

Another Piece of Europe in Your Pocket: The European Health Insurance Card

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Introduction¹

From the earliest days of European integration in the aftermath of the Second World War until the present day, European institutions have actively promoted intra-European movement (Maas 2007). The push to introduce a European Health Insurance Card (EHIC) to replace the paper forms previously needed to access health treatment during a temporary stay in another country fits within this general phenomenon. Introducing the EHIC, Irish prime minister Bertie Ahern called it “a very tangible manifestation of an initiative by the European Union with real, practical benefits for its citizens,” while Commission president Romano Prodi labelled it “another piece of Europe in your pocket” (European Commission 2003a, 2004b). Thus the symbolism of the European health card is not accidental: it was intended to reinforce the portability of benefits throughout EU territory. Its introduction achieves an aim expressed in the 1975 Tindemans report: the “day that Europeans can move about within the Union, can communicate among themselves and when necessary receive medical care without national frontiers adding to the problems of distance, European Union will become for them a discernible reality” (Tindemans 1976: 28). But introducing the card also activated the Telematics for Social Security Programme, which attempts to “speed up and simplify administrative procedures in order to improve the acquisition of entitlement and the granting and payment of social security benefits to migrant workers and other persons who have exercised their right of free movement.”² Furthermore, the agreements concerning the EHIC *required* all member states to issue national health insurance cards. Those member states previously without national cards were obliged to introduce them before the end of 2005. Finally, the Card’s introduction raised the spectre of the further

categorization and sorting of individuals within Europe into those granted entitlements and those not granted them, perpetuating or perhaps even creating social disparities between different categories of people. Despite its novelty as a supranational identity card, the EHIC thus exhibits similar tendencies (potentially empowering yet simultaneously classifying) as other identity cards.

By January 2006, the EHIC was recognized in all 27 EU member states plus Norway, Iceland, Liechtenstein, and Switzerland. It is freely available to any individual covered by health insurance in a member state, giving access to treatment that becomes medically necessary during a temporary stay abroad. The Card proves entitlement to the same level of care covered by the health insurance scheme of the host state, at the same reimbursement level. Health care providers “must therefore provide all the types of medical care and treatment that the patient’s state of health necessitates to enable him to continue his stay in your country under safe medical conditions. The key is that he should not be obliged to cut short his visit in order to return to his country of residence for treatment.”³ As this statement indicates, significant discretion surrounds the determination of what level of treatment is medically necessary. Also open to variability is the intended length of stay. Some categories of people (such as tourists from one European country visiting another) may be entitled to fewer medical benefits than other categories (such as students or posted workers): for students and posted workers, “the period can be relatively long, and the range of treatment accessible may be more extensive.”⁴ As these examples indicate, the purpose of the EHIC is to facilitate free movement by ensuring the coverage of unexpected medical treatment. This is separate from the issue of planned medical treatment, going abroad for the purpose of receiving medical care. Extensive case law dating back to 1998 established the principle that EU citizens may obtain treatment in another European state without prior authorization and still be reimbursed by their own health insurance system.⁵ Because of its roots in the free movement principle, the EHIC thus represents an integral part of the process of creating European citizens in which European institutions such as the Commission, Council, Parliament, and Court are engaged (Maas 2007).

This chapter addresses, in turn, three central questions: the motivations for the ID scheme, its operation in practice, and the lessons for other jurisdictions. The next section

identifies the domestic and international motivations for the EHIC, focusing on the symbolic value of the card for European integration. The following section discusses the card's introduction and various administrative and technological issues it raises, concentrating on the difficulties of coordinating the various national and subnational systems. The section after that extrapolates from the experience to date to discuss both EHIC's role in supporting European integration and its future prospects, drawing lessons for other jurisdictions and the EHIC's future.

Motivations for a supranational European health insurance card

The idea for a common European health insurance card has a long history: as early as 1978, the European health ministers meeting in the Council indicated their interest in a European health card and suggested that the Commission should devise specific proposals. In 1981, the European Parliament followed by arguing for a common European Health Card (European Parliament 2000). The Commission two years later recommended adopting an emergency health card. And in 1986 the Council supported this recommendation with a Resolution specifying that, "in order further to protect the health of European citizens and to enhance their freedom of movement," it was "desirable to provide for means whereby in an emergency their pre-existing or present health problems can be identified" (European Council 1986). But the Resolution was voluntary and non-binding. The 1989 Commission report on the Resolution's implementation concluded that only some countries (e.g. Germany, Luxembourg, and Portugal) had fully developed implementation measures and that technological improvements were needed. The Advanced Informatics in Medicine Project, funded by the Commission, was charged with this task (European Parliament 2000: 1).⁶

Further developments slowed, though in 1995 the member states adopted a Directive on the protection of personal data and data exchange (European Council 1995). More significant was 1996 report of the European Parliament's Committee on the Environment, Public Health and Consumer Protection, chaired by Giacomo Leopardi. The Leopardi Report called on the Commission to develop, by January 1999, "a European health card to be issued to every European citizen" (European Parliament 1996). The Committee's rationale is worth examining in some detail. The Report started

with a recital of eleven reasons (the famous “whereas” clauses that start every Parliamentary report or resolution) for developing the card. The first one specified: “whereas the Treaty on European Union provides for the introduction of a citizenship of the Union, and whereas that must take the form of measures to ease the daily life of its citizens while increasing the protection of their rights and interests.”

This invocation of European citizenship is important because it demonstrates Parliament’s desire to portray a European health card as an essential element of EU citizenship and thus a natural outgrowth of the Union’s political development. The second reason similarly attempts to justify EHIC, adding mobility to citizenship: “having regard to the increasing mobility of the citizens of Europe within the European Union for both business reasons and tourism.” The third asserts that “European citizens are entitled to proper care as required by their state of health while travelling.” All three reasons – EU citizenship’s promise of convenience and the protection of rights and interests, increasing mobility, and the entitlement to proper health care while travelling – focus on the rights of individuals. The next reason switches the emphasis to health: a health card would “help avoid the potentially serious or fatal outcome of ineffective or dangerous treatment, especially in cases of chronic or serious disease or allergies.” The fifth reason asserts the Union’s competence to take action, specifying that Article 129 of the Treaty provides that the EU institutions shall “contribute towards ensuring a high level of human health protection.” Then the focus shifts to the operation of the card itself. The Report asserts that “it is already technically possible to introduce a health card which could be used in all the countries of the European Union and outside its borders,” and that “it must be possible for the card to be used throughout the system, i.e. by doctors, hospitals, casualty departments and duty doctors, since, if the system is not a comprehensive one, it will be neither useful nor secure.”

This invocation of security is immediately followed by two related “whereas” clauses. The first asserts that the 1995 data protection Directive “provides the legal framework for the confidentiality of data entered on health cards,” while the second is much longer, containing several subclauses. It starts by specifying that “the purpose of such cards must first and foremost be to serve the citizen,” continuing that “they may perhaps be a way of reducing health costs but never a surveillance tool for public

authorities of whatever nature.” This is noteworthy because it addresses head-on a key worry surrounding many identity cards, as discussed by other chapters in this volume. Yet the way in which this desire that the cards should never be a surveillance tool should be operationalized is unclear: “the information on the card should not therefore be held in any data file, but should appear only on the card itself,” and “the citizen should therefore decide him- or herself what data should appear, and should have the right to omit certain information.” And “it should be easy to change the information on the card, the issuing of which should not involve the cardholder in any expense.” In the context of the data protection Directive, these are perhaps laudable goals. But they do not seem particularly practical. It is unclear what happens, for example, when cardholders lose their cards: if the data was held solely on the card and not in any file, the card would need to be reissued from scratch, which could become cumbersome if the card contained much data. The final three “whereas” clauses of the Leopardi Report place the proposal for a European health card in the context of other cards in use in Europe and elsewhere, the confusing proliferation of identity and health cards within member states (the implication is that a single European card could eliminate this proliferation), and the interest shown by international health organizations and non-EU countries.

In the aftermath of the Leopardi Report, further work on the European health card continued slowly. A 1997 European Council Regulation established a Technical Commission on Data Processing, adhering to the principle that each member state would be responsible for managing its own part of the telematic services in accordance with EU data protection and privacy provisions, while the Administrative Commission on Social Security for Migrant Workers (discussed further below) would establish provisions for the operation of the common part of the telematic services (European Council 1997).

A more significant impetus for cooperation was provided by two cases decided by the European Court of Justice in 1998, the *Decker* and *Kohll* cases, in which the Court ruled that health care was subject to EU rules on the free movement of goods (*Decker*) and free movement of services (*Kohll*). In both rulings, the Court noted that, while European law “does not detract from the powers of the Member States to organize their social security systems, they must nevertheless comply with Community law when exercising those powers” (European Court of Justice 1998a, 1998b). *Decker* concerned a

Luxembourg national who was told by the Luxembourg health insurance Fund that it would not reimburse him the cost of corrective spectacles he had bought in Belgium, on the ground that they had been purchased abroad without the Fund's prior authorization. The Court found that European law precludes national rules under which member state social security institutions refuse to reimburse an insured person on the ground that prior authorization is required for the purchase of any medical product abroad. *Kohll* concerned another Luxembourg national, who sought orthodontic treatment in Germany for his daughter. The Court ruled that European law precludes national rules under which reimbursement of the cost of dental treatment provided by an orthodontist established in another member state is subject to authorization by the insured person's social security institution. Such rules, it found, deter insured persons from approaching providers of medical services established in another member state, constituting a barrier to the freedom to provide services. The *Decker* and *Kohll* cases thus established that patients receiving health care in other member states were entitled to be reimbursed by their national health insurance. They and subsequent cases exemplify the use of European law to challenge the retention of national borders for healthcare provision, illustrating the growth of a supranational source of rights which augments European citizenship (Martinsen 2005).

In September 2000, representatives of card issuers, consumer and citizen groups, as well as the smart card industry met in Athens to decide on concrete steps for implementing a smart card charter that followed the invitation of the European Council's meeting in Feira in June (European Parliament 2001: 34). The greatest impetus was the creation of qualified electronic signature. The so-called eEurope initiative "triggered a major industry-led smartcard initiative backed by €100m research funding" and established the smart card charter, launched under the Danish Presidency in December 2002 (European Commission 2003b: 16). But tying this charter to the EHIC did not gain the support of the member states, possibly because of the worry that e-smartcards developed for civic purposes for EU citizens would be extended to e-security: it was the potential "surveillance of individuals by unknown agencies for nebulous ends which led to concern that the EU citizen could also be an unwitting 'suspect'" (Lodge 2004: 256).

At the Barcelona European Council meeting in March 2002, Europe's political leaders finally agreed to introduce a European Health Insurance Card, which would replace the paper forms needed for health treatment in another Member State. Under the heading "Promoting skills and mobility in the European Union," they agreed that the card would simplify procedures without changing existing rights and obligations. At the same time, however, the leaders supported the aim of increasing the transferability of social security rights, including pensions, across the European Union. The European Commission was tasked with presenting concrete proposals before the 2003 Spring European Council meeting (European Council 2002: pts 33, 34).

The Commission duly complied and concluded that the European health insurance card was "an ambitious project serving the interests of a real citizens' Europe," and that by drawing on the wealth and diversity of experience of many countries, it would be able to be brought into use "as a simple, practical and flexible facility from 2004" (European Commission 2003a: 16). The Commission urged member states to enact two legislative changes in the proposed health card Regulation. The first was to align all the categories of insured persons, so that they would all be entitled to the same level of care. The existing legislation provided for different levels of care: everyone insured by national health insurance, with the exception of third country nationals and the members of their families, are entitled to all "immediately necessary" care. But the broader category of "necessary" care was available to those receiving retirement or invalidity pensions (E111 with appropriate endorsement), students (in the country of study, using E128), posted workers, seafarers, etc. (E128), transport workers (E110), unemployed persons moving to another Member State to seek work (E119) and employed or self-employed victims of an industrial accident or occupational disease (E123). These differences were "a complicating factor and could increase the cost, in that the cards would have to carry a means of identifying the 'category' of the insured, and the procedures for checking entitlement between social security institutions would be more involved" (European Commission 2003a: 11). The second change involved removing formalities required in addition to presentation of the form for obtaining care. In some member states, for example, the insured needed to go to the social security institution of the place of stay

before approaching a care provider. Introducing EHIC provided a way to eliminate this requirement.

The introduction and operation of the EHIC

EHIC was introduced in the context of the coordination of social security for individuals moving about within the Union. There had been longstanding agreements concerning the coordination of social security, and they included very detailed provisions for emergency health care. Previous agreements had distinguished between “immediately necessary care” and “necessary care,” but the Regulation removed this distinction, specifying that all insured persons would be entitled to the benefits in kind which become necessary on medical grounds during their stay in the territory of another member state (European Council 2004).

The detailed social security provisions under which EHIC fell had been developed over the years by the Administrative Commission on Social Security for Migrant Workers (often known by its French acronym CASSTM), made up of a government representative of each member state. CASSTM is aided by the Advisory Committee on Social Security for Migrant Workers, composed of representatives of governments, trade unions, and employers’ organizations, which prepares opinions and proposals with a view to possible revision of the regulations. CASSTM handles all administrative questions and questions of interpretation arising from the social security Regulation and it is also takes “to foster and develop cooperation between Member States in social security matters by modernising procedures for information exchange.” It is in this vein that it developed the standard forms for the exchange of standardized data (such as E111, which EHIC’s introduction rendered outdated), guides the work of the Telematics in Social Security program, and introduced EHIC.

EHIC demonstrates insurance coverage. Because everyone insured by a social security system of any member state and eligible for care in that member state benefits from the rules on the coordination of social security, everyone so insured is automatically entitled to receive an EHIC (European Commission 2004a: 2). Thus, for example, third country national students studying in the United Kingdom and covered by the National Health Service (or studying in any other EU member state and insured by health

insurance there) could request EHICs for health coverage when they travel to other EU member states.

The EHIC's design is identical in all member states and is intended to enable health care providers throughout the EU and EEA states to identify the card immediately. The only personal information on the card is the cardholder's surname and first name, personal identification number and date of birth. Against some early proposals, discussed above, the EHIC itself does not contain medical data. There are two variants of the common design. The first consists of the common design on the front of the card, with the back available to the issuing member state. This is the option chosen by most member states. The second is for the common design to be placed on the back of an existing national or regional card, an option chosen by Austria, Germany, Italy, Luxembourg, Lithuania, the Netherlands, and Liechtenstein.⁷

Because each member state is responsible for producing and distributing the EHIC to everyone covered by health insurance in that state, the procedures for acquiring or renewing a card differ from member state to member state. For example, residents of the United Kingdom may apply at <http://www.ehic.org.uk>, where they provide their NHS number (England and Wales), CHI number (Scotland), or H&C number (Northern Ireland). The British website is run by the Business Services Authority and the Department of Health, whose data protection guarantee promises that they will use the information provided only for processing the EHIC application, store it for no more than 24 months after the expiry of the EHIC, and not transfer the data outside the European Economic Area or "disclose it to any third party other than the Department for Work and Pensions (for the purpose of validating EHIC claims) and the NHS Counter Fraud and Security Management Service and Department of Health - International Division (in order to prevent and detect fraud and errors)."⁸ By contrast, the equivalent website in the Netherlands – <http://www.ehic.nl/> – collects the information on behalf of several Dutch health insurance companies (at this writing, seventeen health insurance companies used the website; some sixty others did not). The card is issued directly by the insurance companies after they verify that the person requesting the card is covered. Applicants using the website are guaranteed that they will receive their card within four working days. In France, the EHIC must be requested from the local Caisse Primaire d'Assurance

Maladie office and can take up to fifteen days to process. In Ireland, yet another national website – <http://www.ehic.ie/> – facilitates the application process: applications submitted online are processed on behalf of local health offices. Those who wish to fill out paper application forms do so at their local health office. As these examples indicate, the issuing of cards occurs with much national variation.

Similar variation exists in terms of the EHIC's validity. Here also, because member states remain responsible for issuing the card, they may make their own rules regarding validity. For example, an EHIC issued in Ireland is valid for up to two years, up to five years in the UK, but only one year in France. In the Netherlands, the insurance companies determine the validity: some companies make the card valid for only the period requested (for example, to an applicant who requests the card for a short trip) while others make the card valid for up to one year. In all cases, the EHIC remains valid only as long as the holder remains insured. The example of the Dutch insurance companies, each of which establish their own rules for validity and none of which issue cards valid for more than one year, is one response to possible lapse of coverage. The British website, by contrast, places the onus on applicants to inform the NHS if they decide to remain abroad to live or work so that their coverage ceases. Because each member state retains responsibility for issuing the EHIC, the determination of eligibility rests with national authorities or the delegated regional office or private insurance companies. Each authority therefore is responsible for maintaining its own records concerning who is entitled to coverage and hence the EHIC. This means that any changes to the EHIC (for example due to name changes) must be submitted through the issuing authority. A common European database lists all the authorities entitled to issue the card.⁹ For example, at this writing, there is only one authority in the United Kingdom (the Department for Work and Pensions) but there are 76 authorities in the Netherlands (all of the insurance companies) and 2162 authorities in France (all of the local *Caisses Primaires d'Assurance Maladie*). Health care providers consult the common database of issuing authorities when they wish to submit a claim for health care provided. Each issuing authority then verifies coverage, according to its own systems, before any payments are approved.

European integration and EHIC's future prospects

In the hope of bringing “American-style mobility to the European employment market,” the European Commission constantly works to facilitate mobility by attempting to coordinate social security systems, harmonize taxation systems, and increase information about employment opportunities (Maas 2007). Indeed, the Commission had earlier proposed a European identity number similar to the Social Security Number in the United States or the Social Insurance Number in Canada.¹⁰ Those plans were placed on hold when the EHIC was introduced.

The EHIC in its first incarnation is simply a means of demonstrating entitlement to health care on the same terms as insured nationals. But the Commission expected that the card would in the future carry much more information. The “long term intention is that the card will be issued with an electronic chip to greatly facilitate exchange of information between Member States and reduce the risk of error, fraud and abuse. There is no fixed timing for either of these future phases, which depends on the evaluation of the first roll-out of the card, and the development of technological systems that allow exchange of information without changes to the architecture of national systems” (European Commission 2004a: 2). The desire for the EHIC to carry more information is clear, but it is phrased in terms of technological limitations and the need to maintain the existing architecture of national systems.

When EHIC was introduced, the European Commission's Frequently Asked Questions page about the card, responding to the question of whether the card would carry personal information about the patient, asserted that the card simply concerned “making access easier and getting reimbursements more quickly, not carrying information about health status, condition or treatments. Personal information about the card-carrier – e.g. blood type or medical records - will only be included insofar as the European health card is delivered as one side of a national card, and the national card already contains such information. Not all Member States issue national cards, and few Member States that do include personal health information” (European Commission 2004a: 2).

The desire to maintain the architecture of existing national systems (flowing from the requirement that member states retain authority and control over issuing the EHIC)

coupled with the desire to have the card contain no personal health information about the holder, appear to stymie the future development of EHIC as a truly European identity card. As long as national authorities – or even subnational or otherwise delegated authorities, like the Dutch insurance companies – retain responsibility, the sole ‘European’ dimension to the card is its common design. Even the question of the number on the card seems intractable. For example, the British authorities expected that the EHIC would eventually carry the holder’s NHS number in England and Wales, CHI number for residents of Scotland, and Health and card number for Northern Ireland residents (United Kingdom Department of Health 2004: 2). Little scope there for a common European number.

Despite EHIC’s relative inutility as a common European identity card, observers do expect that its introduction and spread will simplify insurance coverage procedures, facilitate access to unplanned and perhaps also to planned medical treatment in other member states (Österle 2007, Hunt and Wallace 2006). At the same time, the mere existence of a common card – even though it is only a common design with very little information – represents another step in the gradual process to a common European health care space. The *Kohll* and *Decker* cases discussed above were only the first in a series of rulings of the European Court of Justice that have strengthened patients’ rights to receive cross-border care. Ongoing efforts at both European and national level ensure that European patients are no longer restricted in their choice of where to receive medical treatment or services. Instead, the newly created and enlarging European health care market has turned patients into pan-European consumers, forcing insurance authorities to adapt (Sieveking 2007). The EHIC is a symbolic representation of that common market.

Conclusion

The development of the European Health Insurance Card reflects the tensions surrounding the construction of a supranational political community in Europe. The vast majority of ID cards are *national* cards, issued by and recognized by national governments. As the other chapters in this volume demonstrate, national states promote ID cards for various purposes, including not only population identification and control but also as a means for individuals to demonstrate entitlement to social or other state-

provided programs. Though many programs in the member states are regulated by European legislation, the European Union is not a state and does not fund its own social programs. There is therefore no easily identifiable functional need for a European ID card. Consistent with the political project of constructing not only a free market area but also a common supranational political community, however, European political leaders introduced the EHIC to help develop in European citizens a feeling of identification with the Union. This aim is captured in Commission President Prodi's characterization of the Card as "another piece of Europe in your pocket," as well as by the debates preceding its eventual introduction.

The EU is not a state, but it fulfills some functions of a state. This explains why, in the field of identity, the EU attempts to act like a state. The EHIC, like other ID cards, fits within the context of the production of identity and the differentiation and categorization of individuals into discrete classifications. EHIC is a good example of the explicit desire to create and foster identity. Because the European Union is not a state in the traditional sense (at least not yet) but does carry out some functions of a state, political leaders favoring further integration use EHIC as a means of gaining popular acceptance and legitimacy to the integration project. A major aim of European integration has been to lower barriers and remove impediments to the free movement not only of goods, services, or capital but also, especially, the free movement of people (Maas 2007, 2005). Though the introduction of the EHIC did not mean any new rights for cardholders, the *symbolic* value of the card is substantial. Cardholders are aware of existing in a common space for health care – just as the existence of a common currency makes consumers aware of the common economic and financial space. But EHIC is less universal than the euro. Consumers use the euro in their own as well as in other states, but the EHIC is – in many states, at least – used only for proving coverage outside the member state. The EHIC's role as another piece of Europe in the pocket of Europeans thus outweighs any other functionality it might have.

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² <http://europa.eu/scadplus/leg/en/cha/c10518.htm>

³ http://ec.europa.eu/employment_social/healthcard/prestataires_en.htm#5

⁴ http://ec.europa.eu/employment_social/healthcard/prestataires_en.htm#oxo

⁵ http://ec.europa.eu/employment_social/social_security_schemes/healthcare/e112/conditions_en.htm

⁶ For a series of papers on the AIM project and its successors, see (Laires, et al. 1995).

⁷ http://ec.europa.eu/employment_social/healthcard/situation_en.htm

⁸ <https://www.ehic.org.uk/> under “terms and conditions”

⁹ http://ec.europa.eu/employment_social/cld/displayMain.do

¹⁰ “EU Plans to Issue ‘Identity Number’ for Every Citizen,” *The Independent*, 5 February 2001