Registered at the EFTA Court under N° E-15/23-4 on 15th of February 2024

EUROPEAN COMMISSION

Brussels, 15.02.2024
sj.j(2024)1346146 ES/ai

TO THE PRESIDENT AND MEMBERS OF THE EFTA COURT

WRITTEN OBSERVATIONS

Submitted pursuant to Article 20 of the Statute of the EFTA Court and Article 90(1) of the Rules of procedure of the EFTA Court by the

EUROPEAN COMMISSION

represented by: Lorna ARMATI, Sandrine DELAUDE and Esther Eva SCHMIDT, Members of its Legal Service acting as agents, with an address for service at: *Service Juridique, Greffe contentieux, BERL 1/093, 1049 Bruxelles*,

in Case E-15/23

concerning a request for advisory opinion submitted pursuant to Article 34 of the Agreement between the EFTA States on the establishment of a Surveillance Authority and a Court of Justice by the National Insurance Court (*Trygderetten*), in the national appeal case No 21/3857

K

\- Appellant -

and

National Office for Health Service Appeals (*Nasjonalt klageorgan for helsetjenesten (Helseklage)*)

\- Respondent -

regarding the interpretation of Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications, and the right to provide and receive services under Article 36 of the EEA Agreement

I. INTRODUCTION

1. The request for advisory opinion seeks clarification on the parameters within which an EEA State may submit the reimbursement of costs for dental treatment received in another EEA State to certain conditions, and in particular the requirement that the treatment be carried out by a dental practitioner with specific (specialist) qualifications. More precisely, the request seeks to ascertain if and to what extent Article 36 EEA, Article 7 of Directive 2011/24/EU and Directive 2005/36/EC must be interpreted as precluding such specialisation requirements in national law.

II. LAW

II.1. EEA law

2. The first paragraph of Article 1 of the EEA Agreement provides that ““*t]he aim of this Agreement of association is to promote a continuous and balanced strengthening of trade and economic relations between the Contracting Parties with equal conditions of competition, and the respect of the same rules, with a view to creating a homogeneous European Economic Area, hereinafter referred to as the EEA". The second paragraph of Article 1 provides that "[i]n order to attain the objectives set out in paragraph 1, the association shall entail, in accordance with the provisions of this Agreement: (...) (c) the free movement of services*".

3. Article 36 of the EEA Agreement provides:

   "*Article 36*

   1. Within the framework of the provisions of this Agreement, there shall be no restrictions on freedom to provide services within the territory of the Contracting Parties in respect of nationals of EC Member States and EFTA States who are established in an EC Member State or an EFTA State other than that of the person for whom the services are intended.

   2. Annexes IX to XI contain specific provisions on the freedom to provide services."

4. Directive 2011/24/EU is applicable to Iceland, Liechtenstein and Norway by virtue of point 2 of Annex X, "*Services in General*," to the EEA Agreement, inserted by Joint Committee Decision No 153/2014 (OJ L 15, 22.1.2015, p. 78 and EEA Supplement No 5, 22.1.2015, p. 11), e.i.f. 1.8.2015. Directive 2011/24/EU has two legal bases: Article 114 of the Treaty on the functioning of the European Union (TFEU), which aims at achieving the objectives set out in Article 26 TFEU, ie establishing or ensuring the functioning of the internal market in which the free movement of persons and services in particular is ensured, and Article 168 TFEU concerning public health.

5. Article 7 of Directive 2011/24/EU reads as follows:

"1. Without prejudice to Regulation (EC) No 883/2004 and subject to the provisions of Articles 8 and 9, the Member State of affiliation shall ensure the costs incurred by an insured person who receives cross-border healthcare are reimbursed, if the healthcare in question is among the benefits to which the insured person is entitled in the Member State of affiliation.

[…]

3. It is for the Member State of affiliation to determine, whether at a local, regional or national level, the healthcare for which an insured person is entitled to assumption of costs and the level of assumption of those costs, regardless of where the healthcare is provided.

4. The costs of cross-border healthcare shall be reimbursed or paid directly by the Member State of affiliation up to the level of costs that would have been assumed by the Member State of affiliation, had this healthcare been provided in its territory without exceeding the actual costs of healthcare received.

[…]

7. The Member State of affiliation may impose on an insured person seeking reimbursement of the costs of cross-border healthcare, including healthcare received through means of telemedicine, the same conditions, criteria of eligibility and regulatory and administrative formalities, whether set at a local, regional or

national level, as it would impose if this healthcare were provided in its territory. This may include an assessment by a health professional or healthcare administrator providing services for the statutory social security system or national health system of the Member State of affiliation, such as the general practitioner or primary care practitioner with whom the patient is registered, if this is necessary for determining the individual patient's entitlement to healthcare. However, no conditions, criteria of eligibility and regulatory and administrative formalities imposed according to this paragraph may be discriminatory or constitute an obstacle to the free movement of patients, services or goods, unless it is objectively justified by planning requirements relating to the object of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources.

[...]

9. The Member State of affiliation may limit the application of the rules on reimbursement for cross-border healthcare based on overriding reasons of general interest, such as planning requirements relating to the aim of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources.

[…]

11. The decision to limit the application of this Article pursuant to paragraph 9 shall be restricted to what is necessary and proportionate, and may not constitute a means of arbitrary discrimination or an unjustified obstacle to the free movement of goods, persons or services. Member States shall notify the Commission of any decisions to limit reimbursement on the grounds stated in paragraph 9."

6. Recitals 11 and 12 of Directive 2011/24/EU read as follows:

"*(11) This Directive should apply to individual patients who decide to seek healthcare in a Member State other than the Member State of affiliation. As confirmed by the Court of Justice, neither its special nature nor the way in which it*

is organised or financed removes healthcare from the ambit of the fundamental principle of the freedom to provide services. However, the Member States of affiliation may choose to limit the reimbursement of cross-border healthcare for reasons relating to the quality and safety of the healthcare provided, where this can be justified by overriding reasons of general interest relating to public health. The Member States of affiliation may also take further measures on other grounds where this can be justified by such overriding reasons of general interest. Indeed, the Court of Justice has laid down that public health protection is among the overriding reasons of general interest that can justify restrictions to the freedom of movement envisaged in the Treaties.

(12) The concept of 'overriding reasons of general interest' to which reference is made in certain provisions of this Directive has been developed by the Court of Justice in its case-law in relation to Articles 49 and 56 TFEU and may continue to evolve. The Court of Justice has held on a number of occasions that overriding reasons of general interest are capable of justifying an obstacle to the freedom of to provide services such as planning requirements relating to the aim of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources. The Court of Justice has likewise acknowledged that the objective of maintaining a balanced medical and hospital service open to all may also fall within one of the derogations, on grounds of public health, provided for in Article 52 TFEU, in so far as it contributes to the attainment of high level of health protection. The Court of Justice has also held that such provision of the TFEU permits Member States to restrict the freedom to provide medical and hospital services in so far as the maintenance of treatment capacity or medical competence on national territory is essential for public health."

7. When it comes to defining "*health professional",* Article 3, point f, of Directive 2011/24/EU lists, in particular, "*a doctor of medicine, a nurse responsible for general care, a dental practitioner, a midwife or a pharmacist within the meaning of Directive 2005/36/EC [...]*".

8. Directive 2005/36/EC is applicable to Iceland, Liechtenstein and Norway by virtue of point 1 of Annex VII, "*Recognition of professional qualifications*", to the EEA Agreement, inserted by Joint Committee Decision No 142/2007 (OJ L 100, 10.4.2008, p. 70 and EEA Supplement No 19, 10.4.2008, p. 70), e.i.f. 1.7.2009.

II.2. National law

9. Chapter 5 of the National Insurance Act, together with the administrative circular accompanying the Act, the Dental Regulation and the Regulation on benefits for healthcare received in another EEA country are cited in the request for an advisory opinion. ([1])

10. Section 5-24a of the National Insurance Act, which is presented as implementing Directive 2011/24/EC in Norwegian Law ([2]), regulates "*Benefits for healthcare in another EEA country*" in the following manner:

    "*Benefits shall be paid for coverage of expenses for healthcare incurred by the insured person in another EEA country under rules laid down by the Ministry by regulation.*

    The Regulation may contain more detailed provisions on inter alia: [...] c. conditions for benefits, including prior approval and requirements in respect of the service provider; [...]".

11. Section 2 of the Regulation on benefits for healthcare received in another EEA country lays down the following "*Main conditions*":

    "*Benefits shall be paid only for healthcare for which the insured person would have received benefits or a contribution under the National Insurance Act or as covered by the public health and care service had the healthcare in question been received in Norway.*

([1]) See Section 4.1 of the request for an advisory opinion.

([2]) Request for an advisory opinion, point (30).

Unless exceptions or adaptations are provided for in the present Regulation, the same conditions shall apply as for equivalent healthcare at public expense in Norway".

12. Section 6 of the Regulation on benefits for *healthcare* received in another EEA country, as it read at the time of the claim, states that:

"*The healthcare must be performed by a healthcare professional having official authorisation in the profession in question which is valid in the country where the healthcare is received.*

When specialist approval is a condition for entitlement to benefits or healthcare at public expense in Norway, the healthcare must be performed by a healthcare professional having equivalent specialist approval that is valid in the country where the healthcare is received. The same is true of other particular competence requirements. Exceptions may be made to this condition if the speciality in question or equivalent formal competence does not exist in the country where the healthcare is received. It is a condition that, instead, it must be documented that the service provider actually has equivalent substantive competence or other doctor specialisation in medicine which is clearly comparable to the speciality required in Norway.

[…]"

13. Section 3 of the Dental Regulation lays down requirements relating to the dental practitioner's and the dental hygienist's competence:

"*[…]*

Expenses for implant-anchored dental prosthetics treatment shall be covered only if the surgical placement of dental implants is performed by a specialist in oral surgery and oral medicine, specialist in maxillofacial surgery or specialist in periodontics. In addition, the prosthetics-related part of the treatment must be performed by a specialist in oral prosthetics or by a dental practitioner having the necessary competence approved by the Directorate of Health. Treatment tasks requiring specialist competence, or particular competence approved by the

Directorate of Health, may not be delegated to another healthcare professional where reimbursement for treatment is claimed pursuant to the present provision.

[…]"

14. The administrative circular accompanying Section 5-24a of the National Insurance Act states in part 6.2 as follows:

"*6.2 Specialist approval and other particular competence requirements*

Where specialist approval is a requirement for receiving benefits for healthcare in Norway, the treatment abroad must be performed by a healthcare professional having equivalent specialist approval. The specialist approval must be valid in the country where the healthcare is received. Norwegian specialist approval is not required.

For specialist doctors in medicine, approved specialities are largely harmonised through the Professional Qualifications Directive, 2005/36/EC.

Thus, the requirement of doctor speciality in medicine will generally be satisfied in most cases. For a more detailed description of qualification requirements, see Annex V – approval of harmonised courses of education.

Where particular competence requirements are imposed with respect to the service provider for entitlement to benefits under Norwegian rules, they shall apply accordingly. Examples include additional courses/education for certain rates for care by a doctor in medicine, manual therapy and psychomotor physiotherapy, and psychological care.

The Regulation allows for exceptions to be made from the condition on equivalent specialist approval or particular competence. Two conditions must be satisfied in order for an exception to be made. First, the speciality in question or equivalent formal competence must not exist in the country where the healthcare is received. Second, it must be documented that the service provider instead actually has equivalent substantive competence or other doctor specialisation in medicine which is clearly comparable to the speciality required in Norway.

Exceptions may not be made if the specialisation in question exists in the country where the healthcare is received.

Specific remarks on specialist approval for implant-based prosthetics

In the regulation for benefits for dental treatment under Section 5-6 of the National Insurance Act, for reimbursement for implant-based prosthetics and implant surgery, particular competence requirements are set out for the dental practitioner who performs the treatment. In order to receive benefits for implant-based prosthetics in Norway, both the dental practitioner who places the implants (the surgeon) and the dental practitioner who performs the prosthetics-related work must have a specified specialist approval.

Dental/oral surgery is referred to in Annex V to the Professional Qualifications Directive. Hence documentation may be required showing that the dental practitioner who performed the surgical placement of implants in another EEA country is in possession of the relevant specialities.

The speciality in oral prosthetics is not, however, referred to in the Professional Qualifications Directive, and not all EEA countries have such specialist approval. Nevertheless, allowance is made for reimbursement for the prosthetics-related part of the treatment in countries where an oral prosthetics speciality does not exist. In such cases, a specific assessment must be made of whether the service provider's competence can be deemed to be almost the same as the specialist competence required in Norway.

Annex 2 accompanying the Regulation on authorisation, licensing and specialist approval for healthcare professionals having professional qualifications from other EEA countries can offer some guidance for the assessment of confirmation of authorisation and the like from other EEA countries. The Annex contains a list of names of diplomas, levels of education, etc., for different groups of healthcare professionals."

III. FACTS AND QUESTIONS ASKED

15. The case concerns a request by a person affiliated to health insurance in Norway (K, the appellant) for reimbursement of the costs incurred for dental treatment carried out in Poland by a dental practitioner established there. The treatment, received in 2017, consisted of implant-anchored dental prosthetics (so-called stage two of treatment for severe marginal periodontitis).

16. By decision of 1 February 2018, the Norwegian Health Economics Administration (*Helseøkonomiforvaltningen* (Helfo)) rejected the appellant's request for reimbursement for the treatment, on the ground that the dental practitioner who carried out the procedure lacked the specialisation required under Norwegian law. According to that law (section 3 of the Dental Regulation), expenses for implant-anchored dental prosthetics are covered only if the placement of dental implants is performed by a specialist in oral surgery and oral medicine, a specialist in maxillofacial surgery, or a specialist in periodontics.

17. K challenged that decision, which was upheld by the National Office for Health Service Appeals on 25 February 2021. K appealed to the National Insurance Court on 7 April 2021.

18. While the appellant claims that the specialist competence requirement in national law is contrary to EEA law because "*such a specific requirement for reimbursement for such a treatment, as provided for under Norwegian law is a restriction whose purpose can be achieved through less restrictive means, such as an individual assessment of the treatment provider's competence*" ([3]), the respondent argues that this is not the case; in particular, the specialisation requirement affects only the right to claim reimbursement and, as a non-discriminatory condition, is allowed pursuant to Article 7(7) of Directive 2011/24/EU as it would "*not place any restriction on the freedom to provide services*".

([3]) Request for an advisory opinion, point (50).

19. The respondent also claims that "[...] *if less stringent requirements were to be imposed for reimbursement for dental treatment received in another EEA country, that would amount to a discriminatory scheme towards those who receive dental treatment in Norway" and that "this will in turn lead to a situation where the quality of healthcare worsens and Norway will incur greater expenditure related to reimbursement of healthcare that has not been performed sufficiently well because the treatment provider lacks sufficient experience* "

20. Being of the view that the case before it raises questions of interpretation of EEA law the answers to which cannot be found in the case law of the Court of Justice of the European Union (CJEU) or the EFTA Court, the National Insurance Court has referred the following questions to the EFTA Court for an advisory opinion:

    "1) Is it compatible with Article 36 of the EEA Agreement and Article 7 of Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare to refuse reimbursement of costs for dental treatment in another EEA State on the ground that the treating dental practitioner does not possess the required specialisation in order to have equivalent treatment reimbursed in the service recipient's home State?

    2) Does it affect the answer to question 1 if the specialisation required in the service recipient's home State is included in Annex V to Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications?

    3) If the specialisation is not included in Annex V to Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications, must the competent authorities in the service recipient's home State also conduct an assessment under Article 36 of the EEA Agreement in order to determine whether the treating dental practitioner has equivalent competence to that required under national law?"

IV. ANALYSIS

IV.1. Preliminary observations

21. By way of preliminary remark, the Commission notes that the facts underlying the present request for an advisory opinion remain unclear in several respects.

22. It is clear, from the national law quoted, that expenses for implant-anchored dental prosthetics in Norway are only reimbursed if the placement of dental implants is performed by a specialist in oral surgery and oral medicine, a specialist in maxillofacial surgery or a specialist in periodontics (Section 3 of the Dental Regulation).

23. This so-called "specialisation requirement" is also applied when treatment of that type is received in another EEA State. When the healthcare provider is not established in Norway, "*equivalent specialist approval that is valid in the country where the healthcare is received*" is required. The rules also make it clear that, where the speciality in question or equivalent formal specialisation does not exist in the country where the healthcare is received, the condition can be met by documenting "*that the service provider actually has equivalent substantive competence or other doctor specialisation in medicine which is clearly comparable to the speciality required in Norway*" (Section 6 of the Regulation on benefits for healthcare received in another EEA country, as it read at the time of the claim). This mechanism is explained in more detail in the administrative circular "*Specialist approval and other particular competence requirements*" (part 6.2).

24. It is however not clear how the Norwegian Health Economics Administration (Helfo) applied those rules in the present case, nor what was the exact reasoning on which the refusal was based. [4] In particular, it is not clear from the request for an advisory opinion whether the dental practitioner that performed the treatment in

---

(4) The Commission notes that the request for an advisory opinion refers to another ground for refusing to reimburse the dental treatment received by K, ie "*because the time and background to the loss of teeth is not sufficiently documented*" (para 13).

Poland was a specialist, or if a claim of "equivalent specialisation" was made and/or assessed. ([5])

25. On the basis of the limited facts set out in the request, the Commission is not in a position to ascertain what specialisations and/or competences the practitioner performing the treatment in Poland actually had, nor how they may relate to the categories of specialist cited in the Norwegian rules. The present observations will therefore focus on the general principles that apply when a country regulates the reimbursement of cross-border healthcare rather than the specific circumstances of the case that gave rise to the request.

26. Furthermore, in order to present these principles in a coherent and systematic manner, the Commission proposes to examine the three questions referred together. Indeed, by those question the National Insurance Court asks, in essence, whether Article 36 EEA and Article 7 of Directive 2011/24/EU preclude national rules such as those at issue, which impose, as a pre-condition for reimbursement of medical costs incurred in another EEA State, the possession by the dental practitioner providing certain types of treatment of a specialist qualification equivalent to that required for reimbursement of medical costs incurred in the EEA State of affiliation; and whether an assessment of equivalence is required and if so, whether the inclusion in Annex V to Directive 2005/3/EC of the qualification of the dental practitioner carrying out the treatment is relevant to that assessment.

IV.2. Rationale and conditions for reimbursement of cross-border healthcare pursuant to Article 7 of Directive 2011/24/EU

27. Directive 2011/24/EU, as is apparent inter alia from its recital 8, codified the case-law of the CJEU on certain issues relating to healthcare provided in a Member State other than the State in which the recipient of care is resident, in particular the reimbursement of that healthcare, in order to achieve a more general and more

---

([5]) The request refers to an argument made by the appellant to the effect that Poland "*has established more specialist branches than, for example, Norway*" (para 52), but does not draw any consequences from the statement in relation to the facts of the case underlying the request.

effective application of the principles developed by the CJEU on a case-by-case basis. [6]

28. As regards the reimbursement of healthcare received abroad, Article 7(1) of Directive 2011/24/EU establishes the principle that "*the EEA State of affiliation shall ensure the costs incurred by an insured person who receives cross-border healthcare are reimbursed, if the healthcare in question is among the benefits to which the insured person is entitled in the EEA State of affiliation*". The financial implications of this principle, which flows directly from the right to free movement of patients, services and goods (see recital 29), are then taken into account in Article 7(4), which provides that the costs of cross-border healthcare are to be reimbursed up to the level of costs that would have been assumed by the EEA State of affiliation for domestic healthcare, without exceeding the actual costs of healthcare received.

29. By the same logic, Article 7(7) of Directive 2011/24/EU allows the EEA State of affiliation to impose certain conditions, criteria of eligibility and regulatory and administrative formalities for the reimbursement. In other words, because it is the EEA State of affiliation that remains liable, it is natural that that State is able to set the rules for reimbursement, *provided that those rules impose the same requirements as would be the case for healthcare provided on its territory*.

30. Directive 2011/24/EU frames the possibility to impose such conditions, criteria and formalities carefully, so as to strike the right balance between, on the one hand, the obligation to respect the competence of the EEA States to organise their healthcare system (where it is for the legislation of each EEA State to determine the conditions under which healthcare is financed, including as regards which treatments are covered by social security benefits), and on the other hand, ensuring compliance with the provisions on the freedom to provide services, which prohibit the EEA

([6]) Judgment of 23 September 2020, *WO v Vas Megyei Kormányhivatal*, C-777/18, EU:C:2020:745, para 65.

States from introducing or maintaining unjustified restrictions on the exercise of that freedom in the healthcare sector. [7]

31. Article 7(7) only allows an EEA State to impose conditions, criteria and formalities for the reimbursement of cross-border healthcare if they:

    (i) are the same as those that would be imposed for the reimbursement of the same care if it were provided domestically:

    (ii) are neither discriminatory nor constitute an obstacle to the free movement of patients, services or goods, unless objectively justified by planning requirements relating to the object of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources.

32. The first condition is not an issue in the present case, as the specialisation requirement applies for all for implant-anchored dental prosthetics treatment, including where provided domestically. By contrast, the second condition warrants a more granular analysis.

IV.3. Conditions, criteria and formalities for reimbursement must not constitute an obstacle to free movement

33. Conditions and formalities for the reimbursement of cross-border healthcare must not be an obstacle to the free movement of patients, services and goods (Article 7(7)). This builds on long-standing case-law of the CJEU on free movement of services, according to which Article 56 TFEU precludes the application of any national rules which have the effect of making the provision of healthcare services

---

(7) Judgment of 16 May 2006, *The Queen, on the application of Yvonne Watts v Bedford Primary Care Trust and Secretary of State for Health*, C-372/04, EU:C:2006:325, para 92 and case-law cited.

between Member States more difficult than their provision purely within a Member State. [8]

34. In fact, conditions, criteria and formalities for reimbursement have a significant potential to undermine the very purpose of Directive 2011/24/EU, namely to facilitate the access to cross-border healthcare (see Article 1(1) and recital 10 of the Directive) and to improve the functioning of the internal market and the free movement of goods, persons and services (see in particular recital 2 of the Directive). As recital 37 of the Directive stresses, "*it is thus appropriate to require that these general conditions, criteria and formalities should be applied in an objective, transparent and non-discriminatory way (...) and that they should not impose any additional burden on patients seeking healthcare in another Member State in comparison with patients being treated in their Member State of affiliation (...)*".

35. In the present case, the condition at issue consists of a requirement relating to the professional qualifications of the health practitioner performing the treatment for which reimbursement is sought. Which brings us to the question: does the requirement contained in the relevant Norwegian rules that the treatment in question be carried out by a practitioner with a specific professional qualification constitute an obstacle to the free movement of patients, services and goods within the meaning of Article 7(7) of Directive 2011/24/EU?

36. By way of general remark, the Commission is of the view that the interpretation of the requirements permitted pursuant to Directive 2011/24/EU should be harmonious with the relevant EEA legislation on professional qualifications, as the CJEU has done in the past. The Commission points as an example to Case C-444/05, *Stamatelaki*, where the Court, when replying to arguments by a Member State aiming to justify restrictions to the free movement of healthcare services, explicitly took into account the system of mutual recognition of professional qualifications

---

([8]) Judgment of 16 May 2006, *The Queen, on the application of Yvonne Watts v Bedford Primary Care Trust and Secretary of State for Health*, C-372/04, EU:C:2006:325, para 94 and case-law cited.

and the resulting trust that could be placed in the professional ability of healthcare providers from another Member State. (9)

37. It is a matter of settled case law that Article 36 EEA precludes the application of any national rules which have the effect of making the provision of services between EEA States more difficult than the provision of services purely within an EEA State. (10) It is also well-established that the freedom enshrined in Article 36 EEA covers both the provision and the receipt of services.

38. More specifically, medical services provided for consideration fall within the scope of the provisions on the freedom to provide services. (11) And the freedom to provide services includes the freedom for the recipients of services, including persons in need of medical treatment, to go to another EEA State in order to receive those services there. (12) This remains true even when reimbursement of the treatment in question is sought within the framework of the system of healthcare in the State of affiliation of the patient - a supply of medical services does not cease to be a supply of services within the meaning of Article 36 EEA on the ground that the patient, after paying the foreign supplier for the treatment received, subsequently seeks the reimbursement of that treatment. Indeed, the freedom to provide services by a health professional in one EEA State to a patient that is part of the healthcare system in another EEA State would be illusory if, by opting for those services, the patient were automatically excluded from reimbursement of the costs incurred.

39. Thus, the Norwegian rule that a particular treatment must, in order to be eligible for reimbursement, be carried out by a practitioner with a specific professional qualification will constitute an obstacle to the free movement of patients, services and goods within the meaning of Article 7(7) of Directive 2011/24/EU if it has the

---

(9) Judgment of 19 April 2007, *Aikaterini Stamatelaki v NPDD Organismos Asfaliseos Eleftheron Epangelmation (OAEE)*, C-444/05, EU:C:2007:231, para 37.

(10) Judgment in case C-372/04, *Watts*, cited above, para 94.

(11) Judgment in case C-372/04, *Watts*, cited above, para 86.

(12) Judgment in case C-372/04, *Watts*, cited above, para 87.

effect of making the provision of services between EEA States more difficult than the provision of services purely within an EEA State.

40. The rule in question requires that the healthcare provider holds one of the following qualifications: specialist in oral surgery and oral medicine, specialist in maxillofacial surgery or specialist in periodontics. When the treatment is provided outside of Norway, that rule is understood as requiring "*equivalent specialist approval that is valid in the country where the healthcare is received*". An additional scenario appears to be envisaged in the Norwegian rules: where the specialisation in question, or equivalent formal specialisation, does not exist in the country where the healthcare is provided, the condition can be met by documenting "*that the service provider actually has equivalent substantive competence or other doctor specialisation in medicine which is clearly comparable to the speciality required in Norway*". In other words, evidence of a specific professional qualification is required when the service is provided within Norway. The question is whether it is more difficult to fulfil the requirement when the service is provided in a different EEA State.

41. Of the three types of specialist referred to in the rule in question, the first is listed in point 5.3.3 of Annex V to Directive 2005/36/EC concerning specialist dentists ([13]) and the second is listed in point 5.1.3 of Annex V to Directive 2005/36/EC concerning specialist doctors. A corresponding qualification for Poland is listed for both these categories of specialist. Point 1 in Annex VII to the EEA Agreement refers to the corresponding Norwegian qualifications for both these categories of specialist. In other words, those qualifications are part of the system of automatic recognition established pursuant to that Directive.

42. That Directive establishes rules according to which an EEA State which makes access to or pursuit of a regulated profession in its territory contingent upon possession of specific professional qualifications shall recognise professional qualifications obtained in one or more other EEA States (Article 1). It shall apply to

---

([13]) The Commission notes a slight discrepancy in the title used in the Norwegian rules in question as compared to the title of the qualification included in point 1 of Annex VII to the EEA Agreement.

all nationals of an EEA State wishing to pursue a regulated profession in an EEA State, including those belonging to the liberal professions, other than that in which they obtained their professional qualifications, on either a self-employed or employed basis (Article 2). The EFTA Court has held that it is not the purpose of the Directive to make recognition of professional qualifications more difficult in situations falling outside its scope, nor may it have such an effect. ([14]) The system of automatic recognition under the Directive thus complements the rights guaranteed under the main part of the EEA Agreement, but does not displace an assessment under those provisions.

43. As a matter of settled case law of both the CJEU and the EFTA Court, by virtue of the rights guaranteed under the main part of the EEA Agreement, the authorities of an EEA State to which an application has been made by a national of an EEA State for authorisation to practise a profession, access to which depends, under national legislation, on the possession of a diploma or professional qualification or on periods of practical experience, are required to take into consideration all of the diplomas, certificates and other evidence of formal qualifications of the person concerned and his relevant experience, by comparing the specialised knowledge and abilities so certified and that experience with the knowledge and qualifications required by the national legislation. The Commission is of the view that the same obligation applies in other situations in which the freedom to provide or receive healthcare services is relied upon.

44. Recognition of professional qualifications (whether pursuant to Directive 2005/36/EC or directly under the EEA Agreement) and reimbursement of costs of cross-border healthcare (pursuant to Chapter III of Directive 2011/24/EU) are, in essence, two sides of the same coin: the former ensures the mobility of healthcare providers whereas the latter facilitates the movement of patients. Both serve the same objective: the free movement of healthcare services, for both providers and recipients of those services.

([14]) Judgment of 25 March 2012, *Lindberg*, E-3/20, para 59, citing the judgment of the CJEU in *Dreessen*, C-31/00, EU:C:2002:35, para 26.

45. Thus, in a situation in which the Norwegian authority is called upon to assess whether the requirement of "*equivalent specialist approval*" is fulfilled, it should do so with the above-mentioned case law in mind.

46. This assessment is likely to be greatly simplified in a situation in which the non-Norwegian qualification is itself listed in Annex V to the Directive or Annex VII to the EEA Agreement for a specialisation for which Norway also has an entry in the latter. Indeed, it is useful to recall that a professional holding a so-called Annex V qualification is entitled to provide services in an EEA State other than the one in which he obtained his qualification (Article 5 of Directive 2005/36/EC), and to establish himself on a stable and permanent basis there in accordance with the principle of automatic recognition of that qualification (Article 21 of Directive 2005/36/EC). In other words, if that professional had come to Norway on a temporary basis to carry out the treatment, he would be entitled to do so without Norway being able to restrict, for any reason relating to professional qualifications, that provision of services. Similarly, that professional would be entitled to settle in Norway and pursue his profession there on the basis of that qualification. There does not appear to be any basis for differentiating between these scenarios when assessing whether a qualification is "equivalent" for the purpose of the specialisation requirement.

47. Similarly, the principles that guide such an assessment will not differ in a situation in which the specialisation in question is not part of the automatic system of recognition: the specialist qualification of the healthcare provider in question must be measured against each of the acceptable Norwegian qualifications in such a way that the assessment enables the authorities of the host State to assure themselves on an objective basis that a foreign diploma certifies that the knowledge and qualifications are, if not identical, at least equivalent to those attested by the national diploma. ([15])

48. On that basis, the principles that guide such an assessment will not differ in a situation in which the healthcare provider in question does not hold a specialisation

([15]) Judgment of 25 March 2012, *Lindberg*, E-3/20, para 65.

– irrespective of whether a relevant specialisation exists in the home State of that professional. The authorities of an EEA State are nevertheless required to take into consideration all of the diplomas, certificates and other evidence of formal qualifications of the person concerned and his relevant experience, again with a view to enabling those authorities to assure themselves on an objective basis that a foreign diploma certifies that the knowledge and qualifications are, if not identical, at least equivalent to those attested by the national diploma.

49. On the basis of the foregoing considerations, the Norwegian rules appear, for the most part, to allow such an assessment to take place. Only the final proviso appears to specifically prevent an assessment in a situation in which, pursuant to the right enshrined in Article 36, according to which the freedom to provide services is guaranteed, one would be called for. However, it will be for the national judge to consider whether the rules, as they are applied in Norway, do indeed require the Norwegian authority to consider, whenever it receives a request for reimbursement of treatment provided in another EEA State, all of the diplomas, certificates and other evidence of formal qualifications of the person concerned and his relevant experience, again with a view to enabling those authorities to assure themselves on an objective basis that a foreign diploma certifies that the knowledge and qualifications are, if not identical, at least equivalent to those attested by the national diploma.

50. If the national judge comes to the conclusion that the system as it functions in practice does not allow for such an assessment in all cases, and thus constitutes an obstacle to free movement because it makes the provision of services between EEA States more difficult than the provision of services purely within an EEA State, it would then need to be assessed whether such an obstacle could be objectively justified on one of the grounds explicitly mentioned in Article 7(7), 3rd sentence, *in fine,* of Directive 2011/24/EU.

IV.4. Possible justifications

51. Conditions which would constitute an obstacle to free movement are, indeed, nevertheless allowed, pursuant to Article 7(7) of Directive 2011/24/EU, if they are "*objectively justified by planning requirements relating to the object of ensuring*

sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources".

52. Like any restriction to the fundamental freedoms, it is for the EEA State concerned to demonstrate, in the first place, that it is justified (in this case on the grounds listed exhaustively in Article 7(7)) and, in the second place, that it observes the principle of proportionality, which means that it is suitable for securing, in a consistent and systematic manner, the attainment of the objective pursued and does not go beyond what is necessary in order to attain it. Those conditions are cumulative.

53. It is not clear from the request for an Advisory Opinion what is the justification invoked by Norway. The national judge does refer, at paragraph 64 of the request, to a situation in which there will be "*greater expenditure related to healthcare that has not been performed sufficiently well*". However, this reference to general considerations of expenditure appears rather cursory and would, in the Commission's opinion, need to be further substantiated.

54. The Commission is of the view that any further observations on this point would be highly speculative, in the absence of a clearly identified obstacle to free movement in the rules underlying the case that gave rise to the request for an opinion. It is only once the restrictive nature of a measure has been established that the objective pursued by that measure can be properly reviewed, and it is for the EEA State concerned to identify the objective being pursued and to bring forward arguments in support of the proportionality of that measure.

V. CONCLUSION

55. In the light of the foregoing, the Commission considers that the questions referred to the EFTA Court for an advisory opinion by the National Insurance Court should be reformulated and answered in a single reply as follows:

Article 36 of the EEA Agreement and Article 7 of Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare must be interpreted as not

precluding, as a matter of principle, national rules, which impose, as a pre-condition for reimbursement of medical costs incurred in another EEA State, the possession by the dental practitioner providing certain types of treatment of a specialist qualification equivalent to that required for reimbursement of medical costs incurred in the EEA State of affiliation, provided that the rules guarantee an assessment of equivalence in each individual case and in line with the principle of freedom to provide services enshrined in Article 36 EEA.

Lorna ARMATI Sandrine DELAUDE Esther Eva SCHMIDT

Agents for the Commission