

**“Consultation regarding Community action on
health services”
European Commission Communication
of 26 September 2006**

**Joint Position Paper
of the European Social Insurance Platform**

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About the *European Social Insurance Platform (ESIP)*

The *European Social Insurance Platform (ESIP)* represents the statutory social insurers from over thirty organisations in fourteen EU Members States and Switzerland. These organisations are active in the field of health insurance, pensions, family benefits, occupational safety and accident insurance and unemployment insurance. The aims of ESIP and its members are to preserve high-profile social security for Europe; to reinforce solidarity-based social insurance systems and to maintain European social protection quality. ESIP builds strategic alliances for developing common positions to influence the European decision-making process and is a consultation forum for the European institutions and other multinational bodies active in the field of social security.

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Preliminary remarks

In February 2006, the European Parliament stated that health services do not fall within the scope of the EU Services Directive¹. It rightly considered that health services unlike most other services cannot be subjected to free market rules without protection – in particular since, according to Article 152 paragraph 5 EC, health matters are subject to the subsidiarity principle and thus fall within the competence of the Member States. On 26 September 2006, the Commission then submitted the announced Communication to implement a public “Consultation regarding Community action on health services²” that again raises the question to which extend supporting measures at Community level are necessary in the area of cross-border health services. In the first instance, the ESIP member organisations question the need for additional legislative measures over and above those that already exist by way of national law and Council Regulation (EEC) No. 1408/71³ (and its successor, Council Regulation (EC) No. 883/04⁴). Open issues on patient mobility can be regulated within these possibilities. At the same time this does not deny EU citizens the rights they are entitled to by virtue of the European Court of Justice (ECJ) jurisprudence. ESIP firmly supports the European Commission’s call for the adoption of these rights in Member States that have so far failed to implement them. Should further measures be considered indispensable to achieve this, then these should be limited to setting out the principles laid down in ECJ case-law.

The European Commission Communication focuses on the lack of or perceived lack of legal certainty in the area of patient mobility as an argument for the need for Community action. It creates the impression that most cases of patient mobility – the

¹ Position of the European Parliament, adopted at first reading on 16 February 2006 with a view to the adoption of Directive 2006/.../EC of the European Parliament and the Council on services in the internal market (EP-PE_TC1-COD(2004)0001)

² Communication from the European Commission “Consultation regarding Community action on health services” of 26 September 2006

³ Council Regulation (EEC) No. 1408/71 of 14 June 1971 on the application of social security systems to employed persons, to self-employed persons and to members of their family moving within the Community

⁴ Regulation (EC) No. 883/2004 of the European Parliament and the Council of 29 April 2004 on the coordination of social security systems

total of which it estimates at about 1% of overall public healthcare expenditure in the EU – are treated without the necessary legal security, particularly with respect to subsequent reimbursement of expenses. This is a misrepresentation of the facts.

For decades, the large majority of patients receiving treatment in another EU country have done so successfully on the basis of Council Regulation (EEC) No. 1408/71 and of implementing Regulation (EEC) No. 574/72⁵. As a rule, the EU Regulations serve as a basis even if separate agreements have been concluded for cross-border healthcare in border areas in the framework of *Euregios* or bilateral treaties.

In preparing this Communication, the European Commission has already had numerous studies carried out on patient mobility⁶. However, the results presented fail to provide a balanced overall picture. For example, there is no detailed analysis of the data on cross-border patient healthcare that is provided within the framework of Council Regulation (EEC) No. 1408/71, to see where and to what extent the Regulation has been successfully employed and where problems have emerged. It follows therefore that there is insufficient analysis of how far it is possible to resolve the problems of patient mobility mentioned in the Communication within the framework of the existing Regulations.

In addition, we refer to the rights that EU citizens are entitled to by virtue of the ECJ jurisprudence transposed into national law. The ESIP member organisations firmly support the European Commission in calling for the adoption of these rights in those Member States which have not yet implemented them.

Approach to answering the questions

The questionnaire differentiates three categories of cross-border healthcare. This differentiation is largely considered in answering the questionnaire. Furthermore, the subject “patient mobility” is divided into three subcategories to better accommodate the various underlying motivations and resulting solutions. Therefore, the questions are answered in the following order:

1. Patient mobility:
 - 1.a Within the scope of Council Regulation (EEC) No. 1408/71
 - 1.b Healthcare in border areas
 - 1.c Other healthcare – in particular through the application of ECJ jurisprudence
2. Provider mobility
3. Mobility of goods and services (telemedicine, laboratory services, etc.)

⁵ Regulation (EEC) No. 574/72 of the Council of 21 March 1972 on the implementation of Regulation (EEC) No. 1408/71 on the application of social security systems to employed persons, to self-employed persons and their families moving within the Community

⁶ Health access project, Busse et al.; Patient in the European Union, Rosemöller et al., Health basket, Busse et al.

Question 1: What is the current impact (local, regional, national) of cross-border healthcare on accessibility, quality and financial sustainability of healthcare systems, and how might this evolve?

1. Patient mobility

1.a Within the scope of Council Regulation (EEC) No. 1408/71

Council Regulation (EEC) No. 1408/71 on the coordination of social security systems has successfully regulated cross-border healthcare in the entire European Economic Area (EEA) and Switzerland for over 30 years. Insured persons are treated during their stay in another EEA country or in Switzerland as if they were insured there. Any risk to the financial balance of the host country is avoided by refunding the costs at the prices applicable in that country. Furthermore, the financial stability of the funding state has barely been affected, as the number of patients concerned currently accounts for only +/- 1% of the total expenditure which is therefore negligible.

Patient mobility particularly affects services offered and the demand for medical healthcare in popular tourist destinations. During high season, a significantly higher demand for medical services may occur that can no longer be covered by the level of services normally sufficient for the local population, and quality and accessibility may suffer as a consequence. These problems can however not be solved by European regulations; the appropriate solution will depend on the individual circumstances and these differ from one place to another.

1.b Healthcare in border areas

In border areas, cooperation between the countries concerned in the so-called *Euregios* has led to improvements in accessibility to healthcare for the insured. This cooperation does not negatively impact on the financial stability of the participating healthcare systems in the *Euregios*, as it entails individual agreements between the participating parties and higher costs for healthcare in a neighbouring country may be offset by savings made by combining resources.

The great advantage of this form of cooperation is the *local care* approach which is individually adapted to the different regional requirements and therefore benefits the patient in terms of accessibility as well as quality. Such approaches, currently supported by the EU Commission through the allocation of INTERREG-III funds should, in ESIP's view, be intensified. However, to standardise such a regional healthcare approach throughout Europe would not be advisable, as this would exceed requirements and also limit the necessary flexibility of the parties involved. Support for the exchange of information on establishing cross-border cooperation could however be a role for the European Commission as this would represent a European added value.

1.c Other healthcare – in particular through the application of ECJ jurisprudence

The judgments of the ECJ on patient mobility have given EU citizens the legal right to avail themselves of medical services in another Member State⁷. With regard to inpatient treatment, it is essentially only the issue of settlement of costs that has been revised; otherwise patients are now entitled on principle to avail themselves of any non-hospital medical services without prior authorisation⁸. To date however, this right has rarely been exercised. If the cost of patient mobility is 1% of the total EU expenditure on health, as estimated by the European Commission, the largest part of this is attributable to payments made within the scope of Council Regulation (EEC) No. 1408/71 and only a very small portion to expenditure on the basis of ECJ jurisprudence.

The ESIP member organisations regard patient mobility based on the cost refund procedures described by the ECJ only as a supplement to the existing procedure under Council Regulation (EEC) No. 1408/71 – not as an alternative. The procedure whereby the billing process is chosen by the respective Member State in conjunction with Council Regulation (EEC) No. 1408/71 is preferred. Even more so, since in some Member States health services are not only provided and / or financed by health insurance funds but also by statutory pensions insurance and statutory accident insurance organisations.

Therefore, with regard to patient mobility ESIP believes that the primary solution lies in the implementation of Council Regulation (EEC) No. 1408/71, respectively Council Regulation (EC) No. 883/04, as well as in analysing and remedying the difficulties that occur here in practice.

2. Service provider mobility

Directive 2005/36/EC on the mutual recognition of professional qualifications which entered into force on 30 September 2005 makes it easier – as did its predecessors – for service providers to have their professional qualifications recognised in a particular Member State. In addition however, it ensures that the quality of service customary in the country where the service is rendered is not undermined; for example, the temporary and long-term provision of services is governed in principle by the regulations of the Member State in which the service is rendered.

No negative impact is expected on the quality and financial sustainability of the respective Member States as a result of temporary or permanent provider mobility as long as the Member States are allowed, in accordance with the *country of destination* principle, to define quality indiscriminately and to apply volume control tools to limit the financial burden on health systems that are based on the principle of solidarity by supply induced demand.

⁷ ECJ Decision of 26 April 1998 in cases C-158/96 and C-120/95 (*Kohll and Decker*); ECJ Decision of 13 May 2003 in case C-157/99 (*Müller-Fauré und van Riet*); ECJ Decision of 23 October in case C-56/01 (*Inzian*)

⁸ ECJ Decision of 12 July 2001 in case C-157/99 (*Geraets-Smits and Peerboms*); ECJ Decision of 12 July 2001 in case C-368/98 (*Vanbraekel*); ECJ Decision of 16 May 2006 in case C-372/04 (*Watts*)

3. Mobility of goods and services (telemedicine, laboratory services, etc.)

The mobility of goods and services, without the patient or the service provider having to be mobile himself, is one of the growing markets in the area of cross-border healthcare. These include, in particular, telemedicine services, laboratory services, the supply of medical agents and devices as well as medicines.

This is however not as easy in some areas as in the field of medicines. While mobility of goods and services ensures access to these services where they were previously not offered due to a lack of expertise or low demand, it raises new questions concerning data security and the application of quality standards. The proportionality of quality requirements that are applied to ensure public health by restricting market access need to be examined on an individual basis. However, the provision of high-quality, reliable services should always be the top priority because of the vital importance of health, which is why the national competence to implement quality assurance measures in the health sector is a central point in the present European legal framework.

Question 2: What specific legal clarification and what practical information is required by whom (e.g. authorities, purchasers, providers, patients) to enable safe, high-quality and efficient cross-border healthcare?

1. Patient mobility

1.a Within the scope of Council Regulation (EEC) No. 1408/71

Today, patient mobility is largely organised on the basis of the European Health Insurance Card - EHIC and form E 112 for planned medical treatment abroad. In this case, the patient may only consult physicians who are approved under the social insurance system of the host country. Generally however, the patient does not know which physicians these are. The listing and publication of such information on the Internet would certainly be possible but it would be expensive to maintain and would create considerable additional administrative costs, e.g. for translation into all languages. Furthermore, it would exclude persons without an Internet connection. It would be far simpler to post a symbol, e.g. that of the EHIC in the lobby of the service provider (in a similar way to credit cards in shops and restaurants) to indicate to the patient that his EHIC is accepted here in line with the Regulation. Furthermore, it would oblige physicians to accept the EHIC instead of treating the patient on a private basis and even demanding a cash payment, which is clearly common practice in many countries. A legal basis in this respect could be created in the implementing Regulation (EEC) No. 574/72.

The Member States themselves must take the necessary steps to ensure that the EHIC, form E 112, etc. are accepted by the service providers and that the Regulation is properly applied. The European Commission has the possibility to examine correct implementation of the Regulations and if necessary to initiate infringement proceedings in accordance with Article 226 EC.

1.b Healthcare in border areas

Generally, consumers and service providers in border areas are aware of the additional healthcare services on offer locally. Any need for improvement to existing regional or local requirements can only be examined on an individual basis and does not require measures at the European level.

1.c Other healthcare – in particular through the application of ECJ jurisprudence

The European Commission has already attempted in Article 23 of its proposal for a directive on services in the internal market to codify ECJ jurisprudence on patient mobility. The ESIP member organisations see no need for this.

The ECJ has given detailed clarification on questions regarding the application of community law in cases of cross-border care. It has established on which grounds prior authorisation can be justified. However, the fact that the social systems and the economic situation in Member States differ widely means that the application of the Court's criteria does not necessarily lead to the same result in all Member States. It cannot be excluded for example that in some Member States the application of the ECJ criteria in fact justifies prior authorisation in the case of non-hospital treatment on the basis of the risk to the financial stability of the system and the need for structural planning ahead. It is therefore the task of the Member States, applying the principles the ECJ has set out, to decide for which treatments authorisation procedures are necessary and justified. The decision should of course be made in such a manner that it is clear to all insured persons in which situations an authorisation procedure is applicable. The ECJ has also decided when authorisation cannot be denied (if treatment cannot be given in the home country without *undue delay*, taking the patient's medical condition into account); to what extent the reimbursement may be limited (real costs, but not more than the costs of a comparable treatment in the home country); and to what treatments the insured person is entitled abroad (in principle, the benefit catalogue of the home country). The ECJ further stated that national access conditions, e.g. the obligatory consultation of a general practitioner prior to consulting a specialist or the obligatory submission of a treatment cost plan for e.g. for prostheses or expensive procedures can be maintained. The ECJ has always stressed the importance of the competence of Member States in creating and organising their healthcare systems according to Article 152 EC, and in preserving their financial stability.

ESIP recognises, as pointed out by the European Commission in its communication that some Member States have not yet transposed these entitlements into national law as required by the EC Treaty and that EU citizens are often ignorant of their rights. In this case, the EU Commission might consider taking further measures, but these should be limited to setting out the principles laid down by the EJC jurisprudence with a view to supporting national legislation, for example in the form of a communication or guidelines.

The design of legal procedures for asserting these rights however does not need to be regulated at the European level as this is already regulated in the respective

social law systems for comparable legal situations. The introduction of additional procedures would be more likely to lead to increased legal insecurity.

2. Service provider mobility

Currently, there is no need for further legal clarification in the area of service provider mobility. It should only be noted that particularly in the case of services rendered directly to patients, the legal and quality standards of the country apply in which the patient receives the treatment. This does not prevent service providers from agreeing higher quality levels among themselves as well as in direct relations with the patient.

3. Mobility of goods and services (telemedicine, laboratory services, etc.)

Particularly in the field of telemedicine there is a need to examine to what extent patient data may be transmitted via the Internet and what criteria need to be applied regarding data protection and data compatibility.

Question 3: Which issues (e.g. clinical supervision, financial responsibility) should be the responsibility of the authorities of which country? Are these different for the different kinds of cross-border healthcare described in section 2.2 above?

1. Patient mobility

Principally, specialist medical supervision must be ensured by the competent authorities and institutions of the country where the services are rendered. The supervision, control and prosecution of possible wrong conduct in one Member State by authorities or institutions of another Member State is unrealistic and impractical. The respective institutions of each Member State must also ensure that patients from other EU countries are treated without discrimination.

The applicable system for regulating complaints and damages is determined by International Private Law (IPL; Rome I and II). IPL intervenes unless otherwise agreed by the parties beforehand. As explained under question 2 No. 1c, the ECJ has confirmed that national access conditions should be adhered to also when seeking treatment abroad. This principle must also apply where the national social security systems have legal and practical provisions to manage the medical care of insured persons in order to ensure a high quality of care in the patients' interest. This applies, not only to the statutory health insurance organisations but also to organisations of statutory accident and pensions insurance which provide health services in order to avoid the need for reduced earning capacity or total disability pensions.

2. Service provider mobility

The principle that applicable law, monitoring and supervision of service providers is the responsibility of the country in which the services are rendered applies to temporary provision of services as well as to permanent establishment of services.

The country of origin principle should be rejected for mobile providers of healthcare. It would create additional legal uncertainty for patients who are in a particularly vulnerable position at the time they avail themselves of the service. Moreover, it would undermine the quality and volume management instruments of the social insurance systems and jeopardise their financial stability.

Question 4: Who should be responsible for ensuring safety in the case of cross-border healthcare? If patients suffer harm, how should redress for patients be ensured?

The respective competent authorities and institutions of the country where the services are provided are responsible for the safety and supervision of service providers. Legal recourse for patients is defined by the respective national administrative and social law as well as international private law (see also reply to question 3).

Question 5: What action is needed to ensure that treating patients from other Member States is compatible with the provision of a balanced medical and hospital service accessible to all (for example, by means of financial compensation for their treatment in “receiving countries”)?

Problems of this kind, if they occur, are likely to have a variety of causes for which different solutions need to be found at a regional level.

1. Patient mobility

1.a Within the scope of Regulation (EEC) No. 1408/71

The seasonal strain on holiday destinations may indeed represent a logistical challenge for the regions involved. However, as a rule it is limited to initial care for patients and – depending on the holiday destination – to certain selective specialist areas such as surgery in ski areas or internal medicine and surgery in Mediterranean regions.

The treatment costs are dealt with by Regulation (EEC) No. 1408/71, and its successor Regulation (EC) 883/04. The distribution of payments from the funding system to the region under Council Regulation (EEC) No. 1408/71 must be assured by the respective Member State itself. Further, additional costs for making personnel and infrastructure available must be borne by the respective Member State or the region itself. This is appropriate since the region concerned earns additional income from tourism. If this is considered insufficient by the regional authorities then they are at liberty to raise a visitors' tax and spend it accordingly. There is no need for European level action.

The situation is similar in the case of pensioners who spend only part of the year in another EU country – mostly in the southern regions. Here also the Member States themselves have to ensure that the pensioners register with the respective system as per Council Regulation (EEC) No. 1408/71 and that the appropriate funds are distributed to the regions in question.

1.b Healthcare in border areas

As regards healthcare in border areas, the problem of insufficient access of the local population does not arise in so far as it is based on cooperation agreements. The objective of such cooperation agreements is the common exploitation of available resources to reduce unnecessary over capacities on both sides of the border.

1.c Other healthcare – particularly with respect to ECJ jurisprudence

In this instance, the possibilities for cost refunds as well as the possibility of higher incomes from treating of foreigners may induce service providers to treat foreigners on a preferential basis.

As the system of Council Regulation (EEC) No. 1408/71 is not applicable in such cases, the respective Member State has to ensure that foreigners and nationals pay the same prices, thus taking away the incentive for preferential treatment of foreigners. In principle, discrimination against foreigners by charging higher prices is inadmissible.

Question 6: Are there further issues to be addressed in the specific context of health services regarding free movement of health professionals or establishment of healthcare providers not already addressed by Community legislation?

1. Patient mobility

The Member States are entitled, in accordance with their national values and standards, to strike services from the list of social insurance services or to totally prohibit the rendering of such services on its territory. The service institutions cannot be obliged to approve such services on a cost-refund basis by virtue of ECJ jurisprudence.

2. Provider mobility

Presently, there is no need for further regulations with respect to the free movement of service providers.

Question 7: Are there other issues where legal certainty should also be improved in the context of each specific health or social protection system? In particular, what improvements do stakeholders directly involved in receiving patients from other Member States – such as healthcare providers and social security institutions – suggest for facilitating cross-border healthcare?

See answers to question 6.

Question 8: In what ways should European action help support the health systems of the Member States and the different actors within them? Are there areas not identified above?

1. European networks of reference centres (ENCR)

There is currently no clear concept as to the actual meaning of ENCR (formerly referred to as European centres of reference) or what their concrete added value could be. In this respect, a number of issues remain to be resolved; these include:

- The tasks and objectives
- The quality criteria for the centres and who determines them
- The contribution to advanced medical care
- Patient access to the centre
- Financing of the network
- Financing of patients' treatment costs
- How to deal with services not contained in all Member States' benefit lists
- Ensuring independence of political considerations in the selection of centres
- Ensuring that the creation of centres of reference does not lead to overcapacities
- Ensuring Member State autonomy in capacity planning and volume management

Further, it might be worth considering widening the scope of the proposed network to include existing national networks in the field of statutory accident insurance e.g. on serious accidents and accident-related illnesses.

Only when the European Commission is able to present a sound concept will it be possible to discuss this issue further.

Principally, each Member State must initially ensure the provision of high quality medical care in its population. Beyond this, ESIP believes that the concept of bilateral cooperation offers a valuable alternative to European networks since cooperation at the former level may be tailored more precisely to the needs and circumstances of the contracting parties. This applies particularly to the patients' cultural and linguistic environment, which is closely connected to patient mobility, as well as to geographic proximity and accessibility.

2. Realisation of the innovation potential (Health Technology Assessment - HTA)

The European Commission's project to improve cooperation on HTA between the Member States and to facilitate access of national institutions to HTA reports is to be welcomed. The framework conditions of the EU healthcare systems however differ widely. Therefore, HTA reports should be viewed against the background of the respective system. This also means that HTA results are generally only transferable in the area of clinical efficacy. With regard to cost effectiveness, HTA results along with the associated social and ethical aspects cannot usually be transferred due to the different nature of the systems. The European Commission should take this into account in promoting the exchange of information in the area of HTA.

3. Common knowledge base for drafting policies

The expansion of data collection in the health sector at the European level should be temporarily deferred in favour of improving the availability of existing data and in particular their validity. Cooperation such as the proposed observatory will only generate added value where different healthcare systems are on approximately the same level and are based on a similar healthcare structure, and as such the basis of the survey is comparable. The reality is that the diverse nature and status of the healthcare systems in the Union do not satisfy these conditions. The primary goal of an "EU health policy" should rather be to support the Member States in improving care at grass-roots level. The further creation of incomparable and unusable "data mountains" would by contrast be expensive and counter-productive.

4. Health System Impact Assessment - HSIA

The idea of HSIA in the context of the Commission's guidelines for integrated impact assessment is worth supporting. It needs to be seen however how the information obtained through impact assessment can and should be integrated into the political process.

Question 9: What tools would be appropriate to tackle the different issues related to health services at EU level? What issues should be addressed through Community legislation and what through non-legislative means?

As stated above, the ESIP member organisations question the need for new legislative measures by the European Commission at this time. Should the Commission nevertheless consider that EU-wide implementation of ECJ jurisprudence can only be achieved through its codification then this should be in the form of a communication or guidelines and **must be limited to setting out the principles laid down by the EJC**. This would allow the Member States to adapt their healthcare systems accordingly where necessary, without the European Commission encroaching on the Member States' freedoms as laid down in Article 152, paragraph 5 EC.

Summary

- **The ESIP member organisations do not consider a need to adopt further legislation in addition to national law and Council Regulation (EEC) No. 1408/71 or its successor, Regulation (EC) No. 883/04. Patient mobility should be regulated within these mechanisms.**
- **ESIP member organisations firmly support the EU Commission's call to adopt the rights due to EU citizens by virtue of ECJ jurisprudence in those MS that have not yet implemented them. Should further measures be considered indispensable in order to achieve this, then these should be limited to setting out the principles laid down by the EJC jurisprudence.**
- **To apply and implement national law according to the criteria set out by the ECJ is the sole responsibility of the Member States.**
- **Service providers should publicise with a "label" that they accept the EHIC and thus provide services in accordance with Council Regulation (EEC) No. 1408/71, and its successor Regulation (EC) No. 883/04.**
- **Service provider mobility has been redefined by Directive 2005/36 EC on the mutual recognition of professional qualifications. The need for additional regulations should be re-examined only after its transposition is complete (in 2008).**
- **ESIP calls for further increased financial support for actions such as the INTERREG programmes.**

The following organisations support this position paper in so far as the matter lies within their field of competence:

AUSTRIA	HVSVT	Hauptverband der österreichischen Sozialversicherungsträger, Vienna
BELGIUM	ONP/RVP	Office National des Pensions/Rijksdienst voor Pensioenen, Brussels
CZECH REPUBLIC	CSSZ	Czech Social Security Administration, Prague
FINLAND	ETK	The Central Pension Security Institute of Finland, Helsinki
	FAII	Federation of Accident Insurance Institutions, Helsinki
	TVR	Finish Unemployment Insurance Fund, Helsinki
FRANCE	FNMF	Fédération Nationale de la Mutualité Française, Paris
	CNAF	Caisse Nationale d'Allocations Familiales, Paris
	CNAM	Caisse Nationale d'Assurance Maladie, Paris
	CNAV	Caisse Nationale d'Assurance Vieillesse, Paris
	CCMSA	Caisse Centrale de la Mutualité Sociale Agricole, Paris
GERMANY	AOK-BV	AOK-Bundesverband, Bonn
	BKK-BV	Bundesverband der Betriebskrankenkassen, Essen
	IKK-BV	Bundesverband der Innungskrankenkassen, Bergisch Gladbach
	LKK-BV	Bundesverband der landwirtschaftlichen Krankenkassen, Kassel
	VdAK	Verband der Angestellten-Krankenkassen, Siegburg
	AEV	Arbeiter-Ersatzkassen-Verband, Siegburg
	Kn	Knappschaft, Bochum
	See-KK	See-Krankenkasse, Hamburg
	HVBG	Hauptverband der gewerblichen Berufsgenossenschaften, Sankt Augustin
	BLK	Bundesverband der landwirtschaftlichen Berufsgenossenschaften, Kassel
	BUK	Bundesverband der Unfallkassen, Munich
	DRV	Deutsche Rentenversicherung Bund, Berlin
	GLA	Gesamtverband der landwirtschaftlichen Alterskassen, Kassel
ITALY	INPDAP	Istituto Nazionale di Previdenza per i Dipendenti Dell'Amministrazione, Rome
	INPS	Istituto Nazionale della Previdenza Sociale, Rome
LUXEMBOURG	ALOSS	Association Luxembourgeoise des Organismes de Securite Sociale, Luxembourg
THE NETHERLANDS	CVZ	College voor Zorgverzekeringen, Amstelveen
POLAND	ZUS	The Social Insurance Institution of Poland, Warsaw
ROMANIA	CNAS	Casa Națională De Asigurări De Sănătate, Bucharest
Slovakia	SOCPOIST	Sociálna poisťovňa, Bratislava
SWEDEN	FK	Försäkringskassan, Stockholm
SWITZERLAND	SUVA	Schweizerische Unfallversicherungsanstalt, Lucerne