BE	11.137.974	99	11.455.519	98.6	11.522.440	n.a.
BG	7.284.552	-	7.000.039	-	6.951.482	-
CH	8.039.060	-	8.544.527	-	8.606.033	-
CY	865.878	-	875.899	-	888.005	-
CZ	10.516.125	100	10.649.800	100	10.693.939	100
DE	80.523.746	89.0	83.019.213	89.0	83.166.711	89.5
DK	5.602.628	100	5.806.081	100	5.822.763	100
EE	1.320.174	93.6	1.324.820	95.0	1.328.976	95.2
EL	11.003.615	n.a.	10.724.599	100	10.718.565	n.a.
ES	46.727.890	99	46.937.060	100	47.332.614	n.a.
FI	5.426.674	100	5.517.919	100	5.525.292	100
FR	65.600.350	99.9	67.177.636	99.9	67.320.216	99.9
HR	4.262.140	-	4.076.246	-	4.058.165	-
HU	9.908.798	96	9.772.756	94	9.769.526	n.a.
IE	4.609.779	100	4.904.240	100	4.964.440	100
IS	321.857	99.8	356.991	99.6	364.134	99.6
IT	59.685.227	100	59.816.673	100	59.641.488	100
LI	36.838	-	38.378	-	38.747	-
LT	2.971.905	91.8	2.794.184	98.7	2.794.090	99.1
LU	537.039	n.a.	613.894	100	626.108	n.a.
LV	2.023.825	n.a.	1.919.968	100	1.907.675	n.a.
MT	422.509	-	493.559	-	514.564	-
NL	16.779.575	99.8	17.282.163	99.9	17.407.585	n.a.
NO	5.051.275	100	5.328.212	100	5.367.580	100
PL	38.062.535	91.6	37.972.812	93.4	37.958.138	93.3
PT	10.487.289	100	10.276.617	100	10.295.909	n.a.
RO	20.020.074	-	19.414.458	-	19.328.838	-
SE	9.555.893	100	10.230.185	100	10.327.589	100
SI	2.058.821	100	2.080.908	100	2.095.861	n.a.
SK	5.410.836	94.6	5.450.421	94.6	5.457.873	94.6

UK	63.905.342	100	66.647.112	100	67.025.542	n.a.

Sources: Resident population: Eurostat, Population on 1 January by age and sex. Data extracted on 23 May 2022 10:35 (CET); Population with compulsory healthcare insurance: OECD.Stat, Social protection - Government/social health insurance – total health care. Data extracted on 23 May 2022 07:39 UTC (GMT). Blue rows: Northern Europe; green rows: Western Europe; yellow rows: Southern Europe; orange rows; Central and Eastern Europe.

Focusing on the insured ones, impressive differences exist between MSs concerning the percentage of population holding the EHIC and the procedures for obtaining it. The share of insured persons with an EHIC varies greatly across MSs, ranging from 1% in Romania and Greece to almost the totality of insured people in Switzerland, Liechtenstein, Germany and Italy (Table 2). Focusing on sub-regions, the highest share of EU citizens holding a EHIC reside in Western EU countries (67.2 per cent), followed by Northern EU countries (43.3 per cent), Central and Eastern EU countries (33.1 per cent) and Southern EU countries (9.36 per cent).[5] However, significant variation exists within sub-regions as well (Northern EU countries: from 60.1 per cent in Denmark to 12.6 per cent in Latvia; Western EU countries: from 100 per cent in Germany, Liechtenstein and Switzerland to 19.1 in France; Southern EU countries: from 100 per cent in Italy to 1 per cent in Greece; Central and Eastern EU countries: from 94.8 in Czech Republic to 1.3 in Romania).

Table 2. EHIC: key figures by country of residence

	2013		2019		2020	
	Total number of EHIC in circulation	% EHIC / insured persons	Total number of EHIC in circulation	% EHIC / insured persons	Total number of EHIC in circulation	% EHIC / insured persons
AT	8,156,265	95.2	8,465,411	94.3	8,523,799	94.9
BE	3,083,658	60.3	4,022,272	35.6	3,225,432	28.3
BG	361,616	5.9	1,910,687	32.1	269,946	4.7
CH	6,700,000	83.1	8,600,000	100	8,700,000	100
CY	app. 44,789	n.a	n.a.	n.a.	n.a.	n.a.
CZ	app. 10,000,000	96.0	app. 10,000,000	94.8	app. 10,000,000	94.8
DE	app. 45,000,000	n.a	app. 73,000,000	app. 100	app. 73,000,000	app. 100
DK	1,672,306	29.9	5,132,222	88.5	3,485,955	60.1
EE	n.a.	n.a	n.a.	n.a.	n.a.	n.a.
EL	123,584	1.2	242,947	4.4	93,346	1.0
ES	3,319,472	7.1	5,565,252	11.3	3,975,683	8.1
FI	1,334,155	24.5	2,078,088	37.5	2,104,361	38.0
FR	4,190,116	7.1	5,805,198	9.8	13,527,269	19.1
HR	260,345	6.0	535,294	13.0	465,943	11.4
HU	1,705,300	18.0	1,439,277	34.7	1,152,863	28.1
IE	1,367,301	app. 34	1,872,575	40.1	1,611,474	31.1
IS	83,946	25.8	162,618	45.7	162,618	45.7

[5] Sub-regions follow the EuroVoc thesaurus: Northern Europe (Estonia, EE; Latvia, LV; Lithuania, LT; Denmark, DK; Finland, FI; Iceland, IS; Norway, NO; Sweden, SE); Western Europe (Austria, AT; Belgium, BE; France, FR; Germany, DE; Ireland, IE; Liechtenstein, LI; Luxembourg, LU; Netherlands, NT; Switzerland, CH; United Kingdom, UK); Southern Europe (Cyprus, CY; Greece, EL; Italy, IT; Malta, MT; Portugal, PT; Spain, ES); Central and Eastern Europe (Bulgaria, BG; Czech Republic, CZ; Croatia, HR; Hungary, HU; Poland, PL; Romania, RO; Slovakia, SK; Slovenia, SI).

IT	app. 58,901,313	100.0		app. 60,000,000	app. 100		app. 60,000,000	app. 100
LI	37,910	100.0		40,165	99.9		40,630	100.0
LT	294,779	9.9		576,586	19.8		533,751	18.1
LU	552,451	72.5		685,135	76.8		703,190	76.2
LV	201,387	8.9		336,719	14.9		286,048	12.6
MT	159,795	77.8		216,943	49.3		207,181	46.8
NL	14,114,209	84.1		10,997,289	64.1		7,913,407	46.0
NO	1,500,000	n.a.		2,340,000	43.6		1,700,000	31.5
PL	1,523,991	4.3		4,164,201	12.2		3,973,446	11.7
PT	1,309,462	n.a		1,935,654	n.a.		1,780,111	n.a.
RO	126,753	0.7		299,426	1.7		221,771	1.3
SE	3,000,000	n.a.		4,024,953	n.a.		3,186,276	n.a.
SI	656,542	31.6		907,712	43.0		737,217	34.6
SK	2,626,676	50.5		3,742,295	72.4		4,014,573	77.5
UK	25,886,427	n.a.		26,903,301	n.a.		22,756,826	n.a.

Sources: De Wispelaere, De Smedt & Pacolet, 2022; Pacolet & De Wispelaere, 2014. Blue rows: Northern Europe; green rows: Western Europe; yellow rows: Southern Europe; orange rows; Central and Eastern Europe.

In this regard, the procedure defined by each MS to issue the EHIC represents a central factor facilitating or hindering the diffusion of the card (De Wispelaere, De Smedt and Pacolet, 2022). Only few countries have opted for issuing the EHIC automatically with their respective national healthcare cards (Austria, Italy). This procedure evidently facilitates 'securing' coverage against any unplanned treatment a citizen may need during a temporary stay in another MS, and reduces the time for processing the application. In the majority of countries, however, the EHIC is issued upon application from the person, either online or at the desks of the competent institution (Table 3). In this regard, the length of the issuing procedure may constitute an obstacle for mobile EU citizens, as it may require up to four weeks to be completed.[6]

Finally, concerning the validity of the EHIC, it varies significantly among MSs (from 1 year in Belgium and France, to 10 years in Czech Republic and Slovakia), as well as between categories of EU mobile citizens within and across countries. As Table 3 shows, economically inactive people and workers are those for whom the validity of the EHIC is shorter, opposed to pensioners. For instance, in Bulgaria the EHIC is valid for one year for workers and 10 years to pensioners; in Lithuania, it is valid for 2 months for unemployed people and 10 years for pensioners.

Table 3. Issuing procedures and validity of EHIC, 2020

	Issuing procedure		Validity of EHIC
	How to apply	Average time to receive a EHIC	
AT	issued automatically (replacement card: desk, telephone or e-mail)	3 to 5 days	1 or 5 years, 10 years (pensioners)

[6] If the person does not have a EHIC during a stay in another MS and is in need of unplanned care, a Provisional Replacement Certificate (PRC) with a limited validity period shall be issued by the competent institution under request of the insured person or the institution of the MS of stay. For instance, Spain, Denmark, Slovenia and France had a ratio of over 10% of PRCs issued to the number of EHICs in circulation in 2018 (De Wispelaere, ., De Smedt & Pacolet, 2021).

BE	fax, telephone, internet, at the desk	immediately at the desk; 2-5 days otherwise; up to 2 weeks in some cases	1 to 2 years (i.e. until 31/12 of the next year)
BG	personally, by application form	14-15 days; urgent cases: up to 2 days	1 year (economically active persons), 5 years (children), 10 years (pensioners)
CH	issued automatically (telephone, fax, e-mail)	10-28 days	5-6 years
CY	desk (by telephone, fax and internet under special circumstances)	immediately at the desk	Max. 5 years
CZ	desk, telephone, e-mail or post (issued automatically to every newly insured person)	max. 14 days	Usually 10 years (this period can vary according to issuing institution)
DE	internet, telephone, desk, in writing (issued automatically upon issue national card)	28 days at the most, generally significantly less	Several months to several years (same period of the national card)
DK	telephone, internet	14-21 days	Max. 5 years; shorter periods (1-2 years) for specific cases
EE	internet, email, post, desk	max. 10 days	Max. 3 years (adults), max. 5 years (children under the age of 19)
EL	e-EFKA: only electronically, desk	e-EFKA: the next day	1 year (employed and self-employed), 1 to 3 years (pensioners), from 3 to 12 months (students)
ES	desk, internet, telephone, text message	5 days	2 years (sea workers and pensioners), 2 years (workers), 3 years (military civil servants), 5 years (pensioners), 2 years (judicial civil servants)
FI	telephone, post, internet, desk	7 days	2 years
FR	internet, telephone, or desk	14 days	1 year
HR	internet, desk, post, automated machines	2 days	3 years (all insured persons), 1 year (unemployed), 1 year (students and pupils)
HU	desk, post, e-mail or internet	immediately at the desk; max. 8 days otherwise	3 years, 12 months (persons whose entitlement is based on social indigent)
IE	internet, post, desk	5-10 days	4 years
IS	internet, telephone, e-mail	3 days	3 years, 5 years (pensioners)
IT	issued automatically with national card (replacement card: desk, fax, internet, email)	15 days	6 years
LI	internet, telephone, post, fax, desk	14-21 days	66 months, 12 months (asylum seekers, short-term residents)
LT	internet, fax, desk	immediately at the desk; max. 14 days otherwise	2 months (unemployed), 4 years (employed), 10 year (pensioners), 1 academic year, but no longer than until the end of the current academic year (full-time students)
LU	internet, telephone, fax, post or desk	13 days	3-60 months (proportionate to the length of the insurance record), 12-60 months (pensioners)
LV	post, desk	immediately at the desk; 3 days otherwise	3 years
MT	through 'Mobile App', 'e-Forms', post or desk	5 days	5 years
NL	telephone, fax, e-mail, social media, (some insurers integrated EHIC in national card)	2-10 days	1, 2, 3 and 5 years (most insurers issue an EHIC for a period of 5 years)
NO	internet, telephone, post, desk	max. 10 days	3 years (regular membership), 1 year (temporary membership)

PL	desk, e-mail, fax, internet, desk	immediately at the desk; 5 days otherwise	5 years (children younger than 18 and old-age pensioners), 3 years (workers), up to 18 months (beneficiaries of preretirement benefits and disability pensions), up to 6 months (uninsured persons entitled to healthcare under the national law), up to 2 months (e.g., unemployed persons), up to 90 days (e.g. persons who meet the income criterion for receiving social assistance benefits), up to 42 days (e.g. insured women with the Polish citizenship who reside on the territory of the Republic of Poland during puerperium)
PT	e-mail, fax, internet, desk	4-5 days	3 years, 1 year (certain health subsystems)
RO	fax, post, telephone	7 days	2 years
SE	internet, telephone, desk	up to 10 days	3 years
SI	internet, text message, desk	4 days	1 year, 5 years (pensioners and their family members, children under the age of 18)
SK	post, fax, e-mail, internet, desk, mobile application	5-10 days	10 years, foreign workers depending on the validity of the working contract
UK	internet, telephone, post	4 days (telephone and internet); 10 days (postal applications)	5 years

Source: De Wispelaere, De Smedt & Pacolet, 2022

1.2. In itinere: access to unplanned healthcare

The 'in itinere' phase concerns the rules regulating the access to unplanned care for EU citizens during a stay in another MS. The creation of the EHIC reduced administrative paperwork for mobile EU citizens in case of a temporary stay in another MS (IN_EX01, IN_BE01). Before its introduction, in fact, EU citizens not only had to apply for a proof of insurance in the MS of residence before travelling abroad. In addition, In the past, they had to contact the social security institution of the MS of stay before approaching a healthcare provider (De Wispelaere & Berki, 2021). With the EHIC, this second administrative procedure is no longer necessary. Consequently, EU citizens insured in their country of residence can go to a health provider in case of unplanned health need and, as long as the provider is part of the country's public health system, they should receive healthcare without further administrative procedures.

However, as highlighted in the annual reports of the EU Commission on cross-border healthcare and confirmed by several research participants, obstacles to access healthcare in a MS of stay for holders of a EHIC exist due to refusals of the card. Lack of knowledge and misinterpretations as regards the concepts of 'unplanned necessary care' and 'temporary stay', the condition according to which the EHIC can be used in public hospitals only, as well as providers' willingness to avoid administrative burden and fear of no or late payment, have been identified as the main reasons for a refusal of the EHIC (IN_EX01, IN_CSO01; De Wispelaere, De Smedt & Pacolet, 2022; ECAS, 2019, 2020).

Concerning the former, the notion of 'unplanned necessary care' has been detailed by the Administrative Commission's decisions and the EU Commission's explanatory notes. Accordingly, Decision S1 of the Administrative Commission of 12 June 2009 defines unplanned necessary care as:

> sickness benefits in kind which become medically necessary and which are granted during a temporary stay in another Member State with a view to preventing the card holder from being forced to return before the end of the planned duration of stay to the competent State or the State of residence to obtain the treatment he/she requires. The purpose of benefits of this type is to enable the insured person to continue his/her stay under safe medical conditions.

More precisely, Decision S3 of 12 June 2009 defines specific groups of treatment which have to be considered as 'necessary care', pointing out that it cannot be interpreted in a narrow way (emergency treatment; Court of Justice, Case C-326/00). Rather, it also covers all those unplanned treatments that may originate from a pre-existed pathology of which the EU citizen is aware, such as a chronic illness,[7] as well as provisions associated with pregnancy and childbirth (except when the sole purpose of the stay is to give birth).[8]

Moreover, the EU Commission's explanatory notes (2011) highlight that 'necessary care' is flexible concept that has to be assessed on a case by case basis, on the basis of the before-mentioned medical criterion as well as the duration of the stay abroad. Specifically, 'temporary stay' has to be understood as a period during which a EU citizen is staying in a place other than the one where she or he habitually resides, as long as she/he does not move the centre of his/her interests to that place. To assess the centre of interests, aspects such as the person's intention, family status and ties, the source of income, the nature of his/her activities should be taken into account. Importantly, the explanatory note clearly mentions that the fact that a person is registered in the place of stay in accordance with the requirements of Article 7 of Directive 2004/38/EC (residence in another MS longer than 3 months) cannot be considered as proof of residence in the sense of the Regulations. Hence, MSs are not allowed to limit the meaning of 'temporary stay' in relation to the EHIC to a period of 3 months.

Despite these clarifications, however, difficulties continue to be reported on the interpretation of 'necessary care' and 'temporary stay' (IN_EX01, IN_EX02, IN_BE01). In the last report on cross-border healthcare (De Wispelaere, De Smedt and Pacolet, 2022), two out of three of the reporting MSs mentioned this problem, which resulted in healthcare providers refusing to provide treatments to EHIC holders, or competent MSs refusing reimbursement of the healthcare provided to their citizens during a stay abroad.

Beyond problems due to the interpretation of the concepts of 'necessary care' and 'temporary stay', other reasons for a refusal of the EHIC by healthcare providers have been identified as follows:

[7] In the case of treatments that are only available in specialised medical units (e.g. kidney dialysis, oxygen therapy or chemotherapy), Decision S3 of 12 June 2009 of the Administrative Commission and the EU Commission's explanatory notes (2011) stipulate that a prior agreement between the person concerned and the institution providing them is required. Consequently, the person concerned should contact prior to her/his departure the specialised medical unit of the place of stay to be sure that the treatment concerned can be provided. However, these documents stress that this does not mean that the person concerned requires a prior authorisation for a specific treatment, but rather a prior agreement that the treatment will be available during her/his stay.

[8] However, the EU Commission's explanatory notes (2011) clearly indicate that this exception has to be assessed carefully and a case by case basis. Presenting some examples for clarification, it mentions the case of an EU migrant citizen who wants to go to her home EU country to give birth. As the text states, 'the purpose of the stay in their home country is not only to give birth but also to return to a familiar environment where they can count on the support of their relatives in the period before and after the birth of their child. Health care provided in this situation to mother and child should be considered as being necessary care and therefore covered by the European Health Insurance Card.'

- lack of information/knowledge concerning procedures;
- to avoid administrative burden;
- fear about failure to pay or insufficient/late payment;
- a private healthcare provider;
- doubts about the validity of the EHIC.

As these findings suggest, many of these problems are clearly related to lack of information and of trust in the functioning of the EU coordination mechanism, and they have been systematically reported over the years (IN_EX01, IN_CS001; De Wispelaere, De Smedt and Pacolet, 2022; ECAS, 2019, 2020; Pacolet and De Wispelaere, 2014).

1.3. Ex-post: reimbursement mechanism

The Regulations define the principle of equal treatment for EU citizens to access sickness benefits during a temporary stay in another MSs, stating that they shall be entitled to healthcare for unplanned care 'as though they were insured under the legislation of the MS of stay (Regulation 833/2004/EC, Article 19). As MSs retain the competence to determine the tariffs or co-payments (if any) that apply for healthcare treatments, the principle of equal treatment implies that if insured residents of a given MS have to pay, then EU citizens receiving an unplanned health treatment in that country will have to pay too. Likewise, if the former are reimbursed for a treatment, then EU citizens showing an EHIC shall be reimbursed too and according to the same tariffs. In cases where the health system requires payments that can be later reimbursed by the health insurers, people using the EHIC can claim reimbursement either in the country of stay (while they are still there) or to the competent institution in their country of residence (once they are back home).

On this aspect, the most recent analysis reports that almost nine out of ten of the reimbursement claims are settled between the institutions of the competent country and the country of stay (De Wispelaere, De Smedt & Pacolet, 2022). For what concerns reimbursement claims from the perspective of the competent MS,[9] the highest number of reimbursement claims were received by Germany, the UK, France and Italy, countries that are characterised by significant rates of temporary outward mobility (Eurostat, [tour_dem_ttw]: Number of trips by country, 2019 / Destination: EU28). Following the flows of reimbursement claims, in 2020 the highest number of claims were received by the UK from Spain (167,576 claims), by Germany from Austria and Poland (142,203 and 121,250 claims, respectively), and by France from Portugal (128,319 claims). In that respect, the use of the EHIC and bilateral reimbursement flows largely follow the mobility flows of tourists between MSs (De Wispelaere & Berki, 2021).

Importantly, a basic principle of the Regulations entails that the cost of healthcare provided by the MS of stay has to be reimbursed by the competent MS in accordance with the tariffs of the former. This principle should avoid a financial burden for the EU citizen receiving healthcare abroad, shifting it to the competent MS. However, this principle has a differential impact in terms of relative expenditure for cross-border unplanned healthcare for MSs (De Wispelaere & Berki, 2021; Stan, Erne & Gannon, 2021).

[9] Number of E125 forms received, when reimbursement is claimed by the Member State of stay, and E126 forms sent, when the competent Member State asks information on the costs to be reimbursed to the insured person who claims for reimbursement after having paid during a stay in another MS

As treatments are reimbursed on the basis of the tariffs set in the MS of stay, competent MSs where medical charges and the healthcare expenditure per inhabitant are lower (Southern and Central and Eastern EU countries to a large extent) show a higher relative cross-border expenditure compared to the ones where medical charges and healthcare expenditure per inhabitant are higher (on average, in Northern and Western EU countries). In other words, outflows from Eastern to Western Europe result in a higher relative burden for the budgets of Eastern European MSs.

Looking at reimbursement from the perspective of the MS of stay,[10] the highest number of claims of reimbursement provided by a MS of stay were issued by Germany (311,419 forms), Austria and Poland (more than 200,000 forms each).[11] Importantly, data for 2020 show that around 2% of the invoices were rejected by the competent institutions (De Wispelaere, De Smedt & Pacolet, 2022). Twenty-one out of 25 reporting MSs indicated that invoices were rejected by their institutions or in other countries, mainly because of an invalid EHIC at the moment of treatment, an incomplete reimbursement claim or missing data concerning the EU citizen.

From the perspective the MS of stay, rejections could lead to an increase of the administrative burden if additional information has to be provided in order to receive the reimbursement, as well as to delays of payments - or even budgetary cost, if claims are not accepted by the competent MSs.

To summarise

The EHIC, and more broadly the current rules on the coordination of health systems across the Union, are of great importance to all EU citizens moving between MSs. Without them, there would be a major barrier for all EU citizens in terms of access and affordability of unplanned and necessary cross-border healthcare, and consequently to freedom of movement. However, despite the increasing circulation and use of the EHIC, some obstacles still exist when it comes to guarantee cross-border health care to EU citizens who temporarily stay in another MS.

> How it is organised, in terms of cross-border healthcare… in theory, it's fine. In terms of policy implementation, there might be several issues. Assume that in 95 per cent of cases it works. But 5 per cent, in absolute figures, it's a high number! There are challenges, and challenges for specific groups, and specific flows for Member States, and for the definition of concepts – planned versus unplanned, private versus public… It works, 'but'. It's at the level of implementation that there are significant margins for improvement and where further steps have to be taken (IN_EX01).

Insufficient knowledge on the side of EU citizens concerning the existence of the EHIC, the procedures to apply for and use it, the existence of administrative barriers and delays, are often identified as the main cause for the limited circulation of the EHIC. Moreover, obstacles to access healthcare in a MS of stay for holders of a EHIC have often been reported due to refusals by healthcare providers. Specifically, lack of knowledge as regards procedures and the interpretation of 'necessary' and

[10] Number of E125 forms issued (when the MS of stay claims reimbursement from the competent MS) and number of E126 forms received (the competent MS requests information from the MS of stay about the costs to be reimbursed to the insured person).

[11] For a detailed presentation of the number of reimbursement claims and amounts, see the annual reports of the EU Commission on "Cross-border healthcare in the EU under social security coordination", available here: https://ec.europa.eu/social/main.jsp?catId=22&langId=en

'unplanned' care, as well as providers' willingness to avoid administrative burden and fear of no or late payment, have been identified as the main reasons for a refusal of the EHIC. Finally, errors and lack of cooperation between MSs have been identified as significant factors affecting the coordination of healthcare and social security systems in the Union (Jorens, De Wispelaere & Pacolet, 2022)

Despite the Court of Justice of the European Union (CJEU) has consistently stressed that the purpose of the rules on the coordination of social security is to prevent citizens from losing their protection when exercising their right to free movement,[12] mobile EU citizens continue to experience challenges and obstacles to maintain healthcare coverage when exercising their right to free movement. These issues have been exacerbated by the outbreak of the COVID19 pandemic. As argued by a research participant,

> It is something a bit new! Before it was just the recognition of your EHIC, the recognition of your papers […]. Now, with the COVID, it has changed. There were really, really issues concerning the access to healthcare. […] Social security in general, not only healthcare, has always been the first topic, the main issue for mobile citizens, really always. But this time, I would say in the last two years, the access to healthcare it is really something new. It is not only administrative issues, or recognition of your documents, it is really people who could not have access to healthcare (IN_CS001).

[12] Case C-2/89 Kits van Heijningen, par. 12; Case C-196/90 De Paep, par. 18; Case C-619/11 Dumont de Chassart, par. 38; Case C-140/12 Brey, par. 40; Case C-535/19, par. 46.

2. Access to healthcare for EU citizens residing in another MS: stratified rights in the Union

According to the Citizenship Directive, EU citizens have the right to take on residence in another MS for more than three months, the conditions for which depend on their occupational status (Directive 2004/38/EC, Article 7). After 5 years of continuous residence in another MS, EU citizens may be entitled to permanent residence (Directive 2004/38/EC, Article 16).

For what concerns access to healthcare, no specific provisions are set by the Citizenship Directive. However, it does states that all EU citizens residing in the territory of a host MS shall enjoy equal treatment with the nationals of that MS (Directive 2004/38/EC, Article 24). Consequently, their entitlement to healthcare should be based on the same principles that apply to the nationals of that MS (insurance-based or residency-based). Yet, as it will be pointed out below, for the first five years of residence in another MS, this principle holds for the category of workers only.

Accordingly, access to social protection for Union citizens in another MS has been consistently interpreted as a key tool to guarantee freedom of movement of workers since the beginning of the integration process. On the contrary, a compromise on the movement and residency rights of students, retired people and the 'independently wealthy' has been reached only after years of stalled negotiations: these EU nationals are simply not granted unconditional free movement rights. As it will be detailed below, their rights to free movement and residency in another MS is conditional on they having 'sufficient resources' to not pose an 'unreasonable burden' on the finances of the host MS and sickness insurance. It is thus in relation to these categories that the EU framework spells out its limits on cross-border solidarity (Mantu & Minderhoud, 2017; Thym, 2015).

2.1. The interplay between residency, occupational status and healthcare rights

The Citizenship Directive distinguishes between 'temporal legal residence' (from more than 3 months to 5 years) and 'permanent residence' (more than 5 years). While the latter grants EU citizens access to any social rights on the same ground of nationals of a MS, the concept of 'temporal legal residence' differentiate the residency rights of EU citizens on the basis of their occupational status, namely workers, economically inactive citizens, students, pensioners and job seekers. This legal differentiation is fundamental to the extent that juridical definitions and administrative processes of residence registration shape conditionality (Bruzelius, 2019). Accordingly, administrative aspects concerning residence can have indirect but far-reaching exclusionary effects on EU migrant citizens' access to social benefits and services in the destination MS. In the words of a research participant,

> It is an issue of residence, it is residence that gives you the possibility to access social security. And it is a bit a vicious circle, because to get your residence card, you need to prove that you have social security! It's really a nightmare… and more and more countries are asking for a private insurance. It is more and more diffused, in Austria, in Denmark… they are making residency and access [to social protection] more difficult. (IN_CSO1)

In theory, no specific conditions apply to workers. Since the beginning of the EU Integration process, in fact, the EU framework has attempted to eliminate as many deterrents from free movement of workers as possible. Accordingly, workers shall be subject to the social security rules of the country

where they work, following the principle of *'lex loci labori'*. Consequently, this category is supposed to be the most secure in terms of access to residency and healthcare rights, as workers should be immediately covered by the health system of the MS where they work (De Wispelaere & Backi, 2021).[13] For what concerns job-seekers, they retain their rights to residency for at least six months if they have worked more than one year in the MS of stay. Expired this minimum period, the person could be forced to leave, unless she or he does demonstrate continuity in seeking employment and that she or he has 'a real chance of being hired'. Holding the status of 'workers' during this period, however, the right to access healthcare should be the same as the one of active workers.

It is interesting to note that the CJEU's interpretations of who a 'worker' is have pushed cross-border solidarity significantly further than EU legislation did in its initial development (de Mars, 2019). According to case law,

> the essential feature of an employment relationship is that a person performs services of some economic value for and under the direction of another person in return for which he receives remuneration (CJEU, Case C-66/85, Lawrie-Blum v Land Baden-Württemberg).

The use of such flexible definition has allowed the CJEU to encompass the multiplication of flexible, atypical, and non-standard work relations that have become a key form of access to employment in several EU countries over the last decades, including part-time or on-demand work, casual work, temporary agency work, fixed-term or seasonal employment, and apprenticeships (Giubboni, 2018). However, these increasing transformations in employment, which have been further accelerated by the outbreak of the COVID-19 pandemic (eg., telework), represent a challenge when it comes to access to cross-border rights. As reported by a research participant,

> Now the main problems concern workers, and particularly which country is the competent one. There are now so many situations and so many different types of work – posting, teleworking – that are confusing not only the citizens but also the employers, they do not know where they are supposed to pay the social security contributions. […] So this is the main issue, which country is the competent one. Often you have situations in which no country says it is competent, others in which the two countries decide they are competent. It is really a mess, it is very complicated. And there is lack of cooperation. So, this is really the main issue now (IN_CSO01).

For what concerns pensioners, they meet the sickness insurance requirement if they are entitled to healthcare at the expense of the competent MS paying their pension (demonstrated by the issue of the portable document S1), while students may demonstrate having sickness coverage by means of an EHIC whose validity covers the period of study in another MS.[14]

Concerning the former, however, EU reports have frequently pointed out the existence of significant administrative obstacles for pensioners to obtain a S1 form in the competent country or having it recognised by the new MS of residence, as well as of errors and lack of cooperation between MSs (De Wispelaere, De Smedt & Pacolet, 2022; Jorens, De Wispelaere & Pacolet, 2022). Concerning students, as already presented in Table 3, the length of validity of the EHIC varies significantly across countries and within categories, with young people and students often falling among the groups for which the

[13] In very specific situations, other criteria apply. Such situations include, *inter alia*, posted workers, i.e., persons who are sent by their employer to carry out services in another MS on a temporary basis.

[14] In addition, students shall demonstrate that they are enrolled at a private or public establishment, accredited or financed by the host MS, to follow a course of study.

card has shorter validity compared to other categories, and pensioners in particular. Hence, the EHIC might not cover the total duration of their residence abroad for study reasons.

Finally, economically inactive citizens hold the right to reside in another MS provided that they have sufficient resources not to become a burden on the social assistance system of the host MS and have comprehensive sickness insurance cover. For what concerns the first requirement, it shall be assessed whether the EU citizen has resources above the threshold for entitlement to social assistance benefits. If that is the case, the person will not be eligible for social assistance in the host MS, hence she or he will not be considered 'a burden' for the system.[15]

With regard to the requirement of having sickness insurance covering all risks in the host MS, the Commission has considered that 'any insurance cover, private or public, contracted in the host Member State or elsewhere, is acceptable in principle, as long as it provides comprehensive coverage and does not create a burden on the public finances of the host Member State' (European Commission, 2009, p.9).

Differently from social assistance, the impossibility of becoming a burden - this time without the qualification of 'excessive' - seems absolute (Carrascosa Bermejo, 2017). Moreover, the fact that the insurance cover has to provide 'comprehensive' coverage might be challenging to assess in several countries (IN_BE05; IN_ES01). In several EU countries, certain healthcare services (eg., orthodontics, ophthalmology) are often excluded from public coverage, meaning that citizens have to buy complementary insurance packages. In this case, it is not clear whether the concept of 'comprehensive coverage' is limited to the basket of services covered by the public system in the host MS or not. In addition, private insurances usually do not provide coverage for all events and treatments (e.g., a pandemic), meaning that holding a private insurance might not be sufficient to comply with this criterion. Consequently, the possibility for economically inactive citizens to actually demonstrate having comprehensive sickness coverage in a host MS might be challenging.

As it will be broadly discussed in Section 3, the entitlement of this category of EU citizens has been the subject of increasingly harsh debates and policy restrictions since the early 2010s, triggering a process of politicisation of the healthcare-mobility nexus and of 'immigrantisation' of EU citizens (Gago, 2021).

To summarise

Guaranteeing access to healthcare for mobile EU citizens represents a key tool to foster freedom of movement of EU citizens across the Union, as well as a duty for MSs to protect the population living within their national borders.

Yet, the current EU framework is structured around clear hierarchies of EU citizens on the basis of their residency and occupational status, thereby leading to the production of stratified healthcare rights among different 'categories' of EU citizens. Workers lie on the top of such hierarchy, enjoying –

[15] In addition, the Directive mentions that the applicant's personal situation shall be taken into account as well and, in any case, applications for social assistance benefits cannot automatically result in an expulsion measure, as long as the person does not become an unreasonable burden on the social assistance system of the host Member State. In order to decide whether the burden is excessive, the Explanatory Memorandum to the of the Directive (European Commission, 2009) considers that it is that it is appropriate to examine whether the request for assistance is due to temporary difficulties, taking into account the duration of residence, personal circumstances or the amount of the assistance granted.

in theory – the most secure access to healthcare. On the contrary, pensioners, students and, most importantly, the economically inactive ones are not granted unconditional free movement and residency rights. For them, the possibility to move to and reside in another MS is guaranteed as long as they do not represent 'a burden' for the welfare and healthcare systems of the host MS. It is thus in relation to the most precarious categories of mobile citizens that the EU framework and MSs spell out their limits on cross-border solidarity (de Mars, 2019; Mantu & Minderhoud, 2017; Thym, 2015).

More broadly, CONFLICTIVE DEFINITION OF RESIDENCE BETWEEN THE DIRECTIVE AND THE REGULATION:

> At the EU level, in the Administrative Commission or the DG, there is a lot of discussion about the link between the Regulation and the Directive. These two frameworks were approved on the same day, on April 20, 2004, but they were negotiated in two separate channels, the Employment one, for the Regulation, and the Justice one, for the Directive. And these two EU frameworks do not refer to each other! They both use the concept of residence, but the definition of residence is different. An anecdote of the decisions at the European level: on the one hand, there is the EU Commission, discussing about an Austrian file. The representative of the DG Justice, which is responsible for the Directive, said to the Austrian colleague: if I have understood your case, you have correctly refused the right of residence to this person on the basis of the conditions of the Directive. Among other things, the person had no health insurance, and Austria did not want to admit him into its system, because it was one of the conditions [of the Directive]. The colleagues of the DG Employment, competent for the Regulation: 'Ah, but we do not agree, because this person intends to reside in Austria, so on the basis of the Regulation, article 11,3.a, Austria must admit him in its system as a resident'. There you have it, two DGs of the European Commission that had a different view! Member States have to apply the legislation correctly, according to EU law, but the two competent DGs frequently do not align themselves! (IN_BE01)

In practical terms, this unclear interplay between the Regulation and the Directive may also have very practical, bureaucratic consequences for EU citizens who intend to move their residence in another MS. As exemplified by the same research participant,

> Under the Directive, for residence purposes, the EU citizen is asked to submit a proof of healthcare coverage, on paper. But under the Regulation, there is the exchange of information with the EESSI, between institutions and not with the insured. So, for example, if I move from Belgium to France, I can go to France, go to a sickness fund in France, and say: 'you want to request, using the EESSI, my documents'. But, at this moment, I do not have a proof on paper of my health coverage to apply for residence. And for that, I would have to ask my Belgian sickness fund for a declaration that shows that I am covered (IN_BE01).

3. The politicisation of the healthcare-mobility nexus in times of crises

The relationship between national welfare and healthcare systems and the EU mobility regime has always been tense, confronting the core EU principle of free movement with the social rights of citizens that have been traditionally a responsibility of MSs (Ferrera, 2009). While MSs agreed to the free movement of people in the Treaty of Maastricht, they were significantly more reluctant to provide grant full social rights to EU migrants. In this context, the CJEU played 'an activist role' that expanded social rights of EU migrants in various rulings (Gago & Maiani, 2022). However, this progressive expansion of rights was not highly contested until the early 2000s: at that moment, MSs did not (yet) consider EU intra-mobility as a threat for their financial and welfare resources. Yet, this perception started to change in the context of the 2004 Eastern and Central European Enlargement (Martinsen, 2011) and worsened since the outbreak of the 2008 economic crisis (Martinsen & Vollaard, 2014; Geddes and Hadj-Abdau 2016), frequently leading to the adoption of restrictive practices to detect and fight abuses of EU citizenship's residency rights on the side of mobile EU citizens, and economically inactive ones in particular (Coldron & Ackers, 2007).

Although cases of frauds have been reported by several interviewees (IN_EX01; IN_EX02; IN_BE01; IN_BE05; IN_BE06; IN_ES01) and EU reports (Jorens, Gillis & De Coninck, 2015; Jorens & De Coninck, 2020; Jorens et al., 2021; Jorens, De Wispelaere & Pacolet, 2022), research has contradicted the existence of fraudulent welfare and healthcare tourism as generalised phenomena and the existence of 'welfare burden' (Martinsen & Pons Rotger, 2017). MSs as well have been unable to demonstrate such claims in relation to healthcare.[16] As pointed out in a Commission study, healthcare spending on non-active EU mobile citizens is very small relative to total health spending (0.2%) or to the economies of the host countries (0.01% of GDP), and EU citizens account for a very small proportion of the recipients of special non-contributory benefits (ICF GHK, 2013). For what concerns healthcare expenditure for temporary mobility, the budgetary impact of cross-border expenditure related to unplanned necessary treatment during a stay abroad on average amounts to 0.1% of total healthcare spending related to benefits in kind in MSs (ICF GHK, 2013).

In spite of this,

> the free movement of EU citizens has become a campaign issue for some political parties; […] there is a risk that this debate, if not addressed rationally, could lead to scapegoating EU citizens from some Member States, or EU mobile citizens, and could lead to a rise in racism and xenophobia (EU Parliament, 2014, p.2[m]).

Accordingly, since the early 2010s, several countries have debated and even introduced restrictions in EU citizens' access to social protection (Carmel, Sojka & Papież, 2016; Lafleur & Stanek, 2017). For instance, in the spring of 2013 ministries of Germany, Austria, the Netherlands and the UK wrote a joint letter to the EU Council and Parliament, warning them on the 'considerable strain' their countries were subject to 'by certain immigrants of other Member states', in particular 'caused by the provision of

[16] Following a request from the Council, in June 2013 the Commission asked MSs to provide, inter alia, information on mobile EU citizens who applied for or received social benefits. Of the 21 MSs that responded, Austria, Belgium, Croatia, Hungary, Poland, Sweden and the United Kingdom were unable to provide this data (EU Commission, 2013).

schooling, healthcare and accommodation'[17], in relation to which they called for tougher controls, including repatriations and re-entry bans. In the same year, the German CDU–CSU–SPD government coalition's programme included a commitment to 'work within the EU to ensure that their countries of origin issue the EHIC to every national' to 'counteract the unjustified use of social benefits by EU citizens' (Stan & Erne, 2021, p. 435).

Likewise, the issue of cross-border healthcare and its impact on national health system has been highly mobilised in the run-up to the Brexit referendum. Accordingly, British tabloids accused Eastern EU citizens of abusing the British health system by using the EHIC delivered by the latter to cover health services provided in their home countries – thus creating a financial burden for the UK because of the payment outflows, although data contradict such drain, and even point out to the opposite (Stan, Erne & Gannon, 2021; De Wispelaere et al. 2020). Discourses about intentionality and planning of abuses from certain EU citizens via the EHIC were part of widespread accusations aimed at delegitimising – or even excluding - them from public healthcare in another MS. Public polling throughout the referendum campaign indicates that concerns about the viability of the NHS and the pressure put on its resources by EU nationals who moved to the UK was a significant public concern (de Mars, 2019).

In such increasing hostile environment towards intra-EU mobility, since the early 2010s several countries have intensified the number of expulsions against certain categories of EU migrants, removing residence permits for those economically inactive ones depicted as a 'welfare burden' (Hepworth, 2012; Fekete, 2014; Lafleur & Mescoli, 2018). Others have adopted procedures to restrict access to social benefits for mobile EU citizens, including healthcare (among others, see: Bruquetas-Callejo & Perna 2020; de Mars, 2019; Heindlmaier & Blauberger, 2017; Mantu & Minderhoud, 2017; Martinsen, Pons Rotger & Thierry, 2019).

In line with these political temperatures, the CJEU has also taken a more cautious approach to the interpretation of the rights to residence and social protection for mobile EU citizens, an economically inactive ones in particular, indicating that certain bans on benefits are justifiable by the MSs out of concern for their public finances (de Mars, 2019; Mantu & Minderhoud, 2017).[18] This point has been recently stressed in a recent ruling of the CJEU on a case between Latvia and an Italian inactive citizen temporarily residing in that country who was refused to register into Latvia's National health system (C-535/19). As affirmed by the Court,

> the residence of a Union citizen for a period of more than three months and less than five years is subject, inter alia, to the condition that he or she has comprehensive sickness insurance cover in order not to become an unreasonable burden on the public finances of the host Member State. [Hence,] Union citizen cannot rely on the right to equal treatment in order to claim access free of charge to the public sickness insurance system, as otherwise that condition would be rendered redundant […]. Thus, any unequal treatment which might result, to the detriment of such a Union citizen, from access which is not free of charge to that system would be the inevitable consequence of the requirement.

[17] https://www.statewatch.org/media/documents/news/2013/apr/eu-4-ms-welfare-letter-to-irish-presidency.pdf

[18] See, for instance, Case C-140/12 Brey ECLI:EU:C:2013:565; Case C-67/14 Alimanovic ECLI:EU:C:2015:597; C-308/14 Commission v United Kingdom ECLI:EU:C:2016:436; Case C-535/19 A (Soins de santé publics) ECLI:EU:C:2021:114.

In other words, national legislations are precluded to exclude economically inactive EU citizens from the right to be affiliated to the public sickness insurance schemes of the host MS. However, it is the principle of equal treatment – a building block of EU citizenship - that can be circumvented.

The relationship between EU citizenship and social solidarity - in the form of healthcare rights for mobile EU citizens – is at stake. Debates that initially focused on economically inactive EU citizens have been extended to EU workers, whose mobility had always been considered a positive aspect of the EU integration, and intra-EU mobility more generally. The results of the discussions at the EU level concerning the revision of the Regulations[19] and the Commission's work on the upcoming reviewed guidance on the Citizenship Directive[20] will indicate towards which direction the EU integration and the project of a Social Europe will unfold.

[19] https://www.europarl.europa.eu/doceo/document/A-8-2018-0386_EN.html

[20] S. Luhmann, Policy Officer for Union citizenship rights and free movement at the European Commission's Directorate General for Justice and Consumer Rights. Intervention at the 'State of the Union Citizens' rights Conference', 29 March 2022. Summary of the intervention available here: https://ecas.b-cdn.net/wp-content/uploads/2022/05/State-of-the-Union-2022-Reinventing-EU-Citizenship-post-COVID-19.pdf

References

Administrative Commission for the Coordination of Social Security Systems. 2003/751/EC: Decision No 189 of 18 June 2003 aimed at introducing a European health insurance card to replace the forms necessary for the application of Council Regulations (EEC) No 1408/71 and (EEC) No 574/72 as regards access to health care during a temporary stay in a Member State other than the competent State or the State of residence (Text with relevance for the EEA and for the EU/Switzerland Agreement.). (2003). Official Journal, L 276, 1-3. CELEX: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:32003D0751[legislation]

Administrative Commission for the Coordination of Social Security Systems. 2009/S1. Decision no S1 of 12 June 2009 concerning the European Health Insurance Card. OJ C-106, 24 April 2010, pp. 23–25. https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=uriserv:OJ.C_.2010.106.01.0023.01.ENG

Administrative Commission for the Coordination of Social Security Systems. 2009/S3. Decision no S3 of 12 June 2009 defining the benefits covered by Articles 19(1) and 27(1) of Regulation (EC) No 883/2004 of the European Parliament and of the Council and Article 25(A)(3) of Regulation (EC) No 987/2009 of the European Parliament and of the Council. OJ C-106, 24 April 2010, pp. 40–41. https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=uriserv:OJ.C_.2010.106.01.0040.01.ENG

Bruquetas-Callejo, M., & Perna, R. (2020). Migration and Healthcare Reforms in Spain: Symbolic Politics, Converging Outputs, Oppositions from the Field. *South European Society and Politics; 25*(1), 75-98. https://doi.org/10.1080/13608746.2020.1769342

Bruzelius, C. (2019). Freedom of movement, social rights and residence-based conditionality in the European Union. *Journal of European Social Policy, 29*(1), 70-83. https://doi.org/10.1177/0958928718756262

Carrascosa Bermejo, D. (2017). Free movement of EU non-active citizens and their access to minimum subsistence income benefits (included healthcare): the impact of EU case-law on cases. *Revista del Ministerio de Empleo y Seguridad Social - Derecho social Internacional y Comunitario, 127*, 127-226. https://libreriavirtual.trabajo.gob.es/libreriavirtual/detalle/W0141727

Carmel, E., Sojka B., & Papież K. (2016) *Free to Move, Right to Work, Entitled to Claim? Governing Social Security Portability for Mobile Europeans*. Berlin: NORFACE Welfare State Futures.

Coldron, K., & Ackers, L. (2007). (AB)Using European Citizenship? EU Retired Migrants and the Exercise of Healthcare Rights. *Maastricht Journal of European and Comparative Law, 14*(3), 287-302. https://doi.org/10.1177/1023263X0701400306

Cornelissen, R. (2009) 50 years of European Social Security Coordination. *European Journal of Social Security, II*/2009, 9-45.

Cornelissen, R., & De Wispelaere, F. (2020). 60 Years of European Social Security Coordination: Achievements, Controversies and Challenges. In B. Vanhercke, D. Ghailani & S. Spasova (Eds.). *Social Policy in the European Union 1999–2019: The Long and Winding Road* (143-66). Brussels: The European Trade Union Institute and the European Social Observatory.

de Mars, S. (2019). Managing Misconceptions about EU Citizens' Access to Domestic Public Healthcare: An EU-Level Response? *European Public Law, 25*(4), 709-733. https://ssrn.com/abstract=3447174

De Wispelaere, F., & Berki, G. (2021). The role and limits of the European Health Insurance Card: (Too) great expectations? *Journal of European Social Policy, 31*(4), 424-431. https://doi.org/10.1177/09589287211023046

De Wispelaere, F., De Smedt, L., & Pacolet, J. (2021). *Cross-border healthcare in the EU under social security coordination - Reference year 2019*. Brussels: European Commission, Directorate-General for Employment, Social Affairs and Inclusion.

De Wispelaere, F., De Smedt, L., & Pacolet, J. (2022). *Cross-border healthcare in the EU under social security coordination - Reference year 2020*. Brussels: European Commission, Directorate-General for Employment, Social Affairs and Inclusion. https://data.europa.eu/doi/10.2767/714637

Dwyer, P. (2001). Retired EU migrants, healthcare rights and European social citizenship. *Journal of Social Welfare and Family Law, 23*(3), 311-327, DOI: 10.1080/01418030126399

ECAS (2016). *YEA Annual Trends 2016*. Brussels: ECAS. https://ecas.b-cdn.net/wp-content/uploads/2017/04/YEA-annual-trends-2016.pdf

ECAS (2019). *YEA Annual Trends 2019*. Brussels: ECAS. https://ecas.b-cdn.net/wp-content/uploads/2020/05/YEA-annual-trends-2019-1.pdf

ECAS (2021). *YEA Annual Trends 2021*. Brussels: ECAS. https://ecas.b-cdn.net/wp-content/uploads/2022/05/Your-Europea-Advice_YEA_Annual_Trends_Report_2021.pdf

European Commission (2004). More Europe in your pocket the European health insurance card. Press corner, IP/04/390. Brussels, 26 March 2004. https://ec.europa.eu/commission/presscorner/detail/en/IP_04_390

European Commission (2004). Explanatory notes on modernised social security coordination Regulations (EC) No 883/2004 & No 987/2009 – Necessary care. https://ec.europa.eu/social/main.jsp?catId=867

European Commission (2009). Communication from the Commission to the European Parliament and the Council on guidance for better transposition and application of Directive 2004/38/EC on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States. COM(2009) 313 final, Brussels, 2 July 2009. https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2009:0313:FIN:EN:PDF

European Commission (2013a). *Investing in Health. Commission Staff Working Document - Social Investment Package*. SWD(2013) 43 final. Brussels, 20 February 2013. https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX%3A52013SC0043

European Commission (2013b). Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions. Free movement of EU citizens and their families: five key actions. COM(2013)837 final, 25 November 2013. https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52013DC0837&from=SK.

European Commission (2017). *Strategic Plan 2016-2020 DG Health & Food Safety*. Ref. Ares(2017) 6260978. Brussels, 20 December 2017. https://ec.europa.eu/info/publications/strategic-plan-2016-2020-health-and-food-safety_en

European Commission (2021). Social security coordination. Digital Information Exchange System. Factsheet. https://ec.europa.eu/social/main.jsp?catId=1544&langId=en

European Court of Auditors (2019). *EU actions for cross-border healthcare: significant ambitions but improved management required*. Luxembourg: European Court of Auditors. https://www.eca.europa.eu/Lists/ECADocuments/SR19_07/SR_HEALTH_CARE_EN.pdf

European Parliament (2014) European Parliament resolution of 16 January 2014 on respect for the fundamental right of free movement in the EU (2013/2960(RSP)). Official Journal of the European Union, C 482/114. https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52014IP0037&from=ES

European Parliament (2016). *Obstacles to the right of free movement and residence for EU citizens and their families. Comparative Analysis*. Brussels: European Parliament. https://www.europarl.europa.eu/thinktank/en/document/IPOL_STU(2016)571375

European Parliament, Council of the European Union, & European Commission (2017). Proclamation of the European Pillar of Social Rights. Gothenburg, 16 November 2017. https://data.consilium.europa.eu/doc/document/ST-13129-2017-INIT/en/pdf

Fekete, L. (2014). Europe against the Roma. *Race & Class, 55*(3), 60–70. https://doi.org/10.1177/0306396813509196

Ferrera, M. (2009). The JCMS annual lecture: National welfare states and European integration: In search of a 'virtuous nesting'. *Journal of Common Market Studies, 47*(2), 219-233. https://doi.org/10.1111/j.1468-5965.2009.00802.x

Fillon, J.C. (2009). Cross-Border Healthcare. In Y. Jorens (Ed.), *50 Years of Social Security Coordination* (213–36). Brussels: DG for Employment, Social Affairs and Equal Opportunities. https://op.europa.eu/en/publication-detail/-/publication/5af665be-4907-48b4-ab85-2135bfa2a82d

Gago, A. (2021). From invisible to real borders: The implementation of a stratified EU mobility regime in Germany and the UK. Paper presented at the ECPR General Conference 2021.

Gago, A., & Maiani, F. (2022). 'Pushing the boundaries': a dialogical account of the evolution of European case-law on access to welfare. *Journal of European Integration, 44*(2), 261-275. https://doi.org/10.1080/07036337.2021.1887860

Geddes, A., & Hadj-Abdou, L. (2016). An unstable equilibrium: freedom of movement and the welfare state in the European Union. In G.P. Freeman and N. Mirilovic (Eds.), *Handbook on Migration and Social Policy* (222-238). Cheltenham: Edward Elgar Publishing.

Giubboni, S. (2018). Being a worker in EU law. *European Labour Law Journal, 9*(3), 223-235. https://doi.org/10.1177/2031952518791828

Heindlmaier, A., & Blauberger, M. (2017). Enter at Your Own Risk: Free Movement of EU Citizens in Practice. *West European Politics, 40*(6), 1198–217. https://doi.org/10.1080/01402382.2017.1294383

Hepworth, K. (2012). Abject Citizens: Italian 'Nomad Emergencies' and the Deportability of Romanian Roma. *Citizenship Studies, 16* (3–4), 431–449. https://doi.org/10.1080/13621025.2012.683256

ICF GHK (2013). *A fact finding analysis on the impact on the Member States' social security systems of the entitlements of non-active intra-EU migrants to special non-contributory cash benefits and healthcare granted on the basis of residence. Final report*. DG Employment, Social Affairs and Inclusion via DG Justice Framework Contract. KE-04-13-060-EN-N. https://op.europa.eu/en/publication-detail/-/publication/c6de1d0a-2a5b-4e03-9efb-ed522e6a27f5

Jorens, Y., & De Coninck, J. (2020). *Fraud and error in the field of EU social security coordination. Reference year 2018*. Brussels: European Commission, Directorate-General for Employment, Social Affairs and Inclusion. https://data.europa.eu/doi/10.2767/22859

Jorens, Y., Gillis, D., De Coninck, J. (2015). *Fraud and error in the field of EU social security coordination*. Brussels: European Commission, Directorate-General for Employment, Social Affairs and Inclusion. https://data.europa.eu/doi/10.2767/585086

Jorens, Y., De Smedt, L., De Wispelaere, F., et al. (2021). *Fraud and error in the field of EU social security coordination. Reference year 2019*. Brussels: European Commission, Directorate-General for Employment, Social Affairs and Inclusion. https://data.europa.eu/doi/10.2767/907070

Jorens, Y., De Wispelaere, F., & Pacolet, J. (2022). *Fraud and error in the field of EU social security coordination. Reference year 2020*. Brussels: European Commission, Directorate-General for Employment, Social Affairs and Inclusion. https://data.europa.eu/doi/10.2767/600659

Lafleur, J.-M., & Mescoli, E. (2018). Creating Undocumented EU Migrants through Welfare: A Conceptualization of Undeserving and Precarious Citizenship. *Sociology, 52*(3), 480–496. https://doi.org/10.1177/0038038518764615

Lafleur, J-M., & Stanek, M. (Eds.) (2017). *South-North Migration of EU Citizens in Times of Crisis*. Cham: Springer Open.

Mantu, S., & Minderhoud, P. (2017). EU citizenship and social solidarity. *Maastricht Journal of European and Comparative Law, 24*(5), 703-720. https://doi.org/10.1177/1023263X17741271

Martinsen, D.S. (2011). Judicial policy-making and Europeanization: the proportionality of national control and administrative discretion. *Journal of European Public Policy, 18*(7), 944-961. https://doi.org/10.1080/13501763.2011.599962

Martinsen, D.S., & Pons Rotger, G. (2017). The Fiscal Impact of EU Immigration on the Tax-Financed Welfare State: Testing the 'welfare Burden' Thesis. *European Union Politics, 18*(4), 620–39. https://doi.org/10.1177/1465116517717340

Martinsen, D.S., Pons Rotger, G., & Thierry, J.S. (2019). Free movement of people and cross-border welfare in the European Union: Dynamic rules, limited outcomes. *Journal of European Social Policy, 29*(1), 84-99. https://doi.org/10.1177/0958928718767300

Martinsen, D.S., & Vollaard, H. (2014) Implementing Social Europe in Times of Crisis. *West European Politics, 37*(4), 677–92. https://doi.org/10.1080/01402382.2014.919773

Pacolet, J., & De Wispelaere, F. (2014) *The European Health Insurance Card - EHIC Questionnaire*. Network Statistics FMSSFE. Brussels: European Commission.

Vollaard, H., van de Bovenkamp, H., & Martinsen, D.S. (2016). The Making of a European Healthcare Union. *Journal of European Public Policy, 23*(2), 157–76. https://doi.org/10.1080/13501763.2015.1034160

Stan, S., Erne, R., & Gannon, S. (2021). Bringing EU citizens together or pulling them apart? The European Health Insurance Card, east–west mobility and the failed promise of European social integration. *Journal of European Social Policy, 31*(4), 409-423. https://doi.org/10.1177/0958928720974188

Stan, S., & Erne, R. (2021). Bringing society back into our understanding of European cross-border care. *Journal of European Social Policy, 31*(4), 432-439. https://doi.org/10.1177/09589287211031815.

Strban, G., Berki, G., Carrascosa Bermejo, D., & Van Overmeiren, F. (2016). *Access to healthcare in cross-border situations. Analytical report 2016*. Brussels: European Commission, Directorate-General for Employment, Social Affairs and Inclusion. https://core.ac.uk/download/pdf/84774906.pdf

Thym, D. (2015) The elusive limits of solidarity: Residence rights of and social benefits for economically inactive Union citizens. *Common Market Law Review, 52*(1), 17-50, https://kluwerlawonline.com/journalarticle/Common+Market+Law+Review/52.1/COLA2015002

Verschueren, H. (2020). The Role and Limits of European Social Security Coordination in Guaranteeing Migrants Social Benefits. *European Journal of Social Security, 22*(4), 390–402. https://doi.org/10.1177/1388262720967938

Wendt, C. (2009). Mapping European healthcare systems: a comparative analysis of financing, service provision and access to healthcare. *Journal of European Social Policy, 19*(5), 432–445. https://doi.org/10.1177/0958928709344247.