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Patients' rights in the European Union

Cross-border care as an example of the right to health care

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The rights of patients to receive health care in other member states of the European Union (EU) are dependent upon both individual rights and social rights. The problem is that these rights differ in character and the way they can be claimed. The right to health care falls under the category of social rights which require the state to provide the necessary health care services. Patients' rights to access to care are sometimes included in administrative regulations and in civil medical contract acts. European legislation and the jurisdiction of the Court of Justice of the European Communities played an important role in reinforcing the rights of patients to have access to health care in other member states. The practical consequences of the existing procedures and criteria have also been investigated. The entitlements based on differing legal procedures and criteria between and even within member states has led to confusion and inequality. Cases with different outcomes based on different legal grounds make it apparent that the rights of patients are dependent on several legal and practical factors. The conclusion is that, in the case of cross-border health care, a balance may be struck between the rights and criteria. This balance should create an equilibrium between general legal principles and national and international legislation.

Key words: authorization, cross-border care, legal cases, legal principles, patients' rights

The rights of patients to receive health care in the European Union (EU) are dependent upon both the individual rights and social rights of patients as entrenched in the legislation of the various EU member states and the recognition of these rights in international (particularly European) legislation.

The legal system of the state itself assures patients of a certain level of access to medical care. The claimed 'right to health care' is regulated by a complex web of laws and regulations which govern the action of patients, health care providers, governments and 'third-party payers'. These laws and regulations, both on a national and European level, serve diverse purposes. The most important of these is to strike a balance between individual freedoms and public needs and interests. The case of cross-border health care is a good example of finding an equilibrium between individual and social rights of patients.

In this article, the actual state of balance with respect to the different types of laws and regulations in the case of cross-border health care will be described. The selected laws and regulations concerning cross-border care correspond to the different legal principles and legal norms behind the individual and social rights of patients. In addition, the role of screening criteria and screening instances will be investigated from a legal point of view. The interpretation of these criteria, which allow patients to receive treatments in other EU states, reflects the balance between the governments' desire to both help patients and realize individual patients' rights and the general social desire to allocate and use resources efficiently both within and between the EU health care systems.

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COMMON VALUES AND BASIC RULES

Within the legal-judicial system, a vast complex of laws and regulations govern the actions of individuals, governments, corporations and other legal entities within society. While these laws and regulations serve diverse purposes, a common and important one is to balance individual freedom against the public good. The right to health care, as a category of human rights, falls under the category of rights that require that the state provides the health services concerned.

The basic idea of inalienable entitlements originates from the seventeenth-century doctrine of the 'natural rights' of every human person. This doctrine was first enunciated in the political theory of John Locke (1632–1704). Locke proclaimed that, in the state of nature, all persons would be equal and endowed with a natural right to life, liberty and estate. Over the years the doctrine of human rights underwent many considerable modifications. Jean-Jacques Rousseau (1712–1778), one of the first proponents of the theory of natural rights, clearly distinguished between the natural and the civil rights of individuals. He believed that, upon entering into the civil state, the individual forfeited his or her natural rights in exchange for a new set of civil rights. The function of the government amounted to no more than a protective role. Immanuel Kant (1724–1804) captured the idea of this protective role of the state. The institutions of governmental power are called upon, by means of instruments of law, to lay

down the conditions under which the will of an individual may co-exist alongside the equal wills of all other individuals under a general law of freedom.[1]

These basic theories on individual human rights and the function of the government are important for the position of patients' rights and the right to health care in particular, because of the distinction that has been made between the rights of individuals and the duty of the state.

The current right to health care clearly does not fall within the classical notion of human rights. Human rights, as originally perceived, required of a government that it leave scope for and not intervene in the exercise of the rights and freedoms concerned, whereas the right to health care falls within the category of rights which involves a duty of the state to provide the services and support included in the concept of health care. The right to health care is currently seen as a social right and the right to self-determination as an individual right. These rights complement each other and are interdependent. Social rights must therefore aim at safeguarding individual rights and individual rights must be considered in relation to the individual's partnership in society.[2]

The conclusion on the right to health care is that a clear distinction should be made between individual and basic social rights. However, these rights complement each other. The social right to health care means that the government has a duty to provide the necessary health care services. How many services should be available is, amongst others, dependent upon the financial means available.

PATIENTS' RIGHTS

In 'The rights of patients in Europe' Asvall[3] argued that various social, economic, cultural, ethical and political considerations have given rise to a movement in Europe towards ensuring the rights of patients. In his opinion, this can be attributed to a return to the values inherent in fundamental human rights and upon which the rights of patients are founded. All over Europe the values of individual freedom and self-determination have re-emerged. Not only individual rights, but also the social dimension of patients' rights have become more important during the past decades. The social dimension takes into account living and working conditions and public health in its broadest sense. A trend can be distinguished which seeks to reaffirm the right to treatment and care, to adequate social cover (including access to care) and adequate information about health services. This means, in other words, the existence of a right to benefit from the supply of health care facilities within the EU. This right forms the basis of the rights of patients to cross-border health care regulated in the EC Treaty and the EC regulations.

Despite these established principles, it is undeniable that users' expectations are not met. Access to care is limited by making choices or postponed by creating waiting lists. This is widely attested by numerous petitions and claims made by patients, particularly in emergency cases, to receive treatment within or outside their country. This practice of petitions and claims made by patients, highlights the difficulties in implementing the rights of patients.

The central position of the patient in health care has been stressed in international regulations and set out in several specific treaties, regulations and directives such as the European Social Charter of the Council of Europe[4] and the Declaration on the Promotion of Patients' Rights in Europe[5] of the World Health Organization.

In the national legislation concerning patients' rights, based on constitutional rights, a distinction must be made between general rights and rights pertaining to special situations. In these specific situations administrative legislation is required because the law must authorize government intervention in the freedom and autonomy of the individuals concerned. Administrative legislation is also the proper instrument for the regulation of rights in legal social security systems. Finally, a third reason for implementing administrative legislation is the protection of the patient against third-party interests.

The social dimension of the right to access to care means a right to benefit from the supply of health services. This right, based upon administrative legislation, forms the basis of the right of patients to cross-border health care.

LEGISLATION ON PATIENTS' RIGHTS TO ACCESS TO CARE

In most countries the right to access to care is based upon individual and social rights' provisions as laid down in the constitution. It is therefore based upon the vertical relationship between the government and patient. In most European countries civil courts have played an important role in the establishment of patients' rights. The civil rights' option allows the patient to take direct action against the health care provider where access to care is denied. In the administrative rights' option this is, in principle, not possible. The patient is dependent upon those benefits available within the particular health care system and the entitlements deriving from public health care legislation.

Both options for legislation on patients' rights occur in almost all countries of the EU although, sometimes, one option for legislation predominates over the other. The Netherlands has chosen the civil rights' option with the introduction by the government of the Medical Contracts Act into the Civil Code in 1995.[6] Finland, on the other hand, has chosen the administrative rights' option[7] as the predominant form of regulation of patients' rights. In 1992, an act on the rights of the patient was issued.[8,9]

The differences between these options are smaller than they might at first appear. When government has taken the option to strengthen the rights of patients by implementing a civil contract, patients' rights may also be strengthened by administrative regulations. For example, patients' rights in The Netherlands are included in the conditions for the licensing of health care facilities. Similarly, under the regulation of administrative rights, the civil option sometimes remains open to the patient. One example is the legal channel that exists in some European

countries for insured patients (public or private) to have emergency case claims attested by civil court decisions.

Furthermore, some specific patients' rights may be based on common general legal norms. One instance of this is the European Convention for the Protection of Human Rights and Fundamental Freedoms.[10] This convention has the force of law in the member states that adhere to it and it supports both the right to consent and to privacy.

An important basis is formed by the individual fundamental rights laid down in the constitution of a member state. This can also provide a legal basis for patients' rights, as can the general principles of civil law and the provisions of penal law.

A solid legal basis for patients' rights is thus not only to be found in specific laws, but also in laws which cover not only health and health care but also the contractual relationship between the patient and the health care provider.

Therefore, civil rights and administrative rights both reinforce the position of the patients. Sometimes they share the same goals and follow the same procedures.[11] However, sometimes they can also differ from case to case and, particularly for patients, it is often unclear on what legal grounds their entitlements are based.

ACCESS TO CARE AND EUROPEAN LEGISLATION

In the Treaty of the European Communities[12] (EC Treaty), the free movement of goods, services, capital and persons is regulated. The law of the EC rests on the basic principles of freedom and equality, non-discrimination, proportionality and subsidiarity. The principles of freedom are laid down in classical negative (guarantees against suppression of self-fulfilment) and positive (social) basic rights. They find expression in the EC Treaty's provisions on the free movement of goods (Article 30) and workers between member states (Article 48), on the coordination of national social security systems (Article 51) and on the provision of services (Article 59).

By virtue of European law, the fundamental rights have been reinforced by EC legislature and rulings of the Court of Justice of the European Communities. The Maastricht Treaty of 1992 has changed the name 'European Economic Community' into 'European Community'. The Court of Justice, however, still refers to itself as the 'Court of Justice of the European Communities'.[13] The EC legislation has played an important role in this respect. In particular, supporting legislation has amplified the basic treaty rules and, in particular in the health care sector, legislative initiatives have further enhanced individual and social rights. The Court of Justice of the European Communities is also very important in realizing patients' rights in the EU. It has produced a considerable number of cases in which common rules and principles have been established that also apply to migration and cross-border care within the EC.

The Single European Act[14] introduced the new Articles 8A, 8B and 8C of the EC Treaty. 'Every person holding the nationality of a Member State shall be regarded as a citizen of the European Union' (Article 8). According to Article 8A (1) 'Every Citizen of the Union shall have the right to move and reside freely within the territory of the Member States'. However this freedom was subject to the limitations and conditions laid down in the treaty and the measures adopted to give it effect. Article 8A transferred the original economic right of free movement into a personal right. This right is subject to two conditions: persons enjoying this right cannot become the responsibility of the social security system of the host country and the health insurance benefits must be provided in accordance with the regulations of the host country. The cost will be borne instead by the state of origin.

The new Article 100A created the possibility of adopting harmonization measures, but this article was not considered to be applicable to the 'free movement of persons' (which covered the free movement of workers as well).[15]

THE FREE MOVEMENT OF WORKERS

The free movement of workers is expressed in Article 48 of the EC Treaty and it entails the abolition of any discrimination based on nationality between workers in member states as regards employment, remuneration and other working conditions. This means that they enjoy the same remuneration and the same social rights, including the right to treatment in another EU member state.

The treaty itself provides no definition of the 'worker'. The interpretation of the notion of a worker has fallen to the Court of Justice the European Communities. In Levin v Staatssecretaris van Justitie[16] the court declared that notion of 'worker' has an EC law content and it rejected Danish and Dutch submissions that national criteria governing minimum wages and the minimum number of hours worked should apply. The court's concept of a 'worker' as an EC law concept is an important element in securing uniform protection throughout the EC of the rights arising under article 48.[17] Divergent interpretations of the right to health care for different categories of 'workers' at a national level have thus been precluded. In Kempf v Staatssecretaris van Justitie[18] the court went one stage further deciding that the status of 'worker' cannot be denied because remuneration is below the minimum national subsistence level. According to the court rulings, not only 'workers' but individuals who do not satisfy EC law requirements to qualify as workers can also rely on EC law. Therefore all kinds of patients or persons, in addition to workers have entitlements under EC law. The worker, however, has a favoured position in claiming social rights available under national (health) law.

Article 48 (2) clarifies the position regarding 'the abolition of any discrimination based on nationality between workers of the Member States'. This is an enlargement of the prohibition of discrimination in Article 6 of the EC Treaty. The scope of the rights is also enlarged in Article 48 (3) which insists that a worker shall have the right to move freely within the territory of member states. However, Article 48 does not address the reality that such rights to cross borders are also dependent on associated rights, such as for patients to bring their families with them to obtain social health insurance benefits.

Workers and the self-employed (according to the Court's rulings this also includes unemployed economically inactive persons with voluntary insurance and part-time workers) and family members have a fairly wide coverage under EC law coordinated according to EC regulations. In practice most competent institutions in the member states appear to be reluctant to authorize treatments in other states of the EU. However, the court has consistently held that the free movement of workers would be frustrated if a migrant were to lose social security benefits, including health care benefits, guaranteed under the law of a member state.

The rights of patients are based upon the free movement both of persons and services. Within the context of the free movement of services (defined by the Articles 59 and 60 of the EC Treaty), the case law of the Court of Justice of the European Communities in the Luisi and Carbone case[19] of 1984, also extended the coverage to cases where it is not the person providing the services who moves, but the person who wishes to receive the service does so by moving to the state where the provider is established. This interpretation allows tourists, recipients of medical treatment and persons on study and business travel to be covered by regulation relating to the free provision of services.[20]

EQUAL ACCESS

Besides working out the principles of freedom, the EC Treaty also specifies the principle of equality.[21] It focuses on the formal principle of equality, leaving out of consideration factual discrepancies in income, age, economic power, health, etc. From the formal equality principle flows general legal rules valid for all legal subjects, such as the general prohibition of discrimination (Article 6 of the EC Treaty) and equal treatment. The principle of equal treatment forms a structural basis for the rights of European citizens to be treated abroad.

In the Royer case[22] the European Court has observed that the basic freedoms are 'based on the same principles in so far as they concern the entry into and residence in the territory of Member States of persons covered by Community law and the prohibition of all discrimination between them on grounds of nationality'. In general this also applies to the health care sector.

SUBSIDIARITY AND ACCESS TO CARE

In the Treaty of Maastricht[23] the process of the reinforcement of the rights of patients has been further developed. This treaty introduced the concept of subsidiarity which has important implications for national policies, including the health and health care policy. However, this leaves room for a broad or narrow interpretation of the EC competence[24] in the field of health care. The Maastricht Treaty also provided specific EU competence in the field of public health. Article 129 is focused on the coordination of national policies on the prevention of major diseases as well as health information and education. However, the scope for action is limited depending again on the interpretation of this provision in the EC Treaty.[25]

Under the principle of subsidiarity, the organization of health care and health services is a matter which essentially remains governed by national policies. Social protection constitutes, in this sector, the principal means of access. However, the means of access have been coordinated in the EU since 1959, originally to facilitate the movement of the workforce (see Hermesse et al. in this supplement[26]).

In Article 51 of the EC Treaty the principle of coordination of the national social security systems is expressed. Regulations 1408/71 and 574/72 and, in particular, Article 22 of EC Regulation 1408/71 form the legal basis for the rights of patients to (pre-)authorized care. According to Article 22, a 'worker' or his or her family member who wishes to go to another member state in order to receive treatment must obtain an E112 form from the competent health insurance institution and present it to the institution of the place of stay. The issue of the E112 form is subject to the condition of prior authorization. The European Court has ruled in the cases Costa v Enel[27] and Amministratione delle Finanzo delo Stato v Simmental[28] that treaty provisions and regulations take precedence over any conflicting national legislation.

COMPATIBILITY OF AUTHORIZATION WITH THE EC TREATY

Finally the question arises whether national rules governing the authorization of treatment abroad are compatible with the EC Treaty provisions on the free movement of goods (Article 30) and services (Article 59). A case is pending before the Court of Justice of the European Communities (N. Decker v Caisse de maladie des employés privés, Case C–120/95: New Cases 1995) in which the Court has been asked to determine whether a Luxembourg rule under which all medical treatment outside Luxembourg must be authorized in advance by a sickness fund, violates Articles 30 and 36 of the treaty.[29] If the Court decides that the national rules are incompatible with Article 30, all member states will be forced to change their 'authorization rules and procedures'. This may lead to the question of whether national E112 rules relating to the movement of patients are consistent with Article 59 of the EC Treaty.

EC law thus considerably reinforces the impact of the fundamental principles of freedom, equality, non-discrimination, proportionality and subsidiarity and the conclusion may be drawn that these principles apply both to health care and national rules for the authorization of cross-border care as well.

NATIONAL AUTHORIZATION PROCEDURES FOR TREATMENT IN OTHER EU MEMBER STATES

The EU regulations establish that all EU citizens who are workers (wage earners as well as the self-employed) and insured as workers under a member state's social security system, including their dependents, are entitled to reimbursement for medical care received in another mem-

ber state. Patients who move abroad to receive medical treatment need the E112 form.

The EU regulations mentioned above establish conditions under which an E112 cannot be refused by the competent national authorities. Most countries more or less follow the EU rules and some, for example, the UK have no additional legislation. In Britain, the Department of Health issues guidelines to district health authorities (DHA) explaining its citizens' rights to referral elsewhere. To obtain medical treatment in another EU member state the patient must gain the approval of an NHS consultant, together with a letter of recommendation for treatment abroad. The letter must then be passed on to the Contracts Referral Unit of the DHA for their agreement to meet the costs of the treatment in another country. If they agree, the consultant's letter is sent to the Department of Health, accompanied by the written consent of the unit agreeing to meet the costs. Upon receiving this information the department may authorize the issue of the E112 form. In the UK there is no formal right of appeal if the case is refused by the DHA. However, the patient may apply directly to the Department of Health to consider payment from its own budget.

In Luxemburg the approval for treatment in another EU state by the medical panel of the social insurer is needed and, in some cases, the second opinion of a consultant physician is required. The decision is taken by the 'conseil d'administration de l'union' of the insurer or by the directors' committees of the insurers. In the case of refusal the patient has the right of appeal based on the Articles 83 and 293 and 294 of the Social Insurance Act. Luxemburg (like Spain) grants permission to go abroad under broader circumstances than those indicated by the EU, for instance in cases of extended waiting periods and for treatments unavailable locally.[30]

Patients have to follow different procedures in the various EU member states to obtain an E112 form. Not only do the procedures vary from country to country, but the criteria to acquire authorization are also different in most member states.

COVERAGE CRITERIA FOR HEALTH INSURANCE

When and how authorization to receive treatment in another EU member state is granted is dependent on the coverage criteria for health insurance within the country of stay.

Within each health care system of the EU member states, rules have been developed to limit coverage for services under public or private insurance. These rules refer to 'screening criteria' or 'referral criteria' which are dependent on relevant clinical indications or findings. Patients who wish to obtain services having failed to meet the relevant criteria of the insurer in their own member state, generally must do so at their own expense. However, patients (usually through their physicians) may attempt to obtain special authorization from designated neutral physicians. In effect they plead 'extenuating circumstances' and ask for an exemption from the rule. Similar coverage criteria are in place for in-patient acute medical, surgical or psychiatric treatment.

One can readily see that the thresholds contained in the coverage rules will largely determine the number of patients who receive the desired care under the health insurance of the member state. As such, these rules serve to balance patients' freedom to obtain desired services against the overall costs imposed on the beneficiaries of the health care system as a whole.

Theoretically, the strictness of the criteria should reflect a balance between the public's desire to help patients and the general social value of efficient use within and outside the health care arena.[31] In practice the strictness of the existing coverage criteria varies substantially, in large part because the criteria are generally developed informally by panels of physicians without explicit reference to public values or the available evidence on the health outcomes of treatment.[32]

GENERAL OUTLINE OF FUTURE LEGAL PROCEDURE

The above-mentioned procedure and criteria differ a great deal across the EU member states. To improve the present confusing situation, a general outline of a new procedure could be described.

In the health care systems of the EU member states, a patient with a perceived health need for a particular treatment seeks the advice of a professional, generally a physician or another provider who counsels the patient. Generally this must be done within the context of the health insurance coverage of the patient.

The next step in the process is for the provider to determine whether the patient's health insurance covers the desired procedure by reference to the criteria. If the patient's condition matches the applicable insurance rules, the procedure is covered and may be obtained within the health insurance cover. If the patient does not match these coverage rules, the patient may either forego the recommended service despite the professional's advice or may obtain the service using private funds. Alternatively, the patient and the provider may elect to appeal for coverage within the health insurance, setting forth their reasons to an ostensibly neutral third-party physician on why the desired procedure should be provided. A judgement that the service should not be provided is, as a rule, not final and can be appealed against by the patient to a second-level judge or court which can either uphold or overturn the denial of coverage.

In most EU member states a final appeal to an administrative legal body is possible should the first bodies uphold the coverage denial.

ANALYSES OF SOME LEGAL CASES AND PROCEDURES

The rights of insured patients could not only be based on national and European legislation but also on jurisprudence. In some court rulings in particular, the interpretation of constitutional and other legal rules has led to criteria for judging in which cases treatments may be allowed or refused for patients in other EU member states. Sometimes different courts (civil and administrative)

have to judge almost the same cases for approximately the same benefits.

Good examples of the legal problems that could occur are found in cases that have recently been brought before civil and administrative courts in The Netherlands, where privately insured and publicly insured heart patients, who were in urgent need of heart transplants, were refused treatment in a Belgian hospital.

The first case concerned a 43 year old man with a terminal heart failure who was privately insured. In 1993 he was referred by his cardiologist to the heart transplant centre in Rotterdam. After screening by the centre in Rotterdam he was refused the transplant operation. The transplant team did not see any possibility of a successful transplant because the patient suffered from a vascular disease. After this, his medical specialist asked for a second opinion from the thorax centre of a Belgian hospital in Aalst. After a new screening, the transplant team of the Belgian centre came to the conclusion that an operation could be performed successfully. However, the private health insurance company refused to pay for the operation. The reason for the refusal was that the Dutch team, using Dutch criteria, had refused to accept the patient for the operation and the insurance policy did not provide for recompense of the costs of the transplant in a Belgian hospital.

The case was brought before a civil court.[33] The judge decided that, in this case, there was a difference of opinion between the Dutch and the Belgian specialists on the predicted success of a transplant on the patient concerned. According to the civil court's judge, the patient was not given the opportunity for an independent second opinion in The Netherlands as the 2 heart transplant centres in Rotterdam and Utrecht worked closely together using the same heart transplant protocol. The patient was therefore dependent on the foreign centre for a second opinion. In this case, on the grounds of reasonableness and fairness, the private insurer could not appeal to the policy provisions. Therefore, the patient could rightfully claim the costs for the treatment in the Belgian hospital.

In a second case, a compulsorily insured patient was also refused a heart transplant by the Dutch transplant team on the same medical grounds. This was sufficient reason for the Dutch sickness fund to refuse authorization to the patient to be treated in the Belgian hospital. In a decision of the administrative court,[34] the court decided that according to Article 9, Section 4 of the act, a sickness fund can allow an insured person to be treated elsewhere. The minister of health can decide in which cases and under what conditions, an insured person is allowed to realize their entitlement to benefits outside The Netherlands. In earlier cases, the Central Appeals Board[35] has proclaimed that Article 9 is not restricted to the Dutch benefits package. However, it is not possible to extend the benefits package by applying Article 9 of the Sickness Funds Act. According to regulations based on the Benefits Decree, an indication for a hospital admission has to exist. Inpatient care in a hospital includes a heart transplant, but only as far as an indication exists. The heart transplant team has to obey the countrywide heart transplant protocol. According to the administrative court, the decision of the sickness fund to refuse authorization is not judged illegal because this benefit is restricted to two Dutch transplant centres, follows an indication and has to fulfil the standards of the protocol. The heart transplant protocol is part of the restricted entitlement to benefits.

These two cases, with different outcomes, based on different legal grounds, make it clear that the rights of insured patients to receive treatment or be reimbursed for treatment abroad are very much dependent upon the way the patient is insured and the legal body which is competent in the case concerned. Civil rights guarantee patients a direct claim, not only on the basis of insurance contracts but also based on general legal principles when the contract does not provide for medical treatment abroad. Administrative rights, on the other hand, are based on the public rights and benefits within the social health care legislation which guarantee patients the necessary benefits. In the examples described the court's decision included the medical protocol in the social health insurance scheme. Different interpretations have been made inside and outside the country about the medical necessity of a treatment. Therefore, patients' rights on cross-border care are much more difficult to realize within the public health insurance schemes, than they are in the private sector.

CONCLUSIONS

This article analyses the principles, values and rights of patients in the EU. Although the EU and the EC Treaty form a small legal basis for the realization of patients' rights, the impacts of EC regulations are considerable, particularly in court decisions. These decisions are basically founded on the fundamental principles of EC law (Court of Justice of the European Communities) and constitutional, civil and administrative rights (national courts). In the case of cross-border health care, a balance can be found between the rights and the criteria to allow patients, on the basis of pre-authorized medical care, to receive treatment in other EU countries and the individual and social rights of patients to health care.

Areas of tension can be found in the practical realization of the rights of patients to be treated in other EU member states. The criteria are different and the interpretation of these criteria also varies from state to state. A possible solution for these problems can be found in the creation of a more uniform legal procedure.

The rights of patients in the EU have 'internal' effects within each member state of the union and 'external' effects by allowing patients to receive treatment in other EU countries.

The horizontal relation between patient and health care provider is the basis for the civil rights of patients to receive treatment. The vertical relation between the patient and government, or the competent authority to authorize medical care in other EU member states, is often based upon public administrative legislation. Patients' rights on cross-border health care should be a well-

balanced equilibrium between civil rights and administrative rights and, ultimately, form a compromise between general legal principles and the values of international, European and national laws and regulations.

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