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Patient Mobility and National Health Systems

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Patient Mobility and National Health Systems


By Mel Cousins

1. Introduction

In the last decade, there have been a number of very important judgments of the Court of Justice in relation to patient mobility under article 49 EC and public health systems. Until recently, however, these had referred only to hybrid and private insurance systems. An important question remained as to whether this line of caselaw applied to national health systems and, if so, in what manner. This has now been addressed by the Court of Justice in the Watts case, which concerned the UK national health system (NHS).

1. Oxford Brookes University.
3. To use the classification suggested by Advocate General Ruiz-Jarabo Colomer in his opinion in *Smits and Peerbooms*.
4. On the characteristics of the NHS, see the opinion of Advocate General Geelhoed at para. 7.
2. Facts of the Case

In September 2002, Mrs. Watts was diagnosed by her general practitioner as having osteoarthritis in both hips and was subsequently advised that each hip needed a total replacement. Her daughter requested the Bedford primary care trust (PCT) to allow her mother to have the hip replacements abroad in accordance with article 22 of regulation 1408/71. Her consultant stated that her mobility was severely hampered and that she was in constant pain. He described her as being as deserving as any of the other patients with severe arthritis on his waiting list, but since her case was categorised as ‘routine,’ she would have to wait approximately 1 year to have the operation at her local hospital. In November 2002, the PCT refused the application under article 22 on the grounds that, as treatment could be provided within NHS Plan targets, the condition of not being able to receive treatment in the member state of residence ‘within the time normally necessary’ had not been fulfilled. The PCT concluded that there was no question of ‘undue delay’ as treatment could be provided locally within the target time of 12 months contained in the NHS Plan.

Mrs. Watts sought a judicial review of this decision, and in January 2003, she traveled to France to consult a medical specialist. The French consultant concluded that her condition had deteriorated and that the hip replacements should be carried out by March 2003. Mrs. Watts was re-examined by the original consultant so that Bedford PCT might reconsider its decision. He then reported that she had become a little worse than the average patient and that he would now categorise her as someone who required surgery ‘soon’. This meant that she should be operated on within three to four months. On this basis, Bedford PCT decided not to revise its initial decision. However, Mrs. Watts arranged to have her hip replacements carried out in France in March 2003, and she paid the fees for that surgery, equivalent to £3,900. She continued with her judicial review proceedings, and ultimately the English Court of Appeal referred a series of questions to the Court of Justice.

3. The Judgment

3.1. Interpretation of Article 22 of Regulation 1408/71

The Court of Justice decided that it should first address the interpretation of Regulation 1408/71. Article 22(1)(c) of Regulation 1408/71 provides that a person authorised to go to another member state to receive treatment is entitled to this treatment in accordance with the legislation of the member state providing the treatment (the host state), as if she were insured in that member state.

5. This is normally the state where the treatment is provided although exceptionally, as in Case C-145/03 Keller [2005] ECR I-2529, treatment may be provided in a third country.
The cost of that treatment is to be borne by the *competent* member state (i.e. the state under whose laws the individual is covered), which refunds the institution of the host state directly. This authorisation may not be refused where (1) the treatment is among the benefits insured in the competent state and (2) the treatment required cannot be provided ‘within the time normally necessary for obtaining the treatment in question in the member state of residence, taking account of his current state of health and the probable course of his disease.’

The question essentially asked whether the criteria for the interpretation of the phrase ‘within the time normally necessary for obtaining the treatment in question’ in article 22(2) of Regulation 1408/71 were the same as those used by the Court to define the term ‘without undue delay’ in the context of article 49 EC. Following its previous case law and the opinion of Advocate General Geelhoed, the Court ruled that ‘there is no reason which seriously justifies different interpretations depending on whether the context is article 22 of Regulation 1408/71 or article 49 EC, since in both cases the question is… whether the hospital treatment required by the patient’s medical condition can be provided on the territory of his member state of residence within an acceptable time which ensures its usefulness and efficacy.’

The Court of Justice then turned to the implications of this approach. The referring court had asked whether, in interpreting the time referred to in article 22, it is necessary or permissible to take account of a range of factors including the existence of waiting times, the clinical priorities defined by the competent NHS body, the management of the supply of hospital care in accordance with priorities intended to give best effect to finite resources, the fact that treatment under the NHS is provided free of charge and the individual medical condition of the patient and the history and probable course of her illness. The Court accepted that in a context where demand for hospital treatment is constantly rising but supply is necessarily limited by budgetary constraints, national authorities ‘are entitled, if they consider it necessary, to institute a system of waiting lists in order to manage the supply of that treatment and to set priorities on the basis of the available resources and capacities’. The Court went on to say that:

‘in order to be entitled to refuse the authorisation referred to in article 22(1)(c) … on the ground of waiting time, the competent institution must however establish that the waiting time, arising from objectives relating to the planning and management of the supply of hospital care pur-
sued by the national authorities on the basis of generally predetermined clinical priorities … does not exceed the period which is acceptable in the light of an objective medical assessment of the clinical needs of the person concerned in the light of his medical condition and the history and probable course of his illness, the degree of pain he is in and/or the nature of his disability at the time when the authorisation is sought’.11

Following the opinion of the Advocate General, the Court emphasised that the setting of waiting times must be done flexibly and dynamically so that a period initially notified to a person may be reconsidered in the light of any deterioration in her state of health. Only if the waiting time set in accordance with general planning objectives did not ‘exceed a medically accepted waiting time’ would the competent institution be entitled to refuse to grant authorisation sought under article 22. The Court held that the fact that the cost of the hospital treatment in another member state was higher than in the national system was not a legitimate ground for refusing authorisation.

3.2. The Application of Article 49 EC

The Court went on to consider the circumstances in which an NHS patient was entitled under article 49 EC to receive hospital treatment in another member state at the expense of the National Health Service. The first issue to be decided was whether Article 49 EC applied. The Court recalled that, according to its previous caselaw, medical services provided for consideration fall within the scope of the provisions of the freedom to provide services. The freedom to provide services includes the freedom for recipients of services, including persons in need of medical treatment, to go to another member state to receive those services. The Court noted that this is precisely what Mrs. Watts had done and held that ‘[t]he fact that reimbursement of the hospital treatment in question is subsequently sought from a national health service … does not mean that the rules on the freedom to provide services guaranteed by the Treaty do not apply’.12 Accordingly the Court ruled that article 49 EC applies where a patient receives medical services in a hospital environment for consideration in a member state other than her state of residence, regardless of the way in which

11. Judgment, para. 68.
12. Judgment, para. 89. It should be noted that neither the Advocate General nor the Court felt it necessary to consider the issue as to whether the National Health Service itself fell within the scope of article 49 EC. On this see Case 263/86 Humbel [1988] ECR 5365; Joined Cases C-159/91 and C-160/91 Pascot and Pissot [1993] ECR I-637 and Joined cases C-264/01, C-306/01, C-354/01 and C-355/01 AOK Bundesverband [2004] ECR I-2493, annotated by M. Krajeski and M. Farley in EL Rev 2004, pp. 842–51. See the discussion of this issue in G. Davies ‘Welfare as a service’, Legal Issues of European Integration 2002, pp. 27–40.
the national system, with which she is registered and from which reimbursement of the cost is subsequently sought, operates.

3.3. Prior Authorisation

The Court of Justice went on to consider whether a requirement that a person going abroad to avail of hospital services must seek prior authorisation (as required by UK law) was consistent with EC law. The Court recalled that article 49 EC precluded the application of any national rules, which have the effect of making the provision of services between member states more difficult than the provision of services purely within a member state. The Court found that a system of prior authorisation was an obstacle to freedom to provide services insofar as it could deter, or even prevent, patients using hospital services in another member state. However, the question still arose as to whether such a requirement could be objectively justified. The Court had, in previous cases, given a number of overriding considerations, which would justify an obstacle to the freedom to provide services. These included the risk of seriously undermining the financial balance of a social security system, the objective of maintaining a balanced medical and hospital service open to all, and the maintenance of treatment capacity or medical competence which is essential for the public health and even the survival of the population.

In this case, following its earlier caselaw, the Court found a particular source of justification in the need for planning. The Court highlighted the importance of planning in the provision of sufficient and permanent access to a range of high-quality hospital services and in the control of costs and prevention of wastage of financial, technical and human resources. On this basis, the Court held that the requirement that the assumption of costs by a national system of hospital treatment in another member state be subject to prior authorisation was ‘both necessary and reasonable’.

However, the Court went on to hold that the conditions attached to the grant of such authorisation must be justified in the light of the overriding considerations mentioned above and must satisfy the requirement of proportionality. The Court ruled that for a system of prior authorisation to be justified, it must be based on objective, non-discriminatory criteria which are known in advance. In addition, it must be based on a procedural system which is easily accessible and capable of ensuring that a request for authorisation will be dealt with objectively and impartially within a reasonable time, and refusals to grant authorisation must be capable of being challenged in judicial or quasi-judicial

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14. Judgment, para. 110 following its approach in Smits and Peerbooms paras. 76 to 80.
15. Thus, a system of prior authorisation could not operate on the basis of discretionary decisions taken by national authorities.
proceedings. The Court noted that the regulations of the NHS did not set out the criteria for the grant or refusal of prior authorization, did not, therefore, circumscribe the exercise of discretionary power by the national authorities, and made it difficult to exercise judicial review of decisions.

The Court concluded this section of its judgment by ruling that a refusal to grant authorisation could not be based merely on the existence of waiting lists without carrying out an objective medical assessment of the patient’s medical condition, the history and probable course of her illness, the degree of pain she is in and/or the nature of her disability at the time when the request for authorisation was made or renewed. Accordingly, authorisation could not be refused on the grounds of the existence of waiting lists, and alleged distortion of the normal order of priorities linked to the relative urgency of the cases to be treated, the fact that the hospital treatment provided under the national system in question was free of charge, the duty to make available specific funds to reimburse the cost of treatment provided in another state and/or a comparison between the cost of that treatment and that of equivalent treatment in the competent state.

3.4. Calculation of Reimbursement and Ancillary Costs

Further issues raised by the referring court concerned:

(i) whether the reimbursement of the cost of hospital treatment should be calculated under article 22 of Regulation 1408/71 by reference to the legislation of the host state or under article 49 EC by reference to the legislation of the competent State;
(ii) whether reimbursement was limited to the actual cost of providing the same or equivalent treatment in the competent state, and
(iii) whether the obligation to fund hospital treatment included the travel and accommodation costs.

Article 22(1)(c)(i) requires that a person with authorisation be entitled to the benefits in kind provided on behalf of the competent institution by the institution of the host state, in accordance with the provisions of the legislation of that State, as if she were registered with that institution. Therefore, (under regulation 1408) the rules for reimbursement laid down by the legislation of the host state are to be applied, with the competent institution responsible for subsequently reimbursing the institution of that state. However, where an

17. Judgment, paras. 119 and 120.
18. As provided for in article 36 of Regulation 1408/71.
insured person is entitled to an amount in the competent state, which is higher than the amount to which she would be entitled under the legislation of the host state, the Court ruled in Vanbraekel that she is entitled to additional reimbursement under article 49 EC.  

Mrs. Watts argued that if a person is entitled to receive treatment in another member state either under article 22 or under article 49 EC, she may opt for the most advantageous method of reimbursement, which in the present case would be that under article 49 EC. She argued where there are no reimbursement rates in the state of residence, the full cost of the treatment should be refunded. However, the Court held that article 49 EC must be interpreted as meaning that where the legislation of the competent state provides that hospital treatment provided under the national health service is to be free of charge, and where the legislation of the host state does not provide for the reimbursement in full of the cost of that treatment, the competent institution must reimburse that patient the difference (if any) between the cost of equivalent treatment in a hospital covered by the service in question up to the total cost of the treatment provided in the host state and the amount which the institution of the latter state is required to reimburse under article 22(1)(c)(i).

The Court held that an obligation on the competent institution in all circumstances to cover the full amount of the difference between the cost of the hospital treatment provided in the host state and the amount of the reimbursement, including where the cost of that treatment is greater than the cost of equivalent treatment in the competent state, would afford the patient cover in excess of that to which she was entitled under the national health service with which she was registered. However, this rationale is flawed (or misstated) given that Mrs. Watts would not have been entitled to treatment abroad at all under the UK national health system. Rather, the correct rationale for this approach is surely that set out in the Advocate General’s opinion, i.e. that where article 49 EC is applicable, it is the legislation of the competent member state which determines the level of reimbursement and that, therefore, a patient is only entitled to the amount which would have been reimbursed if the treatment had been provided in that state.

In relation to travel and accommodation costs, the Court pointed out that Regulation 1408/71 related exclusively to health care expenditure, i.e., in the case of hospital treatment, the cost of medical services strictly defined and the inextricably linked costs relating to the patient’s stay in the hospital for the purposes of her treatment. As article 22 was not intended to cover ancil-

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lary costs, such as the cost of travel and any accommodation other than in the hospital itself, it neither provided for, nor prohibited, the reimbursement of such costs. Accordingly, the Court considered whether any obligation to reimburse such costs might arise under article 49 EC. Relying on its previous case law, the Court ruled that a state was obliged to meet such costs only where it provided reimbursement of those costs when the treatment was provided in a national hospital.

3.5. Compatibility with Article 152(5) EC

Finally, the Court summarily considered a question as to whether article 49 EC and article 22 of Regulation 1408/71 must be interpreted as imposing an obligation on member states to fund hospital treatment in other member states without reference to budgetary considerations and, if so, whether this was compatible with article 152 (5) EC. The Court pointed out, firstly, that the requirements arising from article 49 EC and article 22 of Regulation 1408/71 are not to be interpreted as imposing on member states an obligation to reimburse the cost of hospital treatment in other member states without reference to any budgetary consideration but, on the contrary, are based on the need to balance the objective of the free movement of patients against overriding national objectives relating to management of the available hospital capacity, control of health expenditure and financial balance of social security systems. Secondly, it noted that, while article 152(5) EC provides that Community action in the field of public health is to respect fully the responsibilities of member states for the organisation and delivery of health services and medical care, it does not rule out the possibility that member states may be required under other Treaty provisions, such as article 49 EC, or Community measures such as Regulation 140871, to make adjustments to their national systems of social security.

4. Commentary

The issues raised in Watts (and indeed in this series of cases) are extremely complicated and do not lend themselves to easy resolution. The main outcome of this case, that is the recognition that a person in the position of Mrs Watts is entitled to seek hospital treatment abroad unless it can be provided under the national system within a medically accepted waiting time, is obviously very positive from the point of view of the individual patient. The emphasis on the need to assess the individual circumstances of each case (while admin-

23. In particular, Case C-381/93 Commission v France [1994] ECR I-5145, para. 17; Kohll, para. 33; and Smits and Peerbooms, para. 61
istratively onerous) is perhaps the most appropriate (and certainly the most patient-friendly) manner to resolve, what the Advocate General described as, the inherent tension between ‘the inevitable existence of waiting lists and their role as an instrument for managing and allocating limited resources’ and ‘the interests of patients in receiving adequate and timely treatment’. Indeed, this general outcome was highly predictable in the light of the previous caselaw of the Court of Justice.

4.1. Implications for Social Policy

However, from a broader policy perspective, the approach of the Court does give rise to serious issues. While it is possible, in legal terms, to distinguish between the role of a national health service in providing care within the national territory and its role in the reimbursement of health care provided in another member state, from a policy perspective the objective behind these two activities is precisely the same, i.e. the provision of appropriate and necessary medical care to persons covered by the national system. While the Court carefully avoided the question as to whether national health systems themselves fall within the scope of article 49 EC, there can be no doubt that this series of cases does undermine the territoriality of European welfare states and, implicitly, reduces or qualifies national sovereignty in deciding on the appropriate type and quality of national health care. The issue of particular concern is that measures towards the integration of European health care systems are almost entirely negative in form, that is, they involve the removal of barriers to the free movement of health services between the member states. Integration measures of a more positive nature, such as the establishment of appropriate minimum or benchmark standards or the provision of EU funding to address health inequalities, are either absent or extremely limited.

In Watts, as in previous cases, the Court was keen to reassure member states that its decision would not lead to the undermining of the national authorities’ power to manage available hospital capacity, and indeed, given linguistic and cultural differences, significant numbers of patients may not wish to travel to different jurisdictions to avail of hospital services. However, it remains extremely difficult to predict the ultimate policy implications of this line of caselaw. The case-by-case nature of the development of policy in this area also means that there is an absence of planning as to what the appropriate end-state might look like, and the implications of this series of cases, particularly in relation to, for example, the new member states, have received little

24. Opinion, para. 86.
25. See, in particular, Müller-Fauré at para. 103.
study. However, this is really a criticism of the EU legislature rather than of the Court of Justice. The resolution of the tension between free movement of services and the need to provide appropriate public health care requires policy measures by the legislature, and it is in the absence of such measures that the Court has been forced to act.

4.2. Dual System of Cross-border Health Care

One area where the Court, in my opinion, can be criticised is in relation to its creation of a dual system of cross-border health care (under both the Treaty and Regulation 1408). It is worth noting that, at least in relation to the particular circumstances in this case, the main outcome could have been achieved simply through a broad interpretation of article 22 of Regulation 1408 as the implementation of the right to free movement under the Treaty. However, it is now too late to turn back the clock (and, indeed, other aspects of the Court’s case law, such as non-hospital treatment, might not so easily have been addressed in this manner). The Court has attempted to some extent to align the two systems through, for example, adopting the same interpretation of ‘undue delay’. However, in cases such as Vanbraekel and again in Watts, the Court has exacerbated the differences between the two systems by creating different approaches in relation to reimbursement of costs and travel and accommodation costs. While this may benefit some individual patients, it creates significant (and arguably non-essential) additional administrative burdens. Indeed, it may be very nice to have a system whereby an individual patient can opt for the more favourable approach to reimbursement of costs (of the host or competent state) but somebody has to administer and finance this system. Similar issues may also arise in relation to travel and accommodation costs insofar as these are met under any national schemes. This all adds a further layer of complication to the issue of patient mobility and the administration of health care which, ultimately, cannot be to the benefit of either patients or administrators.

28. See supra note 1, A.P. van der Mei ‘Cross-border Access to Medical Care’ at pp. 64–67.
29. Readers familiar with the case law under Regulation 1408, of course, will recognise that this approach is diametrically opposite to that adopted by the Court in a series of cases concerning that regulation where it has emphasised the importance of the application of the legislation of one member state only in order to facilitate co-ordination of social security systems.
30. As a further complication, it is now necessary to ascertain the cost of equivalent treatment in the competent state.
4.3. Allocation of Costs

In relation to the allocation of costs, as discussed above, there are now two separate systems in operation under EU law. Firstly, under article 22 of regulation 1408/71, medical treatment is provided, on behalf of the competent state, by the host state ‘in accordance with the legislation which it administers’. Therefore, a person who receives medical treatment abroad under article 22 is subject to the rules as to patient reimbursement of the host country. Subsequently, the competent state is liable for reimbursement to the host state in respect of medical treatment provided under article 36 of the regulation. Given that the rules as to patient reimbursement vary significantly from one member state to another, this means that patients may face different costs depending on the rules of the host state. However, this automatically flows from the lack of harmonisation (or indeed any significant co-ordination) of social security systems amongst member states. In contrast, a person who receives treatment under the Treaty provisions may receive reimbursement, where this is to her advantage, under the rules of the competent institution. However, as a result of the judgment in *Watts*, this cannot exceed the amount of ‘equivalent treatment’ in the competent state. The actual implications of this in the *Watts* case are not apparent from either the opinion of the Advocate General or the judgment of the Court, and it is unclear whether there was a significant difference between the alternative approaches. It is, however, clear that it was to Mrs. Watts’ advantage to seek reimbursement under the UK rules rather than French rules. However, in the case of a person traveling from one of the new member states to avail themselves of treatment in, for example, France, it seems likely that the limitation concerning ‘equivalent treatment’ in the host member state would mean that it would be more advantageous for that person to rely on reimbursement under article 22 and, thus, the full implications of this dual system remain somewhat unclear. In the *Vanbraekel* case, in which it was also to the advantage of the individual to rely on the rules of the competent state, the Court of Justice ruled that the fact that the legislation of a member state does not guarantee a person insured in that state at least an equally advantageous level of cover for hospital services provided in another member state constituted a barrier to freedom to provide services. However, the example quoted above shows that the significant variation in medical costs between member states is likely to create a much more significant barrier to free movement. In addition, the ‘system’ as to allocation of costs now established by the Court of the Treaty was not agreed to by the member states and can only be revised by them within the context of the Court’s interpretation of the Treaty provisions (barring amendment of the Treaty itself). Overall, it is perhaps safe to suggest that this case marks the end of the beginning of this line of case law, rather than the beginning of the end.