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Watts v. Bedford Primary Care Trust: The Uncertain Prognosis for Health Tourism in the European Union

Huahan Pai

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I. INTRODUCTION

A self-employed and uninsured patient from Louisiana undergoes surgery in Bangkok to repair a herniated disk in his neck for under $10,000.[1] The same procedure would have cost $90,000 if conducted in the United States.[2] Another patient from Canada has a spinal condition but is on a three-year waitlist for corrective surgery.[3] She chooses to go to India, where her condition is repaired six weeks later, and the province of Alberta reimburses her for the procedure.[4]

These stories represent a growing global trend referred to as "health tourism" or "medical tourism," where patients go abroad for either elective or urgent medical procedures. Patients choosing to go abroad for medical care are usually driven by the high costs, lack of insurance coverage, or long waiting lists in their home countries.[5] The benefits of health tourism include lower costs and greater access to medical care, but disadvantages also exist. The lack of uniform regulatory bodies, varying malpractice laws and the idea of "undergoing invasive medical procedures in a developing part of the world" (which is where most of these

1. *See* Unmesh Kher, *Outsourcing Your Heart,* TIME, May 21, 2006, http://www.time.com/time/printout/0,8816,1196429,00.html.

2. *See id.*

3. Cameron MacIntosh, *Medical Tourism: Need Surgery, Will Travel*, CBC NEWS ONLINE, June 18, 2004, http://www.cbc.ca/news/background/healthcare/medicaltourism.html.

4. *Id.*

5. Louisa Kamps, *The Medical Vacation,* TRAVEL & LEISURE, July 2006, http://www.travelandleisure.com/articles/the-medical-vacation.

procedures are being completed) are just some of the factors that affect patients' choices to seek care abroad.[6]

Though health tourism has mainly been a private phenomenon, it is nothing new in the European Union (EU), where cosmetic surgery is one of the fastest growing commodities.[7] Recently, there have been many cases in the EU where patients from one Member State have traveled to another for both cosmetic surgery and general health care. The surge of health tourists in the EU has generated a need for a coordinated framework.

Rather than waiting a year to have surgery in the United Kingdom (UK), Yvonne Watts underwent hip replacement surgery in France.[8] Watts took her case before the European Court of Justice (ECJ), seeking reimbursement from the British National Health Service. In May 2006, the ECJ ruled that Watts could not receive reimbursements from her home health care institution for medical costs incurred during her surgery abroad.[9] However, the ECJ ruled that patients who face "undue delay" may travel elsewhere to seek treatment.[10] Watts was denied reimbursement only because the Court determined that a year was not too long to wait for surgery.

As this case indicates, the ECJ may be establishing health tourism as a right in the EU and not merely as a lifestyle choice.[11] The ruling will have profound impacts on EU health care law by potentially making it easier for patients to seek treatment in other Member States. One area which will be impacted is the national health systems of EU Member States, since Member States may need to coordinate with each other to accommodate patients' wishes. Another potential impact is that citizens of Member States will have more freedom to move around the EU and possibly even retire in countries other than their home country, increasing the burden on local health care systems.

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6. Mark Repasky, *A Cut Below: Americans Look Abroad for Health Care*, ABC NEWS, Aug. 29, 2006, http://abcnews.go.com/Business/IndustryInfo/story?id=2320839&page=1.

7. *See* Andrew Bounds & Nicholas Timmins, *Europe Squares Up to a New Era of 'Patients Without Borders,'* FIN. TIMES (London), Sept. 6, 2006, Europe, at 14.

8. *Id.*

9. *Id.*; Case C-372/04, Watts v. Bedford Primary Care Trust, 2006 E.C.R. I-04325.

10. *Id.*

11. *See generally* Bounds & Timmins, *supra* note 7.

This Note will discuss the current health tourism phenomenon in the EU and argue that, while the Court correctly decided *Watts v. Bedford Primary Care Trust* and properly followed precedent, its holding will nonetheless lead to uncertainty for European national health care systems. Thus, the EU must develop a clear framework to accommodate this new phenomenon. Part II will provide important factual and legal background by discussing the founding treaty of the European Community and the relevant statutes at issue. Part III will provide a more in-depth analysis of the case itself, with an examination of the Court's application of precedent and a discussion of public-policy considerations. Part IV will indicate how the Court should have helped to facilitate this new phenomenon. Part V will provide a brief conclusion.

II. BACKGROUND

A. Facts of the Case

Yvonne Watts suffered from arthritis in her hips. Her local health care provider, Bedford Primary Care Trust (Bedford PCT), told her that she would have to wait approximately one year to have the surgery performed locally.[12] Thereafter, she asked Bedford PCT about going abroad to have the surgery.[13] Bedford PCT refused, stating that she could receive treatment locally.[14] Watts sought judicial review, but Bedford PCT still refused – even though it had discovered upon re-examination that Watts required surgery sooner than previously thought.[15] Watts then underwent surgery in France, which she paid for with her own funds.[16] She continued to apply for judicial review and entered a claim for reimbursement of her medical expenses.[17]

The High Court of Justice of England and Wales dismissed Watts's application, and the Court of Appeals of England and Wales referred the case to the European Court of Justice.[18] At issue was whether the two conditions of the applicable social

12. *NHS Told to Fund Treatment Abroad*, BBC NEWS, May 16, 2006, http://news.bbc.co.uk/2/hi/health/4985190.stm.
13. *Watts*, 2006 E.C.R. I-04325, ¶¶ 24-26.
14. *Id.*
15. *Id.* ¶¶ 27-29.
16. *Id.* ¶ 31.
17. *Id.* ¶ 32.
18. *Id.* ¶¶ 33-35.

security regulation were satisfied.[19] First, the local health care provider must normally provide the treatment in question. Second, the treatment cannot be obtained locally without unreasonable delay. If these conditions are met, the health care provider is required to grant authorization for a patient to access medical treatment in other EU Member States and to provide reimbursement for those treatments.[20]

The Court's holding had several components. First, the Court held that a health care provider is entitled to refuse authorization on the basis of waiting time, but only if the period is acceptable given the patient's needs.[21] If the waiting period for the treatment is unacceptable, the health care provider must make funds available to reimburse the cost of treatment that the patient obtains abroad.[22] Next, the Court held that where a patient's treatment abroad should have been authorized by a health care provider but was not, the health care provider must reimburse the patient according to the rules set out in the legislation of that Member State where the health care provider is located.[23]

B. Background of the EU

The Treaty of Rome of 1957, also known as the EC Treaty, established the European Community.[24] The EC Treaty went through a number of amendments through the years and eventually led to the creation of the European Union in 1992.[25] The legal landscape of the EU is unique because its main purpose is to integrate the markets, economies, and policies of its Member States.[26] By treating the EU as a multilevel system of governance, policy-making in the EU "cannot simply be understood as being determined by the preferences of the national governments."[27]

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19. *See* discussion *infra* Part III.A.
20. *Watts*, 2006 E.C.R. I-04325, ¶¶ 54-55.
21. *Id.* ¶ 123.
22. *Id.*
23. *Id.* ¶ 126 (citing Case C-368/86, Vanbraekel & Others v. ANMC, 2001, E.C.R. I-5363).
24. TAMARA K. HERVEY & JEAN V. MCHALE, HEALTH LAW AND THE EUROPEAN UNION 32 (2004).
25. *Id.* at 32-33.
26. *Id.* at 31.
27. *Id.* at 34.

Political arenas can also be viewed not simply as located within states, but rather interconnected across state boundaries.[28]

C. Access to Health Care Services in the EU

National health services in the EU are structured to ensure clear lines of responsibility for planning, management, and delivery of health care services on the basis of clinical need, rather than relying on an enforceable right to access health care services.[29] The details of a patient's legal entitlement to access health care services within the EU are determined by national law; all Member States have public national health systems that ensure almost universal access to comprehensive health care.[30] However, national law is affected by legislation promulgated at the EU level as well as litigation based on EU law.[31]

The freedom to provide services is one of the fundamental freedoms in the EU's founding treaties.[32] The stated goals of the EC Treaty for Member States in the EU include creating a common market, creating common policies, and ensuring a high quality of life for its citizens.[33] Of particular relevance to the freedom to provide services is Article 3, which states that a common market between the Member States should be characterized with the "free movement of goods, persons, services and capital."[34]

The broad scope of the freedom to provide services includes a patient's ability to seek medical treatment abroad. The two main legal paths allowing patients in one Member State to access medical treatment in another Member State are Article 22 of Council Regulation 1408/71[35] and Article 49 of the EC Treaty.

Council Regulation 1408/71 establishes a system for coordinating social security systems by setting common rules

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28. *Id.*
29. *Id.* at 110.
30. *Id.* at 110-11.
31. *Id.* at 111.
32. Antonio Segura Serrano, *Recent Development: Improvements in Cross-Border Access to Health Care Within the European Union,* 43 HARV. INT'L L. J. 553, 555 (2002).
33. Treaty Establishing the European Community art. 2, Dec. 24, 2002, 2002 O.J. (C 325) 33 [hereinafter EC Treaty].
34. *Id.* art. 3(1)(c).
35. Council Regulation 1408/71, On the Application of Social Security Schemes to Employed Persons, to Self-employed Persons and to Members of Their Families Moving Within the Community, 1971 O.J. (L 149) 2, *amended by* Council Regulation 2001/83, 1983 O.J. (L 230) 6 [hereinafter Council Regulation 1408/71].

aimed at ensuring that the various national social security systems do not discriminate against persons who are exercising their right to free movement.[36] The regulation also describes the conditions for accessing health care for people moving within the EU. To determine which Member State's domestic social security system controls in each individual case, two basic principles apply: (1) a person is subject to the legislation of only one Member State at a given time, and (2) a person is normally covered by the legislation of the Member State where he or she engages in occupational activity.[37]

Under Article 22(1) of Council Regulation 1408/71, there are certain situations in which a person is entitled to benefits from their home institution. However, there are only two situations which allow for cross-border access to medical care. The first situation is where a patient's condition requires immediate medical attention while in another Member State.[38] The second situation is where a patient may be authorized by the home institution to go to the territory of another Member State to receive the appropriate treatment.[39] Both situations require that the patient initially satisfy the legislation of the home Member State.

Article 22(2) of Council Regulation 1408/71 makes clear that patients do not have the right to claim financial support from their home Member State for treatments received in another Member State which are either not available or not publicly funded in the home Member State.[40] Article 22(2) contains two conditions in which prior authorization for the patient to receive treatment abroad cannot be refused by the home institution. First, "[t]he authorisation required under paragraph 1(c) may not be refused where the treatment in question is among the benefits provided for by the legislation of the Member State on whose territory the person concerned resided."[41] Second, the treatment cannot be given "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

36. European Comm'n, Achieving the Full Benefits and Potential of Free Movement of Workers, http://europa.eu/scadplus/leg/en/cha/c10525.htm (last visited Feb. 9, 2006).

37. *Id.*

38. Council Regulation 1408/71, *supra* note 35, art. 22(1)(a).

39. *Id.* art. 22(1)(c).

40. HERVEY & MCHALE, *supra* note 24, at 116.

41. Council Regulation 1408/71, *supra* note 35, art. 22(2).

the disease."[42] The legislation implies that control over the authorization rules remains firmly at the discretion of the Member States and is not the subject of individually enforceable rights in EU law.[43]

Article 49 of the EC Treaty specifically places restrictions on the freedom to provide services within the EU.[44] In particular, Article 49 states that "restrictions on freedom to provide services within the Community shall be prohibited in respect of nationals of Member States who are established in a State of the Community other than that of the person for whom the services are intended."[45]

On its face, the provisions of Article 49 deal with the freedoms of service providers but do not appear to establish rights for individuals to travel to other Member States to receive services.[46] Through controversial interpretive jurisprudence, however, the ECJ extended the provisions to create enforceable rights for the recipients of services.[47] For example, in *Luisi, Carbone v. Ministry of Treasury*, the ECJ held that the freedom to provide services includes the freedom for recipients of services to go to another Member State to receive treatment without obstructions.[48] Additionally, free movement applies not just to workers; relatives, tourists, and other categories of EU citizens can also make an appeal to benefit from this provision.[49]

The ECJ has also broadly interpreted the term "restrictions" on the freedom to provide services stated in Article 49.[50] For example, the application of the prior authorization rules in Council Regulation 1408/71 can be a "restriction" for the purposes of Article 49.[51] A restriction also exists if the application of the prior authorization rules results in a lower level of health coverage in the Member State where the patient received treatment as

42. *Id.*
43. HERVEY & MCHALE, *supra* note 24, at 116.
44. *See* EC Treaty, *supra* note 33, art. 49.
45. *Id.*
46. *See* HERVEY & MCHALE, *supra* note 24, at 120.
47. *Id.* at 120-21.
48. Joined Cases 286/82 & 26/83, Luisi, Carbone v. Ministry of the Treasury (Italy), 1984 E.C.R. 377, ¶ 16.
49. Andre den Exter, *Access to Health Care in the Netherlands: The Influence of (European) Treaty Law*, 33 J. L. MED. & ETHICS 698, 701 (2005).
50. HERVEY & MCHALE, *supra* note 24, at 121.
51. *Id.* at 122 (citing Case C-157/99, Geraets-Smits & Peerbooms, 2001 E.C.R. I-5473, ¶¶ 60-69; Case C-385/99, Müller-Fauré v. van Riet, 2003 E.C.R. I-4509, ¶¶ 37-44).

compared to the Member State in which the patient is insured.[52] The essence of the Court's approach in determining whether something is a restriction on the freedom to provide services is to consider the potential for the restriction to inhibit the provision of services among Member States.[53]

III. ANALYSIS OF THE ECJ RULING

A. The Court's Interpretation of Article 22(2) of Council Regulation 1408/71

The Court sought to clarify the scope of both the EC Treaty and Article 22 of Council Regulation 1408/7. In essence, the court interpreted the provision so that Member States are required to grant prior authorization when two conditions are satisfied.[54] First, the Court had to interpret the following phrase: "within the time normally necessary for obtaining the treatment in question."[55] Meanwhile, the central issue in *Watts* was whether the second condition was satisfied, which requires that the patient is unable to obtain the intended treatment within the time normally necessary for such treatment in his or her home Member State.[56] In determining this time frame, the Court considers the individual's current state of health and probable course of the disease.[57] In general, authorization is given only in exceptional cases, and in all other situations, authorization may be refused by the Member State.[58] This prevents exporting publicly funded health care benefits from one Member State to another.[59]

Prior case law dictated that the second condition of Article 22(2) is not satisfied if the patient can obtain the same or equally effective treatment in the Member State of residence without

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52. *Id.* (citing Case C-368/86, Vanbraekel & Others v. ANMC, 2001, E.C.R. I-5363, ¶ 45).

53. *Id.* at 121 (citing Case 186/87, Cowan v. Tresor Public, 1989 E.C.R. 195, ¶¶ 15-17; Case C-76/90, Säger v. Dennemeyer, 1991 E.C.R. I-4221, ¶ 12; Case C-43/93 Vander Elst, v. Office des Migrations Internationales, 1994 E.C.R. I-3803, ¶ 14; Case C-272/94, Guiot & Climatec, 1996 E.C.R. I-1905, ¶ 10).

54. Case C-372/04, Watts v. Bedford Primary Care Trust, 2006 E.C.R. I-04325, ¶ 55.

55. Council Regulation 1408/71, *supra* note 35, art. 22(2).

56. *Watts*, 2006 E.C.R. I-04325, ¶ 57.

57. *Id.*

58. HERVEY & MCHALE, *supra* note 24, at 117.

59. *Id.*

undue delay.[60] The Court followed precedent and confirmed the rule which extended the definition of the term "undue delay" from Article 49 to apply in this case.[61]

The Court noted that an institution cannot base its decision exclusively on the existence of waiting lists without taking into account the specific circumstances of the patient's medical condition.[62] Thus, the Court held that to permissibly refuse authorization under Article 22(1)(c) on the basis of waiting time, the institution must establish that the waiting time does not exceed the period which is acceptable based on an objective assessment of the clinical needs of the person.[63] This includes his medical condition, the history and probable course of his illness, degree of pain, and nature of the disability at the time when the authorization is sought.[64] This aspect of the holding was consistent with the decision in *Müller-Fauré v. van Reit*, which viewed the waiting list argument as amounting to no more than an economic consideration which could never justify a restriction on a fundamental freedom.[65] Thus, if the waiting time does not exceed a period determined to be medically acceptable, the institution is entitled to find that the second condition of Article 22(2) is not satisfied and to refuse authorization to the patient.[66]

While the Court's holding confirmed the previous line of cases interpreting the second condition in Article 22(2), it did not actually determine what duration is a medically acceptable period for this particular patient. The Court merely stated that "it is for the referring court to determine whether the waiting time invoked by the [local health care provider] . . . exceeded a medically acceptable period in . . . light of the patient's particular condition . . . ."[67] This cursory treatment of the definition of "undue delay" should have been clarified by the Court, and its failure to provide more guidance will lead to further litigation on the matter. While determinations will necessarily be made on a case-by-case basis since every patient's condition differs, the Court failed to

60. Case C-157/99, Geraets-Smits & Peerbooms, 2001 E.C.R. I-5473, ¶ 103; Case C-385/99, Müller-Fauré v. van Riet, 2003 E.C.R. I-4509, ¶ 89.
61. *Watts*, 2006 E.C.R. I-04325, ¶ 62.
62. *Id.* ¶ 63 (citing *Müller-Fauré*, 2003 E.C.R. I-4509, ¶ 92).
63. *Id.* ¶ 68.
64. *Id.*
65. *See Müller-Fauré*, 2003 E.C.R. I-4509, ¶ 72.
66. *Watts*, 2006 E.C.R. I-04325, ¶ 70.
67. *Id.* ¶ 78.

articulate what key factors referring courts should consider in making such determinations.[68]

B. The Court's Interpretation of EC Treaty Article 49

The Court further addressed the question of when a patient is entitled under Article 49 of the EC Treaty to receive hospital treatment in another Member State at the expense of the home institution. The first step in analyzing the provision involves the concept of remuneration. To fall within the provision, a service must be provided for remuneration, meaning that there must be an economic link between the service provider and the recipient of the service.[69] In this case, the Court held that the supply of medical services fell within the Treaty, even though Watts sought reimbursement from a national health service after paying a foreign supplier for the treatment herself.[70] The Court has explicitly held that privately remunerated services fall within the Treaty provisions on freedom to provide services.[71]

The next step in an Article 49 analysis involves a look at what constitute "restrictions on freedom to provide services."[72] The ECJ has defined the term "restriction" very broadly.[73] As mentioned above, the Court's approach is to consider the potential for a particular restriction to inhibit another Member State's ability to provide services.[74] In applying this principle, the Court also considered the general rule that Article 49 precludes 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.[75]

Under the UK health system, patients are free to go to a hospital in another Member State, but they cannot have treatment in such an establishment at the home health care provider's expense without prior authorization.[76] The Court considered this

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68. *See* HERVEY & MCHALE, *supra* note 24, at 137.
69. *Id.* at 119.
70. *Watts*, 2006 E.C.R. I-04325, ¶ 89 (citing *Müller-Fauré*, 2003 E.C.R. I-4509, ¶ 103).
71. *See* Joined Cases 286/82 & 26/83, Luisi, Carbone v. Ministry of the Treasury (Italy), 1984 E.C.R. 377, ¶ 16.
72. EC Treaty, *supra* note 33, art. 49.
73. HERVEY & MCHALE, *supra* note 24, at 121.
74. *See supra* note 53 and accompanying text.
75. *Watts*, 2006 E.C.R. I-04325, ¶ 94 (citing Case C-381/93, Comm'n v. France, 1994 E.C.R. I-5145, ¶ 17).
76. *Id.* ¶ 95.

system of prior authorization to be an obstacle to the freedom to provide services.[77]

The Court then turned to whether the restriction could be objectively justified. There are three recognized situations in which a restriction on the freedom to provide medical services is justified: (1) there is a risk of undermining the financial balance of a social security system;[78] (2) there is the goal of maintaining a balanced medical and hospital service open to all insofar as it contributes to the attainment of a high level of health protection;[79] and (3) maintenance of treatment capacity or medical competence on national territory is essential for the public health and survival of the population.[80] If one of these justifications exists, the restriction must not exceed what is objectively necessary for that purpose and the same result cannot be achieved by less restrictive rules.[81]

The Court concluded that maintaining a balanced medical and hospital service was a sufficient justification for the "restriction" on the freedom to provide services.[82] In reaching this conclusion, the Court considered the fact that hospitals need to be able to plan to facilitate matters such as the number of hospitals, geographical distribution, organization, and nature of services offered.[83] Also, the Court noted that planning ensures that there is sufficient and permanent access to a balanced range of high-quality hospital treatment.[84]

These factors considered by the Court also create uncertainty for the planning aspects of health care services. The Court used very general terms stated in prior case law, such as stating that planning seeks to ensure "sufficient and permanent access to a balanced range of high-quality hospital treatment," without actually defining how much access is considered "sufficient" or

77. *Id.* ¶ 98 (citing Case C-157/99, Geraets-Smits & Peerbooms, 2001 E.C.R. I-5473, ¶ 69; Case C-385/99, Müller-Fauré v. van Riet, 2003 E.C.R. I-4509, ¶ 44).

78. Case 158/96, Kohll v. Union des Caisses de Maladie, 1998 E.C.R. I-1931, ¶ 41; *Geraets-Smits & Peerbooms*, 2001 E.C.R. I-5473, ¶ 72; *Müller-Fauré*, 2003 E.C.R. I-4509, ¶ 73.

79. *Kohll*, 1998 E.C.R. I-1931, ¶ 50; *Geraets-Smits & Peerbooms*, 2001 E.C.R. I-5473, ¶ 73; *Müller-Fauré*, 2003 E.C.R. I-4509, ¶ 67.

80. *Kohll*, 1998 E.C.R. I-1931, ¶ 51; *Geraets-Smits & Peerbooms*, 2001 E.C.R. I-5473, ¶ 74; *Müller-Fauré*, 2003 E.C.R. I-4509, ¶ 67.

81. *Watts*, 2006 E.C.R. I-04325, ¶ 106 (citing *Geraets-Smits & Peerbooms*, 2001 E.C.R. I-5473, ¶ 75).

82. *See id.* ¶¶ 108-10.

83. *Id.* ¶ 108.

84. *Id.* ¶ 109.

"permanent."[85] In addition, the Court stated that planning is needed to control costs and prevent any wasted resources. With these general statements, the Court then concluded that prior authorization "appears to be . . . both necessary and reasonable."[86]

Even though the right of a patient to receive hospital treatment in another Member State at the expense of the home institution is subject to prior authorization, refusals to grant authorization must be based on specific provisions and must be properly reasoned in accordance with those provisions.[87] In this case, the Court found that the regulations Bedford PCT followed did not set out the criteria for granting or refusing the prior authorization necessary for obtaining reimbursement.[88] Since prior authorization was justified in this situation, the Court reiterated that refusing to grant prior authorization cannot be based only on the existence of waiting lists.[89] An objective assessment of the patient's medical condition, course of his illness, degree of pain, and nature of the disability at the time when the authorization is sought must also be completed.[90]

In terms of reimbursement, the Court held that the rules for reimbursement by the legislation of the host Member State are to be applied. Where the patient's Member State should have been authorized to receive hospital treatment at its expense but did not provide for the reimbursement, the home health care institution must reimburse the patient the difference between the costs of equivalent treatment up to the total amount invoiced for the treatment, had it been provided in the host Member State, as required under Council Regulation 1408/71.[91]

C. Public Policy Concerns and Possible Effects

The Court's ruling may impact the social security systems of the Member States in the EU. While the ruling is a step towards facilitating cross-border medical access for patients, the state of national health systems becomes increasingly unclear. Officially, the European Commission states that Member States are only

85. *See id.*
86. *Id.* ¶ 110.
87. *Id,* ¶ 117.
88. *Id.* ¶ 118.
89. *Id.* ¶ 119.
90. *Id.*
91. *Id.* ¶ 143.

required to *coordinate,* not harmonize, their social security systems.[92] The likely result is that Member States will do more to coordinate their health systems, however, in an effort to facilitate their own policy decisions.

Some of the practical effects of broadening the health tourism phenomenon have been the subject of concern for some commentators. Martin McKee, a professor of European Public Health at the London School of Hygiene and Tropical Medicine, believes that people seeking to retire abroad, especially to the Mediterranean, may impose burdens on local health systems as the onset of old age leads to the development of chronic diseases.[93] Similarly, an unpredictable influx of patients to Member States that provide higher standards of service, better value for money, greater choice for patients, or whose medical professionals enjoy a higher reputation, is also a possibility.[94] Other areas that may be affected by this ruling are health care planning and capacity maintenance.[95] Too much movement by patients could result in overburdening some hospitals, which might lead to closures. This may "jeopardize the social principle of effective health care accessible to all, which underpins the national health . . . systems of all Member States."[96]

In spite of the disadvantages of broadening health tourism, there are numerous advantages as well. A few readily apparent advantages include the potential for accessing higher quality health care than would be available in a patient's home Member State, reducing the costs of co-payments, and alleviating waiting lists. Also, viewing ECJ jurisprudence as moving towards empowering individuals to opt out of inadequate local treatment may have the effect of improving the standards of care available locally.[97] For example, instead of using national funds to purchase treatment in hospitals abroad, the resources could be better spent in improving local public hospitals by keeping wards open and recruiting more nurses.[98]

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92. *Communication from the Commission – Free Movement of Workers: Achieving the Full Benefits and Potential*, COM (2002) 694 final (Nov. 12, 2002).

93. *See* Bounds & Timmins, *supra* note 7, at 14.

94. *See* HERVEY & MCHALE, *supra* note 24, at 139.

95. *Id.*

96. *Id.*

97. *Id.* at 142.

98. *See id.*

Currently, the European Commission is beginning efforts to construct a framework for cross-border health services to deal with the ambiguity of the situation. Markos Kyprianou, Commissioner for Health and Consumer Protection, states that

> [while t]he European Court of Justice has ruled that patients have rights to cross-border care under Community law, . . . there are uncertainties about what this means in practice. A clear, practical framework is needed to enable patients to and those who pay for, provide and regulate health services to take advantage of cross-border healthcare where that is the best solution.[99]

Thus, the Commission will launch a public consultation on this cross-border health care issue by seeking input from Member States, the European Parliament, patients, health professionals, as well as purchasers and providers of care; the goal of which is to bring forward specific proposals in 2007.[100]

While the efforts of the Commission do seem like a step in the right direction, they are merely initial developments in what appears to be a giant space to be filled in the area of cross-border access to health care in the EU. While a legislative response at the EU level would probably be the best solution to deal with the issues arising from the ruling, it will likely be a much slower process than if the Court had announced clearer standards itself. The Commission only recently launched the first round table discussion as a follow-up to the public consultation announcement from several months prior.[101]

IV. PROPOSED SOLUTION

Instead of merely following precedent without announcing any clear standards for the national authorities to follow, the ECJ

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99. Press Release, European Comm'n, Patient Mobility: Commission to Launch Public Consultation on EU Framework for Health Services (Sept. 5, 2006), http://europa.eu/rapid/pressReleasesAction.do?reference=IP/06/1150.

100. *Id.*

101. Press Release, European Comm'n, Health Services: Commissioner Kyprianou and European Health Ministers to Hold First Round Table Discussion (Nov. 28, 2006), http://europa.eu/rapid/pressReleasesAction.do?reference=IP/06/1639&format=HTML&aged=0&language=EN.

should have announced clearer standards. In particular, the Court should have tried to clarify the ambiguity over what is considered an "undue delay" by providing more focused factors. The factors could go beyond medical necessity, but also encompass practical ones, such as patient's ability to work or the impact of the delay on the patient's family life.[102]

Additionally, the Court could have provided further clarification in the area of reimbursements. Under the current rule, patients are entitled to reimbursements for medical care received abroad regardless of whether they sought prior authorization from their home institution.[103] This rule may create uncertainty, causing local health care providers to be uncertain regarding how much of its funds it should allocate to cover such costs.[104] But, as the Court has pointed out in prior case law and reiterated in this case, economic concerns can never justify a restriction on the fundamental right to receive services.[105]

V. CONCLUSION

The ECJ in *Watts* meekly followed precedent in its interpretation of Article 49 of the EC Treaty and Council Regulation 1407/81. Although the Court did not deviate from precedent, it should have provided further clarification in what is quickly becoming an area requiring stability. Skepticism from various commentators and the official position of the European Commission itself indicates that the area of cross-border health care within the EU is an area that requires clarity in the form of a proper framework to achieve coordination among Member States. The Court in *Watts*, however, failed to provide such clarity.

While the volume of patient mobility is currently very low, the numbers could increase dramatically in the coming years, especially as more patients become interested in the concept.[106] Until the Commission reaches more definitive solutions, patients such as Yvonne Watts who are in need of medical attention can

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102. *See* HERVEY & MCHALE, *supra* note 24, at 137 n.181.

103. David Rennie, *Cross Borders to Find Health Care, Urges EU*, DAILY TELEGRAPH (London), Sept. 6, 2006, at 18.

104. *See* HERVEY & MCHALE, *supra* note 24, at 138.

105. *See* Case C-385/99, Müller-Fauré v. van Riet, 2003 E.C.R. I-4509, ¶ 72.

106. *See Consultation Regarding Community Action on Health Services*, at 6, SEC (2006) 1195/4 (Sept. 26, 2006) (estimating that only about one percent of overall public expenditure on health care is spent on patient mobility).

only be confident in seeking cross-border health care if their medical situation is serious or if they have received prior authorization. Although the ECJ decision is a significant leap for patient freedom, the EU has much more work ahead to create a truly functioning "patients without borders" system.

Huahan Pai[*]

[*] Juris Doctor Candidate, May 2008, Loyola Law School. I would like to thank my wife, Alice, for her constant patience, encouragement, and support.