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RIGHT TO HEALTH IN THE CONTEXT OF CROSS-BORDER HEALTHCARE IN THE EUROPEAN UNION

The legal meaning of the right to health within the European Union social security coordination and cross border health care framework reflects the balance between individual entitlements and the limits of EU competence in health policy. While Article 35 of the Charter of Fundamental Rights of the European Union (CFREU) recognizes a right to access preventive health care and medical treatment under conditions established by national law, this provision does not create a harmonized EU-level entitlement. Instead, the right to health in the context of social security coordination is primarily operationalized through Regulation (EC) No 883/2004 and it's implementing Regulation (EC) No 987/2009, which ensure the portability of health benefits and the equal treatment of mobile insured persons across Member States. Case law of the Court of Justice of the European Union (CJEU) has clarified that this right is derivative, conditional, and closely tied to the principle of free movement of persons. By analyzing the legal framework and key CJEU judgments, this paper demonstrates that the EU approach is functional rather than substantive, protecting access to healthcare as a social security benefit rather than as an autonomous human right.

Keywords: *right to health, cross-border health care, EU social security coordination, Regulation 883/2004, CJEU, Directive 2011/24/EU*

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Introduction

The right to health, though universally recognized as a fundamental human right, manifests unevenly in regional legal orders, particularly within the European Union (EU). This article investigates the legal and doctrinal dimensions of the right to health for cross-border workers in the EU, focusing on its normative foundations in international human rights law and its implementation through EU-level instruments such as social security coordination and the Directive on patients' rights in cross-border healthcare.

The article aims to explore how the right to health is defined, constructed, and practically realized in the EU context, especially for mobile individuals. It examines the relationship between individual entitlements, state obligations, and the structural logic of European integration, including the influence of internal market principles on access to healthcare.

Employing a doctrinal methodology, the article critically analyzes legal texts (treaties, regulations, directives), judicial interpretations (notably by the Court of Justice of the European Union and the European Court of Human Rights), and relevant policy instruments. This is complemented by academic commentary addressing the implementation challenges and potential reforms in this domain.

The core research questions guiding this article are twofold: 1. How do EU legal instruments – specifically Regulation (EC) No 883/2004 and Directive 2011/24/EU – operationalize the right to health, and what are their limitations? and 2. To what extent can digitalization and legal modernization enhance the functional realization of the right to health in cross-border settings?

1. The Right to Health for Cross-Border Workers: A Dogmatic Perspective

1.1. International human rights law and its doctrinal evolution

The right to health is a universally recognized human right, encompassing both access to healthcare services and the broader determinants of well-being.

It is a multidimensional human right encompassing various interrelated horizontal and vertical components, and complemented by jurisprudential (normative and case law) coverage approach (universal, regional, supranational and bilateral).

According to international human rights doctrine, *horizontal*ly it includes not only medical care but also broader determinants such as public health, occupational health, environmental hygiene, mental health, and access to essential medicines. Furthermore, the right to health is not simply a right to be healthy, but rather a right to facilities,

goods, services, and conditions necessary to achieve the highest attainable standard of health (CESCR, 2000). This holistic approach reflects the understanding that health is shaped by social, economic, and environmental factors, not limited to healthcare services alone. As such, the right to health extends to preventive care, health education, occupational safety, and sanitation, forming an integrated framework for individual and collective well-being. (UN, 2000).

Vertically, the UN Committee on Economic, Social and Cultural Rights (CESCR)'s AAAQ framework identifies four essential elements – *Availability* of functioning health facilities and services, *Accessibility* without discrimination, including economic and geographical access, *Acceptability* of services in cultural and ethical terms, and *Quality* of care meeting scientific and medical standards – which provide a structured methodology for assessing state obligations and apply across different domains of health provision (UN Committee on Economic, Social and Cultural Rights, 2000).

The international *jurisprudential* dogmatic basis for the right to health originates from the post-World War II human rights architecture (Tilovska-Kechedji, 2023). The forerunner international (multilateral and universal) recognition of the right to health traces to the WHO Constitution (1946), which declares that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being," recognising health as a universal human right central to human dignity and development (WHO, 1946), and to" Article 25 of the Universal Declaration of Human Rights (UDHR, 1948) affirms that everyone has the right to "a standard of living adequate for the health and well-being" of themselves and their family, including access to food, housing, and medical care. This provision laid the foundation for recognising health as a component of the broader right to an adequate standard of living and influenced later binding human rights instruments (UN, 1948).

This right was more robustly inbeded, in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966). It includes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (UN General Assembly, 1966). This right implies not only the availability and accessibility of medical services but also non-discrimination, quality of care, and the freedom to make health-related decisions.

In Europe, the multilateral and regional Council of Europe's (hereinafter: CoE) European Social Charter (hereinafter: ESC) recognizes health rights explicitly (Art. 11), while the European Convention on Human Rights (hereinafter: ECHR) offers indirect protection via the decisions of the European Court of Human Rights (hereinafter: ECtHR) in Strasbourg.

The European Social Charter (ESC) explicitly enshrines the right to health in Article 11, which requires States (which ratified it) to take measures to prevent disease, ensure access to healthcare, and promote public health (Hajdú, 2023). The European Committee of Social Rights (ECSR), which monitors implementation, has interpreted this article as requiring universal, affordable, and non-discriminatory access to both preventive and curative care. In its case law and conclusions, the ECSR has found violations where healthcare is inaccessible due to economic, geographic, or legal barriers, particularly affecting vulnerable groups such as undocumented migrants, persons with disabilities, and Roma communities (ECSR, 2019; ECSR, 2021; Hajdú, 2023). The Committee has also emphasized that States must maintain adequate healthcare infrastructure and respond effectively to public health crises. Through this practice, the ECSR has advanced a substantive and enforceable understanding of the right to health beyond that of the European Convention on Human Rights. (ECSR Conclusions, 2019)

However, the ECtHR's recent jurisprudence illustrates a narrow but real positive obligation on CoE's States Members under Articles 2 and 3 of the ECHR to ensure urgent, life-saving medical interventions, especially where individuals (such as detainees, pregnant women, newborns, etc.) face imminent risk of death or serious harm. While traditional medical negligence might not trigger the Convention, these "exceptional" – cases characterized by complete denial of immediate emergency care or systemic failures in hospital services – have consistently been found to violate Article 2 and Article 3 of the ECHR. The European Court of Human Rights (ECtHR) has interpreted Articles 2 (right to life) and Article 3 (prohibition of inhuman or degrading treatment) to impose limited obligations on States to provide urgent medical care (e.g., Nitecki v. Poland, 2002).[1] Yet, the ECHR system does not guarantee a comprehensive right to healthcare.

[1] Additional ECtHR cases: 1. Asiye Genç v. Turkey (App. no. 24109/07) – A newborn died after being denied admission due to insufficient space/equipment. The Court found a violation of Article 2, holding that the State had failed in its positive obligation to organise effective emergency healthcare. 2. Elena Cojocaru v. Romania (App. no. 74114/12) – A pregnant woman was refused emergency caesarean section and was transferred 150 km away; both mother and baby died. The Court found a violation of Article 2 due to systemic dysfunction and denial of urgent care. 3. Aydoğdu v. Turkey (App. no. 40448/06) – Excessive structural deficiencies in regional health services resulted in the death of a premature baby. The Court held that the authorities must have been aware of real risk and yet failed to take appropriate steps – violation of Article 2. (Source: Gold, 2020) 4. Adchenko and Abramov v Ukraine (Applications nos. 5312/20 & 22627/20, judgment of 18 January 2024) – The Court held that detainees with serious medical conditions had been denied adequate medical treatment, amounting to a violation of Article 3. The Court emphasized that States must ensure prompt, accurate diagnosis and a systematic therapeutic strategy to prevent deterioration in prison. (CDBIO, 2024) Council of Europe, Steering Committee for Human Rights in the Fields of Biomedicine and Health (CDBIO) (2024) https://rm.coe.int/steering-committee-for-human-rights-in-the-fields-of-biomedicine-and-h/1680b0710e?utm_source=chatgpt.com#_Toc168927355

Dogmatically, the multilateral international human rights law treats the right to health as a programmatic and progressively realizable right, imposing both negative obligations (non-interference, non-discrimination) and positive obligations (provision of basic health services) (Toebes, 1999; Chapman, 2010). The progressive realization clause in Article 2(1) ICESCR reflects the structural tension between the justiciability of socio-economic rights and the resource-dependency of their fulfillment.

1.2. The EU legal framework of the right to health

The right to health has long occupied a contested position within the European Union (EU) legal order. Unlike the UN Conventions, or the World Health Organization standards or Council of Europe's ESC. In the supranational EU law, the right to health is not a substantive, autonomous human right in the same way as in certain constitutional or international human rights frameworks. Instead, it is a derivative and functional entitlement, arising from an individual's insured status under a Member State's social security system and serving the broader objective of free movement (Hervey & McHale, 2020). This entitlement is mainly realised through two key principles: equal treatment and portability of healthcare benefits, as set out in Regulation (EC) No 883/2004 (European Parliament & Council, 2004).

The right to health for cross-border persons is a fundamental aspect of EU social law, grounded in both primary and secondary legal sources. In *primarily legislation* via Article 168 TFEU, which requires a high level of human health protection in all policies and Article 35 the Charter of Fundamental Rights of the European Union (CFR), which recognizes access to preventive and medical care under national Member States laws and practices, and also enshrines the right to health care and its practical enforcement for mobile (cross border) individuals is shaped mainly through the *secondary legislation.* Cross-border healthcare in the EU takes place through overlapping legal channels, particularly 1. Regulation (EC) No 883/2004 (Basic Regulation; hereinafter: BR) and Regulation No. 987/2009 (Implementing Regulation; hereinafter: IR) on social security coordination, reflecting both free movement principles and social protection (including healthcare) guarantees and 2. Directive 2011/24/EU on patients' rights in cross-border healthcare, and 3. Extended CJEU case law interpreting the Treaty provisions on free movement of (healthcare) services and professionals.

In brief, the EU social security coordination system guarantees that persons moving within the Union retain healthcare entitlements under the principle of portability of social benefits. In parallel, Directive 2011/24/EU supplements this framework by establishing individual rights to planned cross-border healthcare, particularly when patients seek medical treatment in another Member State. Together, these mechanisms shape a

functional right to health that is derivative of EU citizenship and mobility, rather than an autonomous, absolute right (Hervey & McHale, 2020).

From a Member State point of view, in this legal framework, health is a shared but largely national competence, with the EU playing a supporting and coordinating role (Hervey & McHale, 2020).

These regulations ensure that persons moving within the EU and EEA states do not lose their health insurance coverage or access to necessary healthcare, reflecting a functional interpretation of the right to health as part of portable social security entitlements (Pennings, 2022). Furthermore, these instruments operationalize the right to health by enabling patients to receive care abroad and claim reimbursement, ensuring that national borders do not become barriers to essential medical treatment (European Parliament & Council, 2011, 2004).

In addition, the European Pillar of Social Rights (EPSR) further emphasizes access to healthcare (Principle 16), yet remains a soft-law instrument without direct legal effect (Verschueren, 2020).

Academic literature highlights that the EU right to health in social security coordination is instrumental rather than autonomous. Hervey and McHale (2020) emphasize that EU health law primarily safeguards the market-related dimensions of healthcare, especially in relation to cross-border patient mobility. Similarly, Verschueren (2020) argues that the right to health under the EU coordination regime is derivative of social insurance status, meaning it protects access to benefits only insofar as the individual is covered by a Member State's system.

Academic debate also underscores the tension between Treaty-based market (healthcare services) freedoms and social protection driven social security coordination. The EU Treaties do not establish a general "right" to cross-border healthcare, but the internal market freedoms provide a powerful legal basis. Article 56 TFEU prohibits "restrictions on the freedom to provide services" – including healthcare services as well – within the EU. The CJEU has expressly held that healthcare services fall within Article 56's. In practice, this means that Member States cannot impose unjustified barriers (such as blanket prior authorization or exclusion of foreign services from reimbursement) on patients seeking treatment abroad. Furthermore, the CJEU has historically expanded patient rights through internal market law, as seen in the Kohll (C 158/96) and Decker (C 120/95) line of cases, but coordination law remains state-centered, focusing on non-discrimination based on citizenship and portability rather than substantive equality of healthcare outcomes (Martinsen & Vollaard, 2014).

2. The EU Social Security Coordination System

The legal construction of social security coordination is primarily anchored in three normative layers. First, Article 35 of the Charter of Fundamental Rights of the European Union (CFREU) recognizes a right to access preventive healthcare and medical treatment "under the conditions established by national laws and practices," which reflects the EU's subsidiary role in health matters. Second, Article 48 TFEU provides the legal basis for the adoption of measures in the field of social security coordination to protect mobile workers and their families (free movement of persons). Third, the substantive rules governing cross-border access to healthcare are set out in Regulation (EC) No 883/2004 and its Implementing Regulation (EC) No 987/2009, which collectively operationalize the principle of equal treatment and prevent the loss of health insurance entitlements when exercising free movement rights (equal treatment based on EU citizenship).

From a dogmatic legal perspective, the coordination system does not harmonize national health laws but instead provides a framework for conflict-of-law resolution and the preservation of acquired rights. The lex loci laboris principle (Article 11 of Regulation 883/2004) ensures that cross-border workers are insured under the system of the state of employment,[2] granting them equal access to healthcare services (Article 4). Moreover, frontier workers – those who reside in one Member State and work in another – enjoy special provisions under Article 17 and Article 18, allowing them to access health care in both their state of residence and their state of employment, subject to certain procedural requirements.

The right to health in the context of EU social security coordination exists at the intersection of fundamental rights, social policy, and the free movement of persons. While EU law refrains from harmonizing national health systems, it establishes a legal framework that ensures mobile individuals retain access to healthcare across borders. To understand the EU social security coordination's legal meaning, this following section of the article examines the normative foundations of the right to health in the EU legal order, its operationalization through social security coordination, and the relevant policy and academic discourse.

[2] The relating landmark CJEU decisions, such as von Chamier-Glisczinski (C-208/07), Pensionsversicherungsanstalt (C-135/11), and IKÁ (C-255/13), illustrate that the EU right to health is largely derivative from the status of being insured under a national social security system and the principle of free movement.

2.1. Policy implications of the social security coordination

The following analysis outlines key policy implications and the principal coordination mechanisms – ranging from the European Health Insurance Card (hereinafter: EHIC) to planned healthcare authorisations – demonstrating how they safeguard patient rights while preserving the organisational integrity of national health systems.

2.1.1. Equal treatment and portability of benefits

The equal treatment principle (Art. 4 BR) ensures that persons covered by the legislation of one Member State receive the same treatment as nationals of the host Member State regarding social security, including healthcare (Verschueren, 2020). The portability principle guarantees that benefits, such as healthcare rights, remain accessible when moving or residing in another Member State, avoiding gaps in coverage (European Parliament & Council, 2004).

These principles ensure that cross-border workers, their family members, pensioners, students, and other mobile persons do not face discrimination in accessing healthcare when legally residing or insured in any Member State. (Minderhoud, 2020).

As a result the EU social security coordination system reduces barriers to labour and study mobility and fosters deeper European integration.

2.1.2. Types of coordinated healthcare treatments

The BR and IR regulations establish a comprehensive legal framework to ensure that persons moving across borders retain their social security entitlements, including access to healthcare. This framework reflects key principles such as lex loci laboris, equal treatment, continuity of coverage, and the portability of rights. Various mechanisms – such as the European Health Insurance Card (EHIC), the S1 form, and provisions for planned healthcare abroad – are employed to operationalize these principles for different categories of mobile persons. These include frontier workers, pensioners, posted workers, third-country nationals, and temporary visitors, each with distinct access routes and entitlements. The following overview examines how EU law facilitates cross-border healthcare coordination for these groups, ensuring both legal clarity and the protection of patients' rights across Member States. These options will be introduced briefly here:

A) Patients using the *European Health Insurance Card* (EHIC): This mechanism ensures access to necessary healthcare during temporary stays in another Member State under the same conditions as nationals (Art. 19 of Reg. 883/2004).

B) Patients insured under the *lex loci laboris* principle. Workers are covered by the social security system of the Member State where they work, even if they reside elsewhere. This is relevant for frontier and cross-border workers who access care in both countries, often via S1 forms (Art. 11, 17–18 of the BR) (Schoukens, 2019). In addition to the main guiding principle of working persons (lex loci laboris) in cross border situation the following mechanisms reflect the EU's commitment to equal treatment, continuity of coverage, and portability of rights, forming a core element of the internal market's social dimension.

a) *Frontier workers*,[3] who reside in one Member State but are employed in another, are insured in their country of employment under the lex loci laboris principle (Art. 11). However, they may access healthcare in both states (either home or host where to work is done), typically using the S1 form to register in their state of residence (Art. 17–18), thus ensuring cross-border continuity of care (ETUC, 2022).

b) *Seasonal workers.* The characteristic of seasonal work is that this activity is only carried out during certain periods of the year, in particular in the agri-food and tourism sectors. Very often, seasonal workers must move temporarily to another State to carry out such an activity. Seasonal work is thus characterised by fixed-term short-term employment contracts and precarious working and living conditions. In accordance with the freedom of movement of workers enshrined in Article 45 TFEU, EU citizens have the right to take up employment, including seasonal employment, in another Member State. They have the right to receive the same healthcare from the national employment offices as nationals of the host Member State (ETUC, 2022).

c) *Cross-border teleworkers.* The general provisions of the EU social security coordination rules will not be applied automatically to cross-border telecommuters/teleworkers who regularly telework in their state of residence. Instead, the Framework Exemption Agreement (hereinafter: Agreement) facilitates between the signatory states the conclusion of individual derogations in the interest of a category of employed cross-border teleworkers and their employer(s). Legally speaking, the Exemption Agreement based on the application of Article 16 (1) of BR in cases of habitual cross-border teleworking employees. This bilateral agreement states that cross-border teleworkers can continue to be insured in the member state where their employer is located while working primarily in their home state, provided that the majority (51%) of the work is completed in the employer's country, provided certain requirements are met (Kovacheva & Tsvetkova,

[3] A frontier worker is defined in EU law as a person who works in one Member State but resides in another and returns to their country of residence daily or at least once a week (European Parliament & Council, 2004, Art. 1(f)). This category of mobile worker is covered by Regulation (EC) No 883/2004, which ensures that they are subject to the social security system of the state of employment (lex loci laboris), thereby avoiding dual contributions and gaps in coverage (Art. 11(3)(a)).

2023). The Exemption agreement facilitates between the signatory states the conclusion of individual derogations in the interest of a category of employed cross-border teleworkers and their employer(s) (Cross-border telework in the EU, the EEA and Switzerland, 2023). It is essential for workers participating in cross-border operations inside the EU to be aware of the relevant social security laws.

d) *Third-country nationals*[4] (hereinafter: TCN) legally residing and working in the EU are covered by Regulation (EU) No. 1231/2010, which extends coordination rules to non-EU citizens who move within the EU. This allows them access to healthcare on equal terms with EU citizens, as long as they are insured under the applicable national scheme (Cornelissen, 2018), (European Commission, 2021), (Baas, 2025).

e) *Pensioners* who reside in a Member State different from the one paying their pension may also use the S1 form to register for healthcare in their country of residence, while the costs are reimbursed by the competent state. They are thus entitled to full access to the health system of their country of residence under Article 24 of Regulation 883/2004 (ETUC, 2022).

f) *Posted workers*,[5] temporarily sent to work in another Member State, remain insured in their home country under Article 12 of the BR. During their posting, they access healthcare in the host state using the EHIC or through portable documents like the S1, ensuring they are not subject to a double contribution burden. (Houwerzijl & van Gardingen, 2025), (Bogoeski, 2024), (Lukács Gellérné & Gyulavári, 2025).

C) *Planned healthcare* with prior authorization under the Basic Regulation. Under Article 20 of the BR, insured persons may seek planned healthcare in another Member State, subject to prior authorisation from their competent institution. Authorisation can only be refused if the treatment is available at home within a medically justifiable time, considering the patient's condition. The Court of Justice (e.g., C-372/04 Watts, C-173/09 Elchinov, (C 268/13) Petru) has interpreted this rule broadly, requiring authorisation to

[4] In the context of EU law, third-country nationals (TCNs) are defined as individuals who are not citizens of the EU, the European Economic Area (EEA), or Switzerland. This classification distinguishes TCNs from EU citizens, who enjoy the right to free movement and residence within the Union under Article 21 of the Treaty on the Functioning of the European Union (TFEU). In the area of social security coordination, Regulation (EU) No. 1231/2010 extends the personal scope of Regulation (EC) No 883/2004 to include third-country nationals legally residing and moving within the EU, thereby granting them equal access to social security benefits, including healthcare, under the same conditions as EU citizens.

[5] A posted worker is an employee temporarily sent by their employer to work in another EU Member State while remaining employed and insured in the sending country. This is regulated by dual legislation regime: 1st labour law (Directive 96/71/EC, revised by Directive (EU) 2018/957, which ensures that posted workers are granted core employment rights in the host state, including minimum wage and working time protections, etc. (European Parliament & Council, 1996, 2018), and 2nd EU social security coordination provisions. According to BR, posted workers stay covered by their home country's social security system for up to 24 months, documented by the A1 form (Art. 12 of the BR). This system supports labour mobility while aiming to prevent unfair competition and social dumping.)

be granted where domestic delays would compromise patient health. This mechanism balances patient mobility with Member States' capacity to plan and finance healthcare systems.[6]

The home institution must take into account the individual case of the patient. This includes an objective medical assessment of the patient's condition, history, probable course of illness, the degree of pain and/or the nature of the patient's disability.(Article 8(5) Directive 2011/24) In case prior authorisation was obtained, reimbursement must take place according to the rates of the Member State of treatment. In practice, patients must present to the cross-border care provider a document obtained from their competent institution (the S2-form, previously known as E-112) (Sivonen & Büttgen, 2021).

2.1.3. Importance of administrative efficiency and digitalization in EU social security coordination

Healthcare entitlements for insured persons – such as planned or emergency care abroad, or residence-based healthcare for pensioners and frontier workers, etc. – are made effective through equal treatment and portability of rights. This mechanism would be discriminatory if access depended on nationality or residence status alone (Minderhoud, 2020). Therefore, the equal treatment principle remains the legal foundation for safeguarding non-discriminatory healthcare access under the EU's coordination regime.

Even though, the eligibility and benefit levels are determined by national law, there remains a risk of fragmentation and unequal protection across the EU. Therefore, national policymakers must recognize that delays or restrictive practices in granting health-related social security benefits can indirectly undermine the right to health for mobile persons.

Furthermore, the effective protection depends heavily on timely coordination between Member State institutions, particularly in the exchange of S1, S2, and EHIC-related documentation. Policy reforms could focus on digitalizing and simplifying coordination procedures, reducing administrative obstacles for mobile citizens.

The CJEU's case law indicates that Member States retain the right to protect their welfare systems against unjustified claims. However, excessive reliance on residence requirements or prior authorization procedures could contradict the Union's commitment to mobility and fundamental rights (Verschueren, 2020). A balanced approach

[6] The CJEU in IKÁ (C 255/13) case, emphasized that prior authorization systems for medical treatment abroad must respect the proportionality principle and cannot unduly restrict the effective access to health services for insured persons. Another "undue delay" case was Luisi and Carbone (C 40/02), which though focused on Italy's E112 system also underscored that authorization must not be arbitrary if delay is unreasonable. Similarly, Commission v. Italy (C 265/99) and Commission v. Ireland (C 30/04) affirmed that blanket restrictions on E112 for certain treatments (chemotherapy, etc.) were unlawful.

is necessary to respect national budgetary autonomy while upholding the practical enjoyment of the right to health.

As for practical example of digitalization, the Electronic Exchange of Social Security Information (hereinafter: EESSI) is a good example. It facilitates secure, standardised cross-border data exchange, enabling continuity of social protection for mobile citizens (European Commission, 2023a).

By replacing traditional paper-based processes, EESSI enhances the speed and accuracy of cross-border procedures related to pensions, healthcare, unemployment benefits, and family allowances. It also supports continuity of social protection for mobile EU citizens and helps ensure the portability of their rights (European Commission, 2025). Importantly, the system respects privacy through its decentralised architecture, with no central database of personal information (European Commission, 2023b).

While implementation has advanced, technical and interoperability challenges persist, particularly in linking healthcare entitlements with broader social security data flows (Greer et al., 2022), (ELA, 2024).

2.2. Cross-border patient mobility under Directive 2011/24/EU

The Directive supplements the Basic Regulation by clarifying patient mobility rights when patients choose to receive healthcare abroad, outside of medical necessity. It rests on three key elements: information provision, reimbursement rules, and procedural safeguards.

2.2.1. Mobil patients' right to health in the EU

As it was mentioned, the right to health (care) in EU law is a pragmatic and mobility-driven (cross-border) entitlement, operationalized through a) social security coordination mechanisms and b) patients' right legislation. The Directive 2011/24/EU enhances the individual dimension of this right, ensuring that citizens are not denied effective healthcare merely because of national borders. The Directive 2011/24/EU, applicable from October 2013. It does not supplant the EU social security coordination regulations but operates in parallel and, as the EU Commission notes, confusion still sometimes arises at the border of these regimes (Dates, M, et al., 2022).

The cross-border healthcare – i.e. patients travelling to another EU Member State for medical care – has steadily become more prominent in the EU internal market. Its legal basis lies primarily in the internal market freedoms (notably the freedom to provide services, now codified in Article 56 TFEU) and complementary EU health provisions (e.g. Article 168 TFEU, which obliges the EU to promote a high level of health protection

while respecting Member States' competence over health services).[7] Since the 1990s the European Court of Justice (CJEU) has affirmed that national rules requiring prior authorization or restricting reimbursement for patients seeking care abroad may impede the free movement of (healthcare) services. Unlike the social security coordination regulations, which focus on social security entitlements, the Directive established individual patient rights based on internal market principles (Pennings, 2022). Therefore, in 2011 the EU enacted the Directive 2011/24/EU on patients' rights in cross-border healthcare to codify these rulings and created a clearer statutory framework for patient mobility (Dates, M., et al., 2022).

The Directive 2011/24/EU complements the EU social security coordination regulations by providing a legal basis for reimbursement of cross-border healthcare costs without the need for prior coordination (prioritisation) via national social security institutions (European Parliament & Council, 2011). Patients may seek treatment in another Member State and be reimbursed up to the level that would have been covered domestically, subject to certain conditions. The Directive strengthens patients' rights, ensures transparency and facilitates administrative cooperation between national contact points (van der Zanden, 2024: 746).

In brief, the Directive included a) the right to seek healthcare in another Member State without prior authorization for most outpatient services; b) the right to reimbursement of costs up to the level of domestic entitlement, and c) the right to information about providers, quality, and safety standards in the host Member State. According to Greer, the directive operationalizes a functional right to health by ensuring that national barriers do not unjustifiably restrict cross-border access to care, especially where waiting lists or treatment unavailability might otherwise impede patients. (Greer et al., 2013).

2.2.2. Key elements of the Directive 2011/24/EU

The Directive balances patient mobility with Member States' autonomy over health system organisation. It covers a broad spectrum of services – including telemedicine – and mandates transparency, equal treatment, and proportional prior authorisation mechanisms. While uptake remains limited, the Directive has enhanced legal certainty, transparency, and cross-border cooperation in health service delivery (European Commission, 2022). The key elements of the Directive will be outlined here.

[7] The CJEU has clarified in cases such as C-157/99 Geraets-Smits and Peerbooms and C-385/99 Müller-Fauré that Member States must balance free movement rights with healthcare system sustainability.

A) Reimbursement rules. Patients are entitled to reimbursement up to the amount that would have been paid for the same treatment in their home state (Art. 7 of the Directive), provided the treatment is among the benefits to which they are entitled nationally. (European Union, 2025)

B) Quality and safety Member States must ensure that cross-border care meets the same standards of quality and safety as domestic care, and must provide transparent information on providers (Art. 10–11 of the Directive).

C) Prior authorisation. Basically there is no prior authorisation. However, Member States may require prior authorisation for treatments involving overnight hospital stays or highly specialised care (Art. 8 of the Directive). Authorisation criteria mirror the BR: it may only be refused where the same treatment can be provided at home within a medically justifiable time, or where cross-border treatment would risk serious harm to the patient or public. The ECJ has confirmed that such rules must not constitute arbitrary obstacles to patient mobility (See CJEU cases Watts, Elchinov, Petru). In practice, many states still demand authorization for expensive or elective treatments. The EU Commission audits have noted that the burdens and lack of transparency in prior-authorisation systems continue to impede patients (Reconnet.ern-net.eu, 2024).

D) National Contact Points (NCPs). Member States must designate contact points to inform patients about healthcare abroad (eligibility, quality, safety, etc.) (European Union, 2025). These aim to help patients make informed choices.

E) Telemedicine. Digital health initiatives, such as the eHealth Digital Service Infrastructure (eHDSI) and the MyHealth@EU network, enable cross-border exchange of patient summaries and ePrescriptions. The forthcoming European Health Data Space (EHDS) will further enhance access, interoperability, and secondary use of health data across the Union (European Commission, 2022). Thus, a patient can obtain medication abroad using an e-prescription issued at home, and treating physicians abroad, etc. In line with this progress, the Directive expressly covers healthcare delivered remotely via ICT (Article 3(d)) and requires equal reimbursement conditions for telemedicine services. Telehealth is thus legally within scope, though as discussed below its implementation raises special issues.[8] These initiatives complement the EESSI infrastructure, forming a broader EU strategy for digitalised cross-border healthcare.

[8] CJEU AG Opinion in C 115/24 – Telemedicine and the Country-of-Origin Principle (2024) clarified that pure telemedicine is governed by the law of the country where the provider is established. Host countries cannot impose additional regulatory burdens if services are lawfully provided in the origin country.

Conclusion

The EU's legal architecture for cross-border healthcare – rooted in Treaty freedoms, EU social security coordination (BR and IR), Directive 2011/24/EU, and the jurisprudence of the Court of Justice of the EU – seeks to balance patient mobility with the financial and organisational stability of national health systems. While the Directive enhances transparency, choice, and the patient-centred dimension of the right to health, the coordination regulations remain the primary route for unplanned care and planned inpatient treatment requiring S2 prior authorisation. In this context, the right to health is functional rather than absolute, serving to prevent social protection gaps that could undermine free movement.

Ensuring the effectiveness of this framework requires transparent and predictable authorisation and reimbursement procedures, efficient administrative cooperation through instruments such as the Electronic Exchange of Social Security Information (EESSI), and the elimination of discriminatory practices. Digital integration – via the eHealth Digital Service Infrastructure, MyHealth@EU, and the forthcoming European Health Data Space – offers the potential to improve continuity of care, legal certainty, and system efficiency. Yet persistent national-level challenges, including procedural delays and uneven digital readiness, demand ongoing EU monitoring, legislative refinement, and strengthened cross-border cooperation to translate these legal guarantees into a tangible and substantive entitlement for all mobile Union citizens.

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