Health Law Outside its Traditional Frontiers: "Trading" Medical Tourism for Just Health Care in the Post-Brexit Context

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ABSTRACT / RÉSUMÉ

The number of British patients travelling beyond the frontiers of their health care jurisdiction to receive medical treatment has recently increased because of scarcer resources and unreasonable waiting times in NHS health care facilities. As the United Kingdom prepares for its departure from the European Union, the flows of medical tourists seeking health care in EU member states may become the object of important negotiations. The unbounded phenomenon of medical tourism in the atypical political and economic context of Brexit represents a unique opportunity to conceptualize solutions beyond the traditional frontiers of health care law.

Thus, this paper proposes to take an unprecedented approach using a sociological framework based on Niklas Luhmann's work on autopoietic systems to examine the current European legal framework on cross-border health care services and to formulate a concrete policy proposal to achieve greater social justice in health care using marketplace and trade dynamics. A bilateral treaty on cross-border health care services taking the form of a public procurement could uphold universality of care and equality in treatment in the United Kingdom and participating European member states. Established contracts would offer a sustainable solution to issues of continuity of care, medical malpractice and may lead to significant cost reduction in health care.

Les délais considérables en matière de santé et le nombre limité de ressources disponibles au sein du National Health Service (NHS) motivent certains patients britanniques à traverser les frontières de leur pays pour recevoir des traitements médicaux. Alors que le Royaume-Uni se prépare à quitter l'Union européenne, les flux de touristes en quête de soins de santé en Europe devront faire l'objet d'importantes négociations. La présente analyse adopte donc une approche sociologique basée sur la théorie des systèmes autopoïétiques de Niklas Luhman pour étudier le cadre juridique européen actuellement en vigueur, et pour formuler une solution concrète mariant

les dynamiques du commerce international à celles des politiques de santé européennes et britanniques visant à accroître la justice sociale dans ce domaine. Le phénomène sans borne du tourisme médical et le contexte atypique du Brexit représentent une occasion unique permettant d'imaginer des solutions qui vont au-delà des frontières traditionnelles du droit de la santé.

L'accès universel aux soins de santé au Royaume-Uni ainsi que dans les États membres de l'Union européenne pourrait donc être préservé grâce à un traité bilatéral sur les services de santé transfrontaliers. Ce traité prenant la forme de contrats de marché public offre une solution durable aux problèmes de la continuité des soins, de la responsabilité médicale, et entraînera certainement une réduction significative du coût des soins de santé.

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INTRODUCTION

Patients moving across international borders to receive medical services predates antiquity.[1] With modernity, the number of patients travelling beyond the frontiers of their health care jurisdiction has significantly increased because of scarcer resources and unreasonable waiting times in health care facilities. Insurance companies and patients paying out-of-pocket arrange cross-border treatments with little regulatory oversight from governments and without any clearly established international safety standards. Nonetheless, public health care authorities are considering economically efficient ways to commission health care services abroad.[2]

Countries in Europe are both departure and destination points for these medical travellers. Medical tourists in the region fall under four categories. Some patients are temporary visitors or travellers abroad that develop a need for medical care while visiting Europe.[3] Others are retirees that require treatment while residing in another European country.[4] Medical tourists can also be those that travel to Europe on their own initiative to receive treatment, convinced that other European countries can provide them with higher-quality care, shorter waiting times, or treatment that is prohibited in their home country.[5] Finally, because of shortages in health care provision some

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1. See Neil T. Lunt, Russell Mannion and Mark Exworthy, "A Framework for Exploring the Policy Implications of UK Medical Tourism and International Patient Flows" (2013) 47 Soc. Pol. & Adm. 1 at 3.
2. See e.g. Melisa M. Álvarez, Rupa Chanda and Richard D. Smith, "The Potential for Bi-Lateral Agreements in Medical Tourism: A Qualitative Study of Stakeholder Perspectives from the UK and India" (2011) 7 Globalization and Health 1; Leigh G. Turner, "Quality in Health Care and Globalization of Health Services: Accreditation and Regulatory Oversight of Medical Tourism Companies" (2011) 23:1 Int. J. Qual. Health Care 1.
3. See Helena Legido-Quigley et al., "Cross-Border Healthcare in the European Union: Clarifying Patients' Rights" (2011) 342 B.M.J. 364, at 365.
4. *Ibid*.
5. See Luigi Bertinato et al., "Policy Brief: Cross-Border Health Care in Europe" (World Health Organization: 2005); Helena Legido-Quigley, M. McKee and E. Nolte, "Qual-

patients have been sent abroad by their national public health authorities to receive specialized care.[6]

As the United Kingdom (UK) prepares for its departure from the European Union (EU), increasing flows of medical tourists who fall within the latter two categories may become the object of a trade negotiation. Brexit will also have wider implications for the financing and delivery of health care services in the UK. Breaking away from Europe will lead to some changes in the allocation of resources within and outside of the National Health System (NHS). For instance, the provision of health care services could be impacted by the EU's participation in an international partnership. The Union could enter a free trade agreement similar to the now moribund Transatlantic Trade and Investment Partnership (TTIP) and open its economic markets to foreign health care providers. The prices of medical services provided in the EU would then drop, making the region an even more attractive destination for British medical tourists. Conversely, dynamics associated with a deregulation of cross-border trade could hamper universality of care and the social aims of the NHS in the (so far unlikely) event that Britain commits itself to a similar type of agreement with a foreign trade partner. In both scenarios, the deregulation of the health care marketplace would compromise fairness and equality in the access to and the provision of health care services in the UK.

Since its inception, the NHS has embraced a liberal egalitarian conception of justice in health care. Services are provided equally and universally to all patients based on their health status rather than their ability to pay.[7] In a TTIP-like scenario, however, the increasing number of Britons directly purchasing treatments in the EU would neutralize the NHS' commissioning power essential to the universal provision of health care. UK residents unable to cross borders for treatment would see their access to services compromised. Alternatively, under a UK-foreign-trade-partner type of regime, the NHS would see private entities take over the delivery of elective surgeries and minor treatments. Inevitably public funds would be strained and "heavy-lifting" procedures (surgeries, cancer and chronic illness treatments, etc.) would be left to the NHS. It is possible that patients will then reach a point of no return as they become unable to afford

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ity of Care, Patient Orientation, Information to Patients and Professionals" Technical Report. London School of Hygiene and Tropical Medicine, London (2005).

6. See Legido-Quigley, *supra* note 3 at 365.
7. See Rudolf Klein, *The New Politics of the NHS: From Creation to Reinvention* (Oxford, U.K.: Radcliffe Publishing, 2013) at 1.

private care and the NHS becomes unable to offer treatment because of a lack of resources. Inevitably, the two-way system would erode universality of care in the UK.[8]

In this specific context, the undesirable outcomes in health care can be explained by the different and opposite goals of free trade and health care public policy. Economy commits to the idea that an unregulated marketplace is an optimal and efficient instrument for distributing scarce resources. Health care public policy, on the other hand, is preoccupied with social justice and equality, and traditionally assumes that the allocation of important and scarce resources should be left in the hands of government.[9] The EU has tried to deal with these dynamics by mostly excluding health care and social policy from the trade debate. However, the UK's imminent departure from the EU provides an opportunity to re-examine these conflicting goals and potentially reconcile them to produce greater social justice in health care.

In many respects, Niklas Luhmann's theory of "autopoietic social systems"[10] lends itself to this discussion. Luhmann conceives society as a complex structure consisting of many independent subsystems capable of adapting to turbulent environments by proceeding to internal changes. Luhmann's theory also invites a reflection on the conflicting goals of independent and self-reproducing social systems. His sociological work is valuable in determining how the regulation of medical tourism can bring together the two "autopoietic" (independent, opposite and self-reproducing) systems of free trade and health care public policy. Essentially, autopoietic social system theory becomes a sophisticated heuristic to conceptualize how health law can be taken outside of its "traditional frontiers" to regulate the "unbounded" phenomenon of medical tourism.

The first section of the paper therefore proposes to flesh out Luhmann's sociological approach and theorizes how trade law and health

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8. Academics have argued that even currently, the presence of private providers threatens to dismantle the NHS. See generally David J. Hunter, "A Response to Rudolf Klein: A Battle May Have been Won but Perhaps Not the War" (2013) J. Health Politics, Policy & L. 16; Allyson Pollock, "NHS No More?" (2016) Community Practitioner 21.
9. See Christopher McCruden, *Buying Social Justice: Equality, Government Procurement and Legal Change* (Oxford: Oxford Scholarship, 2007) at 1.
10. Niklas Luhmann, *The Differentiation of Society* (New York: Columbia University Press, 1982). See also Niklas Luhmann, *Social Systems*, translated by John Bednarz, Jr. and Dirk Baecker (California: Stanford University Press, 1995).

care policy can increase social justice in health care in the context of medical tourism post-Brexit. The second section of the paper turns to the law regulating medical tourism and external trade relations in the EU to determine whether the current legal framework allows the use of cross-border trade arrangements to explicitly serve the distributive aspects of health care provision. Each of the presented cases on cross-border health care services illustrates the tension between cross-border trade and the foundational EU principle of freedom of movement of persons (in these cases, patients) and the right of member states to dictate their health care policy. This portion of the paper unpacks how the accumulation of this jurisprudence has led to the enactment of Directive 2011/24/EU on Patients' Rights in Cross Border Healthcare,[11] currently in force.

Finally, the paper closes on the possibility of a bilateral trade agreement between the UK and the EU. A UK-EU partnership on medical tourism could formalize the commissioning of health care services in EU member states to solve access issues in the NHS. The bilateral treaty taking the form of a public procurement would uphold universality of care and enhance equality in treatment on both sides. Established contracts would also offer a sustainable solution to issues of continuity of care and medical malpractice often associated with unregulated medical tourism. The competition among EU providers could drive down the price of treatment and indirectly increase access to care in the NHS. Overall, with the allocation of resources remaining in public hands greater social justice in health care in the UK and in the EU could be achieved.

Since a trade agreement pertaining to cross-border health care services is unchartered territory,[12] the formulation of a proposal in this field mandates an interdisciplinary approach. It is essential in order to consider the impact the regulation may have on British and European societies. Furthermore, existing literature on medical tourism has extensively covered the health economics of cross-border treatments at a regional level. It has not, however, thoroughly addressed issues of health care rationing or trade law to achieve solutions that can increase social justice in health care.[13] Recurring themes addressed

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11. E.C., *Commission Directive 2011/24/EU of 9 March 2011 on the application of patients' right in cross-border health care* [2011] O.J., L 88/45.
12. See I. Glenn Cohen, "How to Regulate Medical Tourism (and why it matters for Bioethics)" (2012) Developing 12:1 World Bioethics at 19.
13. See Jonathan Hanefeld et al., "What Do We Know About Medical Tourism? A Review of the Literature with Discussion on its Implications for the UK National Health Service as an Example of a Public Health Care System" (2014) 21:6 J. Travel Medicine at 411.

by previous studies on medical travel include: volumes of patients and their motivation for seeking cross-border treatment,[14] the effect of the phenomenon on destination countries and their health care systems,[15] as well as issues of portability of care.[16] Academic work in the field has been mostly limited to North-South medical tourism and has failed to address cases of patients travelling from western welfare states to a neighbouring country's mature health care system to seek treatment.

The impact of disruptive political and social events that may put greater pressure on health care systems also remains unaddressed by the literature.[17] Brexit's atypical conjecture provides a unique opportunity to fill this gap. The paper's unprecedented approach therefore uses sociology, the European regulation of cross-border health care services, and trade law to formulate a concrete policy proposal to achieve greater social justice in health care. This will enable health law to remedy the challenges posed by the unrestrained phenomenon of medical tourism and to conceptualize solutions beyond jurisdictional frontiers.

I- SOCIAL SYSTEMS, STRUCTURAL COUPLINGS, AND MEDICAL TOURISM

In the 1960s, cognitive biologists Humberto Maturana and Francisco Varela developed a theory to distinguish living from non-living organisms. Living systems, they posited, are self-reproducing as a result of "autopoiesis."[18] Put simply, autopoietic systems repeatedly reproduce and maintain themselves with their own elements.[19]

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14. See e.g. Richard D. Smith, Chanda Rupa and Tangcharoensathien Viroj, "Trade in Health-Related Services" (2009) 373:9663 Lancet 593.
15. See e.g. Sameen Siddiqi et al., "Assessing Trade in Health Services in Countries of the Eastern Mediterranean from a Public Health Perspective" (2010) 25:3 Int. J. Health Plann. Manage. 231.
16. See e.g. Legido-Quigley, *supra* note 3.
17. See Hanefeld et al., *supra* note 13 at 415.
18. Humberto R. Maturana, "The Organization of the Living: A Theory of the Living Organization" (1975) 7:3 Intl. J. Man-Machine Studies 313 at 150; Humberto R. Maturana and Francisco J. Varela, *Autopoiesis and Cognition: The Realization of the Living* (Drdrecht: Reidel, 1975) [Maturana and Varela, Autopoiesis]; Humberto R. Maturana and Francisco J. Varela, *The Tree of Knowledge: The Biological Roots of Human Understanding* (Boston: Shambhala Publications, 1987).
19. See David Seidl, "Luhmann's Theory of Autopoietic Social Systems" (2004) Ludwig-Maximilians-Universität München-Munich School of Management 36.

Sociologists had unsuccessfully attempted to appropriate the concept[20] until Nikals Luhmann made it the basis of his theory. Luhmann's take on autopoiesis offers a solid alternative to the classic models of external agency. Traditional models understand society as an open system, growing and feeding off outside elements and thereby adapting to its environment.[21] Autopoiesis in the social context, however, recognizes self-reference and recursion as fundamental to human society.[22] Society is a complex system that is capable of adapting to turbulent environments by proceeding to internal changes within its structure.[23] Self-contained, self-reproducing, and self-referencing, it is, itself, consisting of autopoietic subsystems (law, politics, the economy, etc.). These subunits also reproduce themselves through communication and their own elements.[24] They are "operationally closed."[25] Luhmann explains:

> Social systems use communications as their particular mode of autopoietic reproduction. Their elements are communications which are recursively produced and reproduced by a network of communications and which cannot exist outside of such a network.[26]

Subsystems therefore communicate within the boundaries of their own systems.[27] They are nonetheless capable of relationships with each other; Luhmann talks about "structural couplings."[28] These connection points lead to the coordination of structural development, and although operations are distinct, a subsystem's structure can

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20. See Stafford Beer, "Preface" in Maturana and Varela, *Autopoiesis*, *supra* note 18, 63.
21. See e.g. Hans-Georg Moeller, *Luhmann Explained: From Souls to Systems* (Chicago: Open Court, 2011) at 13; Seidl, *supra* note 19 at 4.
22. See John Mingers, "Can Social Systems be Autopoietic? Assessing Luhmann's Social Theory" (2002) 50:2 Sociological Rev. 278 at 279.
23. See *ibid*.
24. See Niklas Luhmann, "The Unity of the Legal System" in Gunther Teubner, ed., *Autopoietic Law: A New Approach to Law and Society* (Berlin: Walter de Gruyter, 1988); Seidl, *supra* note 19 at 5; Gunther Teubner, "Introduction to Autopoietic Law" in Gunther Teubner, ed., *Autopoietic Law: A New Approach to Law and Society* (Berlin: Walter de Gruyter, 1988).
25. Niklas Luhmann, "The Autopoiesis of Social Systems" in F. Geyer and J. Van der Zeuwen, eds, *Sociocybernetic Paradoxes: Observation, Control and Evolution of Self-Steering Systems* (London: Sage Publications, 1986) 174 at 174.
26. *Ibid*.
27. See Hans-Georg Moeller, *Luhmann Explained: From Souls to Systems* (Chicago: Open Court, 2011) at 15; Clemens Mattheis, "The System Theory of Niklas Luhmann and the Constitutionalization of the World Society" (2012) 4:2 Goettingen J. Intl. L. 625 at 629.
28. Seidl, *supra* note 19 at 4.

interact with one of the other subsystems.[29] As part of the same overarching structure (society), they are able to form many operational couplings. In this respect, it is possible to imagine coordinating trade and health care public policy's operations to form couplings increasing social justice.

Medical tourism is a phenomenon that impacts trade of services and, indirectly, the economy of the UK and EU member states. It also has significant consequences for domestic health care public policy. From this perspective, medical tourism acts as a structural coupling between the two autopoietic subsystems of trade and health care public policy and therefore provides an interface for communication.

A. Autopoietic Subsystems: Health Care and the Marketplace

Society's subsystems are autonomous and distinct from their environment. They are not only self-referencing but also independent from the core of the social system and evolve within their own structure. The economy, politics, law, science, the media, education, and religion are examples of these subsystems.[30] Even though they are stable and carry their own identity, they are also capable of radical change.[31]

Health care is a subunit of the subsystem of politics. Politics is itself defined by its power to make collective decisions binding.[32] When it comes to health care, politics is concerned with the distribution of resources, namely the financing and provision of health care services. Not only is health care a subject of politics, the unique nature of its resources also makes it a worthy subject of justice. In fact, the role health care plays in modern society, be it to alleviate suffering or eradicate absolute harm, makes it stand out from other generic goods or products. It may also be argued that health care resources are different as a matter of human dignity in that they are necessary to alleviate inherent social inequalities and enable people to fully participate in their societies.[33] The allocation of these resources should therefore follow principles of justice rather than be left in the hands

29. See Mattheis, *supra* note 27 at 631.
30. See Anthony Giddens, *The Constitution of Society* (Cambridge: Polity Press, 1984).
31. See Mingers, *supra* note 22 at 279.
32. See Moeller, *supra* note 27 at 24.
33. See Alicia Ely Yamin, "Shades of Dignity: Exploring the Demands of Equality in Applying Human Rights Frameworks to Health" (2009) 11:2 Health & Human Rights 1 at 1.

of the market. The foundational value of fairness in access to care – either with the aim of providing equal life opportunities or equality in welfare – often motivates health care policy and dominates the distribution of these resources.

For example, some universal health care systems are organized in a manner that allows patients to have access to health care services based on their needs rather than their means. This is the case with the health care systems that embrace principles of equality and solidarity in Europe. The WHO Ljubljana Charter on reforming health care in Europe states that "[h]ealth care reforms must be governed by principles of human dignity, equity, solidarity, and professional ethics."[34] It qualifies health care as a right and highlights the importance of "universal coverage and equitable access [to] care [for] everyone."[35] In this respect, health care policy is its own autopoietic subsystem. Its social aims in the commissioning of services and the provision of care create a self-producing entity with a separate mode of communication based on these unique goals.

At a national level, the NHS also embraces these values of equality and universality. It is the first universal health care system in the world to offer, through general taxation, free health care services at the point of use to all permanent residents in the UK. Some medical professionals and politicians have also upheld the fundamental principle surrounding the equal provision of health care services. The medical profession has strongly argued that health care resources should not be allocated using market logic, as health care resources are unlike any other consumer good. In this sense, the NHS has been a self-reproducing system that has separated profit from the financing and delivery of health care services.

On the other hand, trade, and more particularly the international marketplace, also belong to a social subsystem: the economy. The economy is defined by its ambition to reduce shortage and to satisfy society's needs.[36] Thus, at the heart of the market lies the idea of competition and deregulation. It aims to achieve maximal efficiency by opening exchanges to all stakeholders. The market is an autopoietic subsystem that allows resources to be allocated through free exchanges without any external intervention.

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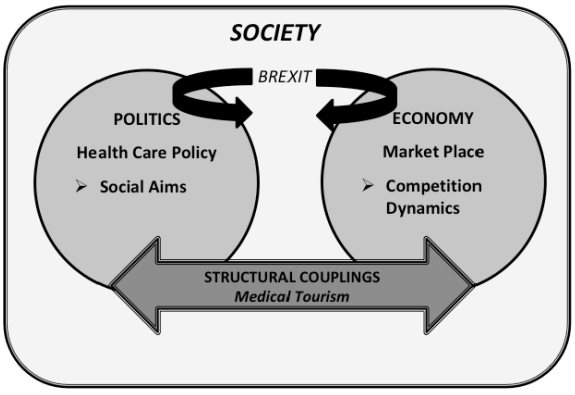
34. WHO, *Ljublyana Charter on Reforming Health Care in Europe*, European Member States of WHO, 19 June 1996, EUR/ICP/CARE 94 01/CN01 Rev. 1 at 5.4.
35. *Ibid* at 5.5.
36. See Moeller, *supra* note 27 at 23.

In this regard, the deregulation associated with free trade and the marketplace may be incompatible with the social aims of health care public policies. Health care systems in Europe are traditionally publicly financed and organized with oversight from governments, leaving little to no place for trade dynamics and market forces. Considering the successive waves of health care reforms in Britain and the inability of governments to tackle health care scarcity issues,[37] one may ask whether public authorities should hold the monopoly on the allocation of health care resources. Perhaps universal access to care could be better achieved and maintained with innovative tools offered by the marketplace.

The answer to these queries may lie in the regulation of growing flows of cross-border medical travels in and out of the United Kingdom that will force structural couplings, i.e. interactions between the independent structures of trade dynamics and public health care policy. Benefits could potentially be derived from the market with the appropriate degree of regulation. Historically, the internal organization of the NHS has proven that communication between these autopoietic systems can achieve some social justice in health care.

Couplings also become more visible through spectacular events that disrupt the system, as was the case for the structural couplings that were created within the structure of the NHS during the 1990s, as further discussed below. Similarly, the UK's departure from the EU may create sufficient disturbance to bring structural couplings to the surface.

SELF-REFERENCING AUTOPOIETIC SYSTEMS



37. See David J. Hunter, *The Health Debate* (Bristol: Policy Press, 2008) at 2.

B. Existing Structural Couplings within the NHS

Founded on William Beveridge's ideal of a unified system based on national solidarity, equality, and universalism, the NHS has provided the entire British population with health care services since 1948. Since then, successive waves of health care reforms have led to the redesign of parts of its financing and delivery structure. One of the biggest overhauls took place during a period of radical reforms in the 1980s. The purchaser-provider divide was introduced to palliate inefficiencies in the health and social system. The idea was to emulate the private sector and offer the possibility of bidding for NHS contracts to trigger more competition and drive down the prices of health care services. This resulted in the creation of a publicly managed health-care trading place. Although it was based on economic principles, universality of care was preserved and equality to access was upheld.[38]

Thus, the seemingly irreconcilable structural attributes of health care public policy and the marketplace have already been brought together within the NHS. Principles borrowed from the economic subsystem were used to work towards achieving social goals. In 1991, strategic health authorities were given the role of purchasing health care services from NHS trusts and general practitioners. These entities had to commission the best services available, irrespective of whether they were dispensed by private or public providers. Their only goal was to cater to the population's health care needs. On the provider side, hospitals (as NHS trusts) had to provide services commissioned by health authorities and General Practitioners fundholding practices. The delivery, purchasing, and planning functions of the NHS were then separated.[39]

Initially, the population and medical professionals were averse to this drastic policy change. Doctors criticized the introduction of market dynamics in health care and social policy. The importance of "value for money" as the basis for provision contracts did not sit well with the medical profession. Doctors disapproved of the process and of the non-medical considerations they had to balance while deciding on a course of treatment. They felt that clinical independence was under threat.[40] They were eventually forced to concede that the NHS' core principle of universality of care based on equality in access were

38. See Klein, *supra* note 7 at 155.
39. See Howard Davies and Hugh Powell, "How to Ration Health Care-and be Re-Elected: The UK Experience" (1991) 3 Stan. L. & Pol'y Rev. 138 at 142.
40. See *ibid* at 143.

unchallenged. The means used to achieve equality in health care were simply different.[41]

The NHS purchaser-provider divide is a compelling example of potential structural couplings between market dynamics and health care public policy. Despite its operative closures, the subsystem of health care public policy opened up to market dynamics and environmental perturbations were certainly a catalyst to this opening. Perhaps the new political and economic climate brought by the UK's departure from the EU could also lead to contact between these autopoietic subsystems. Similarly, British public health authorities could procure health care from EU member states and improve access to care through medical tourism and trade dynamics.

II- THE REGULATION OF MEDICAL TOURISM AND EXTERNAL TRADE RELATIONS IN THE EU

The European Economic Community, established in 1957 and succeeded by the EU in 1992, has facilitated the movement of persons within the European space.[42] Over time, regulation to deal with increasing flows of patients associated with the free movement policy was developed. More specifically, a legal framework for citizens seeking reimbursement of treatments provided in member states outside of their health care jurisdiction was established.[43] In parallel, the EU has become a significant economic power and developed an important external trade policy such that rules governing external relations with foreign trade partners had to be refined. Both of these regulatory frameworks will certainly come into play when constructing post-Brexit relationships around trade and medical services.

A. European Regulation of Medical Tourism

The principle of subsidiarity used to allocate areas of competence between the EU and its member states has indirectly led to some interference with domestic policy making. EU regulation applies directly to member states in the same way as laws enacted through the domestic legislative process. The European corpus also supersedes any conflicting domestic law. This is valid for laws governing health care services, even though the organization and delivery of

41. See Klein, *supra* note 7 at 159.
42. See David Botterill, Guido Pennings and Tomas Mainil, eds, *Medical Tourism and Transnational Health Care* (New York: Palgrave Macmillan, 2013) at 134.
43. See *ibid*.

health and medical care is considered to fall under the purview of the member states.[44] As a result, member states have had to accommodate EU law's principle of free movement of persons[45] impacting decisions regarding the allocation of health care resources within their national health care systems.

Since 2011, the Directive[46] has established a basic legal framework to regulate the provision of cross-border health care services in the EU. The legislation covers treatments regularly offered to patients by their health care jurisdiction but that have been provided in another member state, regardless of how those services are organized, financed, or delivered. The Directive also requires that member states provide safe and high-quality care in their territory and that cross-border services be provided according to domestic safety and quality standards.[47] The UK has complied with this legislation and therefore grants its citizens the right to hospital stays in other member states without advance authorization. In cases of emergencies, the UK also commits to reimbursing health care services up to the amount that would have been provided by the NHS.

The Directive is the result of jurisprudence presented before the European Court of Justice (ECJ) from 1998 to 2003.[48] The rulings of the joint cases of *Kohll* and *Decker* (1998)[49] and of *Geraets-Smits* and *Peerbooms* (2001),[50] as well as the latest case of *Watts* (2006)[51] constitute the essence of the Directive. Prior to the Directive's enactment, Regulation 1408/71 (and later Regulation 883/2004) allowed the reimbursement of emergency care received during temporary visits to another member state via the E111 system, and later via the European health insurance card system.[52] Non-emergency "scheduled" care or

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44. *Consolidated Version of the Treaty of the Functioning of the European Union (2007)*, [2012] O.J. C. 326/47, art. 168 [TFEU].
45. See *ibid*, art. 21.
46. See *Directive 2011/24*, *supra* note 11.
47. See Legido-Quigley et al., *supra* note 3 at 365.
48. Article 56 Treaty of the Functioning European Union "allowed the Court to compensate for the lack of specific rules on cross-border healthcare."
49. E.C.J. *Kohll v. Union des Caisses de Maladie*, Case C-158/96, [1998] E.C.R. I-1931 [*Kohll*]; E.C.J. *Decker v. Caisse de Maladie des Employés Privés*, Case C-120/95, [1998] E.C.R. I-1831 [*Decker*].
50. E.C.J. *B.S.M. Geraets-Smits v. Stichting Ziekenfonds VGZ* and *H.T.M. Peerbooms v. Stichting CZ Groep Zorgverzekeringen*, Case C-157/99, [2001] E.C.R. I-12403 [*Geraets-Smits* and *Peerbooms*].
51. E.C.J. *The Queen, on the application of Yvonne Watts v. Bedford Primary Care Trust, Secretary of State of Health*, Case C-372/04, [2006] E.C.R. I-4325 [*Watts*].
52. See I. Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford: Oxford University Press, 2014) at 169.

"pre-authorized care" was only indirectly regulated by the evolving ECJ rulings in the cases presented below.[53]

1. Kohll *and* Decker

In *Kohll v. Union des Caisses de Maladie*, the request of a Luxembourg national to pre-authorize his daughter's orthodontic treatment in Germany was rejected because of a lack of urgency. However, in the joint case of *Decker v. Caisse de Maladie des Employés Privés*, Nicolas Decker, another Luxembourger, obtained reimbursement for prescription glasses he had purchased in Belgium without his government's prior authorization.[54]

In both cases, the ECJ was asked to determine whether requirements for pre-authorization were subject to the freedom of movement provisions under Articles 49 and 50 of the European Community Treaty.[55] The Court found that the reasons given to justify the restrictions on free movement were insufficient. It stated that prior authorization was creating a barrier to the free movement of patients. Neither public health nor the financial stability of health care systems could justify the infringement of this principle.[56] The Court also added that Regulation 1208/71, which mandates reimbursement based on the tariffs of the member state where the treatment was received, did not have to be interpreted as preventing patients from seeking reimbursement at a domestic rate from their government.[57]

The Court stated that although member states have the freedom to regulate and organize their own social security systems, they must do so in accordance with the principle of free movement of persons. Both cases made clear that the autonomy of member states to oversee the distribution of health care resources is confined to the boundaries set by EU law, unless the general interest of the population requires derogation.[58]

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53. See Botterill, Pennings and Mainil, *supra* note 42 at 135.
54. See Robert F. Rich and Kelly R. Merrick, "Cross-Border Health Care in the European Union: Challenges and Opportunities" (2006) 23 J. Contemp. Health L. & Pol'y 64 at 7.
55. See Cohen, *supra* note 52 at 172.
56. See Kohll, *supra* note 49 at 46; *Decker*, *supra* note 49 at 56-60.
57. See I. Glenn Cohen, "Protecting Patients with Passports: Medical Tourism and the Patient Protective Argument" (2010) 95 Iowa L. Rev. 10 at 1467. See also Cohen, *supra* note 52 at 172.
58. See Rich and Merrick, *supra* note 54 at 9.

Kohll and *Decker* are foundational cases because they illustrate how in reality, two separate and autonomous systems must adapt and find points of contact to survive. The Court had to reconcile the common market, which promoted freedom of exchange within the EU, with member states' social policy, which was concerned with the health care needs of their populations. The tension between these autopoietic systems is relayed in the ruling. Friction between these systems gave rise to an interesting structural coupling. Cross-border health care is no longer the privilege of those who can afford to travel to receive treatment; it has become a universal right for all EU citizens.[59]

2. Geraets-Smits *and* Peerbooms

In 2001, the ECJ heard two other cases relating to prior authorization. The Court issued a single judgment for *Geraets-Smits v. Stichting Ziekenfonds* and *Peerbooms v. Stichting CZ Groep Zorgverzekeringen*. In *Geraets-Smits*, a Dutch national received treatment for his Parkinson's disease in Germany without prior authorization from his government. After paying for the treatment, he turned to the Netherlands Sickness Fund for reimbursement. In *Peerbooms*, a Dutch national went to Austria to receive neurological treatment that was only available on an experimental basis in the Netherlands. He also sought reimbursement from the government post-treatment. In both cases, reimbursement was denied for failure to follow the prior authorization procedure and because both treatments were already available in the patients' health care jurisdiction.[60]

The Netherlands' health care system is organized on a benefit-in-kind basis. Patients are entitled to receive treatment only from providers that have contracted in advance with the National Sickness Fund. Thus, the ECJ had to determine whether the criteria set out in *Decker* and *Kohll*, based on a reimbursement system, also applied to the benefit-in-kind structure and to hospital care. The Court ruled consistently in that it also found the prior-authorization requirement to be in violation of articles 49 and 50 in these cases.[61]

The Court stated that member states were only entitled to withhold authorization in circumstances where an equally effective treatment was available without "undue delay" in the patient's home

59. See *ibid* at 7.
60. See *ibid* at 8.
61. *Ibid*.

country.[62] For this, an evaluation of the patient's present and past conditions had to be conducted on a case-by-case basis. The authorization scheme had to be non-discriminatory and based on non-arbitrary criteria disclosed to the patient ahead of her application.[63]

The ECJ recognized differences between hospital and outpatient services and stated that removing the requirement of prior authorization for inpatient care could seriously endanger the organization of health care systems in the EU by undermining the domestic allocation of health care resources and the organization of the social and care systems.[64] In fact, the Court acknowledged that "if insured persons were at liberty, regardless of the circumstances, to use the services of hospitals with which their sickness insurance fund had no contractual arrangements, whether they were situated in the Netherlands or in another Member State, all the planning which goes into the contractual system in an effort to guarantee a rationalized, stable, balanced and accessible supply of hospital services would be jeopardized at a stroke."[65]

These cases highlight once again the tension between the organization of the national system and dynamics of rationing, particularly in the domain of hospital services and freedom of movement in the EU. On a different but equally important level, the friction between the autopoietic systems of health care policy and the common market is at the heart of this decision. The Court recognizes that cross-border care in the EU should be balanced against the sustainability of member states' social systems. Freedom of movement should not be endangering the organization of health care systems and inversely, member states should not arbitrarily restrict their citizens' freedom to seek treatment outside their health care jurisdiction.[66]

Following these joint cases, the ECJ also addressed the question of the reimbursement rate in *Vanbraekel v. Alliance Nationale des Mutualités Chrétiennes*.[67] In this case, the Court determined that the patients were entitled to whichever reimbursement rate was higher

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62. *Ibid*.
63. See Cohen, *supra* note 52 at 175.
64. See *Geraets-Smits* and *Peerbooms*, *supra* note 50 at 76-80.
65. *Ibid* at 81.
66. See Rich and Merrick, *supra* note 54 at 13.
67. E.C.J. *Abdon Vanbraekel and Others v. Alliance nationale des mutualités chrétiennes*, Case C-368/98, [2001] E.C.R. I-5382.

between the rate in their home country, the member state of affiliation, or the rate in the member state where they sought treatment.[68]

3. Watts

Ms. Watts, a patient of the NHS, was seeking authorization to have her hip-replacement surgery performed in France to avoid the UK's waiting list. Her initial request was denied by the NHS (the Bedford Primary Care Trust) on the grounds that the surgery could be performed in the UK within an acceptable one-year delay.[69] Due to her deteriorating health, she was moved up the waiting list and given priority status with a waiting time of three to four months. Despite the shorter delay, she went to France to promptly receive the treatment. Upon her return her reimbursement claim was denied. She then sought judicial review of the decision.[70]

The Court took this as an opportunity to further clarify the rules on prior authorization. It held that although it is usually a requirement for the reimbursement of cross-border health care services, prior authorization should not be unnecessarily withheld. It restated the criteria established under *Geraets-Smits* and *Peerbooms* and added that the process had to be easily accessible to patients, timely, and challengeable in judicial or quasi-judicial proceeding.[71]

The Court acknowledged that the process was necessary to provide health care authorities with some visibility for planning and allocation purposes. However, the ECJ held that the fact that an intervention could be performed within government-mandated waiting time did not alone constitute a ground for dismissal. A case-by-case analysis had to be conducted by health authorities to determine whether the delay was acceptable or whether it required that the patient seek cross-border health care.[72] It may have been useful for national authorities to put together a list of acceptable waiting times for common procedures to have an informal but objective guidelines based on clinical factors.[73]

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68. See Cohen, *supra* note 52 at 176.
69. Gareth Davies, "The Effect of Mrs Watts' Trip to France on the National Health Service" (2007) 18:1 King's L.J. 158 at 159.
70. See Cohen, *supra* note 52 at 176; Gareth Davies, "The Effect of Mrs Watts' Trip to France on the National Health Service" (2007) 18:1 King's L.J. 158 at 159.
71. See Davies, *supra* note 69 at 161.
72. See *Watts*, *supra* note 51 at 3.
73. See Davies, *supra* note 69 at 165.

The case of *Watts* also affirmed that patients are entitled to the full reimbursement of the cost of treatment received in another member state and that inextricably linked expenses such as travel and accommodation costs may be covered by the member state of affiliation. This applies regardless of whether the treatment was available free of cost in the home country.[74]

The *Watts* case certainly created controversy at the European and national level. The culture of the NHS, based on equality of collective benefits, was challenged by the principle of free movement. Contrary to previous cases, the patient's interests were the heart of the decision rather than health care public policy itself, such that individual justice trumped social justice.[75]

4. EU Directive 2011/24

The ECJ's jurisprudence from 1998 to 2006 was unified by the 2011 Directive. Even though this legislation does not create a unique health care system across the EU, it nevertheless requires member states to reimburse, at the domestic rate, health care services provided to their nationals in any other EU country. The requirement to pre-authorization in particular circumstances (art. 8) and the exclusive competency of member states over the financing and delivery of domestic health care services are also guaranteed.[76] The Directive focused only on scheduled care since emergency services had already been addressed by Regulation 883/2004.[77]

More specifically, the Directive reaffirms the ruling in *Watts* and requires that the denial of prior authorization be justified and restricted. The Directive mentions that it should be limited to instances in which it is necessary to achieve objectives relating to the balancing of a member state's social security budget, or to cater to financial planning needs. It should never be arbitrarily withheld as this would constitute a violation of the fundamental principle of free movement of patients.[78]

According to Article 8(6) of the Directive, a member state can only deny prior authorization in four cases:[79] (1) if, according to a

74. See *Watts*, *supra* note 51 at 143.
75. See Davies, *supra* note 69 at 163.
76. See Botterill, Pennings and Mainil, *supra* note 42 at 135.
77. See Cohen, *supra* note 52 at 179.
78. See Cohen, *supra* note 52 at 180.
79. See *Directive 2011/24*, *supra* note 46, art. 8(6).

clinical assessment, the patient would be exposed to unacceptable risks that outweigh the treatment's benefits, (2) if the general public would be exposed to a substantial safety hazard as a result of the treatment, (3) if the standards and treatment guidelines raise serious concerns for the patient's safety, and (4) if the treatment sought abroad is already available in the domestic health care jurisdiction within a reasonable limit. Even for treatments that are not typically available, member states are not automatically under the obligation to grant prior authorization if the patient can be treated within a medically acceptable delay.[80]

With regard to costs, it is at the discretion of the state of authorization to reimburse any expenses that would not have been covered had the patient been treated in his or her health care jurisdiction. Accommodation or travel costs may be paid directly to the patient in cases where he or she would have been assumed by the domestic health care jurisdiction had treatment been provided at home.[81]

The Directive also expands patients' protection rights. Health care providers are required to supply information to help patients choose among different treatment options. This includes information on availability, quality, safety, and prices of health care services. Member states providing treatments must also ensure that recourse for compensation is made available to patients in cases of medical errors or malpractice. Patients' personal data must also be protected in compliance with EU standards. Finally, member states are responsible for post-treatment care in cases where it would have been made available to the patient had the treatment been provided at home.[82] Overall, the legislation calls for mutual assistance and co-operation among EU member states to coordinate safety, quality of treatment, and information sharing.

The regulation of cross-border health care services in Europe arose out of pure economic interest with a desire to safeguard free movement of patients rather than placing emphasis on their health care rights. Paradoxically, the Directive defines the phenomenon as a citizen's right rather than something pertaining to market dynamics. The Directive exemplifies how health care policy and the market place have come together in the area of medical tourism.[83]

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80. See Cohen, *supra* note 52 at 182.
81. See *ibid* at 183.
82. See *Directive 2011/24*, *supra* note 46, art. 4(2).
83. See Botterill, Pennings and Mainil, *supra* note 42 at 133.

B. EU Regulation of External Trade Relations

The EU constitutes the world's largest trading partner, accounting for 16.5 percent of imports-exports worldwide in 2016.[84] External trade partners are drawn to the region because of the lucrative opportunities that the internal market represents. Also, the EU's capacity to negotiate free trade agreements with a single voice with the Common Commercial Policy (CPP) provides significant economic power to the 28 EU member states.[85]

It was soon after the inception of the European Common Market that external trade policy departed from the European Community's initial inward-looking strategy. The EU progressively embraced a more aggressive free trade agenda, promoting multilateral and bilateral agreements and deep integration.[86] Along with its policy's evolution, the regulation of EU external trade has also progressed to help realize the region's economic ambitions.

EU institutions are competent to act on behalf of member states where treaties have expressly conferred on them the power to do so. Article 5 of the Treaty of the European Union[87] grants, under the CCP, the European Commission the exclusive power to enter into trade agreements on behalf of the Member States. This significantly encroaches on member states' domestic trade powers as over time, the CCP has become quasi-all-encompassing.[88] In fact, the scope of the CCP has been the object of much debate. Article 110 of the Treaty establishing the European Economic Community stated that the policy should "aim to contribute in the common interest, to the harmonious trade and the lowering of customs barriers."[89] Unfortunately, the provision did not expand on the nature of these economic exchanges or whether the CCP extended beyond the traditional trade of goods.[90]

It was not until the Treaty of Amsterdam (1997) and the Treaty of Nice (2001) that trade of services was defined as an integral part

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84. See Official Website of the European Union, "Trade" (March 2016), online: <https://europa.eu/european-union/topics/trade_en>.
85. See Sophie Meunier and Kalypso Nicolaidis, "The European Union as a Conflicted Trade Power" (2006) 13:6 J. European Public Policy 906 at 906.
86. See Billy A. Melo Aranjo, *The EU Deep Trade Agenda: Law and Policy* (Oxford: Oxford University Press, 2016) at 13.
87. Consolidated in the *TFEU*, *supra* note 44,
88. See Aranjo, *supra* note 86 at 50.
89. *Treaty establishing the European Community*, [1957] O.J., C. 224/7, art. 110(1) [TEEC].
90. See *ibid* at 58.

of the CCP.[91] Trade in cultural and audiovisual services, educational services, and social and human health services still constituted a major caveat as they remained under the shared competences of the European Community and the member states.[92] In the Treaty of Lisbon (2007),[93] however, references to shared competences in these areas were removed. Commentators have since concluded that the entirety of trade in services should be interpreted as falling under the exclusive competence of the European Commission.[94]

Thus, despite their sensitive qualities,[95] health care services are now interpreted as falling under the CPP. In the event of post-Brexit negotiations for an agreement on cross-border health care services between the UK and the EU, the European Commission would have the power to act on behalf of the 27 member states. This would certainly simplify the process and avoid the negotiation of 27 bilateral agreements between the UK and each EU member state. The 2011 Directive also facilitates the task, as it offers an ideal template to build on by addressing issues of health care system organization, movement, and health and safety of patients.

III- MEDICAL TOURISM: A CURRENCY TO ACHIEVE SOCIAL JUSTICE IN HEALTH CARE POST-BREXIT?

Waves of incoming medical travellers seeking high quality medical treatments in the UK and inversely, British patients turning to other medical jurisdictions to receive care, have significantly increased since the 1990s. In vitro fertilization, cosmetic and dental surgery, organ and tissue transplantation, and orthopaedic and bariatric surgery are among the most sought-after medical interventions.[96] Europe's geographical proximity makes it a prime destination for British medical tourists. The availability of care in Europe is signifi-

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91. *Treaty of Amsterdam amending the Treaty on European Union, the Treaties establishing the European Communities and certain related acts*, [1997] O.J., C. 340/1; *Treaty of Nice amending the Treaty on European Union, the Treaties establishing the European Communities and certain related acts*, [2001] O.J., C. 80/1.
92. *TEEC*, *supra* 89.
93. *TFEU*, *supra* note 44.
94. See Aranjo, *supra* note 86 at 58.
95. As discussed in Part I.A, health care services in many European welfare states are deemed to have particular features that make them stand out from other goods or products. Accordingly, their distribution should not be purely subject to market forces, but rather requires the oversight of public powers. However, from a trade law perspective, health care services are deemed to fall under the same category as any other goods or services.
96. See Lunt, Mannion and Exworthy, *supra* note 1 at 2.

cantly greater because of the vastly different array of services and technologies offered in each country. Furthermore, in line with the EU Directive, British patients can now seek reimbursement from the NHS to cover the cost of treatments provided in other EU countries.

However, as the UK exits the EU, the Directive will no longer regulate or facilitate cross-border treatments for British patients in the European space. It is therefore likely that unregulated medical tourism will increase. This could have devastating effects on access to care domestically and in the EU. Local European populations may see their health care resources diminished because of British or other medical tourists jeopardizing the organization of European social security frameworks and creating a parallel system of private care. As previously mentioned, the planning and allocation of health care resources for the NHS could also be affected. The lack of regulation could be particularly detrimental to individuals who cannot afford treatment abroad and who remain subject to lengthy waiting times in the UK.

Regardless of whether the procedures are reimbursed by the national system or paid by patients out-of-pocket, post-treatment complications will also continue to give rise to significant costs for the NHS. Without the appropriate framework, physicians following up on medical interventions provided abroad will still not have access to crucial information relating to the course of treatment. Cases of medical malpractice in the cross-border health care context will continue to pose a challenge.

As explained below, the reasons for regulating medical cross-border health care between the UK and the EU reveal that a bilateral framework is best suited to address these issues. They also reveal how trade dynamics are capable of serving the social justice aims of health care public policy in the UK and the EU, if structured in the form of public procurement contracts for the purchase of health care services. The law will allow these autopoietic systems to find common ground and provide a structural coupling in the form of a bilateral trade agreement on cross-border health care.

A. Reasons to Regulate Medical Tourism…

The UK's departure from the EU may be providing an unforeseen opportunity to tackle cross-border health care in an innovative manner. It is worth examining in more detail the reasons supporting the regulation of UK-EU medical tourism through a bilateral agree-

ment to better lay out how trade dynamics and a public procurement structure can help serve these objectives.

1. A More Just Allocation of Resources

In the absolute, more patients seeking interventions abroad should result in shorter waiting lists and better access to care for all. However, the medical exodus of privileged patients will inevitably result in the erosion of the NHS social contract and in crippling the foundational egalitarian principle of universality of care. Wealthier medical travellers will eventually refuse to finance the public system and elect to pay out-of-pocket for all of their medical treatments. This will challenge the taxation system that finances health care services in the UK.

Regulation on cross-border health care services may actually increase patient mobility and bring populations closer to the specialized treatments that are not currently available in the UK. It could also lead to savings for the NHS. EU member states are likely to offer competitive bids to obtain NHS procurement contracts and offer more affordable services. Overall, access within the UK and abroad could be improved by commissioning health care of services from providers in the EU.[97]

A bilateral framework could alleviate pressures on the British health care system and decrease treatment waiting times. The NHS's planning and financing of patients' medical travels would allow for clear benchmarks to be established. A set number of patients would be linked to EU medical facilities and accounted for under the health care policy budget. Scheduled interventions would also help member states plan their budget and determine the resources they wish to allocate to the treatment of British medical tourists. It would prevent the creation of a private and parallel system of care for medical tourists that could erode social justice in these treatment countries.[98]

2. Consistent Treatment of Complications and Continuity of Care

The exact financial burden that post-treatment complications have had on the NHS has not been precisely quantified. However,

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97. See Botterill, Pennings and Mainil, *supra* note 42 at 145; Mark Exworthy and Stephen Peckham, "Access, Choice and Travel: Implications for Health Policy" (2006) 40:3 Social Policy & Administration 267 at 269.
98. See Botterill, Pennings and Mainil, *ibid*.

issues affecting patients after their medical travels are frequent and considered by NHS medical practitioners as undesirable side effects of cross-border treatment.[99]

Patients travelling to receive treatment at a more affordable cost may become suspicious of the quality of care they are receiving and feel more vulnerable or prone to complications. However, there are no correlations between the cost of treatment and its quality. It is often the lack of a constant flow of information between primary care physicians in the UK and treating doctors abroad that increases the need for follow-up visits upon a patient's return.[100] A bilateral agreement could establish a protocol for NHS patients to be closely followed by medical professionals in the UK. This would keep the communication channels open. Incidents relating to a loss of medical records or miscommunication on the course of treatment would therefore be significantly reduced.[101]

3. Reducing Incidence of Medical Errors and Malpractice

Information asymmetry between medical professionals and patients are exacerbated in the context of medical tourism. Complex medical jargon coupled with a language barrier put patients at a significant risk. They are often unable to assess the quality of care or the necessity of treatment, having foregone any consultation with their primary care providers prior to departure. Informed-consent rules and pretreatment counselling are generally omitted.[102] The patient's medical history which relays potential risk factors is often unknown by the treating doctor.[103]

Standard of care and medical malpractice laws vary in treatment countries. Patients are sometimes left with no recourse to obtain compensation or indemnification for the harm they suffered.[104] Language and cultural barriers often hinder a patient's capacity to gain access to justice in a foreign jurisdiction and receive adequate compensation. Medical professionals following up on treatment delivered abroad have also expressed concerns about engaging their liabil-

99. See Hanefeld et al., *supra* note 13 at 413; Turner, *supra* note 2 at 2.
100. See Lunt, Mannion and Exworthy, *supra* note 1 at 7.
101. See Botterill, Pennings and Mainil, *supra* note 42 at 145.
102. See Lunt, Mannion and Exworthy, *supra* note 1 at 8.
103. See Botterill, Pennings and Mainil, *supra* note 42 at 145.
104. See Neil Lunt, Stephen T. Green, Russell Mannion and Daniel Horsfall, "Quality, Safety and Risk in Medical Tourism" in Michael C. Hall, *Medical Tourism: The Ethics, Regulation, and Marketing of Health Mobility* (London, U.K.: Routledge, 2013) 31 at 36.

ity.[105] Thus, a bilateral agreement would provide a clear pathway for continuity of care and a framework to deal with cases of medical malpractice without necessarily engaging the responsibility of NHS medical professionals.[106]

B. With a Bilateral Trade Agreement

The values of equality and universality of care that are the cornerstone of the NHS resonate with the EU's fundamental principles. The Treaty on the Functioning of the European Union mentions that external actions must contribute "to the sustainable development of the Earth, solidarity and mutual respect among peoples, free and fair trade, eradication of poverty and the protection of human rights."[107] The government's participation in the market with the goal of regulating exchanges to achieve greater social justice reflects these ideals. The possibility of a bilateral trade agreement on cross-border health care services between the UK and the EU should therefore be addressed.

This agreement could take the form of a series of public procurement contracts: agreements that are designed to structure public powers' purchase of goods and services.[108] In the case of a post-Brexit UK, this could translate into having groups who are in charge of commissioning health care services for the NHS purchase and arrange treatments in EU member states' health care facilities. These contracts would be structured in terms that would provide a sustainable solution to issues of continuity of care and medical malpractice. Furthermore, the competition among the EU bidders would lead to lower prices for treatments and indirectly better access to care.

1. The Public Procurement Structure

Similar to the purchaser-provider model of the NHS, a bilateral agreement in the form of public procurement contracts will create structural couplings between the autopoietic systems of the economy and politics. Trade of health care services will be regulated in order to achieve health care public policy's social justice aims. Public purchasing power and market forces will come together to improve the allocation of resources and increase patients' safety and well-

105. See Rory Johnston et al., "Canadian Family Doctors' Roles and Responsibilities Toward Outbound Medical Tourists: 'Our True Role Is... Within the Confines of our System'"(2013) 59:12 Cdn. Family Physician 1314.
106. See Lunt, Mannion and Exworthy, *supra* note 1 at 8-9.
107. *TFEU*, *supra* note 44 at art. 3.
108. See Aranjo, *supra* note 86 at 203.

being. However, trading health care services should not result in the commodification of these unique resources, as this could endanger universality of care in the UK and EU member states. The commissioning of services outside of the NHS has to remain a governmental prerogative.[109] In economic terms, this would result in abandoning the logic of Pareto efficiency where better health care for certain patients results in sacrificing resources for others, in order to build on comparative advantage dynamics resulting in more affordable health care and better allocation of resources in the UK and participating EU countries.

Periodically, the NHS will budget for a set number of patients in need of costly medical interventions to be sent to EU facilities to receive specialized care at a competitive price. Standard operating procedures will be established to guarantee continuity of care and facilitate the communication between British medical professionals and EU treating doctors. Competitive bids from EU member states will lead to lower costs for treatments and more effective health care planning on the part of the NHS. EU countries' social security systems will not be compromised by a two-way system because of the limited number of interventions. On the contrary, EU member states will be able to plan the allocation of these resources and redistribute the earnings within their own health care services. The market for cross-border care will thereby be indirectly regulated by NHS procurement contracts without hampering competitive forces or social justice.[110]

2. The Concrete Provisions

The NHS will no longer be put in a position to assume unidentifiable costs for patients seeking medical procedures in Europe. The amount of trade will be formalized under the agreement to account for the number of patients, specific health facilities, and the negotiated prices. Certainty relating to the price of treatment and patient numbers will not only facilitate financial planning but also make for a more transparent process. Altogether, bilateral trade will facilitate a more just allocation of NHS resources.[111]

Patients' freedom of choice will not be significantly limited. The overarching agreement could establish a network of European providers that allows patients to be sent to the medical facility providing

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109. See Ramya M. Vijaya, "Medical Tourism: Revenue Generation or International Transfer of Healthcare Problems?" (2010) 44:1 J. Economic Issues 53 at 56.
110. See McCruden, *supra* note 9 at 25.
111. See Álvarez, Chanda and Smith, *supra* note 2 at 6.

the most appropriate treatment for their condition. Most often, cross-border patients pose a challenge to their primary care physicians who are unable to "gatekeep" access to specialized care abroad. Therefore, an upstream standard operating procedure will be embedded in the agreement.[112]

Participating medical facilities will be authorized to treat NHS patients only if it is established that the quality of care they offer is up to NHS standards. An accreditation system could also be part of the agreement to avoid exposing patients and the local population to health risks. A common standard of training and practice for physicians working in these facilities could also be covered under the agreement, as well as a procedure for incidents of medical malpractice.[113] The British government and participating member states would contribute to a no-fault compensation fund to indemnify patients thereby avoiding unnecessary litigation costs for the NHS and the patients.

Electronic record keeping and sharing between the NHS referring doctors and EU treating physicians will facilitate continuity of care and reduce incidences of medical errors. The pre-established communication between the different members of a treatment team and a mandatory visit to a primary care doctor upon return will also significantly reduce costs associated with post-treatment complications.[114]

CONCLUSION

In previous studies, emphasis was put on patients' movements across physical and virtual (in the case of the EU) geographical boundaries to receive treatment. Flows of patients from the "north" seeking treatment in another mature health care system were unaccounted for. Consequences of medical tourism on the domestic health care jurisdictions were, for the most part, left in the background. Therefore, in addition to highlighting growing trends in medical travel, this paper has adopted a sociological approach to the regulation of medical tourism. This has allowed for a trans-systemic view of the issues to emerge. The autopoietic systems of public health care policy and the marketplace will have to form structural couplings to help the British and other European health care systems communicate more effectively and provide fairer access to care for Britons and Europeans.

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112. See Johnston, et al., *supra* note 105 at 113.
113. See Lunt, Mannion and Exworthy, *supra* note 1 at 9.
114. See *ibid* at 9.

Medical tourism is defined as a transnational phenomenon, and even though Brexit is a clear step towards restoring borders between the UK and the EU, now more than ever before, it mandates a certain degree of regulation to ensure patient safety, uniformity of care and a just allocation of health care resources. This new and atypical political and economic context provides a perfect storm to build an adequate legal framework, and most importantly, to achieve greater social justice in health care.

Indeed, the UK's departure from the EU will create important disruptions that will force trade and public health policy to be re-examined. Brexit will trigger an overhaul in the NHS as resources become scarcer with the changing economic context. Niklas Luhmann's autopoietic systems theory provides an excellent backdrop for theorizing how seemingly irreconcilable systems can be brought together. It demonstrates how disruptive events are capable of creating pathways for communication and therefore potentially solving access and scarcity issues in health care. Medical tourism may be an avenue to bridge trade and public health policy as the British government turns to the EU to form a partnership to regulate cross-border health care services.

The current European legal framework allows for trade arrangements to serve the distributive aspect of health care provision. Although freedom of movement remains at the core of the ECJ's jurisprudence, it does not preclude a more concrete framework for the delivery of care in the EU to be established. The series of cases leading to the enactment of the Directive illustrate the tension between the economic goals of the Union and the right of European citizens to access health care services throughout the EU, regardless of national borders. It also provides insight on the regulation of potentially the largest market for medical tourism and how publicly financed health care systems are affected by this phenomenon.[115] European trade law, for its part, interprets health care services as falling within the competences of the EU and thus allows for a more straightforward and direct negotiation process between the UK and the European Commission.

A free trade agreement on medical tourism taking the form of a public procurement could provide sufficient structural couplings to have trade and public health care policy enter into a dialogue to

115. See Cohen, *supra* note 52 at 170.

achieve greater social justice in the UK and the EU. A trade agreement on medical tourism would certainly improve equality in access across the board, as it would provide a tool to plan and better allocate resources on both sides. A bilateral agreement would also reduce risks of medical malpractice and complications associated with the lack of standardized procedures and regulations of health care services delivered abroad. Indeed, formalizing the commissioning of health care services to EU member states can solve the many issues that have arisen out of unregulated medical tourism. The flow of UK patients seeking treatment in EU member states, currently considered by public authorities as a liability for the NHS, may transform into a solution to solve issues of undue delay and limited access to care.