OPINION OF ADVOCATE GENERAL GEELHOED
delivered on 15 December 2005 [1]

I — Introduction

1. Following the Court's judgments in inter alia *Kohll, Smits and Peerbooms* and *Müller-Fauré,* [2] this case again concerns a problem of patient mobility within the Community. Where the Court has developed a number of principles in respect of the conditions under which patients are entitled under Article 49 EC to receive medical treatment in other Member States and to be reimbursed for that treatment by the national health insurance schemes to which they are affiliated, the Court is now requested to elucidate to what extent these principles apply to the United Kingdom's National Health Service (hereinafter: NHS), which in contrast with the systems which were considered in the case law up till now, is wholly public in character as regards both its organisation and its funding. Besides the matter of the applicability of Article 49 EC to the NHS as such, the reference deals with issues regarding the use of waiting lists as an instrument to balance demand for and supply of hospital services and the budgetary implications of a possible finding that an NHS-type system must make provision for the reimbursement of hospital services received in another Member State. The reference also relates to the proper interpretation of Article 22 of Regulation No 1408/71 in this context.

II — Relevant provisions

A — *Community law*

2. The first paragraph of Article 49 EC states:

'Within the framework of the provisions set out below, restrictions on freedom to provide

1 — Original language: English.

2 — Case C-158/96 *Kohll* [1998] ECR I-1931, Case C-157/99 *Smits and Peerbooms* [2001] ECR I-5473 and Case C-385/99 *Müller-Fauré and van Riet* [2003] ECR I-4509.

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.'

3. According to Article 152(5), first sentence, EC:

'Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care. ...'

4. Article 22 of Regulation No 1408/71 provides:

'1. An employed or self-employed person who satisfies the conditions of the legislation of the competent State for entitlement to benefits, taking account where appropriate of the provisions of Article 18, and:

(c) who is authorised by the competent institution to go to the territory of another Member State to receive there the treatment appropriate to his condition,

shall be entitled:

(i) to benefits in kind provided on behalf of the competent institution by the institution of the place of stay or residence in accordance with the legislation which it administers, as though he were insured with it; the length of the period during which benefits are provided shall be governed however by the legislation of the competent State;

...

2. ... The 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 resides and where he cannot be given such treatment 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 the disease.

3. ...'

...

B — *National law*

5. Section 1 of the National Health Service Act 1977 states:

'(1) It is the Secretary of State's duty to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement

(a) in the physical and mental health of the people of those countries, and

(b) in the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services in accordance with this Act.

(2) The services so provided shall be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed.'

6. Section 3 of the National Health Service Act 1977 states:

'[1] It is the Secretary of State's duty to provide throughout England and Wales, to such extent as he considers necessary to meet all reasonable requirements,

(a) hospital accommodation;

(b) other accommodation for the purpose of any service provided under this Act;

(c) medical, dental, nursing and ambulance services;

(d) such other facilities for the care of expectant and nursing mothers and young children as he considers are appropriate as part of the health service;

(e) such facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service;

(f) such other services as are required for the diagnosis and treatment of illness.'

C — *Essential characteristics of the NHS*

7. The essential characteristics of the NHS may be summarised as follows on the basis of information provided by the referring court in its order for reference:

— NHS bodies provide hospital care, on a non-profit basis, free at the point of delivery to all persons ordinarily resident in the United Kingdom.

— Hospital treatment is funded directly by the State almost entirely from general taxation revenue which is apportioned by central government to Primary Care Trusts (hereinafter: PCTs) according to the relative needs of their populations; there is no system of employee or employer contributions to sickness insurance schemes and no system of patient co-payments for such treatment. The amount made available to PCTs in respect of hospital care is subject to a cash-limit.

— PCTs are statutory bodies established to plan and secure health care including all general medical services in particular geographical areas.[3] All areas of England are covered by a PCT.

— 'NHS trusts' are separate legal bodies which were set up under the National Health Service and Community Care Act 1990 to assume responsibility for the ownership and management of hospitals or other establishments or facilities. Following amendment, Section 5(1) of this Act now provides that trusts are established to provide goods and services for the purposes of the

3 — Section 16A of the 1977 Act as inserted by section 2 of the Health Act 1999 and amended by the National Health Service Reform and Health Care Professions Act 2002.

health service. Generally speaking, NHS trusts receive their funding through payments made by PCTs.

— As NHS trusts always provide (hospital) treatment themselves free of charge to NHS patients or, in a small number of cases, by arrangement for treatment by other providers, the question of reimbursement of the costs of treatment to the patient does not arise and is not provided for. NHS patients have no entitlement under private law to claim funding of medical treatment from the NHS, nor does public law entitle them to any specific treatment at any particular time. They are not as such entitled to obtain hospital treatment in the private sector in England and Wales at the expense of the NHS.

— Access to hospital care is generally dependent on referral by a general practitioner. There are no national lists of medical benefits to be provided.

— Under the NHS system the type, location and timing of hospital treatment are determined on the basis of clinical priority and the availability of resources by the relevant NHS body, and not at the choice of the patient. Decisions of organs of the NHS as to whether to provide medical treatment can be challenged by judicial review according to established principles of domestic public law, but such challenges usually fail.

— The budget allocated to the NHS is not large enough to enable all who wish to have treatment, regardless of its urgency, to receive it promptly. Accordingly, the NHS applies its finite resources by according priorities to different treatments and by having regard to individual cases. This results in waiting lists for less urgent treatment.

— NHS bodies are free to determine the allocation and weighting of clinical priorities within national guidelines. The management of waiting lists is intended to ensure the provision of hospital care in accordance with appropriate priorities and decisions made by the relevant NHS bodies as to the use of resources and to maintain fairness between patients who require hospital treatment for differing conditions and with different degrees of urgency.

— The possibility exists for an NHS patient ordinarily resident in the United Kingdom to receive hospital treatment in another Member State pursuant to Article 22(1)(c) of Regulation No 1408/71 (the E-112 system), in which case reimbursement is made in accordance with that Regulation directly to the competent institution in the Member State in which the treatment was obtained at the rate of reimbursement normally applicable in the Member State of treatment, and not to the patient. There is no United Kingdom legislation implementing Article 22(1)(c) of Regulation No 1408/71.

— Overseas visitors, i.e. persons not ordinarily resident in the United Kingdom, may also receive medical treatment under the NHS, though not free of charge. The NHS (Charges to Overseas Visitors) Regulations 1989, as amended, provide for the making and recovery of charges for NHS treatment provided to overseas visitors. Such charges are collected and retained by the NHS body providing treatment. An NHS trust which provides treatment to an overseas visitor has no discretion not to charge for such treatment, unless that patient satisfies any of the exemption criteria [4] in the Regulations.

III — Facts and proceedings before the national court

8. In September 2002, Mrs Watts was diagnosed by her general practitioner as having osteoarthritis in both hips. On 1 October, she was seen by a consultant orthopaedic surgeon who concluded that she needed a total hip replacement on each side.

9. In the meantime, Mrs Watts' daughter had requested the Bedford PCT to support an application by her mother to have bilateral hip surgery abroad under Article 22 of Regulation No 1408/71, using Form E-112. Her consultant wrote to the PCT stating that Mrs Watts' mobility was severely hampered and that she was in constant pain. In relation to Mrs Watts' question whether the surgery could be performed abroad at the cost of the NHS, he stated that she was as deserving as any of the other patients with

4 — The Regulations provide for exemptions in certain circumstances, for example, treatment within hospital accident and emergency departments, and to reflect the rights of persons insured in other Member States.

severe arthritis on his waiting list. However, as her case was to be categorised as 'routine', she would have to wait approximately one year to have the operation at her local hospital.

10. By letter of 21 November 2002, the PCT refused her application for an E-112 Form, on the grounds that her case had been classified by the consultant as 'routine' and 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' in Article 22 of Regulation No 1408/71 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 Government's NHS Plan. On 12 December 2002, Mrs Watts lodged proceedings seeking judicial review of this decision.

11. In January 2003, Mrs Watts travelled to France to consult a medical specialist. This consultant reached the conclusion that her condition had deteriorated and that the hip replacements should be carried out by the middle of March 2003.

12. At an initial hearing held on 22 January 2003 pursuant to her application for judicial review, the Secretary of State suggested that Mrs Watts might be re-examined with a view to the PCT reconsidering its decision. She was accordingly seen, on 31 January, by the same consultant who had examined her previously. He 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, i.e. in April or May 2003. Subsequently, by letter of 4 February 2003, the PCT confirmed that in the light of this information, it remained unable to support Mrs Watts' application for treatment abroad under Form E-112, since she now would have to wait only a further three or four months for hip replacement surgery in Bedford.

13. Rather than waiting until April or May, Mrs Watts arranged to have her hip replacement operation in Abbeville, France, on 7 March 2003.

14. Upon her return, she continued with her application for judicial review of the PCT's decision not to authorise treatment abroad, and also sought reimbursement of the costs amounting to about GBP 3 900, including the costs of her hospital stay.

15. In a judgment of 1 October 2003, [5] the High Court rejected Mrs Watts' application. Although accepting that the PCT's refusal decisions were erroneous in law for failing to acknowledge that the services received by Mrs Watts fell within the scope of Article 49 EC and that this was not affected by the fact that the question of reimbursement of the costs of treatment arose in the context of the NHS, it dismissed the case on the facts. The court observed that 'any national authority properly directing itself in accordance with the principles laid down by the [Court of Justice of the European Communities], in particular (in *Smits and Peerbooms*) and *Müller-Fauré*, would have been bound to conclude in October-November 2002 that the anticipated delay of approximately one year was on any view "undue", and thus such as to trigger the claimant's right under Article 49 (EC) to reimbursement of the costs of obtaining more timely treatment in another Member State'. Nevertheless, it concluded that Mrs Watts had not faced 'undue delay' after her case was reassessed at the end of January 2003. The waiting time of four months at that point in time did not entitle her to have treatment abroad and to claim reimbursement of the cost from the NHS.

16. Both the Secretary of State for Health and Mrs Watts appealed against the High Court's decision to the Court of Appeal. Mrs Watts' appeal was based on the dismissal of her claim for reimbursement and the court's view that national waiting times are relevant in applying Article 49 EC and Article 22 of Regulation No 1408/71. The Secretary of State for Health's appeal focused on the relevance of Article 49 EC to Mrs Watts' case. He asserts that NHS patients have no entitlement to receive services within the meaning of that provision and that, consequently, her situation is governed exclusively by Article 22 of Regulation No 1408/71. In view of the problems of applying the principles of Article 49 EC, as interpreted by the Court in *Smits and Peerbooms* and *Müller-Fauré*, [6] to the situation of the NHS, the Court of Appeal decided that it was necessary to refer a series of questions to the Court of Justice on this subject.

IV — Preliminary questions and procedure before the Court

17. The interpretation problems encountered by the Court of Appeal are laid down in the following preliminary questions:

Question 1

Having regard to the nature of the NHS and its position under national law, is Article 49

5 — The High Court had postponed judgment to take into account the outcome of the reference to the Court of Justice in *Müller-Fauré* (cited in footnote 2).

6 — Cited in footnote 2.

EC, read in the light of *Geraets Smits*, *Muller-Fauré* and *Inizan*, to be interpreted as meaning that in principle persons ordinarily resident in the United Kingdom enjoy an entitlement in EU law to receive hospital treatment in other Member States at the expense of the United Kingdom National Health Service ('the NHS')?

In particular on the true interpretation of Article 49 EC:

(a) Is there any distinction between a State funded national health service such as the NHS and insurance funds such as the Netherlands ZFW scheme, in particular having regard to the fact that the NHS has no fund out of which payment must be made?

(b) Is the NHS obliged to authorise and pay for such treatment in another Member State, notwithstanding that it is not obliged to authorise and pay for such treatment to be carried out privately by a United Kingdom service provider?

(c) is it relevant if the patient secures the treatment independently of the relevant NHS body, and without prior authorisation or notification?

Question 2

In answering Question 1, is it material whether hospital treatment provided by the NHS is itself the provision of services within Article 49 EC?

If so, and in the circumstances set out in the statement of facts, above, are Articles 48, 49 and 50 EC to be interpreted as meaning that in principle;

(1) the provision of hospital treatment by NHS bodies constitutes the provision of services within Article 49 EC;

(2) a patient receiving hospital treatment under the NHS as such exercises a freedom to receive services within Article 49 EC; and

(3) NHS bodies providing hospital treatment are services providers within Articles 48 and 50 EC?

Question 3

If Article 49 EC applies to the NHS, may it or the Secretary of State rely as objective justification for refusing prior authorisation for hospital treatment in another Member State on:

(a) the fact that authorisation would seriously undermine the NHS system of administering medical priorities through waiting lists;

(b) the fact that authorisation would permit patients with less urgent medical needs to gain priority over patients with more urgent medical needs;

(c) the fact that authorisation would have the effect of diverting resources to pay for less urgent treatment for those who are willing to travel abroad thus adversely affecting others who do not wish or are not able to travel abroad or increasing costs of NHS bodies;

(d) the fact that authorisation may require the United Kingdom to provide additional funding for the NHS budget or to restrict the range of treatments available under the NHS;

(e) the comparative costs of the treatment and the incidental costs thereof in the other Member State?

Question 4

In determining whether treatment is available without undue delay for the purposes of Article 49 EC, to what extent is it necessary or permissible to have regard in particular to the following:

(a) waiting times;

(b) the clinical priority accorded to the treatment by the relevant NHS body;

(c) the management of the provision of hospital care in accordance with priorities aimed at giving best effect to finite resources;

(d) the fact that treatment under the NHS is provided free at the point of delivery;

(e) the individual medical condition of the patient, and the history and probable course of the disease in respect of which that patient seeks treatment?

Question 5

On the proper interpretation of Article 22(1)(c) of Regulation No 1408/71 and in particular the words 'within the time normally necessary for obtaining the treatment in question':

(a) Are the applicable criteria identical with those applicable in determining questions of undue delay for the purposes of Article 49 EC?

(b) If not, to what extent is it necessary or permissible to have regard to the matters set out in question 4?

Question 6

In circumstances where a Member State is obliged in EU law to fund the hospital treatment in other Member States of persons ordinarily resident in the first Member State, is the cost of such treatment to be calculated under Article 22 of Regulation No 1408/71 by reference to the legislation of the Member State where the treatment is provided or under Article 49 EC by reference to the legislation of the Member State of residence?

In each case:

(a) What is the precise extent of the obligation to pay or reimburse the cost, in particular where, as in the case of the United Kingdom, hospital treatment is provided to patients free at the point of delivery and there is no nationally set tariff for reimbursement of patients for the cost of treatment?

(b) Is the obligation limited to the actual cost of providing the same or equivalent treatment in the first Member State?

(c) Does it include an obligation to meet travel and accommodation costs?

Question 7

Are Article 49 EC and Article 22 of Regulation No 1408/71 to be interpreted as imposing an obligation on Member States to fund hospital treatment in other Member States without reference to budgetary constraints and, if so, are these requirements compatible with the Member States' responsibility for the organisation and delivery of health services and medical care, as recognised under Article 152(5) EC?

18. Written observations were submitted pursuant to Article 23 of the Statute of the Court of Justice by Mrs Watts, by the Belgian, Finnish, French, Maltese, Spanish, Swedish and United Kingdom Governments and by Ireland and the Commission. At the oral hearing held on 4 October 2005, further submissions were made on behalf of Mrs Watts, the Spanish, French, Polish, [7] Finnish, Swedish and United Kingdom Governments and Ireland and the Commission.

7 — The Polish Government did not submit written observations.

V — Assessment

A — *General introductory remarks*

19. Seen in its more general context the present case is symptomatic of and revelatory of a number of fundamental tensions which arise from the existence of compartmentalised national systems of health care and health insurance and the way in which these operate in the context of an internal market common to twenty-five Member States. These tensions arise from a number of factors which should be borne in mind in providing answers to the preliminary questions referred by the Court of Appeal.

20. The first aspect concerns the problem of limited capacity in collectively organised and financed systems of health care where human, financial and infrastructural resources are, by definition, finite. In such systems demand for health care will always exceed the supply of medical services and, in contrast with systems of private health care, the price mechanism does not operate as a corrective. Technological developments and innovation often generate new demand rather than creating a greater ability to cope with existing demand. Investments in the health care sector are made with a view to meeting demand for medical services within a medium- to long-term time-scale and cannot be adapted in response to fluctua-

tions in demand in the shorter term. In this situation, persons requiring any kind of medical treatment will not always be able to obtain that treatment within acceptable time-limits within their national systems. Waiting lists are the inevitable consequence and these then assume the function of being an instrument in the hands of health care managers in balancing supply and demand.

21. A second contributory factor is that various systems of health care and health insurance coexist within the Community. In a rough classification, already made by Advocate General Ruiz-Jarabo Colomer in his Opinion in *Smits and Peerbooms*,[8] these include wholly public systems (such as the United Kingdom's NHS), hybrid systems (such as the Netherlands' Ziekenfondswet system (hereinafter: ZFW) and private insurance systems. In the first type, financing is wholly public and care is provided free of charge. The second type of system may be financed from either public or private sources or a combination of these, whereas care is provided in kind or on a reimbursement basis. In the third model care is paid for directly by the patient who subsequently is reimbursed by his health insurer. Depending on the type of organisation these systems will be either tightly managed and relatively closed or more flexible in their management and relatively open.

22. The third source of tension is provided by the internal market itself and, in particular, by the freedom to provide and receive services throughout the Community. Undoubtedly stimulated by the Court's case-law in this field, patients increasingly are seeking health care in other Member States for various reasons such as the availability of treatment sooner in another Member State than in the Member State of residence (Mrs Watts), the availability of treatment in another Member State which is not (yet) available in the Member State of residence (Mrs Keller) or only available on an experimental basis (Mr Peerbooms), or the fact that the patient has more confidence in a care provider established in another Member State.[9] Patient mobility is also stimulated through the availability of more information (internet) on the possibility of obtaining medical treatment in other countries and through the activities of intermediaries, such as care brokers.

23. In this situation, there is an emerging transnational market for health care services which gives rise to problems, not so much in

8 — Opinion in Case C-157/99 (cited in footnote 2) at point 46.

9 — See Case C-145/03 *Keller* [2005] ECR I-2529, and Case C-157/99 (cited in footnote 2).

respect of the right to leave the Member State of residence or the right to enter another Member State to receive medical treatment, but in respect of the terms of financing such treatment. This aspect obviously creates problems where the question of financing health care is addressed strictly in function of the balancing demand and supply within the confines of the national system of health care and health insurance.

24. Cases arising from persons seeking care outside the limits of the national health insurance systems to which they are affiliated have given rise to a series of judgments of the Court over the past 10 years in which it was able to lay down a number of basic principles for resolving the problems concerning the funding of cross-border provision of medical services. Starting with its judgments in *Decker* and *Kohll*, the Court most importantly developed these principles in *Smits and Peerbooms*, which it later refined in *Müller-Fauré*. [10] Other important issues concerning the relationship between Article 49 EC and Article 22 of Regulation No 1408/71 were decided in *Vanbraekel* and *Inizan*. [11] Although the principles elaborated by the Court in these judgments are by now well settled and provide the essential basis for the answers to be given to the questions referred by the Court of Appeal, it must nevertheless be considered whether some further refinement is required given the particular context in which they arose.

25. First, however, it is necessary to define the proper legal context for deciding these questions.

B — *Applicable law*

26. The questions referred by the Court of Appeal focus mainly on the applicability of Article 49 EC to Mrs Watts' case and particularly on the question whether this provision entitles her to reimbursement of the costs of the hospital treatment which she received in France, although she had not been authorised by the NHS or any other competent authority in the United Kingdom to receive this treatment.

27. However, as was pointed out by the Commission, Mrs Watts had first sought authorisation under Article 22 of Regulation No 1408/71 to go abroad for treatment, by applying for an E-112 Form. The PCT, as the competent authority, twice refused to sup-

10 — Case C-120/95 *Decker* [1998] ECR I-1831, and cases cited in footnote 2.

11 — Case C-368/98 *Vanbraekel* [2001] ECR I-5363, and Case C-56/01 *Inizan* [2003] ECR I-12403.

port her application on the grounds that in view of the classification of her condition into consecutive classes of urgency ('routine', then 'soon'), she would be able to receive treatment within the NHS Plan targets for access to hospital treatment of 12 months. The conditions of Article 22 of Regulation No 1408/71 were therefore not met.

28. As both Article 49 EC and Article 22 of Regulation No 1408/71 have a bearing on the case, it is necessary to determine the relationship between these provisions and how they should be applied to it.

29. Article 22(1)(c) of Regulation No 1408/71 provides that where a person has received authorisation to go to another Member State to receive treatment which is covered in the competent Member State (hereinafter also referred to as: the Member State of insurance), he shall be entitled to this treatment in accordance with the legislation of the Member State providing the treatment, as if he were insured in that Member State. [12] The cost of that treatment is to be borne by the Member State of insurance which refunds the institution of the Member State of treatment directly, in accordance with Article 36 of the regulation.

30. According to Article 22(2), second paragraph, of the regulation this authorisation may not be refused where two conditions have been fulfilled: (1) the treatment must be among the benefits insured in the competent Member 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.'

31. It is in the nature of the coordination objective of Regulation No 1408/71 that the Court has interpreted the scope of Article 22 of the regulation narrowly. Thus in *Vanbraekel* it held that it is the 'sole purpose' of Article 22(2) of the regulation to identify the circumstances in which the competent national institution is precluded from refusing authorisation sought on the basis of Article 22(1)(c) and that this provision is not designed to limit the circumstances in which such authorisation may be granted. [13]

32. Furthermore, the Court has determined that Article 22 is not intended to regulate, and therefore does not prevent, the reimbursement by Member States at the tariffs in force in the competent State, of costs

12 — *Vanbraekel* (cited in footnote 11) at paragraph 32.

13 — *Vanbraekel* (cited in footnote 11) at paragraph 31.

incurred in connection with treatment provided in another Member State. [14]

33. Article 22, therefore, leaves it up to the Member States to determine whether and under which conditions treatment received in another Member State may be reimbursed. Where a Member State provides for the possibility of reimbursement to individuals, Article 22 does not prevent it from making this conditional upon the person concerned having been authorised beforehand by the competent authority to receive treatment abroad.

34. A patient failing to obtain authorisation because the conditions of Article 22(2) have not been fulfilled will then not be eligible for reimbursement for treatment received in another Member State, nor indeed will the competent institution be obliged to refund the institution providing that treatment under Article 36 of Regulation No 1408/71.

35. However, the situation is different where a person has applied for permission to receive medical treatment in another Member State but that has been wrongfully refused. Here, the Court has found that the person concerned, who despite the absence of authorisation has gone to another Member State for treatment, is entitled to be reimbursed directly by the competent institution by an amount equivalent to that which it would ordinarily have borne if authorisation had been granted in the first place. [15]

36. A different situation again arises where the refusal to grant authorisation is not based explicitly or solely on the criteria of Article 22(2) of Regulation No 1408/71, but (in addition) is taken by reference to national criteria. If a person nevertheless goes to another Member State for medical treatment which he pays for directly to the care provider and subsequently applies for reimbursement in the Member State of insurance, a refusal to grant such reimbursement falls to be considered under Article 49 EC. In other words the question which then must be answered is whether the refusal to grant reimbursement in such a situation constitutes a restriction on the freedom to provide services and, if so, whether such a restriction is justifiable.

14 — *Kohll* (cited in footnote 2) at paragraph 27 and *Vanbraekel* (cited in footnote 11) at paragraph 36.

15 — *Vanbraekel* (cited in footnote 11) at paragraph 34.

37. This latter situation applies to Mrs Watts' case given the fact that the decision was related to NHS Plan targets. The Court of Appeal was therefore correct to focus attention on the proper interpretation of Article 49 EC for resolving the case in the main proceedings.

C — *The first two preliminary questions: the NHS and Article 49 EC*

1. The scope of Article 49

38. The first two questions are aimed at ascertaining whether, in the light of the specific characteristics of the NHS, a person resident in the United Kingdom is entitled under Article 49 EC to receive hospital treatment in another Member State at the expense of the NHS and if it is relevant in that respect whether or not services provided by the NHS themselves should be considered as services within the meaning of Article 49 EC.

39. The parties having submitted observations take divergent views on the applicability of Article 49 EC to Mrs Watts' claim for the reimbursement by the NHS of the costs of the hospital treatment she received in France.

40. On the one hand, it is asserted by Mrs Watts and by the Belgian and French Governments that Article 49 EC, as interpreted by the Court in particular in *Smits and Peerbooms*, *Müller-Fauré* and *Inizan*, [16] does apply to the NHS so that persons ordinarily resident in the United Kingdom are entitled to receive hospital treatment in another Member State at the expense of the NHS. In this regard, it is irrelevant whether or not treatment provided by the NHS constitutes the provision of services within the meaning of Article 49 EC, though they maintain that that is indeed the case.

41. Where the Commission submits that the case should be decided primarily on the basis of Article 22 of Regulation No 1408/71, it regards the questions in respect of the compatibility with Article 49 EC of the PCT's refusal to authorise Mrs Watts to undergo surgery in France and to reimburse the cost of that treatment as a subsidiary issue. On this point, the Commission takes the view that although it might be argued on the basis of *Humbel* and *Poucet and Pistre* [17] that services provided by the NHS fall

16 — Case C-157/99 and Case C-385/99 (cited in footnote 2) and Case C-56/01 (cited in footnote 11).

17 — Case 263/86 *Humbel* [1988] ECR 5365 and Joined Cases C-159/91 and C-160/91 *Poucet and Pistre* [1993] ECR I-637.

outside the scope of Articles 49 and 50 EC, it clearly follows from the Court's judgments in *Smits and Peerbooms* and *Müller-Fauré* [18] that medical services which are provided in another Member State and are paid for directly by the recipient are services within the meaning of Article 50 EC, unless it must be considered that the Court's findings were limited to the facts of these cases. As regards the existence of restriction, the Commission observes that the NHS system cannot be considered to be discriminatory as there is no specific provision dealing with treatment received in other Member States. However, the absence of a procedure permitting patients to seek the provision of medical services in other Member States and for the cost of these services being reimbursed is likely to deter or prevent them from seeking treatment abroad and, consequently, constitutes a restriction within the meaning of Article 49 EC.

42. The Swedish Government, too, considers that in the light of the Court's case-law, Mrs Watts' situation falls within the ambit of Article 49 EC. However, it points out that it is necessary to take account of the distinctive features of a public health care system. Persons who choose to go outside such a public system without prior authorisation in order to receive treatment by a private health care provider should bear the costs of that treatment themselves.

43. On the other hand, the United Kingdom Government, broadly supported by the Finnish, Maltese and Spanish Governments and Ireland, emphasises that in the context of the NHS, residents of the United Kingdom do not enjoy any entitlement to receive any particular treatment, at a given time or a given location, nor do they have freedom of choice in this respect. In its view, the Court has made clear in its case-law that entitlement to receive treatment under the law of the State of residence is a precondition to being eligible for reimbursement of the cost of treatment in another Member State under Article 49 EC. It states further that any liability on the NHS to reimburse Mrs Watts depends on the hospital treatment provided under the NHS being qualified as a 'service' within the meaning of Articles 49 and 50 EC. Given the fact that the NHS is wholly funded from taxation, such treatment is not provided for economic consideration, so that the element of remuneration which is essential to the definition of a 'service' is absent. It adds that where the Court has held that Article 49 EC precludes the application of national rules which make the provision of services between Member States more difficult than within one Member State, [19] this comparison presupposes that both the intra-

18 — Cases C-157/99 and C-385/99 (cited in footnote 2).

19 — See *Kohll* (cited in footnote 2) at paragraph 33, *Vanbraekel* (cited in footnote 2) at paragraph 44, *Smits and Peerbooms* (cited in footnote 2) at paragraph 61 and Case C-8/02 *Leichtle* [2004] ECR I-2641.

State and inter-State provision of services fall within the scope of Article 49 EC. Consequently, health care provided by the NHS does not come within the scope of Article 49 EC. The NHS differs fundamentally from the Netherlands' ZFW, which was at issue in the cases of *Smits and Peerbooms* and *Müller-Fauré*, [20] not only because treatment under the NHS is not provided for economic consideration, but also because it has no funds for reimbursing patients for the cost of health care provided outside the NHS system.

44. The first point to be decided is whether or not Article 49 EC is applicable to the facts of this case, particularly in view of the arguments advanced by various intervening governments that the public character of the NHS places it outside the scope of this provision.

45. What is relevant in determining whether Article 49 EC applies to Mrs Watts' case and to her claim for reimbursement is the fact that she herself went to France for her hip operation and that she herself paid the institution providing the treatment directly the sum of GBP 3 900.

20 — Cited in footnote 2.

46. First, it has long been determined in the case-law that medical activities as such fall within the scope of Article 50 EC, there being no need to distinguish in that regard between care provided in a hospital environment and care provided outside such an environment. [21] It is also settled case-law that the special nature of certain services does not remove them from the ambit of the fundamental principle of free movement, so that the fact that the national rules at issue are social security rules cannot exclude the application of Articles 49 and 50 EC. [22]

47. Second, the requirement of remuneration is clearly fulfilled, as Mrs Watts settled her hospital bill directly. In this regard she is in the same situation as, inter alia, Mrs Smits and Mrs Müller-Fauré. In the cases of these two patients the Court stressed the fact that the medical treatment which was provided in Member States other than those in which the persons concerned were insured led to the establishments providing the treatment being paid directly by the patients. [23] The Court added that it must be accepted that a medical service provided in one Member State and paid for by the patient should not cease to fall within the scope of the freedom

21 — Joined Cases 286/82 and 26/83 *Luisi and Carbone* [1984] ECR 377, at paragraph 16; Case C-159/90 *The Society for the Protection of Unborn Children Ireland* [1991] ECR I-4685, at paragraph 18; *Kohll* (cited in footnote 2) at paragraph 29 and 51; *Smits and Peerbooms* (cited in footnote 2) at paragraph 53, and *Müller-Fauré* (cited in footnote 2) at paragraph 38.

22 — *Kohll*, at paragraph 20 and *Smits and Peerbooms*, at paragraph 54 (both cited in footnote 2).

23 — *Smits and Peerbooms*, at paragraph 55, and *Müller-Fauré*, at paragraph 39 (both cited in footnote 2).

to provide services guaranteed by the Treaty merely because reimbursement of the costs of the treatment involved is applied for under another Member State's sickness insurance legislation which is essentially of the type which provides for benefits in kind.[24]

48. There can be no doubt, therefore, that Mrs Watts is to be regarded as the recipient of services within the meaning of Articles 49 and 50 EC.

49. It is objected, however, by the United Kingdom, Maltese, Finnish and Spanish Governments and by Ireland, that as the NHS is organised as a wholly public system, Mrs Watts' claim cannot be considered under Article 49 EC.

50. This point has, in fact, been clearly dealt with by the Court in relation to the system operated in the Netherlands under the ZFW. In *Müller-Fauré*, in particular, after having given emphatic attention to the submissions of the United Kingdom Government regarding the NHS (at paragraphs 55 to 59 of the judgment), it held that 'a medical service does not cease to be a provision of services because it is paid for by a national health service or by a system providing benefits in kind. ... [A] medical service provided in one Member State and paid for by the patient cannot cease to fall within the scope of the freedom to provide services guaranteed by the Treaty merely because reimbursement of the costs of the treatment involved is applied for under another Member State's sickness insurance legislation which is essentially of the type which provides for benefits in kind ... There is thus no need, from the perspective of freedom to provide services, to draw a distinction by reference to whether the patient pays the costs incurred and subsequently applies for reimbursement thereof or whether the sickness fund or the national budget pays the provider directly.'[25]

51. Compared to the parallel consideration in *Smits and Peerbooms*,[26] the explicit reference to 'national health services' in this consideration in *Müller-Fauré* was new. In juxtaposition to the term 'a system providing benefits in kind', which could only refer to the ZFW, it would, therefore, appear to be a direct response to the submissions of the United Kingdom Government in that case.

52. Although this would seem to settle the matter, the United Kingdom Government nevertheless submits that, as the particular situation of the NHS was not as such at issue

24 — *Smits and Peerbooms* (cited in footnote 2) at paragraph 55.

25 — *Müller-Fauré* (cited in footnote 2) at paragraph 103.

26 — *Smits and Peerbooms* (cited in footnote 2) at paragraph 55.

in *Müller-Fauré* and the Court's reference to 'national health services' is too oblique as to encompass the NHS, the Court should consider the matter afresh and distinguish the NHS from the ZFW. Apparently, the Court's case-law on this topic requires some further elucidation.

53. Stated in more direct terms, in *Müller-Fauré* the Court found essentially that Article 49 EC applies to a person who has gone to another Member State for medical treatment which he has paid for directly, regardless of the manner in which he is insured against sickness costs in his home Member State. And indeed, from the perspective of the free provision of services under Article 49 EC, the manner in which the financing of the service is arranged is as such irrelevant for deciding whether or not a given transaction comes within the scope of this Treaty provision. The role of the NHS, like that of the ZFW sickness funds in the cases of *Smits and Peerbooms* and *Müller-Fauré*, is merely instrumental in relation to the main transaction between, in this case, Mrs Watts and the hospital which provided her with medical treatment in Abbeville, France.

54. It is true that in *Smits and Peerbooms* the Court, having found that the patients involved had themselves paid for the medical treatment they had received, went on to consider whether payments made by the sickness funds under the ZFW constituted remuneration for the hospitals receiving them and found that this was indeed the case. However, this consideration does not appear to have been of significance in relation to its primary finding that Article 49 EC was applicable in view of the fact that the medical services concerned had been paid for directly by Mrs Smits and Mr Peerbooms respectively.

55. In this light, it is irrelevant to the applicability of Article 49 to a situation such as that underlying the main proceedings whether or not the NHS itself is to be regarded as a service provider within the meaning of that Treaty provision. There is no question of the NHS providing a service to Mrs Watts within the meaning of Article 49 EC. Its role is restricted to the aspect of the possible reimbursement of the costs of the treatment which Mrs Watts received in another Member State. Its possible involvement is ancillary to a transaction which does come within the ambit of Article 49 EC.

56. It might be added that in the course of its everyday operation, in which the NHS provides medical services to residents in the United Kingdom, there will be no question of these activities falling within the scope of Article 49 EC. It must be borne in mind that

this Treaty provision does not apply to purely internal situations [27] and that a cross-border element must be involved. The latter is the case e.g. when persons resident in other Member States than the United Kingdom need treatment in the United Kingdom under the NHS. In such cases overseas visitors to the United Kingdom are required under the NHS (Charges to Overseas Visitors) Regulations 1989 to pay for the medical services provided to them by the NHS, by which token they come within the scope of Article 49 EC. Similarly, there would be a cross-border element if the NHS were to contract hospital services in other Member States in order to increase treatment capacity.

57. The argument advanced by the United Kingdom that where the Court has held that Article 49 EC precludes the application of national rules which make the provision of services between Member States more difficult than within one Member State, this comparison presupposes that both the intra-State and inter-State provision of services fall within the scope of Article 49 EC, cannot be accepted. This finding by the Court clearly relates to the restrictive effects of national rules on the provision of services from other Member States and is not aimed at delimiting the applicability of Article 49 EC to situations where the provision of the services concerned within a Member State is subject to conditions similar to the cross-border provision of these services.

58. Moreover, as has already been observed above, the Court has held that services cannot be excluded from the scope of this provision because of their special nature. Even the fact that the national rules concerned are social security rules cannot exclude the application of Articles 49 and 50 EC. [28] It is difficult, in the light of this case-law, to envisage how medical services provided in the context of the NHS could be excluded from the ambit of the Treaty provisions on the freedom to provide services either by their nature or because they are provided in a wholly public context.

59. Finally, on this same point concerning the applicability of Article 49 EC to the NHS, various intervening governments refer to the Court's Judgment in *Humbel*, [29] where the Court held that a Member State which establishes and maintains a national education system, funded from the public purse, does not seek to engage in gainful activity, but is fulfilling its duties towards its own population in the social, cultural and educa-

27 — See, for example Case C-41/90 *Höfner* [2001] ECR I-1979, at paragraph 37.

28 — *Kohll*, at paragraph 20 and *Smits and Peerbooms*, at paragraph 54 (both cited in footnote 2).

29 — *Humbel* (cited in footnote 17).

tional fields. In such a case, the constituent element of remuneration is absent, so that Article 49 EC does not apply. [30] As the NHS can be compared to such a national education system and is also funded wholly from tax revenue, so, it is argued, the services provided under the NHS are not provided for consideration and, therefore, fall outside the scope of Article 49 EC.

60. Once again, and disregarding whether *Humbel* may still be regarded as being good law, this point has already been submitted to and answered by the Court. Without it being necessary to repeat the considerations from *Smits and Peerbooms* which have been referred to above, suffice it to note that the Court emphasised in its judgment in that case that medical services fall within the scope of Article 50 EC, irrespective of whether they are provided in a hospital environment, and that in the context of the ZFW payments made by sickness funds to hospitals constitute remuneration for the services which the latter provide. At any rate, as I already concluded above, the manner in which the NHS is organised does not affect the applicability of Article 49 EC in the present case, as it is not services provided by the NHS which are at issue. Furthermore, as was also pointed out above (in points 7, final indent, and 56), persons from overseas are required to pay for medical treatment which they receive from NHS bodies. Here, quite obviously, this treatment is provided for economic consideration so that there is no obstacle to the applicability of Article 49 EC.

61. The basic problem in the present case arises from the fact that a person in Mrs Watts' position possesses two different qualities which are inherently contradictory. At the national level, her status is determined by her affiliation to the national social security scheme, under which she does not enjoy entitlement to be treated at any particular time or place. From the point of view of Community law, on the other hand, she is a recipient of medical services, who, subject to justifiable restrictions imposed by national law, enjoys freedom of choice in respect of the treatment she requires. To hold that her status under national law could condition her right to invoke Article 49 EC to challenge the refusal by the scheme to which she is affiliated of reimbursement of services which she received in another Member State, would amount to an unacceptable restriction of the possibilities of reviewing the compatibility with Community law of such a refusal.

62. On the basis of these considerations, I conclude that Article 49 EC does apply to Mrs Watts' claim to the reimbursement of the costs of the hospital treatment which she received in France and that the arguments to the contrary are unfounded. At this stage, I

30 — At paragraphs 17 and 18 of the judgment.

would like to note that this does not mean that the legitimate concerns of the Member States operating public health care systems should not be recognised. These will be discussed in the context of the third preliminary question.

2. Focusing on the issue behind the first two preliminary questions

63. Having concluded that Article 49 EC is, in principle, applicable in the present case, the next question which arises regarding this Treaty provision is whether the refusal by the NHS to reimburse the costs of the treatment which Mrs Watts received in France constitutes a restriction of her freedom to receive services in other Member States.

64. Answering this question requires an adaptation of the perspective chosen by the Court of Appeal in drafting the first two preliminary questions. As drafted, they enquire as to whether a person in Mrs Watts' situation derives an 'entitlement under Community law' to receive services at the expense of the NHS, given the fact that it is a wholly publicly organised and funded health system. Since entitlement under the provisions on the free movement of services is the derivative of the absence of an unjustified restriction to that freedom, it would appear to be more useful to understand these questions as being aimed at ascertaining whether the absence of the possibility of reimbursement under the NHS of the costs of medical treatment received outside the United Kingdom constitutes a restriction to the rights of United Kingdom residents to receive services in other Member States. If this is found to be the case, it must next be examined whether such a restriction can be justified. As indicated, this is the subject of the third preliminary question.

65. The Court has held that Article 49 EC precludes national rules which make the provision of services between Member States more difficult than the provision of services purely within one Member State. [31] It has also determined that national rules which deter or even prevent insured persons from applying to providers of medical services established in another Member State constitute both for insured persons and service providers a barrier to the freedom to provide services. [32]

66. In the present case the restriction to persons insured under the NHS to receive medical services in a Member State other than the United Kingdom consists not so much in a concrete provision limiting the possibility of obtaining treatment abroad, but in the absence of a clearly defined procedure for considering applications for such treat-

31 — *Smits and Peerbooms* (cited in footnote 2) at paragraph 61.
32 — *Smits and Peerbooms* (cited in footnote 2) at paragraph 69.

ment. The absence of such a procedure can indeed be explained by the way in which the NHS operates. Patients have no entitlement to receive treatment at any given time or location, but are dependent on clinical assessments made by care providers within the NHS. It is the NHS bodies which decide on the treatment which will be provided and when and where it will be provided. Persons requiring medical care are diagnosed, then classified according to the seriousness of their complaint, and, depending on that classification, are given a place on a waiting list. It would appear that in this respect the NHS bodies enjoy unlimited discretion.

67. Although it may be inherent to such a publicly financed and operated system that all decisions regarding medical treatment to be provided are taken by the system operators, this very fact implies that persons insured under that system are restricted in their possibilities of seeking treatment outside the system, as they have no certainty that the costs of that treatment will either be paid directly to the care provider or be reimbursed to them. To the extent that they wish to obtain medical services in another Member State, this constitutes a restriction of their freedom to receive services in another Member State.

68. The fact that they are also restricted in their freedom to obtain services in the private sector within the United Kingdom is irrelevant in this regard. This is an internal matter to the United Kingdom and at most may be considered to be an example of reverse discrimination which, as was pointed out by the French Government, is not prohibited by the EC Treaty.

69. Though it has been found above that the manner in which the NHS operates restricts persons insured under this system in their freedom to obtain medical services in other Member States, this does not mean that these persons enjoy an unrestricted right under Article 49 EC to travel to other Member States for this purpose. As the Court has recognised, Member States may impose a prior authorisation requirement before assuming the financial burden of hospital treatment provided in other Member States to persons insured under their social security schemes. Such a requirement is considered as being both necessary and reasonable to ensure that there is sufficient and permanent access to a balanced range of high-quality hospital treatment in the State concerned, to assist in controlling costs and to prevent wastage of financial, technical and human resources in an area in which financial resources are, by definition, limited. [33] The Court has acknowledged that if insured persons were at liberty, regardless of the circumstances, to go outside the system

33 — *Smits and Peerbooms* (cited in footnote 2) at paragraphs 78 to 80.

under which they are insured, all the planning within the system which is designed to guarantee a rationalised, stable, balanced and accessible supply of hospital services would be jeopardised at a stroke. [34]

70. However, the conditions attached to granting prior authorisation must also be justified by overriding considerations of the general interest and must satisfy the requirement of proportionality. On this point the Court has made clear 'that a scheme of prior authorisation cannot legitimise discretionary decisions taken by the national authorities which are liable to negate the effectiveness of provisions of Community law, in particular those relating to a fundamental freedom such as [the freedom to provide services ...]. Therefore, in order for a prior administrative authorisation scheme to be justified even though it derogates from such a fundamental freedom, it must, in any event, be based on objective, non-discriminatory criteria which are known in advance, in such a way as to circumscribe the exercise of the national authorities' discretion, so that it is not used arbitrarily ... Such a prior administrative authorisation scheme must likewise 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 also be capable of being challenged in judicial or quasi-judicial proceedings'. [35]

71. Although the Court thus accepts that the Member States are competent to impose a prior authorisation requirement as a precondition to persons insured under a public insurance scheme receiving hospital treatment outside that scheme and to them being reimbursed for the costs of those services, there are also indications in the case-law that Member States may be obliged to take measures in order to facilitate the cross-border provision of medical services.

72. In considering the justifiability of a prior authorisation requirement for non-hospital services, the Court in *Müller-Fauré* made a number of observations on the alignment of national social security systems with Community law obligations which appear to be so general in nature that they cannot be deemed to be restricted to non-hospital treatment.

73. Taking as its premise that Community law does not detract from the power of the Member States to organise their social security systems, though they must comply with Community law when exercising that power, the Court observed that 'achievement of the fundamental freedoms guaranteed by the Treaty inevitably requires Member States to make some adjustments to their national systems of social security.' According to the Court, this would not undermine their sovereign powers in this field. The Court added that 'when applying Regulation No 1408/71, those Member States which

34 — *Smits and Peerbooms* (cited in footnote 2) at paragraph 81.
35 — *Smits and Peerbooms* (cited in footnote 2) at paragraph 90.

have established a system providing benefits in kind, or even a national health service, must provide mechanisms for ex post facto reimbursement in respect of care provided in a Member State other than the competent State. That is the case, for example, where it has not been possible to complete the formalities during the relevant person's stay in that State [36] ... or where the competent State has authorised access to treatment abroad in accordance with Article 22(1)(c) of Regulation No 1408/71.' In this context, the Court acknowledged that if an insured person receives treatment in another Member State without having obtained authorisation, he can only claim reimbursement within the limits of the cover provided by the sickness insurance scheme of the Member State of affiliation and if he complies with conditions which are compatible with Community law. Finally, the Court indicated that 'nothing precludes a competent Member State with a benefits in kind system from fixing the amounts of reimbursement which patients who have received care in another Member State can claim, provided that those amounts are based on objective, non-discriminatory and transparent criteria'. [37]

74. Although, as stated, these considerations were made in relation to non-hospital services, there is no reason why they should be restricted to those activities in particular. Rather, they must be regarded as giving expression to the more general principle laid down in Article 10 EC according to which the Member States shall take all appropriate measures, whether general or particular, to ensure fulfilment of their Treaty obligations and to facilitate the achievement of the Community's tasks. This principle can require a Member State to adopt particular measures aimed at facilitating the free movement of services where abstaining from taking such measures could lead to a situation which would be in contravention of its obligations under, in this case, Article 49 EC.

75. More particularly, this obligation requires Member States to take positive action to prevent obstacles to free movement within the Community arising, as opposed to the simple repeal of provisions causing such problems. Examples of this, drawn from the comparable context of the free movement of goods, include the obligation to include a mutual recognition clause in national foodstuffs legislation [38] and the obligation to take action against obstacles to free movement created by individual operators. [39] It also includes the obligation to ensure that a prior

36 — See Article 34 of Regulation (EEC) No 574/72 of the Council of 21 March 1972 fixing the procedure for implementing Regulation No 1408/71 on the application of social security schemes to employed persons and their families moving within the Community (OJ 1972 L 74, p. 1).

37 — *Müller-Fauré* (cited in footnote 2) at paragraphs 100 to 107.

38 — Case C-184/96 *Commission* v *France* (*'foie gras'*) [1998] ECR I-6197, at paragraph 28.

39 — Case C-265/95 *Commission* v *France* (*'Spanish strawberries'*) [1997] ECR I-6959, at paragraphs 30 to 32.

authorisation requirement is based on a procedural system which satisfies the criteria identified by the Court and reproduced in point 70 above.

76. On the basis of the foregoing considerations the answer to the first two questions must be that Article 49 EC is to be interpreted as meaning that, in principle, persons ordinarily resident in a Member State operating a national health service, such as the National Health Service in the United Kingdom, are entitled to receive hospital treatment in another Member State at the expense of that national health service. Member States may subject such entitlement to the requirement that the person has obtained prior authorisation, provided such authorisation is based on objective, non-discriminatory and transparent criteria in the context of a procedural system which is easily accessible and capable of ensuring that requests for authorisation are dealt with objectively and impartially within a reasonable time and refusals to grant authorisation are capable of being challenged in judicial or quasi-judicial proceedings. The absence of such criteria and such a procedure cannot deprive a person of such entitlement. It is irrelevant for the purposes of the application of Article 49 EC in the circumstances of the main proceedings whether or not hospital treatment provided by the NHS is itself the provision of services within the meaning of Article 49 EC.

D — *The third preliminary question: justification of refusal of prior authorisation*

77. By its third preliminary question, the Court of Appeal asks whether, in case Article 49 EC applies to the NHS, the refusal of prior authorisation for hospital treatment in another Member State can be objectively justified on a number of different grounds. These include (a) the fact that authorisation would seriously undermine the NHS system of administering medical priorities through waiting lists, (b) the fact that authorisation would permit patients with less urgent medical needs to gain priority over patients with more urgent medical needs, (c) the fact that authorisation would have the effect of diverting resources to pay for less urgent treatment for those who are willing to travel abroad, thus adversely affecting others who do not wish or are not able to travel abroad or increasing costs of NHS bodies, (d) the fact that authorisation may require the United Kingdom to provide additional funding for the NHS budget or to restrict the range of treatments available under the NHS and (e) the comparative costs of the treatment and the incidental costs thereof in the other Member State.

78. Mrs Watts points out that in considering an application for treatment abroad the test which is applied is whether that treatment can be provided within the United Kingdom without 'undue delay' and that this is determined by reference to NHS waiting lists. The method of prioritising on the basis of these waiting lists does not take account of

the clinical need of the individual patient by reference to his clinical condition, history and particular circumstances. In this situation a refusal cannot be justified merely by referring to the existence of waiting lists. Waiting lists and the reason for their existence should be properly scrutinised, taking into account that a waiting time which is too long or abnormal would be likely to restrict rather than enhance access to high-quality hospital care. Mrs Watts asserts that there is no evidence that any of the negative effects mentioned by the referring court in its third preliminary question would occur.

79. The French Government essentially supports this point of view and points out that as most of the negative consequences indicated by the Court of Appeal are financial in character these cannot be justified. The Belgian Government adds that the United Kingdom may be justified in refusing authorisation, but that this must be based on objective, non-discriminatory criteria which are known beforehand and do not deprive the applicable Community provisions of their useful effect.

80. The Commission remarks that in the absence of any procedure in the United Kingdom for the reimbursement of treatment costs outside the context of Regulation No 1408/71 it is impossible to examine any imperative reasons justifying such a restriction.

81. The Spanish, Maltese, Finnish, Swedish and United Kingdom Governments and Ireland, by contrast, consider that even if Article 49 EC applies to the NHS, the objectives of ensuring the financial balance of the NHS and of maintaining a balanced medical and hospital service open to all justify restrictions to the freedom to provide services. The effects listed by the Court of Appeal in its third preliminary question can therefore be correctly invoked to justify a refusal to authorise hospital treatment in another Member State, given the dangers to the balance of the NHS system if large numbers of patients were permitted to seek treatment abroad. The Spanish, Swedish and United Kingdom Governments in particular emphasise the legitimacy of using waiting lists for this purpose, especially as these lists are drawn up on the basis of medical considerations.

82. The point of departure in answering this question must be the Court's settled case-law on the objectives which are deemed capable of justifying national restrictions to an insured person's right under Article 49 EC to receive hospital treatment in another Member State. In particular, it should be examined whether the various effects indicated by the Court of Appeal may be considered to be covered by these objectives and, if not, whether they should nevertheless be accepted as grounds of justification for the refusal to grant authorisations and reimbursement.

83. The grounds of justification which have been recognised by the Court were usefully summarised in *Smits and Peerbooms*. First, the Court has held that it cannot be excluded that the possible risk of seriously undermining a social security system's financial balance may constitute an overriding reason in the general interest capable of justifying a barrier to the principle of freedom to provide services. Second, it has acknowledged that, as regards the objective of maintaining a balanced medical and hospital service open to all, that objective, even if intrinsically linked to the method of financing the social security system, may also fall within the derogations on grounds of public health under Article 46 EC, in so far as it contributes to the attainment of a high level of health protection. Third, it has determined that Article 46 EC 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 the public health, and even the survival, of the population. Finally, where it is possible to invoke these grounds of justification, it must be ensured that the national measure concerned does not exceed what is objectively necessary for that purpose and that the same result cannot be achieved by less restrictive rules. [40]

84. As regards waiting lists in particular, the Court in *Müller-Fauré* explicitly rejected the possibility of a Member State relying not on the fear of wastage resulting from hospital overcapacity, but solely on the fact that such lists exist on national territory without account being taken of the specific circumstances of the patient's medical condition. It observed that it had not been demonstrated that such waiting times are necessary for the purpose of safeguarding the protection of public health. [41] On the contrary, waiting times which are too long or abnormal are more likely to restrict access to balanced, high-quality hospital care. Waiting lists, it noted, appear to be based mainly on considerations of a purely economic nature which cannot as such justify a restriction on the fundamental principle of freedom to provide services. [42]

85. As such it must be recognised that where demand for hospital services exceeds capacity to provide these services, it is impossible to treat persons requiring treatment as and when they need it or even within time-limits which are deemed to be acceptable. Given the fact that human, financial and material resources available to hospitals are limited, it is inevitable that patients are forced to wait for some time before being treated. As demand in this sector is generally much greater than supply, waiting lists operate as an instrument for allocating resources with a view to making optimal use of hospital

40 — *Smits and Peerbooms* (cited in footnote 2) at paragraphs 72 to 75.

41 — That is, despite the explicit submissions of the United Kingdom Government on this point. See *Müller-Fauré* (cited in footnote 2) at paragraph 58.

42 — See *Müller-Fauré* (cited in footnote 2) at paragraph 92.

capacity. Though this makes perfect sense from the point of view of the rational management of resources, the (opportunity) cost of using waiting lists in this manner is delaying access of patients to hospital care. It is this latter aspect which the Court clearly had in mind in rejecting the mere existence of waiting lists as a ground for justifying a refusal to grant authorisation for receiving treatment abroad.

86. There is, therefore, an inherent tension between, on the one hand, the inevitable existence of waiting lists and their role as an instrument for managing and allocating limited resources and, on the other hand, the interests of patients in receiving adequate and timely treatment. These two conflicting interests can only be reconciled in a manner compatible with the Court's case-law if a number of conditions are imposed on the way in which waiting lists are managed. More specifically, waiting lists should not be confined to registering that a given patient is eligible for a given type of treatment with a given degree of urgency. They should be managed actively as dynamic and flexible instruments which take into account the needs of patients as their medical condition develops. This implies that a reassessment of the pathological condition should be able to result in treatment being provided more speedily. In addition, it is important that they should provide for a safety valve, for example by setting maximum waiting times which are reasonable in the light of the medical condition of the persons concerned and beyond which extra efforts should be undertaken to guarantee immediate treatment. Moreover, in the interest of transparency, decisions regarding the treatment to be provided and when that is likely to be should be taken on the basis of clear criteria restricting the discretionary power of the decision-making body.

87. It follows from this that whenever a person seeks authorisation to receive treatment abroad, it is not sufficient for the decision-making authority to reject such an application on the formal ground that treatment can be provided within a target set under the national system. Such a decision should be taken having regard to whether the application of these targets in the given case is acceptable in the light of the individual pathological condition of the patient concerned. To quote the Court once again, regard must be had to the circumstances of each specific case. In addition, due account must be taken not only of the patient's medical condition at the time when authorisation is sought and, where appropriate, of the degree of pain or the nature of the patient's disability which might, for example, make it impossible or extremely difficult for him to carry out a professional activity, but also of his medical history. [43]

88. Consequently, the rejection of an application for authorisation to receive hospital

43 — *Smits and Peerbooms*, paragraph 104, and *Müller-Fauré*, paragraph 90.

treatment in another Member State at the expense of the NHS, solely on the ground that a positive decision would seriously undermine the NHS system of administering medical priorities through waiting lists, cannot be regarded as being justified. Similarly, as such a decision must be based on an assessment of the applicant's pathological condition, considerations which are external to that assessment, such as the effects on the position of other patients on the waiting lists or the reallocation of resources within the NHS, cannot justify a refusal to grant the authorisation sought. As to the former of these two effects, it will be inherent to any positive decision of the NHS decision-making body that the applicant is considered to be someone who indeed requires treatment urgently. As to the latter effect, I would observe that besides being economic in character, as already mentioned above in paragraph 73, Community law requires the Member States to make the necessary adjustments to their social security systems in order to facilitate the achievement of the fundamental freedoms in the EC Treaty. This may be deemed to include sufficient flexibility within the NHS planning system to accommodate applications for treatment abroad in certain circumstances.

89. Again, the fact that authorisation might result in the necessity of allocating additional funding to the NHS budget cannot in itself be considered to be a circumstance which can be taken into account in deciding whether an individual applicant, in view of his medical condition, may be authorised to travel to another Member State at the expense of the NHS to receive treatment deemed necessary. This argument, which is also of an economic character, essentially relates to a situation in which NHS bodies find themselves compelled in view of the applicable criteria to grant authorisations for treatment abroad on a larger scale as a result of which the financial stability of the system might be put at risk. However, it is precisely the function of the prior authorisation requirement which the Member States are entitled to impose to control the outflow of patients with a view to maintaining the financial stability of the system. Granting authorisation presumes that the budgetary consequences thereof are taken into account, so that these cannot be applied as separate grounds of refusal. In this regard, it should be specified that the interest in guaranteeing the financial stability of the system evidently concerns the stability in the longer-term perspective and does not relate to balancing the books on an annual basis. This implies that in applying this criterion, account must be taken not only of the financial burden incurred for hospital treatment provided in another Member State, but also of the costs saved in the longer term of treatment which otherwise would have been provided by the NHS. Not only would this lead to greater stability in the longer term, it would also contribute to a better use of hospital capacity.

90. Compatibility with Community law of a prior authorisation requirement depends on whether the criteria applied in this context are themselves justified. As the only criterion

which at present applies within the NHS context is whether treatment can be provided within NHS Plan targets, and as these do not take the individual needs of patients sufficiently into account, the authorisation procedure in its present form is incompatible with Article 49 EC.

91. The final consideration mentioned by the Court of Appeal, namely whether a refusal to grant authorisation may be based on the comparative costs of the treatment and the incidental costs thereof in the other Member State, also cannot be taken into account for the obvious reason that it, too, is economic in character.

92. I, therefore, conclude that the answer to the third question should be that considerations relating to the management of waiting lists can only justify a refusal of authorisation to receive hospital treatment in another Member State if these waiting lists are managed in such a way that they take the individual medical needs of patients sufficiently into account and do not prevent treatment being provided in another Member State in case of urgency. Where conditions on granting authorisation to receive hospital treatment in another Member State are designed to guarantee the financial stability of the national health system, considerations of a purely budgetary or economic character cannot justify a refusal to grant such authorisation.

E — *The fourth and fifth preliminary questions: waiting times*

93. Both the fourth and fifth questions deal with the topic of waiting times, so that it is convenient to discuss them together. More specifically, the fourth question relates to circumstances to be taken into account in determining whether, for the purposes of applying Article 49 EC, treatment is available without 'undue delay'. The circumstances referred to are: (a) waiting times, (b) the clinical priority accorded to the treatment by the relevant NHS body, (c) the management of the provision of hospital care in accordance with priorities aimed at giving best effect to finite resources, (d) the fact that treatment under the NHS is provided free at the point of delivery and (e) the individual medical condition of the patient, including the history and probable course of his disease. The fifth question asks essentially whether 'undue delay' and 'within the time normally necessary for obtaining the treatment in question' in Article 22(1)(c) of Regulation No 1408/71 are to be assessed according to identical criteria and, if not, to what extent the circumstances mentioned in the fourth question may be applied in the context of the latter provision.

94. Whereas Mrs Watts, relying on *Müller-Fauré*, submits that the question whether there is 'undue delay' may only be assessed in the light of the medical condition of the applicant patient, the Belgian and French

Governments take the view that this assessment may be based solely on a combination of waiting times and the pathological condition of the patient. All these interveners consider that, in the light of *Inizan*, the question of delay under Article 49 EC and Article 22 of Regulation No 1408/71 should be treated according to the same criteria. Mrs Watts emphasises, however, that normal waiting times according to national legislation are without pertinence in the context of Article 22.

95. The Spanish and United Kingdom Governments and Ireland maintain that all the criteria mentioned by the Court of Appeal in its fourth question may be taken into account in determining whether or not there is undue delay in providing the treatment required. The latter two interveners observe that as Article 49 EC (aimed at establishing freedom to provide services) and Article 22 of Regulation No 1408/71 (social security provision aimed at protecting patients) pursue different objectives, the fact that certain of these criteria may not be deemed applicable in the context of Article 49 EC does not in any way affect their applicability in the context of Article 22. The United Kingdom Government emphasises that Article 22 of Regulation No 1408/71 is not intended to lay down a uniform standard for the whole Community in respect of waiting times, but, rather, necessarily refers to the national criteria which apply to waiting times.

96. The Finnish and Swedish Governments submit that even though it follows from the Court's case-law that a refusal to authorise treatment abroad may only be based on the medical condition of the applicant patient, this does not preclude the Member States from taking account of factors which are essential to the proper functioning of the national health care system, such as realistic waiting times for obtaining treatment on national territory and national medical practices. The Maltese Government asserts that the possibility of obtaining timely treatment within the Member State of insurance must be appreciated strictly from a medical point of view, independently of the waiting times for receiving that treatment, but that that appreciation is a discretionary matter for the body called upon to bear the financial burden of the treatment.

97. The Commission takes the view that Article 22 of Regulation No 1408/71 and in particular the words 'within the time normally necessary for obtaining the treatment in question in the Member State of residence' do not preclude the national authorities from having regard to national waiting times provided that the circumstances of each individual case are sufficiently taken into account and the waiting times are themselves based on objectively justifiable medical criteria. This a matter for the national court to decide. It also indicates, citing *Inizan*,[44] that the criteria for deter-

44 — Cited in footnote 11.

mining whether treatment can be provided 'within the time normally necessary' in Article 22 of Regulation No 1408/71 are the same as those applied by the Court in determining whether the treatment can be obtained 'without undue delay' in the context of the application of Article 49 EC.

98. As was observed above, the Court has already provided an answer to the question how it must be determined whether treatment is available without 'undue delay' in the Member State of residence for the purposes of applying Article 49 EC. In a consideration in *Müller-Fauré* (which was cited above, but must be repeated here as the point of departure for answering the fourth question), it held that 'the national authorities are required to have regard to all the circumstances of each specific case and to take due account not only of the patient's medical condition at the time when authorisation is sought and, where appropriate, of the degree of pain or the nature of the patient's disability which might, for example, make it impossible or extremely difficult for him to carry out a professional activity, but also of his medical history'. [45]

99. However, the question raised by the Court of Appeal enquires as to whether other factors may be taken into consideration in this context, including waiting times and clinical priorities set by the NHS bodies. The prime consideration in determining whether treatment can be provided without undue delay, as was emphasised by the Court, is whether postponement of the required treatment for a given period can be regarded as acceptable, given the seriousness of the patient's pathological condition and its predictable development. Any waiting time which is imposed should be based on the concrete indications relating to the patient's condition at the time of assessment. Targets for providing treatment for various ailments do not, in view of their abstract character, comply with this criterion. To the extent that waiting times and clinical priorities are defined on the basis of an individual assessment as described, they may be regarded as being in accordance with the criteria set by the Court in *Smits and Peerbooms* and *Müller-Fauré*. Under this condition, the factors mentioned under (a) and (b) of the fourth preliminary question can be taken into account in assessing whether treatment can be provided without 'undue delay'. The same applies to the factor indicated under (e) of that question as it is a direct reference to the Court's case-law on this matter.

100. By contrast, the two other factors indicated in the fourth preliminary question, namely the management of hospital care in a situation of limited resources and the fact that health care is provided free of charge at the point of delivery, are both concerned

45 — *Müller-Fauré*, at paragraph 90. See, too, *Smits and Peerbooms*, at paragraph 104 (both cited in footnote 2).

with the economic organisation of the NHS and for that reason cannot be taken into account in this context.

101. The Court of Appeal next asks whether these considerations also apply to Article 22(1)(c) of Regulation No 1408/71 and in particular to the words 'within the time normally necessary for obtaining the treatment in question' in that provision. Again reference must be made to answers which are already to be found in the Court's case-law. In *Inizan*,[46] interpreting this second condition in Article 22(1)(c), which if fulfilled precludes a Member State from refusing authorisation of treatment in another Member State, the Court referred directly to its considerations in relation to 'undue delay' in *Smits and Peerbooms* and *Müller-Fauré*.[47] Without stating explicitly that the two concepts have to be interpreted identically, it is clear that this is what the Court intended. Indeed, it does not make sense to apply different criteria in the context of both provisions where the basic issue is the same, namely whether hospital treatment can be provided within an acceptable time-limit by institutions in the Member State of insurance. Any other approach would create further uncertainties and undermine transparency.

102. It is objected, particularly by the United Kingdom Government and Ireland, that Article 49 EC and Article 22 of Regulation No 1408/71 serve different purposes and that this should be reflected in the way they are interpreted. It may be recalled that in *Inizan* the Court pointed out that Article 22 helps to facilitate the free movement of insured persons and, to the same extent, the cross-border provision of medical services between Member States.[48] Indeed it is the basic rationale of Regulation No 1408/71 to create a sufficient degree of coordination between the social security systems of the Member States that insured persons are not discouraged from making use of their freedom to move within the Community for fear of losing right to benefits which they have built up over time. Article 22 of the regulation is designed to ensure that insured persons are entitled to go to another Member State to receive medical treatment when the conditions laid down in that provision are fulfilled, although as observed above this provision leaves the Member States free to be more liberal. Article 22 provides a minimum guarantee. Essentially it therefore pursues the same objective as Article 49, albeit from a different perspective, namely that of the insured person, rather than that of the service itself.

103. It follows that the concepts of 'undue delay', which is applied in the context of

46 — Cited in footnote 11, at paragraphs 44 to 46.

47 — Cited in footnote 2.

48 — *Inizan*, at paragraph 21. See, too, *Vanbraekel*, at paragraph 32 (both cited in footnote 11).

Article 49 EC, and 'within the time normally necessary for obtaining the treatment in question' in Article 22(2) of Regulation No 1408/71, should be interpreted according to the same criteria.

104. The answer to the fourth question should be that in determining whether treatment is available without undue delay for the purposes of Article 49 EC, it is permissible to have regard to waiting times and the clinical priority accorded to the treatment by the relevant NHS body, on condition that these are based on concrete indications relating to the patient's medical condition at the time of assessment, as well as to his medical history and the probable course of the disease in respect of which that patient seeks treatment.

105. The answer to the fifth question should be that on the proper interpretation of Article 22(1)(c) of Regulation No 1408/71 and in particular the words 'within the time normally necessary for obtaining the treatment in question' the applicable criteria are identical with those in determining questions of 'undue delay' for the purposes of Article 49 EC.

F — *The sixth preliminary question: point of reference for the calculation of the amount of reimbursement*

106. The sixth preliminary question concerns the calculation of the amount of the reimbursement. Assuming that it is found that the United Kingdom is obliged under Community law to refund treatment received by persons insured under the NHS, the Court of Appeal asks whether the cost of such treatment is to be calculated under Article 22 of Regulation No 1408/71 by reference to the legislation of the Member State where the treatment is provided or under Article 49 EC by reference to the legislation of the Member State of residence. In addition, it asks for each case what the precise extent of the obligation to pay or reimburse the cost is where there are no nationally set tariffs for reimbursement of patients for the cost of treatment, whether this obligation is limited to the actual cost of providing the same or equivalent treatment in the Member State of insurance and whether there is also an obligation to meet travel and accommodation costs.

107. Mrs Watts maintains that if a person is entitled to receive treatment in another Member State either under Article 22 of Regulation No 1408/71 or under Article 49 EC, he may opt for the most advantageous method of reimbursement, which in the present case would be that related to Article 49 EC. Where there are no reimbursement rates in the Member State of

residence, the full cost of the treatment should be refunded. Travel and accommodation costs are only refundable in case of unlawful refusal of authorisation under Article 22 of the regulation and such costs would otherwise have been paid by the competent institution.

108. The Belgian and French Governments consider that the legislation of the Member State where the treatment is provided applies unless the tariffs applied by the Member State of insurance are more advantageous for the applicant.

109. The United Kingdom Government takes the view that, in the event that Article 49 EC applies to the NHS, the extent of the obligation to reimburse a patient depends on the extent of his entitlement in national law. As to Article 22 of Regulation No 1408/71, the liability of the Member State of insurance is limited to reimbursing the competent authority in the Member State of treatment for that part of the treatment which it bears. This provision imposes no obligation on the Member State of insurance to repay travelling or other expenses. Such costs may only be reclaimed in the context of Article 49 EC to the extent that there is an entitlement to reimbursement under national law.

110. The Spanish and Finnish Governments submit that as Article 49 EC does not apply in this case, the amount of reimbursement must be determined in accordance with Article 22 of Regulation No 1408/71. The latter adds that this provision does not regulate the aspect of travel and accommodation costs, so that this is a matter for national law. Ireland states that any obligation on the NHS to refund treatment provided in another Member State should be maximised and that it does not include the additional expenses. The Swedish Government considers that the national authorities should have the right to refuse reimbursement where the costs are deemed excessive.

111. As is already implied in the sixth question the conditions governing reimbursement of the costs of hospital treatment received in another Member State differ according to whether this treatment was provided in the context of Article 22 of Regulation No 1408/71 or of Article 49 EC.

112. In the former case, the usual situation is that a patient is authorised to receive treatment in another Member State and the cost of that treatment is refunded directly, in accordance with Article 36 of Regulation No 1408/71, to the competent body in the Member State where the treatment is provided. As Article 22(1)(c) of the regulation determines that the benefits in kind will be provided in accordance with the provisions of the legislation which the institution

in the Member State of stay administers, it is clear that the reimbursement is calculated according to the legislation of the Member State providing the treatment.

113. In the event that authorisation, applied for on the basis of Article 22 of Regulation No 1408/71, to go to another Member State for medical treatment is unlawfully refused, the applicant is entitled to be reimbursed directly by the competent institution in the Member State of insurance by an amount equivalent to that which it would ordinarily have borne [49] if authorisation had properly been granted in the first place, [50] i.e. the amount calculated according to the legislation of the Member State of treatment.

114. However, where an insured person is entitled to an amount in the competent Member State which is higher than the amount to which he would be entitled under the legislation of the Member State of treatment, that person, as the Court decided in *Vanbraekel*, is entitled to an additional reimbursement covering the difference between the systems of cover of both Member States. [51]

115. Whereas the point of reference for calculating the reimbursement under Article 22 of Regulation No 1408/71 is the legislation of the Member State of treatment, the situation is different where Article 49 EC applies. As the Court held in *Müller-Fauré*, it is for the Member States alone to determine the extent of the sickness cover available to insured persons. If an insured person goes without prior authorisation to another Member State for medical treatment, he can claim reimbursement of the cost of the treatment given to him only within the limits of the cover provided by the sickness insurance scheme in the Member State of affiliation. [52] Where Article 49 EC is applicable, it is the legislation of the competent Member State which determines the level of reimbursement. This means that he is only entitled to the amount which would be reimbursed if the treatment had been provided in the competent Member State.

116. Although these rules are clear in themselves, the question arises how they should be applied in a situation such as that of the United Kingdom's NHS which provides health care free at the point of delivery and does not provide for any system of reimbursement. Indeed it is pointed out that no rates for reimbursement exist in that system.

49 — I would point out that both the Court's conclusion on this point (paragraph 53) and the operative part of the judgment confusingly refer to the 'amount equivalent to that which would be borne *by the institution of the place of treatment*'. Emphasis added.

50 — *Vanbraekel* (cited in footnote 11) at paragraph 34.

51 — *Vanbraekel* (cited in footnote 11) at paragraph 53.

52 — *Müller-Fauré* (cited in footnote 2) at paragraph 98. See, too, paragraph 106 of this judgment.

117. The absence of a system of rates or tariffs does not as such preclude the application of these rules on the calculation of the amount of reimbursement of costs incurred for medical treatment abroad. I need only recall the Court's considerations in *Müller-Fauré*, cited above in paragraph 73, that the Member States are obliged to establish mechanisms to adjust their social security systems to the requirements of the internal market and the operation of Regulation No 1408/71 and that these can include the setting of rates of reimbursement. As for the NHS, it would appear that such rates must exist for the purposes of determining the costs to be paid by foreign visitors under the NHS (Charges to Overseas Visitors) Regulations 1989. Where no tariffs are available by which the amount of reimbursement may be calculated, the only point of reference which remains is the actual cost of the treatment received.

118. The final point raised by the sixth preliminary question is whether there is a right under Article 49 EC and Article 22 of Regulation No 1408/71 to the reimbursement of travel and accommodation costs related to hospital treatment received in another Member State. First, I would observe that Regulation No 1408/71 only coordinates national social security systems to the extent necessary for ensuring the free movement of insured persons, but that the right to benefits as such is a matter for national law. In this system, Articles 22 and 36 of the regulation provide for the costs only of medical treatment being refunded directly between institutions at the rates applicable in the Member State of treatment. Although the system may include the cost of staying in a hospital, it cannot by its nature include travel expenses or the costs of accommodation outside a medical institution. It follows that any right to reimbursement of travel and accommodation costs in respect of medical treatment abroad is governed primarily by national law. Consequently, where national law provides for the reimbursement of these additional expenses in respect of medical treatment provided on national territory, it follows from Article 49 EC that they should be available under the same limits and conditions for treatment received in another Member State. [53]

119. The answer to the sixth preliminary question should be that where a Member State is obliged under Community law to fund the hospital treatment in another Member State of a person ordinarily resident in the first Member State who has received that treatment outside the context of Article 22 of Regulation No 1408/71, the cost of that treatment is to be calculated by reference to the legislation of the Member State of residence. In the absence of tariffs or rates for calculating the amount of reimbursement, reimbursement must be calculated at the actual cost of the treatment received. The costs of travel and accommodation in relation to hospital treatment

53 — *Leichtle* (cited in footnote 19).

received in another Member State are only reimbursable where this is provided for in national law for treatment on national territory.

limits the obligations arising under Article 49 EC and Article 22 of Regulation No 1408/71 are compatible with Article 152(5) EC. The Belgian Government observes that even though these obligations expose the Member States to costs which exceed those envisaged for the organisation and provision of health care on their territory, there is as yet no indication that these additional costs are likely to upset the financial balance of a national system.

G — *The seventh preliminary question: budgetary constraints and Article 152(5) EC*

120. The final preliminary question asks whether Member States are obliged under Article 49 EC and Article 22 of Regulation No 1408/71 to fund hospital treatment in other Member States irrespective of budgetary constraints and, if so, whether this is compatible with Article 152(5) EC which recognises the Member States' responsibility for the organisation and delivery of health services and medical care.

122. The Finnish and United Kingdom Governments and Ireland take the opposite view that the obligation to fund hospital treatment received in other Member States without reference to budgetary constraints is incompatible with the Member States' responsibility for the organisation and delivery of health services recognised in Article 152(5) EC. Such an obligation would have profound consequences for national systems which are organised along purely public lines which provide benefits in kind and are funded directly from tax revenue.

121. Mrs Watts submits that there is no incompatibility with Article 152(5) EC or interference with the Member States' sovereign powers in this field in determining that budgetary contraints are irrelevant for the determination of the question of 'undue delay'. Economic considerations cannot justify restrictions on the freedom to provide services. The French Government considers that as long as the number of authorisations granted is relatively restricted and the financial burden remains within reasonable

123. I would like to point out first that, seen in the context of Article 152 EC as a whole, the function of the fifth section of this article is to impose a limit on the various activities

and policies which can be adopted by the Community in this field. It is not intended to recognise a general exception to obligations under the Treaty based on the responsibilities of the Member States in the health care sector. Rather, it should be read in line with the Court's well-established approach according to which it is recognised that the Member States retain full power to organise their social security systems, but that in exercising these powers they are required to fully respect their obligations under Community law, particularly those related to the fundamental freedoms guaranteed by the EC Treaty.

124. Secondly, it should not be overlooked that, although the Court does not accept considerations of a purely economic nature as grounds for justifying restrictions to the freedom to provide services, it has acknowledged in the context of Article 49 EC that the risk of the financial balance of the social security system being undermined may justify such a restriction in so far as this may have consequences for the overall level of public health protection. [54] On this basis, the Court has accepted prior authorisation requirements as being reasonable and necessary measures for controlling the outflow of patients from the national health insurance system to hospitals in other Member States, as long as the conditions under which authorisation is granted are compatible with Community law.

125. The Court has thus struck a balance between, on the one hand, the freedom, in principle, of patients to receive hospital services in other Member States and, on the other hand, the budgetary concerns of the Member States resulting from persons going outside the national system of health care and health insurance. It has defined the limits within which the Member States are entitled to control these movements with a view to maintaining the financial balance of the national systems. Where a Member State succeeds in demonstrating that the liability of complying with the obligation to fund hospital treatment provided to insured persons in other Member States has reached such a level that it directly threatens the viability of the national system and thereby may undermine the quality and continuity of the provision of health care in its territory, it can justify measures designed to restrict the outflow of patients to acceptable limits. In isolation from a general policy aimed at maintaining the financial stability of the system, budgetary restraints alone cannot, however, justify the restriction of a person's right to receive hospital treatment in another Member State.

126. By reconciling the requirements of the freedom to provide hospital services with the vital interests of the Member States in guaranteeing the stability of their national health care systems, the Court has indicated within which limits budgetary limits can be taken into account. This interpretation fully respects the responsibilities of the Member States for the organisation and delivery of

54 — *Kohll*, at paragraph 41, *Smits and Peerbooms*, at paragraph 72, and *Müller-Fauré*, at paragraphs 72 to 73 (cited in footnote 2).

health care services and medical care within the meaning of Article 152(5) EC.

127. As for Article 22(2) of Regulation No 1408/71, its purpose is to lay down the conditions in which authorisation to receive medical treatment in another Member State may not be refused. While this provision is not intended to limit the circumstances in which authorisation may be granted, it does not permit the Member States to introduce further criteria for refusing authorisation. To the extent that budgetary considerations are related to what may be deemed to be what is a 'normal' waiting time within the Member State, I have already concluded, in conformity with the Court's case-law on this matter, that this criterion may only be applied having regard to the pathological condition of the patient applying for authorisation.

128. In conclusion, Article 49 EC does not permit budgetary considerations to be taken separately into account in determining whether a Member State is obliged to refund the cost of hospital treatment provided in another Member State, except where it is demonstrated that compliance with this obligation on a more general scale would threaten the financial balance of the national health care system. Budgetary considerations cannot be taken into account in decisions refusing authorisation under Article 22 of Regulation No 1408/71. This interpretation is fully compatible with Article 152(2) EC.

VI — Conclusion

129. In view of the foregoing I suggest that the Court provide the following answers to the preliminary questions referred by the Court of Appeal:

(1) Article 49 EC is to be interpreted as meaning that, in principle, persons ordinarily resident in a Member State operating a national health service, such

as the National Health Service in the United Kingdom, are entitled to receive hospital treatment in another Member State at the expense of that national health service. Member States may subject such entitlement to the requirement that the person has obtained prior authorisation, provided such authorisation is based on objective, non-discriminatory and transparent criteria in the context of a procedural system which is easily accessible and capable of ensuring that requests for authorisation are dealt with objectively and impartially within a reasonable time and refusals to grant authorisation are capable of being challenged in judicial or quasi-judicial proceedings. The absence of such criteria and such a procedure cannot deprive a person of such entitlement. It is irrelevant for the purposes of the application of Article 49 EC in the circumstances of the main proceedings whether or not hospital treatment provided by the NHS is itself the provision of services within the meaning of Article 49 EC.

(2) Considerations relating to the management of waiting lists can only justify a refusal to receive hospital treatment in another Member State if these waiting lists are managed in such a way that they take the individual medical needs of patients sufficiently into account and do not prevent treatment being provided in another Member State in case of urgency. Where conditions on granting authorisation to receive hospital treatment in another Member State are designed to guarantee the financial stability of the national health system, considerations of a purely budgetary or economic character cannot justify a refusal to grant such authorisation.

(3) In determining whether treatment is available without undue delay for the purposes of Article 49 EC, it is permissible to have regard to waiting times and the clinical priority accorded to the treatment by the relevant NHS body, on condition that these are based on concrete indications relating to the patient's

condition at the time of assessment, as well as to his medical history and the probable course of the disease in respect of which that patient seeks treatment.

(4) On the proper interpretation of Article 22(1)(c) of Regulation No 1408/71 and in particular the words 'within the time normally necessary for obtaining the treatment in question' the applicable criteria are identical to those in determining questions of 'undue delay' for the purposes of Article 49 EC.

(5) Where a Member State is obliged under Community law to fund the hospital treatment in another Member State of a person ordinarily resident in the first Member State who has received that treatment outside the context of Article 22 of Regulation No 1408/71, the cost of that treatment is to be calculated by reference to the legislation of the Member State of residence. In the absence of tariffs or rates for calculating the amount of reimbursement, reimbursement must be calculated at the actual cost of the treatment received. The costs of travel and accommodation in relation to hospital treatment received in another Member State is only reimbursable where this is provided for in national law for treatment on national territory.

(6) Article 49 EC does not permit budgetary considerations to be taken separately into account in determining whether a Member State is obliged to refund the cost of hospital treatment provided in another Member State, except where it is demonstrated that compliance with this obligation on a more general scale would threaten the financial balance of the national health care system. Budgetary considerations cannot be taken into account in decisions refusing authorisation under Article 22(2) of Regulation No 1408/71.