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Patient mobility in the context of austerity and an enlarged EU: The European Court of Justice's ruling in the Petru Case☆

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ABSTRACT

Since 1998, the European Court of Justice (EUCJ) has established a set of principles concerning patient mobility across Member States. At present, these principles are challenged against a new background, i.e., an enlarged EU and austerity-driven measures in the field of healthcare. This is even more relevant in view of the significant differences between countries and between services on healthcare access. In the Petru case, a Romanian woman sought healthcare in Germany due to an alleged lack of basic infrastructure in her local Romanian hospital. A crucial question arises in this context of whether the patient's interests (i.e., right to cross-border healthcare) or the Member State's interests (i.e., financial stability of the healthcare system) prevail. We analyse this case and its implications for future patient mobility. From the point of view of patients, the EUCJ's decision implies that also a lack of medication and basic medical supplies can be claimed as "undue delay", however for Member States it is sufficient to provide quality treatments in at least one hospital. Although the Court has provided a solution for the Petru case, we argue that major challenges remain, such as the definition of the international state-of-the-art or other limitations to reductions of the health basket.

1. Introduction

In Europe, healthcare systems rely on geographical and membership boundaries, which are necessary to secure financial stability and to ensure adequate planning of healthcare infrastructure and capacity. In the past, domestic control of the patient flow was viable due to marginal demand from patients to receive healthcare abroad. This is no longer true: medical tourism has grown at a remarkable pace, driven for example by American insurances that offer reductions to policy-holders who are willing to be treated in other countries [1], and by a number (5%) of European citizens [2] seeking medical treatment, financed by their public insurer in another EU country [3–7].

In a first wave (1998–2007) of cases (Kohll [8]; Vanbraekel [9]; Smits and Peerbooms [10]; Müller-Fauré and van Riet [11]; Inizan [12]; Leichtle [13]; Watts [14]; Stamatelaki [15]), the European Court of Justice (EUCJ) had to deal with patients belonging to "wealthy" healthcare systems, while this was not true for the second wave (2010–2014) of cases (Elchinov [16]; Luca [17]; Petru [18]) [19,20].

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Although this case-law on patient mobility [21] has been codified in the new Directive on patients' rights in cross-border healthcare [22], we are not going to focus on this. Firstly, because this Directive, which had to be implemented by 25 October 2013 at latest, has not yet been fully implemented in all the Member States [23–25], and secondly, because under this directive, patients have to pay up-front, which can remain a challenge, not only for patients from the new Member States, but also for those suffering from austerity-driven [26,27] measures. In this context of new Member States and austerity [3,28–31], the last case decided so far – the Petru case – reveals some challenges.

For years, Ms. Petru had been suffering from a serious cardiovascular disease and in 2009 she had to undergo open heart surgery to replace the mitral valve and insert two stents. As she believed that the infrastructure in Romania was inadequate [32], she decided to travel to a clinic in Germany where the surgery was finally carried out, resulting in expenses of € 17 714.70 [18]. The national Romanian court referred the case to the EUCJ, whose judgment may open up new scenarios concerning patient mobility in Europe with the problems brought about by enlarged EU and austerity. The crisis has increased waiting times, out-of-pocket payments and has "produced significant differences between countries and between services on healthcare access" [3,28–30].

2. The stakeholders in cross-border healthcare

In the case of cross-border healthcare, patient aspirations to receive better healthcare may not coincide with the government's objectives, as patients are maximising their own utility function, while governments try to secure a planned and equitable allocation across patients within the limits of their budget constraint (see Table 1).

In general, patients are more sensitive to quality issues and to their personal needs and seek the best care for themselves. They prefer to be treated **close** to their home. However, if they perceive that the level of **quality** is "sufficiently low", they are open to seeking treatment abroad. As far as governments are concerned, a certain degree of mobility may be beneficial, especially if treatment abroad is cheaper.

Mobility that derives from patient choices is different. In deciding whether to allow the patient to go abroad, the Government has to consider the implications for providing healthcare to residents. Allowing this patient to receive care abroad means that the cost of healthcare may increase, which will have to be financed either through an increase in the revenue or by a decrease in expenditure. The Government, in this case, has to consider several equity issues and trade-offs. In fact, the welfare gain from patients receiving care abroad has to be balanced against the welfare loss of residents whose tax bill will be increased and/or whose level of service will decrease. For a low-income country, or for those where the economic crisis has meant the introduction of austerity measures, budget-balance issues are important and they will certainly be less willing than richer countries to let their patients travel abroad.

Table 1
Stakeholder perspectives in cross-border healthcare.

	Patient aspirations	Government objectives
Home or abroad	Preference to be treated as **close** to home as possible [22], but they are **open** to travel for faster or better quality treatment [2].	Governments are often reluctant, as in terms of hospital care they have to **pay** for **both** the infrastructure and the treatment abroad; however, if treatment abroad is cheaper (especially for outpatient care), they could even **save money** [22].
Quality vs. costs	Receive the **best** healthcare they can afford, **even** if this results in additional **private costs** to receive treatment abroad.	**Balance quality** with costs. Governments have to take into account the welfare of the whole population; they may have to reduce the average level of quality.
Timing	The patient requires care **on demand**, when it is deemed necessary and would like to receive it without delay.	Governments have to **plan** healthcare both in terms of infrastructure and healthcare basket in order to be equitable.
Welfare	Patients maximise their **own** welfare functions and consider their private benefit (e.g., to evade waiting times by seeking treatment abroad).	Governments consider the benefit of all the patients against the opportunity cost of not treating **other patients** (or to increase healthcare expenditure); this can also raise fairness issues, if some patients evade waiting lists.

3. The EUCJ decision (Petru case)

In the case of a dispute between a patient and his/her Government, the rulings of the EUCJ have balanced both perspectives in terms of availability of treatment, waiting time, coverage of costs and prior authorisation, as summarized in Table 2.

In previous cases, the Court has re-affirmed the principle of prior authorisation, but it has restricted the notion of undue delay. In Petru, the EUCJ decided both in favour of the patient (as also a lack of medication etc. can result in un-due delay), but also in favour of governments (as the Member States can comply with their obligation to provide due treatment in terms of all their hospital establishments). As mentioned above, it should be noted that patients in the first wave of EUCJ cases basically belonged to "wealthy" healthcare systems and required treatment that could not be provided (or was "less attractive") in their country of residence. Treating them was certainly affordable by their healthcare system and the same treatment intensity could have been offered to any other resident (on the principle of equal access to equal need). Most patients in the second wave of EUCJ cases belong to low-income countries (Romania and Bulgaria) whose health budget might imply that

Table 2
EUCJ judgment in Petru [18].

Pre Petru	Post Petru
Availability	
• Member States basically have the right to determine their "health basket" [10,14,33].	• *Basically, no change*
• However, the international state-of-the-art ("what is sufficiently tried and tested by international medical science") has to be taken into account [10,34]; especially for treatment received abroad which is perceived to be experimental in the patient's home country (i.e., possible **future** developments).	• Impact still to be discussed
	• **Not** offering treatment **at all**, especially in the case of a life-threatening situation, is very problematic. As the Court has emphasized, "the public health, and even the survival of, the population" [10] has to be taken into account. • A **reduction in quality** of treatment (if this helps to save money) would also have to be assessed against the international state-of-the-art (in this case however, we are dealing with a backward development, rather than with experimental treatment).
Waiting times	
• Member States are basically competent for the organisation and delivery of health services.	• *No change*
• However, this competence is limited by the requirement "that the same or equally effective treatment cannot be given without undue delay in the Member State of residence of the insured person" [16].	• Also a lack of medication and basic medical supplies can result in an undue delay [18]. • The possibility of providing adequate treatment should be evaluated by "all the hospital establishments in the Member State of residence that are capable of providing the treatment in question" [18], not simply the ones in the area of residence of the patient.
Undue delay has to be based on an individual medical assessment [16], where necessary, also after re-examination [14] of the patient's health. The assessment is made using international standards [35].	• *No change*
Undue delay is sufficient to seek care abroad without prior authorisation, as long as the treatment is part of the "health basket" at home.	• *No change*
Medical and travel costs	
Direct payment of medical costs only if a specific agreement exists between countries for cross border treatments [36,37].	*No change*
The directive on patient mobility [22] provides for an ex-post reimbursement which cannot be higher than the level of the home country [14].	
Travel and accommodation costs are reimbursed only if they would also be reimbursed for treatment "at home" (i.e., in a hospital covered by the national system in question) [13,14].	
Prior authorisation	
• Patients have to ask for prior authorisation if the hospital treatment is planned and there is no "undue delay" [37].	• Requirement of prior authorisation **reinforced**, due to clarification concerning waiting time, as mentioned above.

paying for patients going abroad could result in a reduction of the level of care of residents.

4. Possible future scenarios

Income **differences** between old and new Member States on the one hand, and austerity-driven reduction of available healthcare on the other, may significantly **challenge** the role of patient mobility across Member States. The Petru case is very important from this point of view, in terms of the decisions taken by the Court, and the questions that have not been answered.

In terms of possible changes, first, a change in the **Regulation** on social security coordination [36] is not very likely. The **Directive**, not yet fully implemented, could theoretically be changed after the Commission's report, expected for the end of 2015 [22]. Yet also this second "pillar" continues to be sensitive. Consequently, the question remains whether, apart from the EU legislator (European Parliament and Council), the third major stakeholder (the **EUCJ)** will change its case-law in the future. A complete change in the case-law is not very likely, since the Court affirmed the right of patients to receive treatment abroad when the quality of care in their own country is not up to international standards.

However, **quality** in healthcare is an **elusive** concept [38]. Several options are open to Member States in interpreting the principle of "quality" and new court cases challenging this point may have different outcomes.

One of the most challenging discussions (from both a medical and a legal perspective) will be the definition of the **international state-of-the-art**, and "undue delay" as it moderates Member States' competence to define the national health basket. The decisions of the Court, to date, leave several possibilities open, as such international state-of-the-art sometimes does **not exist** [39]. Nonetheless it is clear that healthcare has to be **evidence-based** [40]. The EUCJ's reference "to all the hospital establishments in the Member State of residence" can be seen as a **challenge** for patients, as it might be almost impossible for them **to prove**

that treatment was not available in other hospitals in that country. However, this challenge is **limited** by the concept of undue delay. After this acceptable waiting time, patients can go abroad if the treatment has not been provided. However, determining this acceptable waiting time in a specific case can be very challenging.

The Court (and the Advocate General) have emphasized that the regulation "does not distinguish between the different **reasons** for which a particular treatment cannot be provided in good time" [18,32]. This is bad news for Member States, as financial constraints cannot be invoked in this regard. This principle may lead to an increasing stream of patients that travel to receive better healthcare.

However, Member States may limit patient mobility by reshaping their **health basket** or by restricting the reimbursement to a specific group of patients [41]. In this case, these treatments would also not be available for patients "at home" and the only argument against this competence can be the right to life, as enshrined in Article 2 CFR [42], which would come into play for life-threatening cases. According to Karanikolos et al. [29], some countries have already started this process, but their likely impact cannot be foreseen at the moment.

An argument in favour of a restriction on patient mobility may come from an interpretation put forward by the **Advocate General** in Petru, concerning "undue delay" due to poor quality. According to the Court's Advocate General, "a Member State is not required to authorise the provision of a service that is among the benefits covered in a situation where there are structural [!] and prolonged [!] deficiencies in hospital facilities – even if this may effectively mean that certain healthcare services cannot [*sic*] be provided – except where such authorisation would not put at risk, the viability of the welfare system in that Member State" [32].

Under this scenario, patients' mobility abroad would be severely restricted; moreover, a patient may be denied adequate treatment at home without being allowed to seek treatment abroad. That treatment would in fact still be part of the national health basket, without actually being provided. The Advocate General's proposal would also allow a country under financial constraints to determine the level of adequate care using national standards rather than the international state-of-the-art.

This notion of the Advocate General has two dimensions, one with regard to time ("prolonged") and one with regard to intensity ("structural"). This idea has been rejected by the EUCJ for obvious reasons. From a legal perspective, it would be a change of paradigm in terms of the freedom of services. From a practical perspective, it would reward Member States that have failed in the provision of healthcare. Consequently, although the concept of the financial balance of a social security system [8–11,13–16] — as a justification for restrictions on cross-border (!) healthcare – remains valid, a country cannot invoke reasons, that are not related to cross-border healthcare.

5. Conclusion

EU enlargement and the present economic crisis are **challenging** national welfare systems and, consequently, also patients' rights across Member States. In the void created by the delay in the implementation of the new Directive on patient mobility, the **EUCJ** has recently better defined the boundaries of patients' rights: while, **in principle,** patients have the right to receive care abroad, such freedom is **not unlimited**. Each country can set limits to the basket of services, and prior authorisation might be required. The latter cannot be denied in the case of undue delay or poor quality of care, but in both cases it is necessary to prove that no domestic provider could supply the treatment under the required conditions.

While changes in the legislation are not likely to occur in the near future, the recent decisions of the EUCJ may reshape the role of patient mobility across EU Member States through the interpretation that National Governments give to requirements such as "international state-of-the-art" or "undue delay". In the paper, we have highlighted both arguments in favour of a restriction and an enlargement of patient freedom. Future EUCJ judgments will determine the future of patient mobility. Although the numbers remain small, unavailability and quality of treatment remain the major drivers in cross-border healthcare [2] and this phenomenon should not be disregarded.

Conflict of interests

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