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Editorials

Patients seeking treatment abroad

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Another challenge for general practice commissioning

If Andrew Lansley's proposals for reorganisation of the NHS survive parliamentary scrutiny, large numbers of general practice commissioning groups will soon be taking responsibility for purchasing much of the specialist care provided to their patients.¹ Many of these groups may already be thinking how they will deal with a very different set of providers, including increasingly independent foundation trusts, some of which may have become social enterprises outside the NHS, and an expanded private sector. They may have given less thought to those patients who choose to seek treatment abroad. Yet they may need to, and as a recent court ruling illustrates,² this may be more complicated than they realise.

Although the number of patients seeking treatment elsewhere in the European Union is small,³ this could easily change, especially if people are faced with growing waiting lists or other forms of rationing as the new groups seek to control their budgets. British residents have had the right to obtain treatment in another EU country since 1971.⁴ Initially, the opportunities were limited mainly to people who fell ill when abroad or, less often, when the NHS agreed that there were good reasons for patients being treated abroad (for example, a citizen of another country resident here returning home to give birth).

To the dismay of several countries, including the United Kingdom, the situation changed dramatically in 1998. Two patients from Luxembourg argued that their health insurer could not restrict their right to be reimbursed for health services (in their cases dental treatment and spectacles) in another member state. The European Court of Justice agreed with them.^{5 6} A major consideration had been that these services were not provided in hospitals so, even if large numbers of people crossed borders to take up this right, it could not destabilise existing hospital provision.

These cases set an important precedent but, as with all groundbreaking cases, there was extensive debate about what they meant for healthcare in general. Would the ruling apply to national health services or only social insurance systems? What comprised hospital care? How would levels of reimbursement be set when countries had different prices?

A series of further cases allowed these questions to be largely resolved.^{7 8 9} The crucial distinction was between hospital care (treatment that can be provided only within a hospital setting) and non-hospital

care. In the first case, patients had to apply for authorisation to go abroad, but their healthcare funder could not deny them as long as the treatment was deemed medically necessary (taking account of international medical opinion and not just their own views); it would normally be provided in their home state; and it was not being provided in good time, taking account of their medical condition. In the case of non-hospital care, patients could go abroad freely without seeking authorisation.

Some national governments, especially those that had traditionally controlled costs in part by limiting supply, such as the UK, viewed this situation as highly unsatisfactory. Even the European Court of Justice recognised that it was undesirable to allow the steady accumulation of case law to establish policy. Yet, although all of the member states sought clarity, which could be achieved only by primary legislation, they could not agree what the new system of patient mobility would look like. Earlier this year, the Spanish presidency of the EU overcame this log jam to design a proposal that the member states could support, but this is now stuck in the European Parliament.¹⁰ As a consequence, the court has continued to step into the breach when required.

The most recent occasion was earlier this month, in a case where the European Commission had initiated proceedings against France for allegedly restricting patient movement.² French insurers had demanded that anyone going abroad to use certain “major medical equipment,” such as cyclotrons, positron emission tomography scanners, and magnetic resonance imagers, had to seek prior authorisation in order to claim reimbursement. The European Commission argued that this was illegal because although these facilities were often located in hospitals, they need not be. The court upheld the French argument, on the basis that, like hospitals, it was necessary that European law did not threaten a system of planning that would ensure an appropriate geographical distribution of such costly equipment.

This ruling is important because it begins to clarify the previously uncertain legal interface between hospital and non-hospital care. It is not whether complex treatments must or must not be provided in a hospital setting. Rather, it is whether their cost and the importance of avoiding waste from the underuse of facilities demands that their distribution be subject to planning. It also supports the English Department of Health’s revised advice, issued earlier this year, which—although it reminded commissioners of the necessity of complying with European Court rulings—highlighted the lack of clarity about use of specialised or cost intensive equipment or infrastructure.¹¹

If general practice commissioning groups do come about they may not have to deal with many patients who choose to obtain treatment abroad, but they should be aware that some may exercise their rights to do so. Where this involves inpatient care or “major medical equipment” they will need to establish mechanisms for authorisation that must be based on criteria that are “objective, non-discriminatory, known in advance, in such a way as to circumscribe [their] discretion so that it is not used arbitrarily.”² Quite how they will do this remains to be seen.

Notes

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Footnotes

- Competing interests: All authors have completed the Unified Competing Interest form at www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and

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