KAMU HUKUKU/PUBLIC LAW
Araştırma Makalesi / Research Article

Medical Tourism in European Union Law and the Impact of CJEU Decisions*

Avrupa Birliği Hukukunda Medikal Turizm ve ABAD Kararlarının Etkisi

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ABSTRACT

European Union (EU) Member States are known for their high-quality healthcare standards. Therefore, medical tourists prefer EU countries for various medical procedures. Not only international patients, but also regional medical mobility, are observed within the Union. However, the biggest obstacle to intra-EU patient mobility is the exclusive competence that EU Member States have over healthcare services. The European Court of Justice (CJEU) has played a significant role in overcoming this barrier and promoting the growth of medical tourism within the EU. This study was designed to understand the impact of CJEU on EU medical tourism. In this context, the study focuses on examining the influence of CJEU on EU medical tourism. The findings of the study indicate that the impact of CJEU has been to facilitate the removal of national barriers to access to cross-border healthcare services for citizens of EU Member States. CJEU's decisions have enabled easier access to cross-border healthcare services for patients and contributed to the growth of medical tourism. In conclusion, CJEU's decisions are a significant factor in advancing the free movement of healthcare services among EU countries and making substantial contributions to the growth of medical tourism.

Keywords: CJEU decisions, European Union, medical tourism, free movement, Grogan case.

* Makale gönderim tarihi: 04.06.2024. Makale kabul tarihi: 26.06.2025. Muzaffer Akdoğan, "Medical Tourism in European Union Law and the Impact of CJEU Decisions", *İstanbul Medipol Üniversitesi Hukuk Fakültesi Dergisi*, Cilt 12, Sayı 2, 2025, ss. 504-526, DOI: https://doi. org/10.46547/imuhfd.2025.12.2.1

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Çatışma Beyanı: Yazar/lar herhangi bir çatışma beyanı bildirmemiştir.
Conflict of Interest Statement: The author(s) have declared no conflict of interest.

ÖZ

Avrupa Birliği (AB) Üye Devletleri, yüksek kalitede sağlık hizmetleri standartlarına sahip olmalarıyla bilinir. Bu nedenle, medikal turistler, çeşitli tıbbi işlemler için AB ülkelerini tercih etmektedir. Sadece uluslararası hastalar değil, aynı zamanda Birlik içinde de medikal hareketlilik görülmektedir. Ancak, AB içinde hasta hareketliliğine yönelik bu bölgesel yaklaşımın önündeki en büyük engel, AB Üye Devletlerinin sağlık hizmetlerine ilişkin sahip oldukları münhasır yetkidir. Avrupa Birliği Adalet Divanı (ABAD), bu engelin aşılmasında ve medikal turizmin gelişiminde önemli bir rol oynamıştır. Bu çalışma, ABAD'ın AB medikal turizmi üzerindeki etkisini anlamak amacıyla tasarlanmıştır. Bu bağlamda çalışma, ABAD'ın AB medikal turizmine olan etkisini incelemeye odaklanmıştır. Çalışma bulguları, ABAD'ın etkisinin, AB Üye Devletlerinin vatandaşlarının sınır ötesi sağlık hizmetlerine erişiminde ulusal engelleri aşmayı kolaylaştırmak olduğunu göstermektedir. ABAD'ın kararları, hastaların sınır ötesi sağlık hizmetlerine daha kolay erişmelerine ve medikal turizmin büyümesine katkıda bulunmalarına olanak tanımıştır. Sonuç olarak, ABAD'ın kararları, AB ülkeleri arasında sağlık hizmetlerinin serbest dolaşımını teşvik eden ve medikal turizmin gelişimine katkıda bulunan önemli bir faktördür.

Anahtar Kelimeler: ABAD kararları, Avrupa Birliği, medikal turizm, serbest dolaşım, Grogan davası.

Introduction

Medical tourism is a concept that refers to patients traveling to other countries to receive health services. The European Union (EU) is both a source and a destination for medical tourism. However, EU countries have high quality standards in healthcare services. Therefore, medical tourists prefer EU countries for various medical procedures.

International patients exhibit mobility, both at the regional level and globally. In Europe, patient mobility is realized through a regional approach. The EU facilitates this patient mobility through a series of legal regulations in the field of cross-border healthcare services. In particular, the "Cross-Border Health Services Directive" aims to ease EU citizens' access to healthcare services between EU countries. This Directive regulates the ability of patients to receive healthcare services in another EU country and the reimbursement of the costs of these services.

This study aims to understand the impact of the Court of Justice of the European Union (CJEU) on the development of EU medical tourism. In this context,

the focus of the study is to examine the influence of the CJEU on EU medical tourism. A literature review was preferred as the data collection method in the study. The sources used for the research consist of primary and secondary legal documents and literature data. The collected data were examined with a qualitative approach and presented in a descriptive manner.

The findings of the present study contribute to the understanding of the role of the CJEU in the development of EU medical tourism, and its impact. The primary finding, reached through the literature review, is that the most significant impact of the CJEU on medical tourism is in facilitating access to cross-border healthcare services for citizens of EU Member States. The decisions of the CJEU have facilitated EU citizens' access to cross-border healthcare services and regulated the financing of these services. These decisions are one of the key factors contributing to the growth of medical tourism and promoting the free movement of healthcare services among EU countries.

I. Medical Tourism in the European Union

Advances in health care and medical infrastructure in the EU are a factor supporting the development of medical tourism within the Union. Therefore, in understanding the issue of medical tourism within the Union, it is important to start by providing information about EU healthcare services and health tourism.

A. Health Services in the European Union

In EU Member States, healthcare services are typically provided through collaboration between the public and private sectors, and citizens have the right to access comprehensive medical services. Therefore, healthcare services in the EU are the subject of significant public expenditure, and are also closely associated with complex national social insurance programs. The EU has been influenced by specific cases concerning the free movement of individuals and the judgments of the CJEU on this issue. European public procurement and competition legislation has significantly influenced the regulation of health care in the Member States, leading to the adoption of specific rules at European level to recognize the specific nature of health care. However, the issue of access to health care has become a part of governance mechanisms, as a requirement of the EU's soft macroeconomic policy[1].

The EU does not have a single healthcare system. EU Member States have exclusive competence in this area, and each provides healthcare services to their

1 Anniek de Ruijter, *EU Health Law & Policy: The Expansion of EU Power in Public Health and Health Care*, Oxford University Press, Oxford, 2019, p. 79.

citizens. There are two primary healthcare systems in the Union: Beveridge and Bismarck. However, both systems should be considered to some extent as hybrids. In the Beveridge system, as used in the United Kingdom's National Health Service, healthcare services are funded through general taxation and are typically provided to patients free of charge at the point of use. Countries such as Italy, Spain, Greece, Portugal, Denmark, Ireland, Finland, and Sweden also use this system. In the Bismarck system, as in Germany, healthcare services are financed through social insurance funds via mandatory contributions. These funds are used to pay healthcare providers for the services rendered. The differences among healthcare systems in the EU partly explain the mobility observed in cross-border care: Service providers in one Member State can offer very different services and technologies compared to another. The interaction between these systems is quite complex for EU medical tourism, as patients may transition from one system to another while seeking cross-border care[2].

Individual health care and medical care are important goals of EU health policy. Specifically, adhering to the principle of universal access, all Member States in the EU are influenced by welfare state arrangements and social insurance benefits that are central to the redistribution of value[3]. With the Lisbon Treaty, Member States have had the opportunity to reaffirm their autonomy concerning access to individual health services[4]. Article 152(5) of the Treaty on the European Community (TEC) initially reads as follows: "Community action in the field of public health shall fully respect the responsibilities of the Member States for the organization and delivery of health services and medical care."[5] However, the Treaty on the Functioning of the European Union (TFEU), which was renumbered in the Lisbon Treaty, added the phrase, "The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them." to Article 168(7)[6].

EU Member States are responsible for the provision of health services within their national borders. Therefore, health services are not included in the EU

2 I. Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics*, Oxford University Press, New York, 2014, p. 171 and 172.

3 Council of the European Union, *Council Conclusions on Common Values and Principles in European Union Health Systems,* OJ 146/01, 2006/C.

4 de Ruijter, p. 78.

5 Official Journal of the European Communities, *Consolidated Version of the Treaty Establishing the European Community*, https://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:12002E/TXT (24.12.2002).

6 Official Journal of the European Union, *Consolidated Version of the Treaty on the Functioning of the European Union,* OJ C 326, http://data.europa.eu/eli/treaty/tfeu_2012/oj (26.10.2012).

Treaties as a responsibility of the Union. Nevertheless, the EU's formal policy area includes provisions affecting health services[7]. In some cases, the EU has appeared to intervene in the governance of healthcare systems within its Member States. One of these interventions of the EU is related to freedom of settlement. A healthcare professional who settles in another Member State has their medical qualifications recognized by the Union rules. Article 53(2) TFEU deals with the medical profession. The provision of the Article ensures the necessary coordination between the Member States and the removal of restrictions on the freedom of establishment. Another way the EU intervenes in healthcare services is by establishing and developing reference centers, particularly focused on rare diseases that require specialized care, networks, and facilities. The idea behind these centers in EU hospitals is to contribute to economies of scale within the EU and support efforts focused on treatment and research in the field of rare diseases. However, such intervention by the EU is entirely related to the soft coordination of healthcare workers and hospital representatives of the Member States. In the field of e-health, soft coordination and incentives allow the EU to be involved in health policy. The aim here is not for the physician to go abroad to treat the patient, but for the patient to be treated cross-border through telemedicine or tele-surgery based on medical imaging[8].

B. Health Tourism in the European Union

A 2014 study by Mainil and colleagues on behalf of the European Parliament's Transport and Tourism Committee estimated that there were 61.1 million health tourists traveling within the EU-28, of which 56.0 million were domestic and 5.1 million were international[9]. This sector generates revenues of 46.9 billion euros, of which 4.6% corresponds to total tourism revenues and 0.33% to EU-28 gross domestic product. It can be concluded that this market is stable and is expected to show an increase in revenues every year[10].

In the EU region, qualified healthcare professionals (doctors and nurses) migrate to the United Kingdom, Germany, and Sweden, while patients move in

7 Herbert E. G. M. Hermans, "Cross-Border Health Care in the European Union: Recent Legal Implications of 'Decker and Kohll'", *Journal of Evaluation in Clinical Practice*, Volume 6, Issues 4, 2000, p. 432.

8 de Ruijter, p. 83 and 84.

9 Tomas Mainil, Eke Eijgelaar, Jeroen Klijs, Jeroen Nawijn, Paul Peeters, *Research for TRAN Committee – Health Tourism in the EU: A General Investigation*, European Parliament, Policy Department for Structural and Cohesion Policies, Brussels, 2017, p. 26.

10 Sabina Hodzic, Hana Paleka, "Health Tourism in the European Union: Financial Effects and Future Prospects", 9th International Conference of the School of Economics and Business Conference Proceedings, pp. 162-174. https://www.efsa.unsa.ba/ef/sites/default/files/ices2018_conference_proceedings_final_version_2.pdf (12.10.2018).

the opposite direction to Poland, Latvia, and Hungary[11]. Generally, Europeans, excluding Eastern European countries, are more willing to travel for quality health care and reduced waiting times rather than lower costs. While 53% of EU citizens are willing to travel abroad for health care, this percentage varies significantly among Member States. For instance, it is as high as 88% in Cyprus, while in Finland, it drops to 26%, because many people in Finland are satisfied with local services[12].

EU Member States generally have modern healthcare systems that provide high-quality healthcare services. Developed public healthcare services and medical infrastructure are a feature that enhances the potential for health tourism within the EU. Healthcare services in EU Member States; hospitals, clinics, and health centers are equipped with modern medical technology and expert staff. These high-quality healthcare services serve as an attractive factor that encourages the flow of international patients. There are patients who come to EU countries for health tourism, especially for rare diseases, complex surgical interventions, or treatments requiring expertise. Additionally, Europe's central location and transport infrastructure make it an accessible destination. This advantageous position enables some EU Member States to play a leading role in the global health tourism market[13]. However, mobility of Union citizens within the EU also draws attention to controversial issues, such as abortion. In places where abortion is illegal, or where there is a fear of social stigmatization, pregnant women seeking to terminate their pregnancies may travel to countries where they can access such services. For example, Polish women often end their pregnancies in Belarus or Ukraine to escape their country's abortion bans, while relatively wealthy women go to nearby EU countries (such as Slovakia and the Czech Republic) or to more expensive countries (such as Germany, Austria, and Belgium). Many Western European countries, particularly Sweden and Spain, have become destinations for women seeking late-term abortions, and Barcelona is known as Europe's abortion capital, for women from many parts of the continent to escape late-term abortion bans[14].

Today, many countries offer a variety of established and trial-stage treatments to international patients. These services are provided in accordance with the EU Directive (2011/24/EU), which grants EU residents the right to seek health

11 John Connell, *Medical Tourism*, CAB International, 2011, p. 114.

12 Connell, p. 119.

13 Hodzic, Paleka, p. 168.

14 Connell, p. 143.

care and access to these treatments within EU Member States, with limited restrictions[15]. However, Mainil et al. (2017) view the Directive 2011/24/EU as a missed opportunity for the development of medical tourism and specialized accommodations and services, due to its inadequate alignment with national laws[16]. Nevertheless, the economic impact of health tourism in the EU cannot be ignored, despite incomplete data[17]. Medical tourism is likely to grow in the EU. Because patients are encouraged to cross borders within EU Member State systems[18].

The lack of a common definition for health tourism and the difficulty in tracking statistical data in this area are fundamental weaknesses hindering the development of health tourism. Undoubtedly, the insufficient awareness of Directive 2011/24/EU, which regulates this field, is a significant obstacle to utilizing the potential of health tourists within the Union. In addition, there is a lack of cooperation and grouping among health tourism enterprises, as well as a deficiency in joint promotion and collaboration[19].

C. Medical Tourism in EU Cross-Border Healthcare Regulations

The distinction between medical tourism and cross-border healthcare services is becoming increasingly blurred. In Europe, the movement of patients across national borders is a significant phenomenon, and Europe's approach and practices differ from those in Asia or America. The EU's Member States, adhering to the principle that health is a public good and a right of citizenship, have developed robust social security systems. In the context of European integration, the term "cross-border healthcare" has gained prominence in discussions concerning the provision of healthcare services across national boundaries. Therefore, the term "medical tourism" has become more common in European countries, as well as cross-border healthcare services[20].

The EU project's primary objective is to achieve economic integration by eliminating barriers to the free movement of goods, services, persons, and capital within the EU internal market. When it comes to healthcare services,

15 Sharon Kleefield, "Choosing the Good Hospital: Helping Medical Tourists Make Informed Decisions", Ed. Melanie Kay Smith, László Puczkó, *The Routledge Handbook of Health Tourism*, Routledge, Abingdon and New York, 2016, p. 234.

16 Mainil, Eijgelaar, Klijs, Nawijn, Peeters, p. 67.

17 Hodzic, Paleka, p. 171.

18 Connell, p. 176.

19 Hodzic, Paleka, p. 168.

20 David Botterill, Tomas Mainil, Guido Pennings, "Introduction", Ed. David Botterill, Guido Pennings, Tomas Mainil, *Medical Tourism and Transnational Health Care*, Palgrave Macmillan, London, 2013, p. 2.

the main principle considered is the freedom to provide and receive services, as outlined in Article 56 of the TFEU. Article 56 prohibits any restrictions on the freedom to provide services. The CJEU has recognized that this prohibition can also apply to restrictions on the freedom to receive services. In the case of cross-border healthcare services, the CJEU has relied on Article 56 to limit any restrictions. The CJEU has determined that health services, which are provided for a fee, indirectly fall within the scope of the TFEU[21].

In their study, Mainil et al. (2013) argue that the discussion about patients being both citizens and consumers within the EU, particularly in the context of medical travel and the provision of healthcare services, should focus on the perspective of the patient rather than the medical tourism industry. They highlight that European law addresses the dual role of patients through mechanisms that regulate cross-border relations and Directive 2011/24/EU, which is also known as the Patients' Rights Directive. The authors emphasize that when European citizens seek healthcare services in a country that is not their own, they perceive themselves not only as consumers, but also as citizens. This suggests that the debate on this topic should prioritize the rights and needs of the patients, rather than solely focusing on the interests of the medical tourism industry[22].

The legal rules governing cross-border health care in Europe have evolved over time, shaped more by economic interests, legislation, and case law than by EU or Member State health policies. Hence, the definition of cross-border health care within the EU is intertwined with not only consumer capabilities but also citizens' rights, creating a sort of paradox. EU citizens receiving health care in another Member State are no different from other patients traveling for treatment anywhere in the world.

The EU prioritizes the free movement of people, capital, goods, and services across its Member States. Article 119 TFEU (ex Article 4 TEC) ensures that EU citizens benefit from an economic policy grounded in the principles of a free, competitive, and open market economy[23]. Therefore, the legal framework governing cross-border health care in Europe is largely influenced by economic factors, as reflected in the political and judicial decisions made in this area[24].

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21 Cohen, p. 173 and 174.

22 Tomas Mainil, Matt Commers, Kai Michelsen, "The European Cross-Border Patient as Both Citizen and Consumer: Public Health and Health System Implications", Ed. David Botterill, Guido Pennings, Tomas Mainil, *Medical Tourism and Transnational Health Care,* Palgrave Macmillan, London, 2013, p. 132.

23 Official Journal of the European Union, *OJ C 326,* (26.10.2012).

24 Mainil, Commers, Michelsen, p. 133.

Mainil et al. (2013) distinguish between 2 types of patients: Cross-Border Access Searchers (CBAS) and Trans-Border Access Seekers (TBAS). These two classifications result in four types of patient mobility, each involving a distinction between public and private health care. This patient mobility is shown in Table 1[25].

Table 1. Typology of Cross-Border Patient Mobility

	Type	Patient Type	Patient Characteristic	Example Case
CBAS	Public	Patients' use of a proximal healthcare system through the public insurance system	Acting within the framework of citizen and cross-border health care; other criteria include cultural proximity and the patient's access to information	Dutch people crossing the border to receive healthcare in Belgium
	Private	Patients using a healthcare system close to their own financial resources	Consumer, medical tourist and primary outlet; cultural proximity and patient access to information	Patients from the UK receiving treatment in Belgium for treatments not covered by health insurance
TBAS	Public	Patients using a distance healthcare system through the public insurance system	Acting within the framework of citizen and cross-border health services; cultural proximity and the patient's extensive seeking behavior	Arab patients covered by insurance traveling for cancer treatment in Germany receive treatment
	Private	Patients using a distance healthcare system with their own financial resources	Consumer, medical tourist and primary outlet; cultural proximity and the patient's extensive seeking behavior	Russian patients paying out of pocket for stem cell treatment in Germany

The proposed typology is based on a concept of citizenship defined by social coordination mechanisms and the Patients' Rights Directive (2011/24/EU), making citizenship the foundation of EU cross-border health care[26].

D. Evaluation of Medical Tourism as a Service

Medical tourism poses a significant challenge for the EU. The primary issue is balancing the sovereign rights of Member States to regulate their social security systems, especially regarding healthcare access, with the EU's commitment to ensuring the free movement of people, goods, capital, and services. Understanding how EU jurisprudence addresses this issue is important, not only to grasp the significance of medical tourism as a substantial market, but also to consider the challenges it poses to publicly funded health insurance systems in a broader context[27].

In Europe, as in other regions such as Canada and the United States, there are also cross-border movements in Africa, Asia, and the Middle East. However,

25 Mainil, Commers, Michelsen, p. 140 and 141.

26 Mainil, Commers, Michelsen, p. 133.

27 Cohen, p. 173.

a large part of medical tourism consists of regional movements and, contrary to popular belief, it is not carried out to distant developed countries[28]. While medical tourism is commonly understood as patients from relatively affluent developed countries seeking treatment in developing countries like India and Thailand, within Europe, there are significant differences in treatment costs between countries. Moreover, the expansion and integration of the EU have led to increased mobility of patients (and healthcare workers) within the EU region[29]. Medical tourism has long been a growing phenomenon in the historic centers of Europe and has recently gained prominence as an elite form of mobility within the EU's cross border movements[30].

In the 1990s, there were efforts to improve access to cross-border healthcare services for patients in the EU. However, concerns arose about Member States losing control over their own health systems due to the influence of the CJEU. Additionally, the requirement for patients to travel abroad and obtain authorization from the host country's health authority posed a significant problem. Therefore, access to cross-border health care was considered a limited right. Member States have historically used prior authorization methods to restrict access to such services, viewing cross-border health care as health tourism rather than a medical necessity[31].

When the CJEU started playing a significant role in establishing the right to health care in Europe by directly using the primary provisions in the Treaties, it changed the rules of the game. It has even been claimed that the Court adopted a "patient-centered" and "needs-based" approach in this context. In the 1991 Grogan case, the Court ruled that, under EU law, the provision of abortion services is considered part of the freedom to provide services[32].

Article 57 TFEU (ex Article 50 TEC) outlines the definition of "services." It includes all activities typically provided for remuneration and not governed by the rules on the free movement of goods, capital, and persons. Services particularly encompass industrial, commercial, craft, and professional activities. Subject to the right of establishment, individuals seeking to provide services may temporarily carry out their activities in another Member State

28 Connell, p. 3.

29 Irene A. Glinos, Rita Baeten, Hans Maarse, "Purchasing Health Services Abroad: Practices of Cross-Border Contracting and Patient Mobility in Six European Countries", *Health Policy*, Volume 95, Issues 2-3, 2010, pp. 103-112.

30 Connell, p. 56.

31 de Ruijter, p. 81.

32 Case 159/90, The Society for the Protection of Unborn Children Ireland Ltd v. Stephen Grogan and others, ECR 4685, 1991.

under the same conditions as those applied to nationals of that State. This provision of Article 57 pertains exclusively to commercial activities, thereby excluding charitable activities, religious activities, and public education.

The CJEU has interpreted the concept of "services" broadly in its decisions. Below are some examples of activities that are considered to constitute services[33]:

- Activities of businesses engaged in trade and industry;
- Professional services, such as law or medicine;
- Tourism and travel services;
- Educational services, although public education is generally excluded from this scope;
- Health services;
- Advertising and marketing services;
- Banking and financial services;
- Transportation and logistics services;
- Information technology and IT services;
- Construction and engineering services.

The CJEU has adopted an approach aimed at facilitating the cross-border movement and trade of services, and it has issued significant rulings on the free movement of these services. Some of the cases interpreted by the CJEU as services are shown in Table 2.

Table 2. Cases Interpreted by the CJEU as Service

Service Activity	Cases
Medical Treatment	Müller-Fauré v. Onderlinge Waarborgmaatschappij OZ Zorgverzekeringen UA (C-385/99) [2003] ECR I-4509
Abortion	The Society for the Protection of Unborn Children Ireland Ltd v. Stephen Grogan and others (C-159/90) [1991] ECR I-4685
Tourism	Salah Oulane v. Minister voor Vreemdelingenzaken en Integratie (C-215/03) [2005] ECR I-1215

The Grogan case in Ireland involved employees of a student union providing information to pregnant women seeking abortion options in other countries. This included publishing the details of abortion clinics in England, which

33 Gabriël Adelin Moens, John Trone, *Commercial Law of the European Union*, Springer, Netherlands, 2010, p. 101.

goes against the protection of the right to life of the unborn child, as stated in the Irish Constitution. Ireland, as an EU Member State, had initially banned abortion through traditional and customary law, and later introduced a constitutional ban through the Eighth Amendment Referendum in 1983. However, the judgment from the CJEU established the principle that Irish citizens cannot be denied access to medical services in another EU Member State. This case is controversial because it not only recognizes health care as a "service" under EU law (Article 49 of the TEC–Article 57 of the TFEU), but also reinforces the freedom of EU citizens to travel to other Member States for health care unless there are legal or moral restrictions. This landmark case has sparked a debate regarding the use of EU law to address ethically and morally contentious practices, such as reproductive and end-of-life tourism[34].

The issue of abortion in Ireland is a contentious and divisive topic, especially due to the country's predominantly Catholic population. In 1983, a constitutional amendment was made, stating that the state recognizes the right to life of the unborn child and aims to defend and justify this right in its laws. As a result, Ireland became the only EU Member State to formally acknowledge the right to life of the unborn child in its Constitution[35]. However, this position was later relaxed by an amendment in 2018, allowing for the regulation of termination of pregnancy through legislation. This gradual shift towards more liberal abortion laws has been met with opposition from Catholics, who have opposed similar developments in other EU countries and globally. The issue of abortion remains a highly debated and sensitive topic in Ireland[36].

Protocol No. 17 (known as the Grogan Protocol) stipulates that "Nothing in the Treaty on European Union, the Treaties establishing the European Communities, or the Treaties or Acts modifying or supplementing those Treaties shall affect the application of Article 40.3.3 of the Constitution of Ireland in Ireland." This provision originates from the landmark Grogan ruling by the CJEU. Despite not having the authority to rule on the legality of abortion, the CJEU determined that medical termination of pregnancy constitutes a service under Article 60 of the Treaty. However, the CJEU also ruled that Ireland's ban on promoting and providing information about abortion clinics did not violate EU law. According to the CJEU, Member States have the authority to restrict

34 de Ruijter, p. 81 and 82.

35 Deidre M. Curtin, "Case C-159/90, The Society for the Protection of Unborn Children Ireland Ltd v. Grogan, Judgment of 4 October 1991", *Common Market Law Review*, Volume 29, Issue 3, 1992, p. 585.

36 Electronic Irish Statute Book, *Irishstatutebook.ie*, https://www.irishstatutebook.ie/eli/2018/ca/36/schedule/enacted/en/html#sched-part2 (14.10.2023).

the free movement of services for public policy reasons, and Ireland's case falls within this scope. The legal process led Ireland to negotiate a permanent protocol to protect the right to life of the unborn, resulting in Protocol No. 17 as the EU's response to Ireland's concerns[37].

In 1994, a case involving a 59-year-old woman who traveled from the UK to Italy for IVF treatment reignited the debate on the limitations of the free movement of services in the EU. The Court took a market-oriented stance on healthcare services. In the 1998 Kohll case[38], the Court determined that Member States could breach primary treaty law by restricting access to cross-border healthcare services. The case centered on a Luxembourg citizen who sought reimbursement for dental care received in Germany without prior authorization, under the Social Security Regulation. The Court concluded that the unique nature of certain services does not exclude them from the fundamental principle of free movement[39].

E. Social Security Dimension of Medical Tourism in European Union Law

Medical tourism is a complex issue within EU law, particularly regarding social security. EU Member States are required to regulate access to cross-border healthcare services not only for their own citizens, but also for patients coming from other EU countries. While balancing the regulation of these services, Member States must also ensure the maintenance of free movement for their citizens. This situation highlights the intrinsic connection between the principle of free movement and healthcare services within the EU.

The European Economic Community (EEC–Treaty of Rome in 1958) provided the legal foundation for the creation of social security measures. Regulation No. 3 of 1958, adopted pursuant to Article 51 of the EEC Treaty, which established the common market and ensured the free movement of workers, introduced a set of social security rights for migrant workers (employed), retirees, and their dependents[40]. Shortly thereafter, this Regulation became instrumental in enabling migrant workers to access cross-border healthcare insurance. In the early 1970s, it was superseded by Regulation 1408/71, which established a mechanism allowing Europeans to access healthcare services in another Member

37 Pietro Faraguna, *A Living Constitutional Identity: The Contribution of Non-Judicial Actors*, New York University School of Law, New York, 2015, p. 52.

38 Case 158/96, Kohll v. Union des Caissesde Maladie, ECR I-01931, 1998.

39 de Ruijter, p. 82.

40 Council Regulation, Regulation No. 3 of the Council on Social Security for Migrant Workers, OJ 30/561, 25-09-1958, p. 561.

State[41]. These regulations were developed in the context of the need to promote and support the mobility of cross-border workers by ensuring the protection and coordination of national social security rights among Member States[42].

Shortly after the social security regulations were adopted in the 1970s, calls for reform began. These regulations restricted access to healthcare services (cross-border) with certain procedures and required the approval of the competent health authority of the Member State in practice. These practices, which concerned European citizens, led to an increase in applications to the Commission. However, social security legislation reform has been very difficult since cross-border access to social security requires a unanimous decision in the Council. After all, it took nearly 40 years to establish the new version of the Social Security Regulations (Regulation 883/2004)[43].

The secondary legislation related to medical tourism was designed to make it easier for people to work and live in different European countries. Regulation 1408/71 was created to help these people, including their families, by making sure their social security benefits followed them when they moved. These provisions were later replaced by Regulation No. 883/2004 in 2004. The Regulation was expanded to cover all people legally resident in the Member State and came into force in 2010[44].

The recent Directive (2011/24/EU) offers clarity regarding the entitlements of patients pursuing health care in a different EU Member State, further reinforcing the rights already outlined at the EU level via the regulation on social security schemes coordination (883/04). It aligns with the Council's aim to fully uphold the jurisprudence of the CJEU concerning patients' rights in cross-border health care, all the while safeguarding the authority of Member States to structure their own healthcare systems[45].

There are parallel procedures among the Member States for patients seeking medical treatment outside their countries. These procedures function similarly between the Member States' own judicial systems and the Regulation, regulated by the EU legislative body. At the same time, the CJEU has developed a new procedure, while applying the principles of free movement to healthcare

41 Council Regulation, Council Regulation (EEC) No. 1408/72 on the Application of Social Security Schemes to Employed Persons, to Self-Employed Persons and to Members of their Families Moving within the Community, OJL149, 05-07-1971.

42 Hermans, p. 432.

43 de Ruijter, p. 79 and 80.

44 Cohen, p. 174.

45 Council of the European Union, *Directive on Cross-Border Health Care Adopted,* Brussels, 7056/11, PRESSE 40, 28 February 2011.

services. This procedure is based on a different legal basis compared to the traditional social security coordination mechanism and includes different conditions regarding access to and reimbursement of healthcare services. Member States have generally been slow and reluctant to adapt to the new procedure. The CJEU's decisions have focused on allowing cross-border movement of patients and subsequent reimbursement of their costs by host country health budgets. Today, patients' rights are at the forefront, rather than traditional financial issues. These rights include quality of care, responsibility, compensation, legal disputes, and similar issues[46].

While Union citizens have the principle of freedom to seek health care from any healthcare provider of their choice, this freedom is, in practice, restricted by the conditions or payment options set by public and private healthcare financing systems. These restrictions have been relaxed through bilateral agreements, which have sought to provide access to health care for people living and working in EU Member States. A broader exemption has been established over time under Article 42 TEC, based on the most fundamental principle of European integration: the free movement of people. In the context of the European Economic Area (EEA), further steps have been taken to provide patients with choices based on the CJEU case law on the principle of free movement of services contained in Article 49 TEC[47]. Considering medical activities within the scope of the free movement of services, the CJEU narrowed the scope of Member States' refraining from covering the costs of treatment in another Member State and created an alternative Treaty-based path for accessing health care outside the country[48].

The legal status of EU citizens who pay social security premiums in their own country and receive medical treatment in another Member State is regulated by EU law[49]. These regulations aim to secure the right of EU citizens to access cross-border healthcare services. In other words, EU citizens are granted the right to receive healthcare services in an EU Member State other than their own, and this right comes with freedom of movement. In addition, the issue

46 Elias Mossialos, Govin Permanand, Rita Baeten, Tamara K. Hervey, "Health Systems Governance in Europe: The Role of European Union Law and Policy", Ed. Elias Mossialos, Govin Permanand, Rita Baeten, Tamara K. Hervey, *Health Systems Governance in Europe: The Role of EU Law and Policy*, Cambridge University Press, Cambridge, 2010, p. 67 and 68.

47 Willy Palm, Irena A. Glinos, "Enabling Patient Mobility in the EU: Between Free Movement and Coordination", Ed. Elias Mossialos, Govin Permanand, Rita Baeten, Tamara K. Hervey, *Health Systems Governance in Europe: The Role of EU Law and Policy*, Cambridge University Press, Cambridge, 2010, p. 509 and 510.

48 Mossialos, Permanand, Baeten, Hervey, p. 68.

49 Hermans, p. 432.

of reimbursement of the costs incurred by the treatment received by patients is also addressed in these regulations. In this way, Union citizens have the right to have their treatment costs reimbursed from their own country's health insurance or public resources. However, these rights are subject to certain rules and conditions. For example, patients may need to obtain prior authorization, or the treatment must meet specific medical requirements. Furthermore, EU Member States have the authority to prevent the abuse of these rights and ensure the quality and safety of healthcare services.

II. Impact of CJEU Decisions on European Union Medical Tourism

The interpretation of treaties and ensuring that the law is observed in practice are the competence of the CJEU. It is established by the established case law of the CJEU that EU law prevails over national law. Therefore, national provisions must comply with EU law. However, Article 168 TFEU (ex TEC Article 152) leaves the organization and provision of health services to the competence of the Member States. According to this provision of the Treaty, the internal management of health systems and the right of patients to treatment are governed by national law rather than EU law. Essentially, the conflict is between these two legal situations. EU legislation and the CJEU's case law on medical tourism attempt to reconcile this conflict[50].

An increasing number of Union citizens are receiving medical treatment outside their country of residence. This particularly concerns migrant workers, persons benefiting from dual access to health care, those temporarily staying in another country (tourists, short-term workers, students), those in need of emergency care, and patients who have received prior authorization from the competent authorities for medical treatment in another Member State[51]. Patient mobility, while often a numerically limited phenomenon, raises a range of important issues and can impact the delivery of healthcare services by allowing patients to move more freely between healthcare systems. As these numbers increase, issues such as the quality, accountability, and safety of healthcare services received abroad become even more important. With the rulings of the CJEU, issues of patient mobility and cross-border health care have become more on the political agenda at both Member States and EU levels. CJEU's rulings have shaped the legal framework in this field, emphasizing patients' right to access cross-border healthcare services[52]. However, CJEU has often

50 Cohen, p. 174.

51 Hermans, p. 431.

52 Palm, Glinos, p. 510.

avoided answering medical or ethical questions and limited itself to the legal interpretation of Treaty provisions. Therefore, CJEU, like other courts, tends to answer only the questions necessary for the resolution of the case at hand, without addressing relevant issues[53].

After 1998, with the CJEU's Decker and Kohll judgments, the issue of insured individuals seeking medical treatment abroad without prior authorization and then returning to their home countries to request reimbursement has gained a new dimension[54]. The CJEU's jurisprudence on medical tourism came to the fore with the Kohll case in 1998. The case of Kohll v. Union des Caisses de Maladie concerned a request by a Luxembourg national to have his daughter treated by a German orthodontist. However, the request for prior authorization was refused on the grounds that the treatment was not an emergency and that it could be carried out in Luxembourg. The main question for the CJEU in this case was whether the requirements for prior authorization in the health systems of the Member States for care to be provided abroad were subject to the free movement provisions of the Treaty. The CJEU emphasized the importance of the freedom of each Member State to regulate and organize its own social security system. However, in situations where the regulation of the healthcare system affects the right to free movement within the EU, or where Member State laws conflict with EU agreements, the CJEU has taken the approach that the discretion granted to the Member State must be justified by an exception allowed by the EU Treaties or by overriding reasons in the general interest. Specifically, in relation to prior authorization, the CJEU has taken the view that the requirement of prior authorization discourages patients from seeking treatment in another Member State, creates a barrier to the free movement of patients, and that this barrier cannot be justified by a derogation under the Treaties or by a "compelling reason" relating to public health or the financial stability of the social security system of the host Member State[55]. The Decker case concerned the failure of a health insurance fund operating in Luxembourg to reimburse the cost of spectacles requested by its insured. In this case, the CJEU held that reimbursement of the cost of goods purchased in another Member State could not be refused on the grounds that this was contrary to the EC Treaty guaranteeing the free movement of goods[56].

53 Markus Frischhut, "Legal and Ethical Issues of Cross-Border Reproductive Care from an EU Perspective", Ed. Melanie Kay Smith, László Puczkó, *The Routledge Handbook of Health Tourism*, Routledge, Abingdon and London, 2016, p. 210.

54 Hermans, p. 431 and 432.

55 Cohen, p. 177 and 178.

56 Hermans, p. 433.

The CJEU ruled that the demand for medical tourism could only be refused in cases where there is no undue delay in obtaining the same or equally effective treatment from a body with which the insured person's sickness insurance fund has a contract. This approach was also followed in subsequent cases. Although Kohll ruled that prior authorization is not justifiable for outpatient care, in the Commission v. France case, the CJEU softened its previous stance by accepting that prior authorization could be justified for outpatient care involving "significant medical equipment."[57]

The Decker and Kohll decisions were decisions of the EU Court of Justice regarding the medical treatment of a citizen of a Member State in another Member State, and these decisions brought a completely new dimension to EU health policy. With these decisions, the EU Court of Justice subjected valid health services to the basic principles of the EU (free movement of goods and services) for the first time. As a result of these landmark judgments, healthcare services can now be considered as subject to trade, irrespective of the individual's country of residence or health insurance status. Thus, they can be assessed under the TEC, and the powers of national payers or providers can be curtailed. Both decisions have had a challenging impact on health policy in the short term and a comprehensive impact in the long term[58].

In 2001, the ECJ gave a decision combining two cases: Geraets-Smits v. Stichting Ziekenfonds, and Peerbooms v. Stichting CZ Groep Zorgverzekeringen[59]. In one of these cases, a Dutch citizen named Smits received treatment for Parkinson's disease at a specialized German clinic without prior authorization and paid for the services. Subsequently, he requested reimbursement for these medical expenses from the Dutch sickness fund. The sickness fund denied the reimbursement claim, arguing that the medical methods used in Germany did not add anything to those applied in the Netherlands. Similarly, in another case, a Dutch citizen named Peerbooms received treatment in the Netherlands without prior authorization from the Austrian authorities and requested reimbursement from the sickness fund. Peerbooms, who had paid directly in the Netherlands, had his reimbursement claim denied. The sickness fund refused the reimbursement on the grounds that the treatment provided in the Netherlands was considered experimental (and could also be provided at rehabilitation centers in both countries) and was not defined

57 Cohen, p. 181.

58 Hermans, p. 433.

59 Case 157/99, B.S.M. Geraets-Smits v. Stichting Ziekenfonds VGZ & H.T.M. Peerbooms v. Stichting CZ Groep Zorgverzekeringen, ECR I-5509, 2001.

under the legally mandatory health insurance. In these cases, CJEU, on one hand, supported medical tourists, but also pointed out that there were some differences between the services provided to these patients and inpatient care services. The Court stated that medical services provided in hospitals required significant infrastructure and, therefore, the requirement for prior authorization for services provided in hospitals posed a risk to the financial stability of social security systems.

The Court, considering this as a compelling reason that reasonably restricts the freedom to provide services in the interests of the public, also acknowledged that the aim of providing accessible and balanced hospital services for all citizens could fall under "public health exemption" in accordance with Article 62 of the TFEU. Within this exemption, the Court stated that Member States might be permitted to restrict the freedom to provide medical and hospital services when it is important to maintain on-site treatment capacity or medical expertise for national public health[60].

Conclusion

The CJEU has established a legal framework for medical tourism within the Union, thereby eliminating uncertainties in this area and facilitating access to cross-border healthcare services, thus strengthening citizens' rights.

The CJEU, which has made significant decisions shaping the legal structure of cross-border health care in the EU, has greatly contributed to the development of medical tourism by supporting patients' rights to access healthcare services in another Member State. Within the framework of these decisions, the CJEU has addressed important issues, such as the financial responsibilities of both patients and Member States, ensuring the quality and safety of cross-border healthcare services, and the requirement of obtaining prior authorization from the competent authority.

The CJEU has consistently emphasized that patients within the Union have the right to receive healthcare services in another Member State. The CJEU's rulings have been influential in protecting and enhancing this right, which includes the freedom to travel to different EU countries to receive necessary medical treatment. These decisions, which facilitate greater access to cross-border healthcare services, have played a significant role in the development of medical tourism. However, while the CJEU has expanded patient rights, it has also imposed certain obligations on Member

60 Cohen, p. 178 and 180.

States to ensure these rights are protected and that patients can easily access cross-border healthcare services. Therefore, the decisions of the CJEU have had an impact not only on patients, but also on healthcare systems and policymakers across the EU.

The CJEU decisions have challenged restrictions on obtaining prior authorization for access to health care, and have particularly advocated for the right of patients in need of treatment to seek medical care abroad without prior authorization. These decisions aimed to encourage easier access for patients to cross-border health care and reduce barriers to accessing such services. CJEU's decisions in this direction have particularly strengthened patients' rights regarding prior authorization requirements and reimbursement matters.

The CJEU has addressed patients' rights to have the costs of treatments received abroad reimbursed in their own countries and has made significant rulings on this matter. These rulings have emphasized patients' right to claim reimbursement for treatment expenses from national health insurance or public funds and have been significant in safeguarding this right. In particular, CJEU's decisions on this matter have reinforced the principle that when patients incur treatment expenses in another EU country, these expenses should be reimbursed in their home country. For patients, this has provided a significant financial advantage and made access to cross-border health care more attractive. However, these decisions of the CJEU have caused some uncertainty in regulating the conditions and processes of reimbursement. Each EU Member State has its own national healthcare system, and the different rules governing these systems can make reimbursement processes quite complex. Therefore, the application and interpretation of CJEU decisions at the national level are crucial for patients receiving cross-border health care today, given the complexities involved in accessing and reimbursing such services across different EU Member States.

Ensuring that health care received abroad meets the required standards and is adequately safeguarded has been a significant concern for the CJEU. The CJEU is also sensitive to some of the risks associated with medical tourism, and has addressed certain measures in this field. CJEU's measures aim to reduce the potential risks associated with medical tourism.

In conclusion, the legal framework of the EU provides a comprehensive regulatory environment for cross-border healthcare services, including their financing. The CJEU, through its jurisprudence, has played a pivotal role in

facilitating access to cross-border health care for EU citizens. By establishing clear rules on the financing of such services, the CJEU has not only contributed to the growth of medical tourism, but has also fostered the free movement of healthcare services within the internal market.

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