THE IMPACT OF THE CASE LAW ON PATIENT MOBILITY OF THE EUROPEAN COURT OF JUSTICE UPON THE DEVELOPMENT OF EU LAW AND POLICY IN RELATION TO HEALTH CARE

A thesis presented to the University of Leicester in fulfilment of the requirements of the degree of Doctor of Philosophy

Arabella Stewart
Faculty of Law
University of Leicester

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ABSTRACT OF THESIS

The impact of the case law on patient mobility of the European Court of Justice upon the development of EU law and policy in relation to health care

Arabella Stewart

This thesis examines the impact of the case law on patient mobility on the development of EU law and policy in relation to health care. It takes the view that there has been a spillover from internal market integration into the area of health care policy, consistent with the neo-functionalist theory of European integration, in spite of the reluctance of the Member States to relinquish control in this area.

This research considers the responses of the EU institutions to the patient mobility judgments and evaluates the legislative and policy initiatives leading from the case law, and influenced by it. It is contended that the impact of the case law has been significantly wider than simply according individuals with the right to be reimbursed for cross border treatment. In particular, it is argued that the case law has acted both as a catalyst, and as a justification, for policy development and attempts at legislative action in the field of health care, which seek to go beyond a codification of the case law into other aspects of health care policy. Furthermore, whilst the case law starts from an internal market perspective, an analysis of the relationship between the conditions for access to cross border care contained in the case law on patient mobility and the fundamental right to health care shows a substantial degree of consistency between the two.

In conclusion, it is suggested that, in the evolving role of the EU in relation to health care, there are signs of a shift away from the conception of health care as a service within the internal market and towards an approach which recognises an autonomous right to health care.
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<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>AIM</td>
<td>Association Internationale de la Mutualité</td>
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<tr>
<td>BMJ</td>
<td>British Medical Journal</td>
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<tr>
<td>BSE</td>
<td>Bovine Spongiform Encephalopathy</td>
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<td>CMLRev</td>
<td>Common Market Law Review</td>
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<tr>
<td>CLP</td>
<td>Current Legal Problems</td>
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<td>COR</td>
<td>centres of reference</td>
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<td>DG</td>
<td>Directorate General</td>
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<td>EC</td>
<td>European Community Treaty</td>
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<td>ECJ</td>
<td>European Court of Justice</td>
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<td>ECHR</td>
<td>European Convention on Human Rights and Fundamental Freedoms</td>
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<td>ECR</td>
<td>European Court Reports</td>
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<td>EEC</td>
<td>Treaty establishing the European Economic Community</td>
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<td>EHPF</td>
<td>European Health Policy Forum</td>
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<td>EHRLR</td>
<td>European Human Rights Law Review</td>
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<td>EJPL</td>
<td>European Journal of Public Law</td>
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<td>ELJ</td>
<td>European Law Journal</td>
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<td>ELRev</td>
<td>European Law Review</td>
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<tr>
<td>EPL</td>
<td>European Public Law</td>
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<td>ESC</td>
<td>European Social Charter</td>
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<tr>
<td>EU</td>
<td>European Union</td>
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<td>GP</td>
<td>general practitioner</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HLG</td>
<td>High Level Group on Health Services and Medical Care</td>
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<td>ILJ</td>
<td>Industrial Law Journal</td>
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<td>IMCO</td>
<td>Committee on the Internal Market and Consumer Protection of the European Parliament</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>IVF</td>
<td>in vitro fertilization</td>
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<td>JCMS</td>
<td>Journal of Common Market Studies</td>
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<td>JSWFL</td>
<td>Journal of Social Welfare and Family Law</td>
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<tr>
<td>LIEI</td>
<td>Legal Issues of European Integration</td>
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<td>MJ</td>
<td>Maastricht Journal of European Law</td>
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<tr>
<td>MISSOC</td>
<td>Mutual Information System on Social Protection</td>
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<td>MLR</td>
<td>Modern Law Review</td>
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<tr>
<td>NGO</td>
<td>non-governmental organisation</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NIE</td>
<td>Network of Independent Experts</td>
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<td>NLJ</td>
<td>New Law Journal</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<td>OJ</td>
<td>Official Journal</td>
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<tr>
<td>OJLS</td>
<td>Oxford Journal of Legal Studies</td>
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<tr>
<td>OMC</td>
<td>open method of co-ordination</td>
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<tr>
<td>OUP</td>
<td>Oxford University Press</td>
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<td>PL</td>
<td>Public Law</td>
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<td>SARS</td>
<td>Severe Acute Respiratory Syndrome</td>
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<td>SGIs</td>
<td>services of general interest</td>
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<td>Sol J</td>
<td>Solicitors Journal</td>
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<tr>
<td>SSGIs</td>
<td>social services of general interest</td>
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<tr>
<td>SPC</td>
<td>Social Protection Committee</td>
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<tr>
<td>TEU</td>
<td>Treaty on European Union</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>USA</td>
<td>United States of America</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>Yale LJ</td>
<td>Yale Law Journal</td>
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including measures to facilitate the effective exercise of the right of establishment and freedom to provide services, OJ L 033, 11/02/1980.


Council Directive 2004/58/EC of 29 April 2004 on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States


Decisions


Recommendations


Resolutions


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Introduction

Background and choice of research area

Historically, the provision of health care is an area of policy over which the Member States of the European Union (EU) have wished to retain complete control. However, the process of European integration is not one which always remains confined neatly within intended policy boundaries. It is often observed that activity in one policy field at EU level can spill over, leading to unintended or accidental effects in another. When this occurs, Member States are faced with a choice. They may, for example, resist the invasion of so called ‘creeping competence’, or elect to make adjustments to the division of responsibilities between themselves and the EU to enable an extension of competence into the new area. Consensus on how to respond is difficult to achieve and its absence may lead to legislative false starts and policy impasses, with the EU institutions adopting their own positions. In examining the impact of the jurisprudence on access to cross border medical treatment of the European Court of Justice, this thesis explores what happens when such a spillover occurs.

The background to this choice of research topic was the judgment of the Court of Justice in the case of Kohll\(^1\) in 1997. The possibility of enforceable rights to cross border care based directly upon the free movement of services appeared highly significant, particularly from the perspective of lengthy waiting lists for NHS treatment in the United Kingdom. What has become known as patient mobility has proved to be a fast moving area during the period of this study, with many repercussions in terms of the development of law and policy. The Court has dealt with a number of further references, considerably extending the principles established in Kohll. At the same time, the Commission has been gradually developing its policy on health care, in the face of very limited competence, through the use of informal or soft law processes. In the midst of it all, the draft Services Directive proved to be a political flashpoint, due to the attempt to include social services, such as health care,

within its scope. Despite the failure of this strategy, the Commission remains committed to introducing legislation in the field of patient mobility.

**Scope and aim of research**

The purpose of this thesis is to examine the impact of the case law on patient mobility on the development of EU law and policy in relation to health care. This research attempts to add to the existing literature by examining the impact of the case law in different areas and from different perspectives. In particular, it analyses its relationship with the co-ordination of social security; its impact in the field of the regulation of services in the internal market; the development of EU policy in relation to health services through the use of informal policy co-ordination and the open method of co-ordination (OMC); and the extent to which the case law has been informed by, or reflects, the fundamental right to health care. Whilst there has been considerable academic discussion of the case law itself, there has been relatively little analysis of the wider policy initiatives and legal reforms which have been influenced by it. Equally, there has been comparatively little focus upon the interplay between rights to cross border care and the fundamental right to health care, notwithstanding the more comprehensive coverage of these issues found in Tamara Hervey and Jean McHale's work, *Health Law and the European Union*.\(^2\)

The impact of the case law on patient mobility has been considered within the wider framework of European social policy, itself an aspect of the overall project of European integration. Two main explanations for the development of social policy - the neo-liberal market perspective and the rights-based approach - have informed the examination of the impact of the case law upon EU action in relation to health care, with specific reference to the various legislative and policy developments which have ensued following the jurisprudence. The research provides evidence that the impact of the case law is far wider than merely giving individuals the right to be reimbursed for cross border treatment, where particular conditions are met.

My approach has been primarily to consider the actions of the EU institutions in relation to patient mobility and health care policy. I have not taken the perspective of a particular Member State nor taken a comparative approach between states. It is also beyond the scope of this research to consider in any detail the area of the free movement of health care professionals, although this has been referred to briefly, where relevant.

Research methods

The research method applied has been a survey of relevant primary sources and available literature. In particular the following sources have been used:

Primary sources include official publications of the institutions of the European Union such as judgments of the European Court of Justice, opinions of the Advocates General, legislation, draft legislation, white papers, policy documents, reports of the European Parliament, proceedings of the Council and reports and documentation of other EU bodies such as the Social Protection Committee, the High Level Group on Health Services and Medical Care, the High Level Committee on Health, the Health Open Forum and the Working Party on Health Systems.

Further primary sources consist of judgments of the European Court of Human Rights, official publications of the Council of Europe, publications of the World Health Organisation and other publications by non-governmental organisations. Secondary sources include academic books and journal articles, newspaper reports and websites.³

Structure

The study starts by examining the nature and scope of European social policy in the broader context of European integration. Within this discussion, Chapter 1 introduces competing integration theories and the role of law in the integration process. The development of

³ Libraries used for this research include those at the University of Leicester and the Institute of Advanced Legal Studies, University of London, the Squire Law Library, University of Cambridge and the British Library.
European Union health policy is then examined, together with an analysis of the legal framework in relation to public health. The chapter outlines the theoretical basis for the involvement of the EU in social policy areas such as health care and provides the framework for the discussion of the impact of the case law of the European Court of Justice on patient mobility which follows. **Chapter 2** presents the legislative background to the case law, outlining the development of the provisions on the co-ordination of social security which underpin the exercise of free movement rights. In particular, the regime providing for the reimbursement of the costs of cross border medical treatment will be examined.

In **Chapter 3**, following an introduction to the principle of the free movement of services, the case law on patient mobility is explored in detail. In addition, this chapter considers the relationship between the case law on patient mobility and the fundamental right to health care, exploring the actual and potential influence of human rights law upon rights of access to cross border health care in EU law.

The impact of the case law is considered in **Chapters 4 and 5** in an assessment of the legislative and policy repercussions. In particular, Chapter 4 considers the legislative responses to the case law, whilst Chapter 5 focuses on the development of EU policy in relation to health care. The substantive chapters are followed by a Conclusion.
Chapter 1: Theories of European social policy and the role of the EU in relation to health

1.1 Introduction

In order to assess the impact of the case law on patient mobility upon the development of European Union (EU) law and policy in relation to health care, it will be necessary to examine the context within which these effects are taking place. It will be seen that whilst historically within the EU, economic policy goals have been given primacy over social aims, a considerable body of social policy has nonetheless developed, often as a counterpart to market integration. Despite this, EU involvement in the health field has until recently remained relatively under-evolved largely due to the limitations in EU competence in relation to health. It will be argued later in this thesis that the case law on access to cross border care has increased EU activity in relation to health care, particularly on the part of the European Commission, by providing a rationale and justification for co-ordination in this field.

The examination of the impact of a particular body of case law of the European Court of Justice upon the development of EU law and policy within a specific field raises broader questions about the role of law in the process of European integration. In particular, it assumes the existence of a causal relationship between litigation at Community level and subsequent legislative and policy evolution. Accordingly, this chapter will commence with an account of differing views of the role of law in the integration process and an explanation of the position taken by this research.

This chapter will then consider the principles which underpin European social policy and the place of health policy within it. The theoretical framework of social policy in the EU will be examined, highlighting the different social models which have been identified and assessing the main explanations for the evolution of European social policy. Different types of institutional action affecting the development of social policy will also be considered.
The final part of the chapter will focus on the basis for the role of the European Union in relation to health law and policy in light of the theoretical discussion in part 1. The Treaty base for action in the field of public health will be examined and the Commission’s policy response to the strategy of modernising social protection, announced at the Lisbon Council in 2000, will be introduced. It will be suggested that, despite considerable limitations in competence, the Commission was increasingly showing an interest in matters relating to health care by the time the cases on cross border care were starting to come before the Court of Justice.

1.2 The role of law in European integration

This thesis adopts the position that the judgments of the Court of Justice are capable of having causative effects in terms of influencing legislative and policy developments in the EU. A starting point for examining this approach is to consider the differing roles ascribed to the influence of law within various theories of European integration. It has been suggested that there is no single theory:

“widely held to be a comprehensive and adequate explanation of the various developments which have taken place within the EU...Rather the various theories reflect and complement the various stages in the Community’s growth and development.”¹

Similarly, there is no single view of the role of law; for example, it has been suggested that federalists² regard the Court of Justice as a federal constitutional court and recognise the integrative power of its rulings, which are seen as a means of transferring sovereignty from national to European level.³ However, different views are taken by proponents of two

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2 Federalism is one of the earliest and best-known theories of European integration. It explains the motivation for the establishment of the Community by the Treaty of Rome in terms of a desire to secure peace and economic stability after World War II, by taking steps towards the gradual creation of a federal, state-like entity with a constitution and central political institutions. See, for example, Burgess, M., ‘Federalism’ in Wiener, A. and Diez, T., (eds) *European Integration Theory*, Oxford University Press, 2004.
further integration theories which have been particularly dominant since the mid 1960’s, neo-functionalism and intergovernmentalism. According to neo-functionalists, integration is not driven by the Member States but by the supranational institutions created by them, including the Court of Justice, together with interest groups, social movements and political parties. The main actors in the integration process are therefore found both above and below state level and the supranational institutions need to be qualitatively different to those normally found in a traditional intergovernmental organisation in that they require direct contact with the sub-national actors. The most important concept in relation to neo-functionalism is that of spillover, the effect whereby integration in one sector creates pressure for integration in other related areas.

The approach of neo-functionalism to the role of law can be contrasted with that of intergovernmentalism. As its name suggests, intergovernmentalism sees national governments as the dominant actors in the integration process. The EU is cast as a forum within which the national governments of the Member States engage in bargaining of policy choices reflecting decisions arrived at through debate at domestic level. It is often argued that intergovernmentalism pays insufficient attention to the power of the EU institutions generally and it has been claimed that the theory either ignores the Court of Justice or sees it as existing merely to serve the interests of the Member States.

This thesis rejects the intergovernmentalist view that the role of the Court of Justice is of limited significance. Instead it agrees with theoretical positions which acknowledge the importance of the activities of the Court and the influence of its case law in the integration process. There is much evidence to support this approach, indeed, the role of the Court in

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7 It has been suggested by Weiler that in latter years the interdependence of EU policy areas reflects the neo-functionalist spillover model which is manifested in the ever-widening scope of the legislative and policy agenda. Weiler, J.H.H., 'The Transformation of Europe' in Weiler J.H.H., *The Constitution of Europe “Do the clothes have a new emperor?” and other essays on European integration*, Cambridge University Press, 1999, p.65.
the integration process has been widely acknowledged in the relevant academic literature. For example, in relation to the status of Community law, Weiler explains that the introduction into Community law by the Court of the doctrines of direct effect, supremacy, implied powers and human rights, had the effect of constitutionalising the EC Treaty. He further argues that this process, together with the Court's jurisprudence on remedies, effectively nationalised EC obligations giving Community law the same level of respect as domestic law.\(^{10}\) This standing gives law an important role in the integration process.

Whilst Weiler sees political and legal integration as complimentary processes,\(^{11}\) other commentators take a stronger view of the role of law in European integration. Greer describes the Court of Justice as a "supranational promoter of integration",\(^{12}\) whilst Weatherill sees the Court as an innovative policymaker which has been instrumental in the gradual expansion of Community competence.\(^{13}\) Dougan describes a process of "integration through law" in which the role of the Community legal order is to advance and consolidate European integration through the creation of a uniform body of binding law,\(^{14}\) and it has been argued by Burley and Mattli that, by transforming the Treaty of Rome into a constitution, the Court laid the legal foundation of economic and political integration in Europe.\(^{15}\) They explain legal integration as a gradual penetration of Community law into the domestic law of the Member States with two dimensions; formal and substantive penetration.\(^{16}\) Formal penetration consists of the treaties and legislation which take precedence over national law, substantive penetration involves the 'spilling over' of community legal regulation from the economic domain into areas dealing with issues such as health and safety and social welfare. This neo-functionalist perspective on legal integration is shared by Stone Sweet who believes that the Community legal system has:

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\(^{11}\) ibid., p.96.


\(^{14}\) Dougan, M., National Remedies Before the Court of Justice - Issues of Harmonisation and Differentiation, Hart, 2004, p.69.


\(^{16}\) ibid.
“worked steadily to expand the supranational character of the EU, to push the integration project much further than Member States’ governments would have been prepared to go on their own, and to structure intergovernmental bargaining and the decisionmaking of the EU’s legislative organs.”

This view, which sees case law as being capable of having a direct impact upon future legislative and policy developments, is consistent with the approach taken in this research on the impact of the case law on patient mobility.

In terms of the mechanism by which these effects are achieved is concerned, Burley and Mattli stress the importance of the preliminary reference procedure in the integration process, seeing it both as providing a link between the Court of Justice and the sub-national actors recognised by neo-functionalism and as a means of transferring a high proportion of the interpretation and application of Community law away from the control of Member States.

In relation to the use of preliminary reference procedure for so-called ‘opportunistic litigation’ in situations where Community law is used to strike down national restrictions, Poiares Maduro believes that:

“the broad scope and the uncertainty of the free movement provisions have promoted litigation and offered new grounds of challenge to legislation by individuals. Community law has been a new source of legal arguments even in a purely national context.”

Dehousse echoes the view that the relatively vague nature of many treaty provisions lends itself to wide interpretations by the Court of Justice and argues that this leads to a juridification of many political choices. In other words, he suggests that many essentially

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political decisions formerly falling within the political sphere are now coming within the ambit of legal proceedings.\textsuperscript{20}

A further analysis of the role of law in European integration focuses on the influence of rights as an integrative force. De Burca observes that, whilst on a Durkheimian view, law is seen largely as the expression of an underlying social solidarity, the reverse is found in the Community, where there appears to be an attempt to create solidarity through law by the declaration of common principles and rights in the hope that these will influence the legal systems of the Member States as an integrating force.\textsuperscript{21} She notes that the concept of rights as a tool of integration is familiar in federal societies such as the USA and Canada\textsuperscript{22} and endorses Frowein's view that the question of common values protected by law cannot be avoided if a process of integration is to progress towards the creation of a union.\textsuperscript{23}

These observations help to explain the relationship between the role of law and the theoretical framework of European integration. This in turn can be linked to the theoretical framework relating to the development of European social policy, itself a sub-area of European integration, which is considered in the next part of the chapter. They also seek to explain and justify the methodological assumptions underlying this research in relation to the causal relationship between law and litigation, on the one hand, and legislative and policy development on the other.

\textbf{1.3 European social policy – the theoretical framework}

The social dimension of the European Community and Union has its roots in employment related policies, designed to promote and facilitate the free movement of workers and ensure a level playing field of employment conditions for men and women. However it has

\textsuperscript{20} Dehousse, R. 'Integration through law revisited: Some thoughts on the juridification of the European political process' in Snyder, F., (ed) \textit{The Europeisation of law: the legal effects of European Integration}, Hart, 2000, p.25.


\textsuperscript{22} ibid., p.41-42.

\textsuperscript{23} ibid.
evolved into something much broader encompassing a wide range of policy areas such as education, addressing social exclusion and public health.\(^\text{24}\)

Underlying the development of EU social policy is the question of what type of social model is appropriate or desirable for the European Union and the extent to which the divergent social models of the Member States have affected the nature and scope of the European Social Model.

1.3.1 The role of the EU in social policy

The question of whether and to what extent the European Union should have a role in creating and developing social policy is an intensely political one. It has been suggested that Member States in part derive political legitimacy from their domestic social policy and are therefore reluctant to cede control of this area to the EU.\(^\text{25}\)

Furthermore, for those who favour a purely economic community, the absence of a significant social policy dimension at EU level is evidence of its limited role.\(^\text{26}\)

Conversely, the existence of an active social policy would be seen as indicative of a more powerful supranational entity.

In addition, the spectrum of possible levels of intervention ranges from total harmonisation, through co-ordination, to the exclusion of social policy from EU competence altogether. There are many difficulties in assessing the nature and scope of an appropriate and effective role, not least the existence of a range of different types of social system in the Member States of the EU, which reflects the fact that social policy has traditionally been a matter for each individual state to determine, on the basis of its own cultural perspectives, resources and political philosophy.


In 1990, Esping-Anderson identified three basic types of welfare system, features of which could be observed in the systems prevailing within the European Community; the ‘liberal’ welfare state, characterised by means-tested assistance, modest universal benefits or social insurance with strict entitlement rules and stigma attached to welfare dependence; conservative or ‘corporatist’ welfare states, heavily influenced by traditional Christian family values, providing higher levels of social insurance for workers and family benefits to encourage motherhood but with underdeveloped provision to enable women to work and the ‘social democratic’ regime type, providing higher-level universal benefits at a high cost to the state and taxpayer.

More recently, Hervey distinguishes four models: Scandanavian, Bismarkian, Anglo Saxon and Latin Rim. The Scandanavian model comprising Denmark, Sweden and Finland, is based on the concept of a right to work and provides high levels of benefit. It corresponds with the social democratic model described above. Bismarkian systems, such as those found in Germany, Austria and to some extent, France, Italy and Ireland and corresponding to the conservative or corporatist model of Esping-Anderson, provide welfare through social insurance and work-related entitlement to benefits. The Anglo-Saxon (or liberal) model found in the United Kingdom is based upon the provision of a minimum safety net. Finally, the Latin Rim model, found in Greece, Spain and Portugal generally has lower levels of provision than the Anglo-Saxon model. The ten Member States which acceded to the EU in 2004 each manifest characteristics of one or more of these models.

Despite these differences, the Member States have been prepared to confer competences in certain areas of social policy upon the EU in successive treaties, thereby creating a multi-tiered governance in this area. However, the limited scope of these competences is indicative of the tension between their desire to retain sovereignty over social policy on the one hand, and the need to create a social policy dimension at EU level on the other.

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There are a number of different theoretical approaches to EU social policy. Hervey has categorised these into four models and argues that all four are to some degree reflected in EU social law and policy.\(^{30}\)

The neo-liberal market model sees a social dimension as costly and undesirable. According to this model the EU institutions should not set Europe-wide social policy standards but leave this to the market. Individuals should be enabled to compete within the market place, but no further intervention is justified. It may even be argued from this perspective that EU regulation of social policy may actually introduce inefficiencies into the market, as high social standards should be seen as rewards for efficiency and should not be imposed by the market.\(^{31}\)

The convergence model holds that political and economic forces within the internal market will themselves encourage a tendency towards convergence of national social policy standards. Therefore, interventionist European level social policy is superfluous.

Under the social cohesion model social policy measures are necessary to maintain and support the established social order and to militate market forces, which, if left uncontrolled, would marginalize sections of society. Some harmonisation is necessary to avoid distortions to the market which would arise from divergent social standards in the Member States known as 'social dumping'.

Finally, the social justice model sees social policy as necessary to humanise the market for reasons of fairness and distributive justice. According to this approach, European social policy must be based on two concepts: social solidarity, with welfare seen as a collective rather than an individual responsibility and social citizenship and the belief that welfare is superior to the market. Economic efficiency must be balanced by welfare objectives, by the creation of a European social market economy. An extreme form of this model advocates the creation of a European 'welfare superstate'.


Hervey explains that whilst the neo-liberal and convergence models suggest institutional inaction, the social cohesion model links social regulation with notions of competitiveness, social efficiency, level playing fields and social dumping and is the model which is reflected in most EU social policy measures, as these are situated within the economic endeavour. Where EU-level policy has been developed, the conceptualisation of division of competence promoted by the social cohesion model has become more firmly embedded than the other models in the policy making process. However, the social justice model places economic and social policy aims in tension against one another and as a result has not been the predominant basis of EU social policy although it may partially underpin some provisions.32

If each of these models has influenced some elements of EU social policy this would suggest a somewhat muddled picture, lacking ideological consistency. However, this criticism could equally be levelled at the Member States themselves and is an intrinsic feature of any democratic entity subject to periodic changes in political direction. Furthermore, the absence of a single theoretical basis is only part of the reason for the 'mishmash of social measures'33 forming EU social policy. The other main reason is the deliberately limited scope of EU competence in relation to social policy.

To better understand the nature and role of European social policy it is important to examine why and how it has come into being. These questions will be considered in turn. In practice the former is often conflated with the relationship between economic policy and social policy. One position held by many commentators is to regard the historical development of social policy as the result of a spillover from internal market integration. This view is consistent with neo-functionalism theory. A contrast is seen in the form of a rights-based approach which argues for an autonomous role for social policy based upon conceptions of social and fundamental rights and distinct from associations with economic integration. These perspectives, which can be seen as points on a spectrum with many

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shades of opinion in between, will now be considered in greater detail, followed by a review of the different methods via which social policy can be introduced at EU level.

1.3.2 Explanations for the development of European social policy I – a neo-functionalist approach

The concept of spillover is related to neo-functionalism, which is one of a number of theories of European integration described earlier in this chapter and is widely regarded as the primary explanation for the inclusion of a social dimension in the European project. Neo-functionalistists believe that within the integration process, spillovers inevitably occur from one type of policy area to another.34

In this approach to analysing the underlying rationale of European social policy, its role has been described as that of modifying market outcomes and correcting any market failures arising from the creation of the internal market.35 The internal market is seen as neo-liberal in nature, that is to say dedicated to deregulation, or the removal of barriers to a free market. This view is supported, for example, by Davies who sees the free movement principles as remaining at the heart of the Community project despite the emergence of competing policies.36 Whilst Weatherill asserts that the case law of the Court of Justice is correctly regarded as providing a strong emphasis in favour of deregulation within the Community,37 Weiler believes that the need for a successful market manifests a social and ideological choice which places market efficiency and free competition above other competing values.38

It has been suggested that spillovers occur because some of the consequences of the completion of the internal market place pressure on the EU to enter the social policy domain to vitiate undesirable effects by filling in regulatory gaps.\textsuperscript{39} An example of this is seen in the insertion into the Treaty of Rome of the equal pay provisions.\textsuperscript{40} This was done because France had already enshrined the principle of equal pay in its national law and argued that it must be introduced as a Community-wide principle to avoid France being at a competitive disadvantage within the Common Market as a result of having relatively high labour costs.

In the early decades of the European Community a number of measures designed to facilitate the free movement of persons which contained aspects of social policy were introduced, such as provisions on the conditions for the exercise of free movement rights for workers\textsuperscript{41} and requiring the co-ordination of social security regimes to cover workers from other Member States.\textsuperscript{42} Further legislation focused upon a variety of social aims including decisions on setting up an advisory committee on safety, hygiene and health protection at work\textsuperscript{43} and concerning a programme of pilot schemes and studies to combat poverty,\textsuperscript{44} directives regarding equal pay\textsuperscript{45} and regulations creating European bodies charged with promoting vocational training\textsuperscript{46} and the improvement of living and working conditions.\textsuperscript{47} It can be argued that the spillover from economic integration is seen in the main emphasis remaining upon measures to support the free movement of workers and the harmonisation of employment rights. Taking the example of patient mobility, rights to cross border care derive from two provisions. Firstly they are found in regulations on the co-ordination of social security for migrant workers (see Chapter 2) and secondly from an extension of the free movement of services principle found in Article 49 of the EC Treaty,


\textsuperscript{40} Originally Article 119, EC, later renumbered to Article 141, EC.


to enable patients to be treated abroad at the expense of their national systems (see Chapter 3). Both of these can be seen as spillovers from the primary aims of the internal market.

Additional support for the view that European social policy occurs as a spillover from economic integration is found in the academic literature on the asymmetry between the two which, according to Sharpf, is caused by the selective Europeanisation of policy functions. In other words, whilst at national level economic and social policy enjoy the same constitutional status, this is not reflected in EU law.48 Instead, an asymmetry is created as a result of the decision to limit competence of the EU in social policy fields.

Beck et al identify a number of implications of the asymmetrical relationship between economic and social policy.49 They note that it restricts the scope of social policy and underestimates its potential, and that economic priorities dominate in EU policy making. They believe that the scope of EU social policy is too narrow and that the dominance of economic policy reinforces the centralisation of decision making and budgetary control, distancing these from EU citizens. However, even if European social policy is seen as following behind economic integration, it may still have significant effects and it has been suggested that:

"the movement towards market integration will be accompanied by a gradual erosion of the autonomy and sovereignty of national welfare states; national regimes will become more and more enmeshed in a complex, multitiered web of social policy."50

Such erosion manifests itself in a number of ways, for example in a Member State's inability to limit eligibility for welfare benefits to its own nationals or within its own territory and even in the potential for competition from other Member States' welfare

systems, for example in relation to medical treatment. Greer believes that neo-functionalists would expect that pressures from spillover and the activities of the EU institutions would lead to an EU policy on health services regardless of the wishes of the Member States in this regard.

Although the view that social policy arises as a spillover from internal market integration relies upon a conception of the internal market as essentially neo-liberal in character, in other words dedicated purely to the removal of all barriers to the free movement of goods, workers, services and capital, it is increasingly being argued that the internal market is not, or is no longer, an exclusively neo-liberal construct. For example, Dougan believes that economic considerations have become supplemented by what he terms a welfare perspective. Whilst he appears to accept spillover from economic integration as one possible cause of the development of European social policy, he offers two alternative reasons for it. Firstly he argues that it reflected concerns that the Community was becoming too economically orientated. In a similar vein, Craig observes that as the Community evolved concerns arose that the single market project would not succeed without public support. In order to secure this there would be a need for increased involvement in social policy by the Community.

Secondly Dougan recalls that the original underlying rationale of the Community was to use economic integration as a springboard for closer co-operation in a wider range of areas. According to this view, social policy is seen as one of the original aims of

55 ibid.
57 Dougan, M., National Remedies Before the Court of Justice - Issues of Harmonisation and Differentiation, Hart, 2004, p.78.
European integration rather than as an add-on or a spillover. It is consistent with this view that the internal market is seen as having a social dimension and Dougan concludes that:

"the Community no longer dances to the tune of the Internal Market alone...Instead...the Treaty sanctions the simultaneous pursuit of a range of polices...".\(^{58}\)

Craig also regards social policy as integral to the single market programme\(^{59}\) and as fitting into the overall approach of EU citizenship.\(^{60}\) He argues that, over time, a reconceptualisation of the internal market has taken place, away from pure economic integration to encompass other aims such as consumer protection, social rights and the environment.\(^{61}\) He sees evidence of this in a number of policy papers emanating from the Commission and the European Council, for example, in relation to the Lisbon process and the 2000 Review of Internal Market Strategy and the Communication on Services of General Interest, which emphasise the importance of both economic and social policy.\(^{62}\)

There appears to be increasing support for the view that whilst social policy may have begun as a spillover from economic integration, the balance has since shifted to a more even-handed relationship between economic and social goals. One possible factor in such a shift is the increasing importance of fundamental rights in the dialogue on social policy, which will now be examined.

1.3.3 Explanations for the development of European social policy II - a rights-based theory of European social policy

Often seen as an alternative to the conception of social policy development as a spillover from economic integration, it has been argued that, particularly in recent decades, an autonomous rights-based role for social policy has emerged. This approach has gained in

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\(^{60}\) ibid., p.29-30.

\(^{61}\) ibid., p.38.

\(^{62}\) ibid., p.40.
importance as successive treaties have extended competences and emphasised the social
dimension of the EU, seen in particular, in the addition of the Social Chapter by the Treaty
of Amsterdam. Its growing significance can also be observed in the introduction of rights-
based instruments such as the Community Charter of Fundamental Social Rights of

The former instrument, heralded as the social dimension of the Single European Act, contained provisions on a range of issues including: freedom of movement, employment and remuneration, the improvement of living and working conditions, social protection, health protection and safety in the workplace, and elderly and disabled persons. Despite the appearance of a wide scope, the Charter related to the rights of workers rather than citizens in general and had a clear focus on employment related rights.

The latter Charter, unlike its predecessor, applies to all EU citizens (and often to all persons within EU territory). It contains a wide range of fundamental and social rights. Social rights include a host of employment rights, rights to social security and social assistance and a right to preventative health care and medical treatment. The EU Charter of Fundamental Rights was solemnly declared by the heads of the Member States at the Nice Council in 2000. It has been incorporated into the Constitutional Treaty but the ratification process in relation to the latter has been put on hold pending a period of reflection by the Member States.

Whilst these instruments lack binding legal force at present, they have influence over European Community law through the jurisprudence of the Court of Justice, which takes inspiration from them. Equally, in determining the direction of social policy and law,


64 Articles 27-33, EU Charter of Fundamental Rights.

65 ibid., Article 34.

66 ibid., Article 35.

67 This occurred as a result of the rejection of the Constitution in referenda in France and the Netherlands in 2005.
consideration is also given by the Commission, European Parliament and Council to the protection and promotion of the rights contained in the various Charters.

It has been suggested that:

"the concept of human and fundamental rights may be seen as capable of providing a moral grounding to a legal order which...was established principally to support the pursuit of economic goals, and also to forge an identity [with] cross national appeal [which emphasises] shared or common values already existing within Member States."  

Under the rights-based approach, European integration may be regarded as a means of safeguarding the welfare state whereby: "the European Union is the new forum in which social rights, no longer viable at national level due to economic competition among states, are re-introduced." In other words, it is argued that economic integration should be subject to a legal framework which includes a set of social rights.

A further view of the rights-based model focuses on the importance of the linkages between the political and constitutional dimension of the EU on one hand, and its social policy dimension on the other. In this conception, the latter is dependant upon the constitutional evolution of the EU. It is noted that historically the development of social policy (and social rights) has been connected with the development of nation states and the protection of their citizens. Arguably the introduction of the status of EU citizenship in the Treaty on European Union is suggestive of a state-like relationship, albeit an incomplete one. The scope of 'social citizenship' and the rights which attach to it, is evolving through the jurisprudence of the Court of Justice. The focus of many of the cases is upon cross border

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71 ibid., p.12.
72 Article 18, TEU.
rights to various social benefits and entitlements. However, it can be argued that EU citizenship has given additional impetus towards an enforceable catalogue of social rights for all. Kenner believes that in the future:

“social citizenship rights may evolve as free-standing rights which are not dependant solely on the goal of economic integration, but instead reflect a direct political link between the citizens of the Member States and the... Union.”

In order to assess the relevance of a rights-based approach in the context of patient mobility, the fundamental right to health and its status within the EU legal order will now be examined.

1.3.4 The rights-based approach and health care

A rights-based approach to patient mobility would be focused on the fundamental right to health care. The exact meaning and scope of such a right are, in fact, rather difficult to determine. The first explicit reference to the right to health care in an international legal instrument can be found in the International Covenant on Economic, Social and Cultural Rights which recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and further requires states to take steps to achieve the full realisation of this right including:

“the creation of conditions which would assure access to all medical services and medical attention in the event of sickness.”

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76 ibid., Article 12(2)(d). This provision demonstrates the relationship between the right to health and the right to health care, with the latter expressed as an aspect of the former. See, for example, Toebes, B., The Right to Health as a Human Right in International Law, Intersentia, 1999, p.19.
There are also a number of relevant provisions in regional human rights instruments. Of particular note are the European Convention on Human Rights, the European Social Charter, the WHO Declaration on the Rights of Patients in Europe and the EU Charter of Fundamental Rights.

The European Convention on Human Rights (ECHR) is one of two treaties together with the European Social Charter, devised by the Council of Europe to promote and protect human rights in Europe. Although the ECHR contains no express provision guaranteeing a right to health care, a number of its articles do have a bearing on health and have been raised in cases involving medical treatment before the European Court of Human Rights. Perhaps the most useful article in this regard is Article 8 which proclaims the right to respect for family and private life. This latter concept has been given a very wide judicial interpretation and encompasses ideas such as dignity and identity. It has been described as covering:

“anything having to do with personal health, philosophical, religious or moral beliefs, family and emotional life, friendships and, subject to reservations, professional and material life as part of private life.”

Arguably, access to medical treatment is necessary for the protection of ‘private life’ in this sense. Furthermore, the Convention has a specific significance within the EU legal framework as it forms the basis for the understanding of fundamental rights within it.

The European Social Charter (ESC), which has been described as the natural complement to the European Convention on Human Rights, was adopted in 1961 and revised in 1996. The ESC is referred to in the EC Treaty as a source of fundamental social rights to be borne

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79 This is possible because all the Member States of the EU are also signatories to the Convention.
in mind by the Community and the Member States.\textsuperscript{82} The ESC contains two provisions on the right to health care, Articles 11 and 13. Whilst the former is entitled ‘the right to protection to health’,\textsuperscript{83} the latter deals with the right to social and medical assistance.\textsuperscript{84}

Article 11.1 provides that:

“With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly, or in co-operation with public or private organisations, to take appropriate measures designed \textit{inter alia};

1. to remove as far as possible the causes of ill-health.”

In the Digest of Case Law of the European Committee of Social Rights,\textsuperscript{85} the purpose of which is to present the interpretation the Committee has made of the different articles of the ESC, a wide understanding of ‘removing the causes of ill health’ is found, which includes the right of access to health care.\textsuperscript{86} The Committee regards this right as having four aspects.\textsuperscript{87} Firstly, health care should be funded collectively; secondly the costs should not be too onerous; thirdly, the Committee states that access to health care should be provided without undue delay; and, fourthly, provision of health personnel and equipment should be sufficient.

A further instrument emanating from the Council of Europe which touches upon the right to health care is the 1997 Convention on Human Rights and Biomedicine.\textsuperscript{88} Designed to respond to accelerating developments in the field of biomedicine, the Convention covers

\textsuperscript{82} Article 136, EC.
\textsuperscript{83} Article 11, Revised European Social Charter.
\textsuperscript{84} Article 13 relates to the funding of health care and requires states to set up health services on a basis which is affordable to their populations.
\textsuperscript{86} \textit{ibid.}, Introduction.
\textsuperscript{87} \textit{ibid.}, p.57.
matters such as consent to treatment, the use of genetic testing and organ transplantation. It also contains a number of general provisions, one of which provides that:

"Parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality."^89

Turning to the EU itself, it should be noted at the outset that the EU Charter of Fundamental Rights does not at present enjoy binding status. Despite this apparent disadvantage, the EU Charter has been referred to by Advocates General and the Court of First Instance on a number of occasions^90 and was cited in a Court of Justice judgment for the first time in 2006.^91 It could, therefore, be referred to in the context of a preliminary reference concerning access to cross border care, although this has not happened at the time of writing.

It should also be acknowledged that the EU Charter does not mark the introduction of fundamental rights into the EU legal order. Over the lifetime of the Community, the Court of Justice has developed the status of fundamental rights in Community law through its case law, starting with the cases of Stauder^92 and Internationale Handelsgesellschaft.^93 In the latter, the Court of Justice held that respect for fundamental rights, inspired by the constitutional traditions common to the Member States, formed an integral part of the general principles of law protected by the Court. Later, in Nold^94 the Court extended the scope of fundamental rights protection holding that the contents of the international human

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rights instruments to which the Member States were party should also be observed within the framework of Community law.

The stated purpose of the EU Charter is to raise the profile of the fundamental rights respected in EU law by consolidating them into a single instrument. In line with the conception of fundamental rights as a general principle of EU law, the EU Charter of Fundamental Rights expressly draws inspiration from the ECHR and the ESC, as well as from the jurisprudence of the Court of Justice and the national constitutional traditions of the Member States. The right to health care is found in Article 35 of the EU Charter of Fundamental Rights. Article 35 has two aspects. Firstly, it provides that:

"Everyone has the right of access to preventative health care and the right to benefit from medical treatment under the conditions established by national laws and practices."

It goes on to state that:

"A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities."

Whilst the latter paragraph replicates Article 152(1) of the EC Treaty and essentially provides for the mainstreaming of public health policy in all fields of Union action, the scope and meaning of the first paragraph is rather more difficult to determine. In interpreting the provision it is necessary to have regard both to the Preamble of the Charter and to the General Provisions contained in Chapter VII. The Preamble indicates that the Charter reaffirms the rights which result from, inter alia, the European Social Charter and the Revised European Social Charter. Article 35 must, therefore, be read in conformity with Article 11 of the European Social Charter to determine its meaning. Further consideration is required in relation to the effect of the provision and, in particular, the question of its enforceability. The General Provisions set out the scope of the Charter thus:

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95 Preamble of the EU Charter of Fundamental Rights, para 4.
96 Preamble of the EU Charter of Fundamental Rights, paras 5 and 6.
97 Articles 51-54, EU Charter of Fundamental Rights.
“The provisions of this Charter are addressed to the institutions and bodies of the Union ... and to the Member States only when they are implementing Union law...”

The limitation in respect of the application of the Charter to Member States seems restrictive. However, it has been suggested that it would include situations where, for example, a failure on the part of a Member State to implement EU law is alleged. In Article 35 the rights to preventative health care and medical treatment are expressed to be exercisable under the conditions established by national laws and practices. This appears to further limit the rights referred to by subjecting them to national norms, rather than guaranteeing a European Union-wide entitlement. It has been suggested that by entrusting the content of the rights contained in Article 35 to the Member States, the Charter only ensures the principle of equality of access to health care. Whilst the precise scope of the right remains to be interpreted by the Court of Justice, the extent to which the case law of the Court on patient mobility is consistent with the fundamental right to health care will be considered in Chapter 3.

1.3.5 Explanations for the development of European social policy – concluding remarks

The two approaches examined offer different accounts of the development of European social policy, both of which are relevant to the area of patient mobility and health care. The neo-functionalist perspective predicts the inevitability of spillover effects and the patient mobility case law fits this approach. Meanwhile, a rights-based approach reflects the fact that many social entitlements, such as health care, have been accorded the status of fundamental rights and, as such, they are to be respected within the EU legal order. This thesis examines the impact of the case law on patient mobility upon the development of EU law and policy in relation to health care in the light of these two contrasting approaches. It will be argued that whilst patient mobility may be seen as a spillover from internal market integration, it has provoked, and fed into, legislative, soft law and policy developments

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98 Article 51, EU Charter of Fundamental Rights.
with results which may signal the beginnings of a shift towards a more rights-based approach to rights to health care in the EU.

1.4 How EU social policy is developed

Having examined differing views as to why European social policy has evolved, the different mechanisms used to introduce it will now be considered as these have a bearing upon the ways and rate at which different social policy areas are advanced. The first of these is deregulation which takes the form of prohibiting, and requiring the removal of, barriers to the smooth running of the internal market. This process, described as negative integration, may have the incidental effect of removing national social policy measures. A second mechanism known as positive integration, or re-regulation, may act to correct such adverse effects by introducing EU law to replace national measures which have been removed by deregulation. However, problems may arise from asymmetry between the two. Whereas deregulation is based upon Treaty provisions, re-regulation requires legislative competence and political will on the part of the EU institutions. Both have harmonising effects but as re-regulation is harder to achieve regulatory gaps may emerge, whereby a social interest is left unprotected by EU law or national law.\(^{101}\)

In terms of positive integration, whilst the Commission has frequently been an enthusiastic proponent of social policy it can only propose policy in areas permitted by the Treaties. Since these are both narrow and fragmented, the role of the Commission has been described as that of a skilful policy entrepreneur requiring the ability to devise proposals with maximum prospects for success.\(^{102}\) The task is made more difficult by the fact that action taken by the Community in areas which do not fall within its exclusive competence, such as social policy, is subject to the principle of subsidiarity.\(^{103}\) This means that such action can only be taken where the objectives cannot be sufficiently achieved by the Member States acting alone.

\(^{103}\) Article 5, EC.
Although it is one of the functions of the Commission to initiate policy, much of the
ultimate control over legislative development rests with the Member States via the Council.
In the absence of consistent political will to enact social policy measures, the alternative
mechanism through which European social policy can evolve is by the deregulatory activity
of the Court of Justice which is characterised by decisions requiring the removal of barriers
to the four freedoms of movement enshrined in the EC Treaty.

In the same way that the Court of Justice is seen as an important force in the overall process
of European integration, it has been specifically described as an arena for social policy
promotion,104 and is regarded as a major influence in the development of EU social
policy.105 In examining the contribution of the Court of Justice in this regard, Poiares
Maduro acknowledges that its case law has at times appeared to follow a neo-liberal model
by promoting deregulatory consequences at national level with negative effects upon social
rights.106 However, he argues that the Court has also used the market integration process to
promote social rights.107 For example, citing the Court's very wide interpretation of the
equal pay provision, Article 141 EC, he suggests that here:

"The Court has picked up a norm the social content of which was, in its original
construction, instrumental to the aim of protecting equal conditions of competition and
raised it to the status of a true fundamental social right."108

A further example given is that of the Court's application of the non-discrimination
principle found in Article 12 EC. It is observed that this has been used by the Court to
extend the protection of social rights for migrant EU citizens, for example through the

105 Streeck, W., 'Neo-voluntarism: A New European Social Policy Regime?' in Marks, G. et al, (eds)
106 Poiares Maduro, M., 'Striking the Elusive Balance Between Economic Freedom and Social Rights in the
107 ibid., pp. 455-458.
108 ibid., p.455.
interpretation of 'social advantages'\textsuperscript{109} and the approach to the social rights of citizens seen in \textit{Martinez Sala}\textsuperscript{110} and subsequent cases on citizenship.

There are a number of factors which have influenced the Court's exercise of this role.\textsuperscript{111} Firstly, it has been argued that, unlike the Council and Commission, the Court of Justice cannot avoid making policy decisions when confronted with litigation which raises questions of social policy. Secondly, the Court is able to rely on secret majority votes, which saves it from the problems of achieving political consensus which the other institutions face. Finally, it is noted that Court of Justice decisions are relatively robust in that, once made, they can only be reversed by the Court itself or by a vote from the Council.\textsuperscript{112}

The harmonisation of social policy often entails the setting of minimum standards, with Member States free to make provision above these levels, should they wish to do so. The focus on minimum standards is, however, something of a double-edged sword. Whilst harmonisation confers basic entitlements on all, it is also seen as acting as a disincentive to states to provide more generous benefits, thus encouraging a race to the bottom' to counter the threat of 'welfare tourism'.\textsuperscript{113} Views differ as to the extent of this threat. Many commentators argue that reductions in the quality of social provision could occur in response to pressure from welfare tourism.\textsuperscript{114} However, others see less evidence that European integration will fuel social dumping\textsuperscript{115} and it has been suggested that:

\textsuperscript{110} Case C-85/96 \textit{Martinez Sala} [1998] ECR I – 2691.
\textsuperscript{112} For instance, the amendment of Article 22(l)(c) of Council Regulation 1408/71/EEC on the application of social security schemes to employed persons and their families moving within the Community following the judgment of the European Court of Justice in Case 117/77, \textit{Bestuur van het Algemeen Ziekenfonds, Drenthe-Plateland v Pierik} [1978] ECR 825. This is examined in Chapter 2.
\textsuperscript{114} See, for example, Hervey, T., 'Mapping the Contours of European Union Health Law and Policy' (2002) 8 EPL 85.
"national welfare states and social regimes have been notably able to maintain their distinctive developmental paths (disproving the assumptions of convergence) and their overall level of provision and social coverage (disproving fears of overall social policy decline and retrenchment)."\textsuperscript{116}

An alternative, less interventionist, approach is that of co-ordination which leaves different national laws and systems intact, but may require, for example, their application to nationals of other Member States,\textsuperscript{117} or the recognition of professional qualifications gained in other Member States.\textsuperscript{118} This approach is the forerunner of the open method of co-ordination which was introduced in 2000. The open method of co-ordination (OMC) comprises four main elements. Firstly guidelines are set for EU action with specific timetables for meeting specified goals. Then indicators and benchmarks are established as a means of comparing best practice. Measures are then adopted by the Member States, taking into account national and regional differences. Member States give periodic reports to the EU institutions on progress which are combined, evaluated and fed back into the process.\textsuperscript{119}

\textbf{1.5 The role of the EU in relation to health law and policy}

As has been noted, the development of European social policy has embodied a mixture of theoretical approaches. The same can be said in relation to EU policy on health related matters. In addition to coming within the EU’s social policy ambit, health strategy has been affected by other fields of EU action; in particular social security co-ordination, free movement and the internal market, fundamental rights and citizenship.

Health policy and provision is a major preoccupation and priority of all national governments in Europe. Each Member State of the European Union has a highly developed


\textsuperscript{119} For a full discussion of the open method of co-ordination, see Chapter 5.
health system with a strong element of public funding and public health policies and systems. Both public health and the provision of health care are aspects of social policy. Whilst the former has been treated as a legitimate policy domain for the European Union since the original public health article appeared in the TEU,\textsuperscript{120} traditionally the responsibility for the provision of health services has been closely guarded by the Member States.

The health systems of the Member States of the EU fall into two main categories which are known as Bismarkian and Beveridgian systems, in recognition of their historical origins.\textsuperscript{121} The publicly funded health systems of the 25 EU Member States are roughly speaking equally divided between these two types of system.\textsuperscript{122} The first of these types, which can also be described as a social insurance system, generally offers various levels of category-based coverage. Individuals make the required social insurance contributions or may have these made on their behalf by an employer or by the state itself. Within this type of health system two methods of meeting the costs of medical treatment can be identified: some states operate a reimbursement system whilst others provide benefits in kind upon evidence of being insured. The second type of system can be described as a national health service. Here the state (directly or indirectly) is itself a provider of care which is usually universal and free at the point of delivery.

For a number of reasons in recent years an EU policy on at least some aspects of health care delivery appears to be emerging. To assess the role of the EU in relation to health policy it is first necessary to examine its competence in relation to public health and corresponding activity. It will be seen that the parameters set by the Treaty seek to limit the policy space available to the EU in relation to health care. However, it has nonetheless been possible for

\textsuperscript{120} Article 129, TEU.

\textsuperscript{121} Palm, W., Nickless, J., Lewalle, H. and Coheur, A., 'Implications of recent jurisprudence on the co-ordination of health care protection systems', Association Internationale de la Mutualité, 2000, p.16.

\textsuperscript{122} ibid., p.17, and MISSOC INFO 2/2004. Social insurance systems exist in 13 Member States: Belgium, France, Luxembourg, Austria, Germany, the Netherlands, the Czech Republic, Slovakia, Slovenia, Lithuania, Estonia, Hungary and Poland. National health service systems of various kinds exist in the remaining 12; the United Kingdom, Ireland, Spain, Italy, Portugal, Greece, Denmark, Finland, Sweden, Cyprus, Latvia and Malta.
the Commission to address issues in this field through other areas of policy, such as social protection.

1.6 The development of EU action in relation to health

Activity at Community level in relation to public health matters existed as early as the 1970s despite the absence of an express competence in the health field in the original EC Treaty. Since this time the health ministers of the Member States have met to discuss health-related issues of common concern and which arise from the process of economic integration. This wide range of issues, grouped under the term 'public health', overlaps with other policy areas such as consumer and environmental protection. Concerns about health and safety led to the harmonisation of consumer protection laws, whilst in the field of environmental protection measures such as the adoption of common standards for air pollution and drinking water have been introduced to safeguard public health. The notion of public health is also connected to the free movement of goods, persons and services, appearing in the EC Treaty as a ground of derogation from these freedoms. This makes the development of a common notion of public health seem desirable.

In addition to activity in relation to public health matters, attention has also been given to the provision of health services. For example, in 1984 as one of a number of proposals relating to social protection, the Council suggested that, on the basis of periodic reports from the Commission, the Council would examine the means employed to control trends in health expenditure and that the Commission would examine, with the Member States, the possibilities for co-operation in the field of health. Although expressed in broad terms, this proposal for the first time identified health provision as a legitimate policy area within the context of social protection, and thus within the realm of social policy, at a time when there was no basis within the EC Treaty for Community-level action in relation to health.

124 Articles 30, 39(3) and 46, EC.
The lack of a proper treaty basis for action in the public health field was rectified by the Treaty on European Union which inserted a new public health article into the EC Treaty.\textsuperscript{126} This heralded the start of a new era in EU health law and policy which was further advanced by the Treaty of Amsterdam four years later. The scope and impact of these developments will be considered by examining two main areas: the evolving legal framework for health through Treaty reform and the development of health-related policy by the Commission, particularly following the introduction of a dedicated directorate general for public health and consumer protection in 1999.

\textbf{1.6.1 The scope of EU competence in relation to public health}

As noted above, the EU's first treaty-based powers with respect to public health were introduced in the Treaty on European Union.\textsuperscript{127} The competence in relation to health came from two provisions: Article 3(o) which empowered the Community to contribute to the attainment of a high level of health protection and Article 129, a detailed provision on public health. Under Article 129 the Community was ascribed a supporting role in ensuring a high level of human health protection by encouraging co-operation between Member States in the public health field and the mandate to take action with the aim of preventing 'major health scourges' including drug dependence through research into their causes and health information and education.\textsuperscript{128} Co-operation with third countries and relevant international organisations would also be fostered.\textsuperscript{129} The Article also declared that:

"health protection requirements shall form a constituent part of the Community’s other policies."\textsuperscript{130}

\textsuperscript{126} Article 129, TEU.
\textsuperscript{128} Article 129(1), TEU.
\textsuperscript{129} Article 129(3), TEU.
\textsuperscript{130} Article 129(1), TEU.
The article has been described as a compromise between those Member States seeking an enhanced role for the EU in relation to health and those which opposed this.\textsuperscript{131} It can be seen either as delimiting the EU’s powers and ending creeping competence in the health field or conversely as validating previous collaboration on health with the intention of taking this further.\textsuperscript{132} Dashwood has suggested that:

"The specific and detailed attribution of competences was taken to fresh lengths in the new legal bases which the Treaty of Maastricht provided...The tight drafting of the relevant provisions makes clear the ancillary nature of the Community’s role in those fields, and that the shaping of policy remains a national preserve."\textsuperscript{133}

Article 129 was open to a number of criticisms. In particular, key concepts such as ‘public health’, ‘major health scourges’ and ‘a high level of human health protection’ were not defined. Furthermore, the Community was given limited authority to tackle public health issues – specifically the Council was limited to adopting recommendations, a non-binding form of legal instrument, under the Article. All in all, Article 129 did not radically alter the relative responsibilities of the EU and the Member States in relation to public health, with the latter retaining primary control.\textsuperscript{134}

Article 129 was amended and renumbered to Article 152 in 1997 by the Treaty of Amsterdam. It has been suggested that:

"The BSE crisis in particular put the role of the Community in the public health field in a different perspective. The discovery of the disease in the United Kingdom and the

\textsuperscript{132} ibid., pp.72-73.
implications for the other Member States, made it clearer than ever that public health must play a central role in the European integration process.\textsuperscript{135}

Article 152 is subject to many of the same criticisms levied at Article 129. Once again, as is often the case in the EC Treaty, key terms are largely undefined and it is not made clear how the aims will be pursued. The amended provision has been described as a missed opportunity for a re-evaluation of the EU's role in public health.\textsuperscript{136} However, a more positive view focuses on the opening declaration of Article 152 which states that:

"A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities."\textsuperscript{137}

In comparison with the corresponding part of Article 129, set out above, the revised provision appears considerably more robust, even implying that health protection may be given more weight than other types of interest. Furthermore, Article 152 provides for increased legislative powers in relation to measures setting standards in relation to human organs, blood and blood products and health protection measures in the veterinary and phytosanitary fields.

Whilst powers in relation to public health were enhanced, the same cannot be said of the role in relation to health provision. Although the second paragraph of Article 152 preserves the Community's role of encouraging Member State co-operation in the areas referred to in the Article, significantly, one of the effects of the amendment was to provide that Community action in the field of public health shall fully respect the responsibility of Member States for the organisation and delivery of health services and medical care.\textsuperscript{138} It is thought that the insertion of this provision reflects the concerns of Member States about the possibility of spillover of competences from the public health domain into health

\textsuperscript{136} Mossialos, E. and Permanand, G., Public Health in the European Union: Making it Relevant, London School of Economics, 2000, p.43.
\textsuperscript{137} Article 152(1), EC.
\textsuperscript{138} Article 152(5), EC.
provision itself. Whether the provision will have the desired effect is uncertain as it
could be argued that the requirement to accord full respect to Member States does not
automatically preclude public health action which impinges upon health care and that the
Article does not, in any event, cover EU action outside the field of public health, such as in
the internal market area, which impacts upon health care delivery. Davies believes that the
point has been reached where Community action is touching upon a number of sensitive
areas of, traditionally, national competence, including the welfare state, with the result that:

"The choices that countries can make in these areas are becoming increasingly tightly
contained by the consequences and requirements of removing borders. The current
problem is deciding the extent to which the Community may legitimately make demands
and legislate in these areas...".

Examples of action taken under the public health competence include targeted action
programmes for example in relation to cancer, AIDS, drug abuse and pollution-related
diseases. From 1996 a new approach has been taken whereby policy has been steered
through the medium of successive five or seven year programmes covering a variety of
public health issues. There are common themes running though these programmes and
the most recent proposal, placing emphasis on both internal and external threats to public
health, such as environmental hazards and global diseases such as SARS and avian
influenza. A further common link is a focus on health information as a means of
empowering EU citizens. The most recent proposal introduced by the Commission is for a
The public health aims of this programme include tackling health inequalities, promoting
health and preventing illness, health systems and health information.

The programmes are largely implemented by soft law measures and co-ordination
strategies. However, there is also a growing body of EU public health legislation for

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example regulations on drug precursors\textsuperscript{143} and establishing a European Centre for disease prevention and control,\textsuperscript{144} and directives on the approximation of national laws in relation to clinical drug trials\textsuperscript{145} and setting safety quality and standards for the donation and use of human tissue.\textsuperscript{146}

The public health article was once again reworded as part of the process of drafting a constitution for the European Union.\textsuperscript{147} At present, the process of ratifying the Constitutional Treaty has been put on hold and it is impossible to say whether or when the new provision might take effect. However, it is instructive to assess the changes which were agreed by the Member States. The new article expands on the contents of Article 152 in a number of ways. Firstly it adds a new field of action for the EU – that of monitoring and controlling serious cross border health threats.\textsuperscript{148} A further amendment appears in relation to the Union’s role of encouraging co-operation between Member States and supporting their action. Here the new article provides that the EU:

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shall in particular encourage co-operation between Member States to improve the complementarity of their health services in cross-border areas.
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The new formulation shows a shift towards a more defined role for the EU in relation to cross border health services. The concept of the EU encouraging cross border co-operation in health provision is not a new one. Under the Interreg projects, since 1992 the sharing of medical facilities between Member States was promoted in certain regions such as Hainault-Nord-Pas-de-Calais and Meuse-Rhine.\textsuperscript{150} However, these were very much pilot projects whereas the amendment to the article suggests that the policy is now to be pursued generally. One way in which complementarity in cross border areas can be achieved is through sharing of health care facilities by Member States. This policy is in line with

\textsuperscript{147} Article 111-278, EU Constitution.
\textsuperscript{148} Article 111-278(1)(b), EU Constitution.
\textsuperscript{149} Article 111-278(2), EU Constitution.
recent proposals published by the Commission for the establishment of European ‘centres of reference’.\textsuperscript{151} The co-ordination of Member States’ activities is further expressed in the new article as involving the elements associated with the open method of co-ordination; the setting of guidelines and indicators, the exchange of best practice and periodic monitoring and evaluation.\textsuperscript{152} The application of this method to health care co-operation will be examined in Chapter 5.

In terms of the legislative powers of the EU in relation to public health, these are extended to two new areas: setting safety and quality standards for drugs and medical devices\textsuperscript{153} and the monitoring and combating of serious cross border health threats.\textsuperscript{154} Legislative powers are also given to establish incentive measures in relation to the latter and also in relation to public health issues arising from tobacco and alcohol.\textsuperscript{155}

Finally, the new article retains and strengthens the reservation of competence by Member States over the organisation and delivery of health services which was added to the Treaty in Article 152. The corresponding section of the new article has been reworded to add that Member States are responsible for the definition of their health policy and that their responsibilities shall include the management of health services and medical care and the allocation of resources assigned to them.\textsuperscript{156}

This elaboration on the previous wording suggests continued concern on the part of Member States about creeping competence and the spillover of rights to exercise the economic freedoms which form the backbone of EU law into the field of national health provision. This concern no doubt arises from the case law of the Court of Justice on access to cross border care which will be fully examined in Chapter 3. In essence the effect of these judgments has been to oblige Member States in certain circumstances to fund cross border care for patients in accordance with the principle of the free movement of services

\textsuperscript{151} COM(2004)301, Follow-up to the high level reflection process on patient mobility and healthcare developments in the European Union. See Chapter 5 for a fuller discussion.
\textsuperscript{152} Article 111-278(2), EU Constitution.
\textsuperscript{153} Article 111-278(4)(c), EU Constitution.
\textsuperscript{154} Article 111-278(4)(d), EU Constitution.
\textsuperscript{155} Article 111-278(5), EU Constitution.
\textsuperscript{156} Article 111-278(7), EU Constitution.
found in Article 49 EC. Such decisions, although few in number and subject to conditions and limitations, nonetheless pose a threat to the ability of Member States to have complete control over their health care systems. The new article attempts to delimit the respective competences of the EU and the Member States in relation to health care more clearly than ever before. However, the control of Member States over their health systems remains subject to the operation of internal market principles such as Article 49 of the EC Treaty. This tension will be examined throughout the thesis.

1.6.2 EU policy on health care provision in the context of social protection

Despite the constraints of Article 152, a limited EU policy on health care has emerged in the context of Commission proposals relating to social policy in general. For example, in 1997 the Commission issued a Communication on ‘Modernising and Improving Social Protection’. This called, inter alia, for a European dimension to health services with an emphasis upon improving the efficiency, cost-effectiveness and quality of health systems in order to meet the growing demands of an ageing population. The view has been expressed that it is difficult to see how such an aim could be pursued in the absence of a competence over health services.

In a further policy initiative, the decision of the Lisbon European Council in March 2000 to encourage the reform of social protection systems in the EU, led the Commission to issue a communication on the future of health care and care for the elderly. The Communication notes that despite the diversity of funding and organizational arrangements of national health systems, public-sector funding forms a significant proportion of health expenditure in all Member States which is in turn subject to the Community’s economic policy guidelines.

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159 COM(2001)723. This proposal was issued by the Employment and Social Affairs Directorate.
160 ibid., pp.8 – 9. Health care spending is stated to be subject to the Broad Economic Policy Guidelines for 2001.
Two areas of Community policy are identified as particularly relevant to health care. The first of these is the public health competence contained in Article 152 of the EC Treaty. In this regard, the Commission identifies the provision of health care as a key aspect of public health on the basis that it is the health services of the Member States which must meet their populations’ (public) health needs. The public health competence is thus used to form part of the basis for the creation of an EU policy in relation to health care and to justify the involvement of the Commission in seeking a role in co-ordinating this. The second area identified as being of particular relevance to health care is internal market policy. Here the Commission implies that Member States’ control over their health systems is secondary to internal market goals, observing that:

"Under the oft-reiterated jurisprudence of the Court of Justice, while Community law does not impinge on the responsibility of the Member States when it comes to organizing their social security system, the Member States must respect Community law in the exercise of this responsibility."

It is further noted that whilst the organization and funding of health care systems is the task of Member States, this responsibility is increasingly pursued within a general framework upon which many Community policies have a bearing, a situation which is an argument for strengthening co-operation in relation to health care strategy. The policies in question include the free movements of goods, persons and services and the functioning of the internal market, as well as competition and public health.

The Commission suggested three long-term objectives in relation to health care and care for the elderly; accessibility, quality and financial viability. With regard to accessibility it is noted that the EU Charter of Fundamental Rights guarantees access to preventative health care and medical treatment for all. In relation to quality the Commission asserted:

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161 COM(2001)723, p.9. The cases in question are discussed in detail in Chapter 3.
162 ibid., pp.7-8.
163 ibid., Annex 1.
164 Article 35, EU Charter of Fundamental Rights.
"Good quality health care is an essential requirement for all Europeans. It is a major public health objective." \(^{165}\)

The quality of health care is seen as having two aspects, both of which vary between Member States; the level of provision and the nature of the care offered. The Commission maintained that comparative analysis and the identification of 'best practice' would contribute to improving the quality of health care systems and medical treatment in the EU. \(^{166}\) In its conclusions the Commission remarked that attaining these objectives would require the co-operation of all the parties involved in health care, including public authorities, medical professional, social protection bodies, insurers and patients. \(^{167}\) The Commission also acknowledged the inherent difficulties arising from the varying interests of those involved.

The contents of this Communication represented a new policy step for the Commission into the area of health service delivery. However, despite links to Treaty bases such as Article 152, the policy of co-operation between Member States in relation to certain aspects of the delivery of health care does not fall squarely within the Treaty competences of the EU. Action in this area will be based on the open method of co-ordination in so far as it falls outside other areas in which the EU does have competence such as the principle of free movement of services within the internal market.

Arguably, it is the relationship between health and other, mainstream, policy areas, in particular the co-ordination of social security for migrant workers and the regulation of the internal market, which makes it possible for the Commission to attempt to construct a policy on health care in this way. Since this Communication there have been a number of further significant policy developments arising, at least in part, from the case law of the Court of Justice on access to cross border medical treatment within the EU. These developments, which have emanated from both the Public Health and the Employment and

\(^{166}\) ibid., p.11.
\(^{167}\) ibid., p.14.
Social Affairs Directorates, will be examined in detail in Chapter 5, following a discussion of the background to this aspect of health policy in the intervening chapters.

1.7 Conclusions

European social policy development is an aspect of the broader project of European integration. It has been argued that law plays a highly significant role in both processes and this premise underpins the examination in this thesis of the impact of the case law on patient mobility upon the development of EU law and policy in relation to health care. Just as there are a range of integration theories, there are also different possible explanations for the development of social policy in the EU. Two, in particular, have been explored to inform the discussion in this thesis, namely the neo-functionalist view that social policy arises as a spillover from internal market integration and the rights-based approach.

In tracing the historical evolution of European social policy, it has been seen that, despite having a relatively limited competence in the field of social policy, the social policy dimension of the European Union has developed in a number of directions, many of which have become independent of employment policy to which it was so strongly tied in the early years of the Community. However it remains:

"a complex and often confusing melange of polices and institutions...forming a social policy regime...that defies easy categorisation and differs fundamentally from what exists in national welfare states."\(^{168}\)

It has been argued that the successful development of social policy is largely due to the persistence of the Commission in forming social policy proposals and to the creative jurisprudence of the Court of Justice as foreseen by theories of European integration such as neo-functionalism and, to some extent, federalism. Its shortcomings, such as the absence of a single theoretical model, a lack of coherence across the range of social policy areas and

the politically imposed constraints found in the Treaty provisions, are responsible for and indicative of its sporadic and incremental evolution. Moreover, European social policy remains capable of being undermined by deregulatory internal market policies and arguably needs a much stronger Treaty basis to protect it.

Turning to the area of EU policy in relation to health care, it is noted that the Treaty basis for Community action in the field of public health, Article 152 EC, attempts to delimit competence for health services by requiring that the responsibility of Member States for the organisation and delivery of health care must be fully respected. However, this fails to take into account the effects of other policy areas such as the co-ordination of social security and the promotion of the freedom to receive services within the internal market upon the health sector. This has created the potential for a spillover, as measures taken outside the public health field in relation to the internal market impact upon the ability of Member States to control access to and from their health services.

It will be seen that the jurisprudence of the Court of Justice on patient mobility recognises individual rights to cross border care on the basis of the free movement of services but fails to address the status of health care as a fundamental right (see Chapter 3). It will be argued that whilst the effect of such judgments in requiring Member States to fund cross border care can be seen as a spillover from internal market integration, the Court’s approach to the conditions for the exercise of patient mobility rights is, in fact, broadly compatible with interpretations given to the fundamental right to health by relevant international and regional human rights institutions.

Whilst in the field of patient mobility, spillover effects have been dominant historically in terms of the development of EU level policy in relation to health care, it will be argued that the influence of rights may be increasing. This is evidenced, for example, by the inclusion of health-related provisions within the Charter of the Fundamental Rights of Workers and the EU Charter of Fundamental Rights. There are also signs of a more rights-orientated approach being taken in the language of the Commission in recent policy papers (see Chapter 5).
Despite a growing school of thought which sees social policy as an integral part of the internal market, the recent development of law and policy in relation to access to cross border medical treatment provides an insight into the tensions which can still exist between economic and social interests in the form of a clash between neo-liberal market deregulation and the desire of Member States to retain sovereignty over their health systems. To examine how this area is evolving, Chapter 2 will outline the legislative background to patient mobility and Chapter 3 will examine the case law of the Court of Justice in relation to it. In Chapters 4 and 5, legislative and policy responses to the jurisprudence on cross border care will be assessed.
Chapter 2: The legislative background to the case law on patient mobility

2.1 Introduction

In order to examine the impact of the case law on patient mobility upon the development of EU law and policy in relation to health care, it is first necessary to explain the background to the case law itself. In order to do so, this chapter will consider the legislative backdrop to the cases on access to cross border health care, in particular Regulation 1408/71 on the co-ordination of social security.\(^1\) This examination is required both to set out the framework within which the cases arose and to explain, at least in part, why individuals sought to rely directly on the EC Treaty freedom to receive services in order to gain access to cross border care. It will be shown that whilst, on the one hand, the Regulation contained the possibility for planned cross border treatment, on the other hand the limitations attaching to the provision itself and the reluctance on the part of Member States to apply it led to the pursuit of an alternative legal route by patients wishing to have treatment in another Member State.

Firstly, the general principles underlying the co-ordination of the social security systems of the Member States will be considered, followed by an examination of the specific provisions on access to cross border health care. The limitations of this approach will then be addressed, together with the response of the Court to particular issues raised in relation to their application.

Following this discussion, Chapter 3 will set out and analyse in detail the cases themselves and subsequent chapters will investigate the impact of these cases on the development of EU law and policy in relation to health care.

2.2 The co-ordination of social security in the EU

2.2.1 The background to Regulation 1408/71

The origin of the co-ordination of social security in the EU was to support the free movement of workers. The free movement of workers and self-employed persons is a fundamental tenet of the Community. From the outset it was understood that free movement rights needed to be underpinned by appropriate social protection for those exercising them. One important aspect of this is access to health care provision for such persons and their families. One possible method would have been to attempt to harmonise health care provision in the European Union. However, in light of the considerable disparity in the type of system prevailing within the Member States this would have been regarded as a purely theoretical possibility. Instead, the approach has been one of co-ordination and the resulting social security co-ordination system now in place within the European Union has been described as:

"the most comprehensive system of access to cross-border care in the field of international social law."*

The introduction of a system primarily intended to support migrant workers can be seen as a spillover from the economic policy of promoting free movement. It also reflects the social cohesion model of social policy in so far as it represents an intervention to preserve rights to social security for free movers.

The origins of the co-ordination of health care systems can be traced back to the early part of the twentieth century and the principles underlying early co-ordination agreements were

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3 Articles 39, 43 and 49, EC.


5 In particular to health conventions of 1910, 1925 and 1930 between France and Germany and France and Belgium.
to form the basis of the European Community's co-ordination regime. The Community's competence in this field derives from Article 42 EC which gives the Council the power to adopt:

"such measures in the field of social security as are necessary to provide freedom of movement for workers."\(^6\)

Acting in accordance with the Treaty the Council introduced legislation to co-ordinate the social security systems of the Member States, the central plank of which is Regulation 1408/71.

2.2.2 **Regulation 1408/71 — the general principles**

Regulation 1408/71 co-ordinates a range of social security provision, including medical treatment which comes under Chapter I of Title III on Sickness and Maternity Benefits. Within this category such benefits are further subdivided into 'benefits in kind' and 'cash benefits'.\(^7\) Medical treatment constitutes a ‘benefit in kind’ for the purposes of the Regulation. The provisions of the Regulation apply in general to all employed persons, the self-employed and students who “are or have been subject to the legislation of one or more Member State” and their families.\(^8\) Since June 2003 this includes third country nationals who are legally resident in the territory of a Member State who fall within the above categories, providing there is an EU cross-border aspect to their situation.\(^9\)

There are four main principles underlying the regulation: equality, aggregation, exportability and the 'single state' principle.

The primary aim of the Regulation is to ensure equality of access to social security between persons covered by its provisions in all Member States, regardless of their nationality. In

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\(^6\) Article 42, EC.
\(^8\) ibid., Article 2.
relation to the types of social security covered by the Regulation\(^\text{10}\) such persons residing in a host Member State shall "be subject to the same obligations and enjoy the same benefits under the legislation of any Member State as the nationals of that State."\(^\text{11}\)

Access to various types of social security may be dependant upon the completion of certain minimum periods of insurance, employment or residence. In order to avoid free movers being required to re-serve such qualification periods upon arriving in a new Member State, the Regulation provides that "periods completed under the legislation of any...Member State" must be taken into account by the authorities of any other Member State when assessing eligibility for benefits "as if they were periods completed under [its own] legislation."\(^\text{12}\) This is described as the principle of aggregation.

Furthermore, certain types of long term benefits, such as pensions and invalidity benefits are payable to persons covered by the Regulation regardless of where they reside within the Community.\(^\text{13}\) This enables, for example, pensioners to retire to another Member State and continue to receive the pension(s) to which they are entitled from the State where they were formerly employed. This is often referred to as the principle of exportability of benefits.

Finally, the co-ordination of the social security schemes of the Member States is achieved through the principle that persons covered shall be subject to the legislation of only one State at any one time.\(^\text{14}\) This is most significant where a person is permanently resident in one State but works in another. Alternatively, a person may be living and working in one State but their family may reside in another. In such circumstances the State which is *prima facie* responsible for the social security of the person (and by extension that of their family) is the State in which the person is employed, self-employed or a student.\(^\text{15}\)


\(^{11}\) ibid., Article 3.

\(^{12}\) ibid., Article 18.

\(^{13}\) ibid., Article 10.

\(^{14}\) ibid., Article 13.

\(^{15}\) Sometimes referred to by the Latin term *lex loci laboris*. 

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Regulation 1408/71 sets out the principles to be applied to the co-ordination of social security systems. The administrative mechanisms through which this goal is achieved are set out in a further regulation, Regulation 574/72. Under this latter measure a series of special forms are prescribed for use by persons wishing to rely on the main regulation. The overall process of co-ordination is overseen by the Administrative Commission on Social Security which is a specialist body of the Commission. Its functions include dealing with all questions of interpretation of the Regulation and the power to issue decisions, recommendations and resolutions. However, these are not legally binding on national courts but are merely advisory in nature.

2.2.3 Criticisms of Regulation 1408/71

Despite the pre-eminence of its role in co-ordinating social security entitlement within the European Union, a number of criticisms of Regulation 1408/71 can be made.

Firstly, it should be noted that the fact that as a regulation, the provisions are directly applicable and are not transposed into national law means that migrant workers often do not know their rights and cannot obtain correct information about them by reference to national social security legislation alone. The smooth running of the co-ordination system relies upon Member States correctly applying the Regulation. It will be seen that this has not always been the case in relation to the provisions on cross border care.

It may also be argued that the Regulation is, by its very nature, limited as it seeks not to harmonise but merely to co-ordinate. Inconsistencies will persist between the types and levels of benefits available in different Member States and also in the criteria for eligibility for those benefits. In this regard the main distinction lies between states in which eligibility for benefits is based on residence and those in which it is based upon earnings-related contributions. It could be argued that social security provision within the EU should be

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harmonised to avoid inequality between citizens and that co-ordination is an inadequate approach from the standpoint of securing sufficient social protection. However, the choice of co-ordination as a method reflects the fact that the Regulation is a result of a spillover from economic policy rather than an attempt to create rights.

In this regard it can be noted that ‘inactive’ citizens, that is to say those who are not engaged in economic activity, study or are job seekers or pensioners, fall outside of most of the provisions of the Regulation. This approach may be regarded as incompatible with the increasing trend in many Member States towards eligibility for health care and social security being based upon residence alone and doubts have been expressed about the continued appropriateness of the *lex loci laboris*, or state of employment principle, as a means of determining responsibility between states for an individual’s social security.

The link between economic activity and the entitlement to social security is largely maintained by the Regulation and ‘inactive’ citizens are excluded from entitlement to benefits or access to health care in host Member States. This is consistent with the position of citizens of the European Union who do not fall within the above groups. Article 18(1) of the EC Treaty provides that the right of free movement of citizens and their families is subject to the limitations and conditions laid down in the treaty and in other legal instruments. The relevant conditions are found in Article 7 of Directive 2004/38/EC, which states that for residence of more than three months’ duration, such persons and their families must be covered by sickness insurance in respect of all risks and have sufficient resources to avoid becoming a burden on the social assistance system of the host Member State.

The application of this principle has been tested before the Court of Justice. For example, in the case of *Baumbast* the UK authorities sought to remove an EU citizen on the grounds, *inter alia*, that his health insurance did not cover emergency treatment. The European Court of Justice held that the limitations and conditions attaching to the free movement of citizens must be applied in accordance with the general principles of

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Community law and in particular the principle of proportionality. Accordingly a refusal on this basis could amount to a disproportionate interference with a citizen's right to reside in another Member State, depending on all the circumstances of the case.

Commentators note that the reason for the choice of the state of employment principle taken when the Regulation was drafted was because the social security systems of the six founding Member States\(^{20}\) were based on earnings-related social insurance.\(^{21}\) In contrast, the majority of states subsequently acceding to the European Community have residence-based systems and a balance in terms of the two types of system has been achieved by the 2004 enlargement.

Whilst the application of the state of employment principle to residence-based schemes presents practical difficulties for Member States, there are also difficulties with the alternative approach. For example in situations where a worker is employed in one Member State but their family (and permanent residence) are in another, applying a state of residence basis for determining which state is responsible for their social security may lead to undesirable inequalities. Pennings argues that this approach could lead to 'social dumping' as, if the employer were no longer responsible for making social security contributions, 'foreign' workers would become cheaper to employ than nationals.\(^{22}\) It could also lead to discrimination for example in relation to eligibility for child and family benefits if these are higher in the state of employment than in the state in which the family resides.\(^{23}\)

Using the state of employment principle avoids such disparities by ensuring (at least in principle) that migrant workers receive the same salaries and social security benefits as their counterparts in the host state. This, in turn, is important in encouraging free

\(^{20}\) Belgium, France, Italy, Luxemboug, the Netherlands and West Germany. These were the existing Member States when Regulation 1408/71/EEC was introduced.


\(^{23}\) ibid., p.234.
movement, and maintaining a healthy labour supply, within the European Union. However, even with a state of employment-based approach discrimination may still occur. Jorens asserts that despite the fact that one of the main aims of the Regulation is to prohibit discrimination in relation to social security between workers on grounds of nationality, reports from Member States:

"demonstrate that, in practice, it is quite difficult to distinguish between those differences in the treatment of national and migrant workers that are justified by the discrepancies within the social security legislation of the Member States, and criteria which must be considered as discriminatory under EC law...Some ministries in member States acknowledge that cases of indirect discrimination arise."\(^\text{24}\)

In addition to failing to be easily adapted to fit residence based, national health service type schemes, the Regulation has been criticised for failing to cover all types of benefit now available.\(^\text{25}\) Problems may also be caused by the absence of co-ordination of non-state benefits which are excluded from the provisions of the Regulation such as private pension schemes.\(^\text{26}\) The Regulation has also been accused of failing to incorporate all of the principles laid down by the jurisprudence of the European Court of Justice with the result that it does not reflect the full body of applicable law.\(^\text{27}\) This observation holds true for the case law on cross border care.

Shortcomings of the Regulation were identified by the High Level Panel on the free movement of persons, an advisory body to the Commission. In its 1997 Report the High Level Panel acknowledged that "certain gaps in the existing Community rules [had] been identified" and that the disparity between the employment-based approach of the Regulation and the recent "tendency in all Member States...to develop systems financed

\(^{25}\) In particular the so called 'pre-retirement' benefits are not covered.
\(^{26}\) Report of the High Level Panel on the free movement of persons chaired by Mrs Simone Veil, 18th March 1997, European Commission document 7035/97, p.44.
not from contributions but by public authorities...has led to problems to delimitation of the competence of the Member States with regard to the collection of contributions.”  

The Report further argued that the increasing diversity in national schemes jeopardises the whole co-ordination systems and that to minimise this adverse effect Member States should discuss any planned social security reforms prior to implementing them.

2.3 Receiving cross border treatment under Regulation 1408/71

2.3.1 Health care – specific principles

Under the provisions on Sickness and Maternity Benefits an employed or self-employed person residing in the territory of a Member State other than the state responsible for his or her social security (the state of employment, self-employment or study), known as ‘the competent state’, is entitled to benefits in kind in the state of residence. Employed and self-employed persons are also entitled to benefits in kind in the competent state “as though [they] were resident there...”. The position is mirrored for the family members of the employed, self-employed and students. There are special rules for unemployed persons and pensioners.

Where a person is given benefits in kind in a state other than the competent state, the institution providing the treatment is deemed to be doing so on behalf of the responsible institution in the competent state unless, in the case of a family member living outside the

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29 ibid.
32 ibid., Article 19(1)(a).
33 ibid., Article 21. Frontier workers, defined as workers residing in one Member State and employed in another who return home at least once a week, also have the choice of receiving benefits in their state of employment or that of residence under Article 20.
34 ibid., Articles 25 and 25(a).
35 ibid., Articles 26-34.
competent state, that person has rights of their own under that system for example by virtue of employment in that state.\textsuperscript{36}

The implications of these provisions are found in Article 36 of the Regulation which requires that the cost of benefits in kind provided by one institution on behalf of another are to be fully refunded.\textsuperscript{37} This is designed to ensure that a single Member State bears the financial responsibility for providing benefits in kind to an individual and their family.

Thus, the Regulation attempts to cover the varying types of situation arising from the exercise of free movement rights with the main aim of allocating financial responsibility for the provision of health care services to such persons and their families between the Member States concerned. The fact that different states have different systems and varying criteria for the delivery of health care is implicit in the terms of Article 19. Notably, the Regulation does not dictate which benefits in kind states must provide but only seeks to ensure that free movers are not disadvantaged or left without whichever benefits that state provides to its own nationals or residents.

\textit{2.3.2 Article 22}

The provision of health care by Member States has historically been based upon the principle of territoriality. This has two consequences; firstly, health care is only generally made available to those residing within the territory of a state and secondly, these residents are expected to use only the health services provided within that state.\textsuperscript{38} The principle of territoriality is reflected in the funding arrangements in both tax-based and insurance-based health systems.

\textsuperscript{37} ibid., Article 36.
\textsuperscript{38} See Van der Mei, A-P., \textit{Free Movement of Persons within the European Community: Cross-Border Access to Public Benefits}, Hart, 2002, p.226 for a more detailed account. This principle does not apply to private health care, which is not the subject of this research.
Despite this, the Regulation is not confined to guaranteeing access to treatment to those exercising free movement rights. It also provides for the possibility of medical treatment in a Member State other than that of a Community national's residence or employment in certain circumstances. The relevant provisions are found in Article 22 of the Regulation which set out the following entitlements:

"(1) An employed or self-employed person who satisfies the conditions of the legislation of the competent state for entitlement to benefits...and
(a) whose condition necessitates immediate benefits during a stay in the territory of another Member State...
(b) (...) or
(c) who is authorized by the competent institution to go to the territory of another Member State to receive there the treatment appropriate to his condition shall be entitled:
(i) to benefits in kind provided on behalf of the competent institution by the institution in the place of stay...
(ii) to cash benefits...".39

Thus, persons falling within two categories are able to receive treatment in a Member State other than that of their residence, at the expense of their own national authorities - those who fell ill whilst in another Member State and require immediate treatment and those who are authorized to travel to the other Member State by their national body to receive medical treatment. The first is essentially concerned with emergency treatment whilst the second relates to non-emergency or planned care.40 The extent to which this latter is and should be available has been said to lie "at the heart of the debate on free movement, or not, of patients in the European Union."41

40 Council Regulation 574/72/EEC [1972] OJ L 74/1 on the implementation of Regulation 1408/71/EEC deals with the mechanics of reimbursement in these two sets of circumstances. For emergency treatment the patient must complete a form E111, for planned care a form E112. The E111 form is in the process of being replaced by the new European Health Insurance Card.
41 Palm, W., et al, 'Implications of recent jurisprudence on the co-ordination of health care protection systems', Association Internationale de la Mutualité, May 2000, p.34.
The ambit of the Regulation was initially confined to workers and their families. However more recently its scope was extended by Article 22(a) which applies Article 22 to all "persons who are nationals of a Member State and are insured under the legislation of a Member State and to the members of their families residing with them." \(^{42}\)

This provision has been interpreted as covering any national of a Member State who is entitled to sickness benefits in kind.\(^{43}\) Article 22(a) therefore breaks the link between economic activity and entitlement to receive cross border treatment. White observes that:

"There is certainly no problem over the inclusion of non-economically active persons resident in countries with a residence based system. In other cases, entitlement will...turn on whether a person is insured..."\(^{44}\)

It is possible that inconsistencies could arise as a result of the lack or harmonisation of social security systems. In states which provide a national health service, coverage is generally universal, however, in states offering insurance-based systems there may be gaps in coverage.

### 2.3.3 The conditions for authorization for cross border treatment under Article 22

Under Article 22(1)(c) the key to planned patient mobility is prior authorization by the competent authority in the patient’s state of residence which will, after all, be bearing the cost of the treatment. The conditions for authorization were originally set out in the following manner:

"The authorization required under paragraph 1(c) may not be refused when the treatment in

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question cannot be provided to the interested party in the territory of the Member State in which he lives."\(^{45}\)

In the case of *Pierik*\(^{46}\) the Court of Justice was asked to interpret this provision. Mrs Pierik had challenged a refusal by the Dutch insurance fund to authorize payment for a course of hydrotherapy undertaken in Germany. The grounds for the refusal were that hydrotherapy was not a treatment covered by the Dutch health insurance system. The Court held that the effect of the provision was that authorization should be granted in two sets of circumstances:

"both cases where the treatment provided in another Member State is more effective than that which the person concerned can receive in the Member State where he resides and those in which the treatment in question cannot be provided on the territory of the latter state."\(^{47}\)

This understanding was reinforced by a judgment upon a second reference arising from the same case.\(^{48}\) The judgments appeared to open the floodgates to cross-border care. Writing at the time Watson concluded that as a result of the judgment: "persons covered by Regulation 1408/71 are...entitled to the best medical treatment they can get in the European Community"\(^{49}\) and Van der Mei states that in the judgment: "The Court had virtually recognised a free movement of patients."\(^{50}\)

The implications of the judgments were to prove unacceptable to the Member States. The Commission quickly submitted a proposal for the amendment, *inter alia*, of Article 22(2) of

\(^{46}\) Case C-117/77 *Bestuur van het Algemeen Ziekenfonds Drenthe-Platteland v Pierik* [1978] ECR 825.
\(^{47}\) ibid., para 4.
Regulation 1408/71. Reasons given included that the application of this provision would give rise to abuse in the form of 'health tourism' and would aggravate the financial difficulties faced by their sickness insurance schemes.

The European Parliament opposed the amendment of Article 22. An analysis of the Parliament's arguments reveals that they fall into two camps. The first of these was those based on external principles such as the free movement of workers, health protection and the principle of legitimate expectations. Here the Parliament, taking a rights-based approach, challenged the proposed amendment on the basis that it conflicted with a fundamental principle, namely the right to increasingly full and effective health protection, which it argued could not be abrogated or limited. The proposed amendment was also opposed on the following grounds: that it would be retrograde and weaken the social protection of workers, that it contradicted the legitimate expectations created by the ten year existence of the original provision and that it would recreate differentiations between workers.

The second type of argument related to internal inconsistency created by the amendment. Here the Parliament was concerned with the legal basis of the provision, its form and sense in that it was inconsistent with Article 22(1)(c) which confirms the purely medical principle of 'treatment appropriate to' the person's state of health, which in turn would give rise to disputes and problems of interpretation. A further argument put forward was that to limit authorization in cases of planned care to treatments available in the Member State in which the person is insured creates "illogical and unjustified discrimination in particular in relation to the case covered by Article 22(1)(a)...".

This provision, which remained unaffected by the proposed amendment, gave workers who found themselves temporarily in another Member State, for example, on business or on holiday the right to emergency treatment. The provision covered such a person where their

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52 See the Resolution of the European Parliament against the amendment to Regulation 1408/71, [1981] OJ C 144/112, paras 6 b) and c).
53 ibid., para 3.
54 ibid., para 7.
'condition necessitates immediate benefits' and was unqualified. Thus in the case of emergency care there was no limitation to the type of treatment to which the insured person is entitled and it was not necessary that such treatment would have been available to them at home. It was asserted that the inconsistency thus created was as likely to lead to abuse of the provision, in the form of 'health tourism' as the Court of Justice's interpretation of the original form of Article 22(2).  

The Parliament's opposition did not result in a retraction of the amendment. It duly came into force via Regulation 2793/81, the preamble of which makes only an oblique reference to the reasons for its introduction simply stating that the discretionary power of an institution of a Member State in granting or refusing authorization to a worker going to another Member State to receive appropriate medical treatment should be extended.  

This hardly appears an adequate explanation or justification for the amendment of a ten-year old law. The underlying economic motivation was unacknowledged and it was left to the Court of Justice in later decisions to tackle the central issues at stake; in particular, the principle of free movement versus the economic interests of Member States. The contrast between the neo-liberal stance of the Member States and the rights-orientated view of the Parliament illustrates nicely the divergence between the two ends of the European social policy spectrum.

Van der Mei comments that:

"The mere fact that the States (or better: the Council) amended Article 22(2) may be understandable, but is to be noted that the 'legislative correction' of the Pierik judgments went quite far...The Regulation...leaves it largely up to the Member States to decide whether or not authorization is given and in practice, authorization is indeed usually refused."

The Regulation now lays down the parameters for authorization of treatment abroad in the following terms:

"The authorization required under paragraph 1(c) may not be refused when the treatment in question is among the benefits provided for by the legislation of the Member State on whose territory the person concerned resides and where he cannot be given such treatment within the time normally necessary for obtaining the treatment in question in the Member State of residence, taking account of his current state of health and the probable course of the disease."\(^{58}\)

This formulation enables Member States to limit authorization to treatment which would normally be available nationally but which cannot be provided within the usual timeframe. The interpretation of the meaning of the provision by the Court of Justice will be considered in Chapter 3.

### 2.3.4 Criticisms of Article 22

The provisions of the Regulation relating to the conditions for access to cross border medical treatment are subject to a number of specific criticisms. The most important issue has been the compatibility of Article 22 with the principles of the free movements of goods and services. In particular it has been successfully argued before the Court of Justice that the requirement for prior authorization contained in the provision is a barrier to the free movement of services.\(^{59}\) Arguably, it is the limitations of Article 22 which led to the case law on cross border care.

In relation to Article 22(1)(a), which entitles insured persons to emergency treatment in other Member States, it has been noted that there is scope for abuse of the provision as

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\(^{59}\) This is dealt with extensively in Chapter 3.
"the wording of Article 22(1)(a) leaves room for the view that it can also be relied upon by persons who know in advance that they will come to need medical treatment." 60

There are at least two aspects to this argument. Firstly, it is suggested that individuals may be able to circumvent the need to gain prior authorization for cross border treatment under Article 22(1)(c) by simply going to another Member State, when ill, and presenting for emergency treatment. It is very difficult to establish the frequency with which this occurs and it may also be difficult to distinguish between emergency and non-emergency cases in these circumstances – in practice this will be the decision of the hospital managers or treating physician.

On the other hand, it is necessary to consider the position of persons suffering from medical conditions which require some form of ongoing treatment such as kidney dialysis. Such persons would be effectively denied their free movement rights if they were unable to seek treatment which inevitably becomes necessary during a stay in another Member State.

In this regard, the Administrative Commissions for Social Security has issued decisions that sufferers of certain conditions can rely on Article 22(1)(a) to secure necessary medical care during stays in other Member States.61 Similarly the position of pregnant women has been the subject of a Commission decision.62

In relation to 22(1)(c), the main criticism relates to the restrictive nature of the amended conditions for authorization and inconsistent application of these by Member States. The former is the legacy of the Pierik case and has been discussed earlier in this chapter.


With regard to the application of Article 22(1)(c) by Member States, research conducted on behalf of the Commission\(^6\) shows a lack of consistency in approach. Areas of discrepancy include the type of organisation designated for the purposes of granting authorization. In the twelve Member States studied, this varied between central government agencies, local government departments, private health insurance funds and hospitals themselves. Often the authorization mechanism involves a combination of bodies. The range of decision makers arguably detracts from consistency of approach to granting authorization required by Article 22(2).

A further area of inconsistency is whether or not authorizing bodies within a Member State apply a common set of criteria for this purpose. In a third of the states studied, this was not the case, with the decision-makers free to apply their own criteria.\(^6\)

The research indicates that outside the framework of Regulation 1408/71, most of the Member States had cross-border agreements with neighbouring states securing co-operation in the provision of health services in particular in border areas. It appears widely accepted that medical facilities situated in border regions should be open to those resident nearby regardless of state boundaries through the operation of reciprocal arrangements. However, for those living outside such areas the research reveals that most Member States take a very restrictive approach to authorizing cross-border treatment. In some instances this is reflected in the internal organisation of health care which may also restrain patients from receiving treatment outside their own region.\(^6\)

This approach to the granting of authorization for cross border treatment may be challenged. Modern transport networks make wider patient mobility practical for most Europeans and there seems no justification for a policy that allows residents of border regions to enjoy greater access to cross border treatment than others.

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\(^6\) Palm, W., et al, 'Implications of recent jurisprudence on the co-ordination of health care protection systems', Association Internationale de la Mutualité, 2000, pp.44-61. Data on 12 Member States was collected, namely; Austria, Belgium, Denmark, Finland, France, Germany, Greece, Luxembourg, the Netherlands, Spain, Sweden and the UK.

\(^6\) France, Germany, Spain and Sweden.

\(^6\) For example, France.
Further criticisms of the operation of Article 22 include the difficulty in establishing accurate costs of cross border treatment and the lack of consistency in defining the concepts within it. In particular, for the purposes of Article 22(1)(a) it seems that states have difficulty with the concept of when a condition 'necessitates immediate treatment'. Problems have also arisen in relation to the application of the reimbursement mechanisms contained in the regulation. Some examples of the issues which have been brought before the Court of Justice will now be considered.

2.3.5 Application of Article 22 – Vanbraekel, IKA and van der Duin

In the case of Vanbraekel, the Court was asked to consider the applicable rate of reimbursement for cross-border treatment obtained in accordance with Article 22 of the Regulation.

In national proceedings the Belgian Court had determined that prior authorization for an orthopaedic operation in France should have been granted to a Belgian insured under a sickness insurance scheme in accordance with Article 22(1)(c). The insurer was ordered to reimburse the patients' survivors for the costs of the treatment. The sole issue referred to the European Court of Justice was whether the retrospective reimbursement of the insured's estate should be paid at the level calculated at the French or the (higher) Belgian rate. In this regard it was noted that Article 36 of Regulation 1408/71 did not indicate the appropriate rate for reimbursement.

The Court held that the correct rate for reimbursement was that of the Member State of insurance rather than that in which the treatment was provided, as reimbursement at a lower level:


“may deter, or even prevent [a] person from applying to providers of medical services established in other Member States and constitutes, both for insured persons and for service providers, a barrier to freedom to provide services.”68

Whilst the issue could not be determined by reference to the Regulation alone, the underlying principle of the freedom to provide services found in Article 49 EC required that an insurer reimburses a patient who has received treatment abroad at the same rate as if they had stayed at home.

Serrano cautions that:

"the judiciary can only go so far on its own to integrate health care. The Court operated in Vanbraekel as if Article 22 of Regulation 1408/71 was not the rule governing the case at all. Although the Court framed the national legislation in accordance with [Article 22] it immediately resorted to the freedom to provide services doctrine to reach a result as close as possible to that sought by the Regulation... the prior authorization requirement played no part in the final solution of the case."69

The case of Vanbraekel reinforces the need for an overhaul of the complex and confusing legislation governing reimbursement for medical costs.

The special position of pensioners in relation to reimbursement for the cost of cross border treatment was referred to the Court of Justice in Idryma Koinonikon Asfaliseon (IKA) v Ioannidis.70 The Regulation makes specific provision for pensioners to receive cross border medical treatment. By virtue of Article 31 of the Regulation:

“A pensioner entitled to a pension or pensions under the legislation of one Member State or to pensions under the legislation of two or more Member States who is entitled to benefits

70 Case C-326/00 Idryma Koinonikon Asfaliseon (IKA) v Vasileios Ioannidis [2003] ECR I-1703.

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under the legislation of one of those States shall, with members of his family who are staying in the territory of a Member State other than the one in which they reside, receive:

(a) benefits in kind provided by the institution of the place of stay in accordance with the provisions of the legislation which it administers, the cost being borne by the institution of the place of residence of the pensioner or the members of his family.
(b) cash benefits…”

The case concerned a Greek pensioner who underwent medical treatment of a non-emergency nature during a visit to Germany, without having gained prior authorization from the Greek health authorities. The main issue for the Court of Justice was whether the ability of national institutions to require prior authorization to be obtained for non-emergency treatment extended to pensioners.

Under Article 31 of Regulation 1408/71, publicly-insured European Community pensioners and their families staying in the territory of another Member State are entitled to receive benefits in kind in that state, with the cost being borne by the relevant institution in their home state. Unlike Article 22 of the Regulation, Article 31 does not limit entitlement to emergencies and cases where prior authorization has been granted. The Court concluded that this difference in approach on the part of the legislators could be explained by:

“a desire to promote effective mobility in that category...of persons, taking into account certain characteristics which typify them, such as a potentially greater vulnerability and dependence in health terms and an increased freedom from commitments permitting more frequent stays in other Member States.”

Accordingly, the Court held that pensioners covered by Article 31 could not be subjected to a requirement that treatment be immediately necessary, or be obliged to obtain prior

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73 Case C-326/00 IKA [2003] ECR I-1703, para 38.
authorization before receiving it. It might appear that pensioners should henceforth enjoy
unlimited access to funded cross border treatment, however, the judgment was based on the
stated assumption that the stay in Germany of the Greek patient in question, Mr Ioannidis,
was not:

“planned for medical purposes, in which case Article 22(1) c [of Regulation 1408/71]
would be solely applicable...to the exclusion of Article 31 of that regulation.”74

The Court stressed that the purpose of the trip was a matter of fact to be determined by the
national court. The Court’s interpretation that Articles 22 and 31 are mutually exclusive
resolves the apparent overlap between the provisions. However, the resulting distinction
based upon the patient’s motives will pose evidential difficulties and may prove
unworkable. Since Article 31 does not expressly preclude planned treatment, the outcome
is also arguably inconsistent with the Court’s view that the legislature wished to endow
pensioners with a higher level of benefit than other categories of person, particularly as the
Court rejects the proposition that treatment for pre-existing or chronic conditions should be
excluded from the ambit of Article 31.75

In a further case involving a pensioner a different situation arose.76 A Dutch pensioner, and
his wife retired to Spain in 1995. Having taken up residence there they registered with the
local sickness insurance institution. In 1996 Mrs van Wegberg - van Brederode returned to
the Netherlands for an operation. She thereafter attempted to have the costs of the
treatment met by the Dutch sickness fund to which she had previously been affiliated.

Her claim was refused on the basis that, Article 22 being the relevant law, the E111 with
which she had been issued was inapplicable as the treatment did not constitute an
emergency and she had not obtained an E112 authorizing the treatment from the Spanish

74 Case C-326/00 IKA [2003] ECR 1-1703, para 28.
75 ibid., para 41.
76 Case C-156/01 van der Duin v Onderlinge Waarborgmaatschappij ANOZ Zorgverzekeringen and
institution. She argued that she was nonetheless entitled to reimbursement by the Dutch fund under the special provisions for pensioners; Articles 28 and 31.

Once again the Court of Justice was required to consider the relationship between Article 22 and the prior authorization requirement, and the pensioner provisions. Here the main issue was which institution was responsible for meeting the costs of treatment and for dealing with requests for cross border treatment in the case of a pensioner from one Member State who retires to another.

As in IKA, the question of the purpose of the visit to the Member State where the treatment was obtained was important. Again the Court held that Article 31 only applied where the treatment was incidental to the visit. Therefore, Article 22 was the applicable provision. The Court noted that in relation to pensioners residing in a state other than that from which they receive their pension, Article 95 of Regulation 574/72 provides that reimbursement for treatment provided in the state of residence is made by means of an annual lump sum payment calculated with reference to:

"the average annual healthcare costs generated by a pensioner falling within the system of the Member State of residence, which lump sum therefore includes the cost of any healthcare that may be provided in a Member State other than that of residence."  

The Court concluded that for the Dutch insurer to meet the claim would be a case of double payment and that once pensioners who move to another Member State were registered with the appropriate institution in their state of residence, that institution becomes the competent institution and is responsible for meeting the costs of their care according to the legislation of that state. Furthermore, it is for that institution to deal with requests for authorization for treatment in another state.

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77 Case C-156/01 van der Duin [2003] ECR l-7045, para 44.
78 ibid., para 47.
79 ibid., para 54. Here the Spanish institution had refused, retrospectively, to issue an E112 form.
2.4 Conclusions

This chapter contributes to an understanding of the impact of the case law on patient mobility by examining the legislative framework on the co-ordination of social security which formed the background to the case law. The primary purpose of Regulation 1408/71 is to ensure unbroken social security cover for persons exercising free movement rights on a long term basis and, as such, it can be regarded as a spillover measure from the free movement of workers provisions, rather than as a rights-based initiative. In particular, in order to facilitate co-ordination in this field, mechanisms for reimbursements between different social security systems were put in place. This made it possible to include within the ambit of the legislation provision for emergency medical treatment to be available for Community nationals whilst temporarily in another Member State. It also enabled a provision to be included to facilitate and regulate planned cross border treatment. The approach taken was to give Member States control over patient mobility by requiring that authorization must first be obtained.

In principle, Article 22 creates the possibility for EU citizens to have cross border care at the expense of their own social security system. Even in its more restricted, amended form, the article requires Member States to grant authorization in certain circumstances. However, concerns about cost containment and the territoriality principle are very deeply embedded and Member States have operated the criteria very conservatively, often with the effect of severely limiting patients’ access to cross border care. In response to the restrictive use of the mechanism contained in the Regulation, individual patients sought an alternative basis for claiming reimbursement for the costs of cross border care from their national authorities – that of reliance directly upon the freedom to receive services under Article 49 of the EC Treaty. These claims resulted in the references to the European Court of Justice which are examined in the next chapter. Following the case law, the Regulation has been subject to various amendments and a new regulation to replace 1408/71 has also been introduced. These developments will be considered discussed in Chapter 4.
Chapter 3: Patient mobility and the free movement of services

3.1 Introduction

The European Economic Community was created with the object of establishing of a common market in which the Member States could trade freely without obstacle. Fundamental to this were the four freedoms asserted in the Treaty: the free movement of goods, persons, capital and the related freedoms of establishment and the provision of services. Together these form the internal market within which barriers are prohibited, subject to certain exceptions. As well as being a form of social protection, to which the Community rules co-ordinating social security apply (see Chapter 2), health care provision is an economic entity which forms an important sector of the economies of the Member States. As such, it is not immune to the rules and requirements of the internal market which lie at the heart of the EU, and has been categorised by the Court of Justice as a ‘service’ falling within the scope of Article 49 of the EC Treaty.

In relation to the free movement of services the Treaty prohibits restrictions in respect of European Community nationals who are established in one Member State and provide a service to, or receive a service from, a person in another. As well as constituting the provision of a service, the delivery of health care may involve the use of goods for example glasses or pharmaceutical products. In recent years a body of law regulating the exercise of the freedom to receive cross border health care has evolved upon the basis of these principles. This chapter considers the relevant case law and examines the issues it has raised, in order to lay the ground for the analysis of its impact on the development of EU law and policy in relation to health care.

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3 Article 49, EC prohibits restrictions on the freedom to provide cross border services.


Whilst the organisation and delivery of health care remains within the competence of the Member States, these cases have the potential to increase rights to patient mobility by requiring Member States to fund cross border medical treatment in a wider range of circumstances than was previously the case under the regulation co-ordinating social security. The deregulatory approach of the Court of Justice in this field reflects the neo-functionalist approach, with new rights to health care emerging as a spillover from the application of internal market principles and has been criticised for its lack of attention to the European social model or the notion of social solidarity.

It is also notable that in these decisions the Court has failed to address the fact that access to health care is a fundamental right. Since fundamental rights are respected within the EU legal order it is possible to argue that this aspect of patient mobility should have received attention. By examining the principles established by the Court of Justice in relation to the conditions for the exercise of patient mobility, in the light of the interpretations given to the right to health care by relevant human rights bodies, it will be seen that the former to some extent reflect the latter. It is suggested that examining the cases from a rights-based perspective may assist in assessing the nature of the impact of the case law on the development of EU law and policy in relation to health care in Chapters 4 and 5.

This chapter is structured in three parts. Part I will trace the development of European Community law in relation to the freedom to provide services and the emergence of a freedom to receive services. Part II focuses in detail on the case law, as it is evolving, on the position of European Community nationals seeking medical treatment in a Member State other than their state of establishment and assesses the extent to which internal market principles have increased access to cross border health care, in the absence of a specific EU competence in this field. Finally, Part III will examine the relationship between the patient mobility case law and the fundamental right to health care.

6 Article 152(5), EC.
3.2 Part I - The free movement of services

3.2.1 The definition of services

The free movement of services, together with that of goods, labour and capital, has been described as the rock upon which the European Community is built, and as the conditio sine qua non of European economic integration. Article 49 of the EC Treaty accords European Community nationals with the freedom to provide services and a definition of services is given in Article 50 EC, which states that:

"Services shall be considered to be ‘services’ within the meaning of [the] Treaty where they are normally provided for remuneration, insofar as they are not governed by the provisions relating to freedom of movement for goods, capital and persons."

This definition has enabled the Court of Justice to interpret the concept of services widely. Furthermore, Article 50 requires that services must stand free of parallel provisions on goods, capital or persons to be covered by this Chapter of the EC Treaty. This might suggest that the freedom to provide services is in some way subordinate to the other freedoms. Alternatively, it may simply acknowledge the overlaps which will often occur between the freedoms. Article 50 continues by stating that ‘services’ shall include industrial, commercial, craft and professional activities. These broad categories are not intended to be exhaustive and other types of activity such as entertainments and sports have been held to constitute services within the meaning of the Treaty.

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10 This is of particular relevance in relation to the key issue of whether insurance-backed and publicly funded health care services constitute ‘services’.
11 The extent to which this has led to a convergence in jurisprudence in relation to goods and services will be noted later in the chapter.
12 Case C-275/92 HM Customs and Excise v Gerhart Schindler and Jorg Schindler [1994] ECR 1039 “the recreational aspect of the lottery does not take it out of the realm of services”, para 34.
13 For example, Cases C-51/96 and C-191/97 Deliège v Ligue Francophone de Judi et Disciplines Associées ASBL [2000] ECR 1-2549.
In the early years of the European Community the focus of the legislators was on setting up a legal framework to underpin the free movement provisions of the Treaty. Legal instruments giving rights such as residence and equality of treatment to workers were gradually extended to cover the self-employed who would either be exercising rights of establishment or the freedom to provide services depending on the permanency of their activities. The two freedoms were distinguished in Gebhard in which the Court held that establishment consisted of an European Community national settling in another Member State to participate in its economic life on a stable and continuous basis, whereas the provision of services involves the performance of activities of a temporary nature and is to be determined in the light of the duration, the regularity, the periodicity and the continuity of that activity.

In relation to the provision of cross border health care services, a health professional wishing to perform his or her professional activities in another Member State may do so on either of these bases, or may do so as a 'worker' for example if employed by a hospital or medical practice.

3.2.2 Restrictions on the freedom to provide services

Article 49 expressly prohibits restrictions on the freedom to provide services. However, to outlaw all measures used by Member States which impact upon the free movement of services would give unfettered scope to the internal market. Such an approach would be unacceptable to the Member States for a number of reasons. Firstly, it might encompass measures which were not designed to interfere with the internal market and this could be

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14 The right to set oneself up in a self-employed capacity in another Member State, Article 43, EC.
16 Some commentators regard the distinction as tenuous, for example see Hatzopoulos, V., 'Recent Developments of the Case Law of the ECJ in the Field of Services' (2000) 37 CMLRev 45.
17 Under Article 28, EC.
seen as an unnecessary incursion into Member States’ domestic arrangements. Secondly, it would hamper their ability to restrict services for legitimate policy reasons. To take account of this, both the Court of Justice in its interpretation of the Treaty, and the Treaty itself, have provided exceptions. In particular, the Court has done so by distinguishing between discriminatory and non-discriminatory obstacles, whilst there is a provision in the Treaty which permits derogations from the free movement principle on certain grounds.19

In the case of *Van Binsbergen*20 the Court of Justice held that certain national provisions which interfered with the freedom to provide services would only be permitted if they were non-discriminatory, proportionate and objectively justifiable in terms of the common good. This principle was developed in later cases such as *Säger v Dennemeyer* in which the Court observed that:

“The freedom to provide services may be limited only by rules which are justified by imperative reasons relating to the public interest and which apply to all persons and undertakings pursuing an activity in the State of destination insofar as that interest is not protected by rules to which the person providing the service is subject in the State in which he is established.”21

This principle was applied by the Court of Justice in *Schindler*.22 The case arose from the seizure by customs officials of envelopes dispatched from the Netherlands containing application forms for participation in a lottery. Under United Kingdom law lotteries of the relevant kind are prohibited. Before the national court the defendants argued that this constituted a breach of either the free movement of goods or the freedom to provide services in European Community law. The customs authorities asserted that the rules applied to all lotteries, whatever their origin and that the prohibition was justified on social policy and fraud prevention grounds. The Court of Justice found that a lottery fell within

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19 Article 46, EC.
20 Case 33/74 *Van Binsbergen v Bestuur van de Bedrijfsvereniging Metaalnijverheid* [1974] ECR 1299.
22 Case C-275/92 *Schindler* [1994] ECR 1039.

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the scope of services rather than goods and that the services in question were of a cross-border nature. In addition to the United Kingdom, a number of other Member States submitted observations in this case. All agreed that legislation prohibiting lotteries was justifiable and several possible imperative grounds were suggested including the protection of public morality, crime prevention and consumer protection. Whilst the Commission argued that the United Kingdom’s prohibition was disproportionate to its aim the Court held that the restriction was justified on the grounds of social policy and fraud prevention.

The ‘imperative reasons’ approach is considered very similar to the ‘mandatory requirements’ principle established in relation to measures of equivalent effect to quantitative restrictions in Cassis de Dijon. The principles only apply to non-discriminatory measures and constitute a judicially-created means of justifying apparent breaches of internal market rules. The approach can be regarded as a way of balancing economic and social objectives. As such, it is capable of producing a compromise between the neo-liberal and social cohesion models of social policy.

Hatzopoulos describes an increasing consensus amongst commentators that the case law of the Court in relation to the justification of restrictions on the four freedoms is heading towards a single set of rules. However, White notes a significant difference: whilst the Treaty provisions on goods are directed at measures taken by Member States, those on the free movement of services also apply to restrictions imposed, for example, by professional regulatory bodies. Furthermore, Barnard observes that because national regulation of

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24 In particular: Belgium, Denmark, France, Germany, Greece, Ireland, Luxembourg, the Netherlands, Portugal and Spain.
25 In Case 120/78 Rewe-Zentrale AG v Budesmonopolverwaltung für Branntwein (Cassis de Dijon) [1979] ECR 649, para 8, it was held that “Obstacles to movement within the Community... must be accepted in so far as those provisions may be recognised as being necessary in order to satisfy mandatory requirements relating in particular to the effectiveness of fiscal supervision, the protection of public health, the fairness of commercial transactions and the defence of the consumer.” This list is non-exhaustive and has been added to by the Court in subsequent cases.
services has to take account of a wide range of interests, it tends to be more detailed and complex than the regulation of goods. She believes that:

“This has posed a tremendous challenge to the Court in balancing the Community interest in opening up the services market and the need to preserve the often legitimate interests of the State.”

In addition to the possibility of justifying an obstacle to the freedom to provide services on the basis of imperative reasons in the public interest, the EC Treaty provides Member States with the ability to derogate from the freedom in two different ways. Significantly, these can also be relied on to justify discriminatory measures. Firstly, the freedom does not extend to activities which “are connected, even occasionally, with the exercise of official authority.” This exception, which mirrors that applicable to workers, has been interpreted very narrowly by the Court of Justice. In relation to cross-border health care provision, the position has been further clarified by a Commission Notice which lists public health care services as one of a number of sectors which in general fall outside the scope of the official authority exception. Given the nature of services as defined in Gebhard it is relatively difficult to imagine the circumstances in which official authority would be exercised by a service provider (that is to say on a self-employed and temporary basis) in any event.

The second category of derogation may have greater significance for the service provider. Article 46 of the EC Treaty permits “special treatment for foreign nationals on grounds of public policy, public security and public health.” The scope of this article is further defined in Directive 2004/38/EEC, which applies to the rights of citizens of the EU to move and reside freely within the territory of the Member States. Article 27 of the Directive

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30 Article 45, EC, applied to Chapter 3 by Article 55, EC.
34 Article 46, EC is applied to the free movement of services by Article 55, EC.
permits Member States to restrict the free movement of persons on grounds of public policy, public health and public security, whilst stating that these grounds may not be invoked to serve economic ends. Article 29 deals specifically with restrictions on public health grounds and states that only diseases defined by the World Health Organisation as having epidemic potential and those infectious and contagious parasitic diseases which are subject to national controls shall justify measures on this ground. However, it will be seen that the Court of Justice has further defined the scope of the public health derogation to cover the ability of a state to provide an adequate health care system to its population in a number of cases on cross-border health care which are discussed later in this chapter.

Examples of services in relation to which the Court has accepted Member States may exercise legitimate control through derogations to Article 49 include debt recovery and cable television advertising. It is clear from such cases that the Court of Justice is willing to accept well-founded arguments of public policy in relation to restrictions on the free movement of services.

3.2.3 The application of justifications and derogations by the European Court of Justice

The established practice has been that, in considering whether a justification advanced by a Member State in relation to a restriction on the freedom to provide services, the Court of Justice would firstly determine whether or not the restriction was discriminatory and then consider the applicable grounds or principles for possible justification. If the measure was discriminatory, only the derogations under Articles 45 and 46 EC would be available, whereas if the measure was non-discriminatory the Court would also consider imperative reasons in the public interest. Some commentators believe that the distinction between the two avenues has become blurred. O'Leary and Fernández-Martin assert that in some recent cases:

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“the Court has ignored the need to classify impugned national rules as discriminatory or indistinctly applicable and had instead directly moved to the analysis of possible justifications, be they express Treaty exceptions or unenumerated judicially-created ones, or both.”

They also note two other recent tendencies of the Court of Justice; firstly, the inclusion in the concepts of public health or public policy types of justification which might normally be regarded as kinds of imperative requirement, and secondly the use of imperative requirements to justify apparently discriminatory measures on the basis that they:

“are not in fact discriminatory due to the imperative requirements which they pursue.”

It has also been suggested that whilst purely economic reasons for derogation from the free movement of services principle are not permitted, the Court has sometimes accepted justifications which do have an economic aspect. These observations, which indicate a shift in the approach of the Court of Justice, which has become both more flexible and less predictable, will be illustrated in the discussion of case law on access to cross border health care in Part II of this chapter.

3.3 The freedom to receive services

From the principle of the freedom to provide services has stemmed a corresponding freedom to receive services. Neilsen and Szyszczak believe that:

“Given the multiplicity of the various forms of services on offer this is potentially an extensive right.”

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41 ibid.


The provision of health care by a medical professional to a patient from another Member State involves the exercise of both freedoms. Before the introduction of the European Union and the concept of citizenship, the EC Treaty only provided rights to nationals of one Member State to stay or reside in another if they were either pursuing an economic activity or studying there. However, in the case of *Luisi* a further possibility was identified when the Court held that:

“In order to enable services to be provided, the person providing the service may go to the Member State where the person for whom it is provided is established or else the latter may go to the state in which the person providing the service is established. Whilst the former case is expressly mentioned in [Article 50] the latter case is the necessary corollary thereof, which fulfils the objective of liberalizing all gainful activity not covered by the free movement of goods, persons and capital.”

The Court’s determination was consistent with certain provisions on residence rights found in two directives which applied, *inter alia*, to ‘recipients of services’. In relation to the facts of the case the Court held that tourists, persons receiving medical treatment and persons travelling for the purpose of education or business were to be regarded as recipients of services.

This line of reasoning was revisited in the case of *Cowan* in which a British national who had been assaulted whilst in Paris sought compensation for his injuries from a fund set up by the French authorities to compensate the victims of violent crime.

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45 Rights of residence attach by extension to the families of these groups.
The Court of Justice held that:

"When Community law guarantees a natural person the freedom to go to another Member State the protection of that person from harm...on the same basis as that of nationals and persons residing there, is a corollary of that freedom of movement."\(^{49}\)

The compensation scheme should therefore be open to Community nationals who find themselves in a host Member States as recipients of services. The guiding principle in Cowan seems to be that the temporary nature of providing or receiving a service should not place the provider or recipient at a disadvantage in comparison with someone exercising rights as a worker or right of establishment.

The development of the freedom to receive services has been fundamental to the ability of patients to seek health care in other member states. Persons seeking medical services were expressly accorded the status of service recipient in Luisi\(^{50}\) but the case did not directly address the issue of patient mobility or, in particular, public funding of cross border medical treatment. Part II of this chapter will focus on legal developments in this regard.

3.4 Part II - The freedom to receive health care services

It is recalled that Regulation 1408/71 ensures that European Community workers, the self-employed and their families have access to health services in their State of establishment.\(^{51}\) Furthermore, under Articles 22 and 22(a), all European Community nationals\(^{52}\) covered by their home state’s health service arrangements are entitled to treatment in other Member States in certain circumstances.\(^{53}\)

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\(^{51}\) For a detailed explanation of the operation of the Regulation, see Chapter 2.

\(^{52}\) Note that pensioners are covered by separate provisions found in Section 5, Chapter 1, Title III of Regulation 1408/71/EEC [1971] OJ L 149/2, (Consolidated version) [1997] OJ L 28/1.

\(^{53}\) In particular, emergency and pre-authorized treatment. See Chapter 2 for a fuller explanation of the regime.
Under Article 22 of the Regulation, the key to planned treatment abroad is prior authorization by the competent authority in the patient’s state of residence which will bear the cost of the treatment. The conditions for authorization were originally set out in the following manner:

“The authorization required under paragraph 1(c) may not be refused when the treatment in question cannot be provided to the interested party in the territory of the Member State in which he lives.”

In Pierik the Court of Justice held that the effect of this provision was that authorization must be granted in two sets of circumstances:

“cases where the treatment provided in another Member States is more effective than that which the person concerned can receive in the Member State where he resides and those in which the treatment in question cannot be provided on the territory of the latter state.”

This judgment appeared to open the floodgates to cross-border care and this understanding was reinforced by a second judgment arising from the same case. The Court’s findings proved unacceptable to the Member States and legislative action was taken to amend the authorization criteria, once again restricting opportunities for patient mobility.

However, in the last two decades there has been a succession of cases before the Court of Justice challenging refusals by national authorities to reimburse patients for treatment received in another Member State. In these cases, to overcome the limitations of Article 22 of the Regulation, direct reliance has been placed upon the freedom to receive services found in Article 49 EC. Accordingly, the Court has been asked on a number of occasions to clarify the scope and meaning of this principle in relation to cross border health care.

56 ibid., para 4 of the judgment.
58 For a more detailed account, see Chapter 2.
The first of the cases which merits detailed discussion, Decker,\(^{59}\) in fact concerned the free movement of goods.

### 3.4.1 Decker and Kohll

Mr Decker, a Luxembourg national, was refused reimbursement for the cost of a pair of spectacles which had been obtained on the prescription of an ophthalmologist established in Luxembourg from an optician in Belgium. The grounds of the refusal by the competent authority, an insurance company, were that the glasses had been purchased abroad without its prior authorization.

The relevant national law provided that, whilst insured persons could approach the medical specialist of their choice, they could only choose a doctor established abroad with the consent of their sickness fund except in the case of emergency treatment. Such consent could not be withheld if the treatment abroad was recommended by a doctor in Luxembourg or was unavailable there.\(^{60}\) Mr Decker had not obtained prior authorization. However, he argued that he should not have been required to do so as such a requirement was an obstacle to the Community law principle of the free movement of goods. The national tribunal referred the issue to the European Court of Justice.

The first argument submitted by Luxembourg, and a number of other Member States, was that the national law in question fell outside the scope of the free movement of goods because it concerned social security. It could be argued that where the cost of the goods in question is met by the social security system of a Member State such ‘goods’ should be regarded as non-commercial. Alternatively it could be submitted that social security arrangements and the principles of free movement are mutually exclusive. To support this view the Luxembourg government argued that to challenge the national rules on authorization on the basis of the principle of the free movement of goods would call into question the validity of Article 22 of Regulation 1408/71, with which the national rules

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\(^{60}\) ibid., para 8.
were consistent. In other words, if the national rules complied with the social security Regulation, and the Regulation was valid, then the logical conclusion would be that social security falls outside the free movement principles, or at least that these latter do not preclude the existence of rules compatible with the regulation.

In its judgment the Court noted that it had been established in previous case law that Community law did not detract from the powers of the Member States to organise their social security systems.61 Such powers involved both determining the conditions for insurance by the system in question and the conditions for entitlement to benefits under it.62 However, the Court concluded that the fact that the national rules at issue fall within the sphere of social security could not exclude the application of Article 28 of the Treaty because Member States must comply with Community law when exercising their powers in relation to social security.63 This was consistent with the Court’s earlier decision in Duphar64 that social security measures which affect the marketing of medical products and indirectly influence the ability to import those products from one Member State into another, were subject to Treaty provisions on the free movement of goods. This analysis enabled the Court to proceed to examine the compatibility of the national authorization rules with the Treaty provisions on the free movement of goods. This involved a two stage process; firstly an assessment as to whether there had been a breach of Community law and secondly whether any such breach could be justified.

In relation to the argument that the national rules in question were, nonetheless, consistent with the relevant regulation the Court asserted that:

"Article 22 of Regulation No 1408/71, interpreted in the light of its purpose, is not intended to regulate and hence does not in any way prevent the reimbursement by Member States at

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63 ibid., para 25.
64 Case 238/82 Duphar [1984] ECR 523.
the tariffs in force in the competent State of the cost of medical products purchased in another Member State, even without prior authorization."65

The Court further concluded that the national rules in question:

"must be categorised as a barrier to the free movement of goods since they encourage insured persons to purchase [medical] products in Luxembourg rather than in other Member States...".66

On the question of whether the rules were a justifiable barrier, the Luxembourg government argued that they were imperative on the basis of the need to control health expenditure.67 This submission was rejected by the Court on the grounds that the cost to the insurer would have been identical regardless of where the spectacles were purchased because the reimbursement was of a fixed amount. The Court added that:

"It must be recalled that aims of a purely economic nature cannot justify a barrier to the fundamental principle of the free movement of goods. However, it cannot be excluded that the risk of seriously undermining the financial balance of the social security system may constitute an overriding interest capable of justifying a barrier of that kind."68

65 Case C-120/95 Decker [1998] ECR I-1831, para 29. In contrast, the Advocate General believed that "the analysis of the justifications relied on and its outcome will inevitably imply a view on the validity of Article 22. If the disputed rules are found to be incompatible with [the Treaty] this may result ipso facto in the relevant Community provision being declared invalid.", Joined Opinion of Advocate General Tesauro in cases C-120/95 and C-158/96, delivered on 16 September 1997, [1998] ECR I-1831.
67 There are two possible bases for justification for a prima facie breach of Articles 28 and 29 which assert the principle of the free movement of goods. The first is to derogate from this principle under Article 30 on one of a number of set grounds. The second way, which is only available in relation to indistinctly applicable measures is based on the rule of reason and consists of asserting that the breach is necessary in order to satisfy a 'mandatory requirement', essentially an indispensable matter in the public interest. The latter route was established in the case of Cassis de Dijon [1979] ECR 649. It is difficult to see why the Court should have entertained submissions based on the public interest here as the measure is clearly distinctly applicable. However, Craig and de Búrca note that "The ECJ may well treat a case as coming into the Cassis category because it wishes to allow the state to avail itself of one of the mandatory requirements even though... the measure appears to be discriminatory..." p.660, and further that "recent case law has cast doubt upon whether the list in Article 30 really is exhaustive." p.634, Craig, P. and de Búrca, G., EU Law Text, Cases and Materials, 3rd Ed, Oxford University Press, 2003. It is notable that the Court in Decker refrains altogether from addressing whether the measure is distinctly or indistinctly applicable.
The first part of this paragraph of the judgment could be regarded as excluding the possibility of reliance on a ground outside Article 30.69 However, the second part would seem to contradict this view as it appears to accept in principle, the application of a mandatory requirement in a case of this kind. This can be seen as an acknowledgement by the Court of the financial concerns of Member States demonstrated by the Council and Commission following the Pierik judgments.70

Before analysing the implications of Decker it is necessary to consider the judgment of the Court of Justice in case of Kohll71 which was given on the same day, “sending shivers through all social security and health care funds”.72 This case also concerned a Luxembourg national, this time challenging a refusal by his insurer to authorize payment for dental treatment for his daughter, received in Germany. The applicable national rules were similar to those in Decker. These required that prior authorization for any treatment abroad be obtained and further stipulated that such authorization would be granted only upon a written request from a medical specialist established in Luxembourg.

Although consistent with Article 22 of Regulation 1408/71, Mr Kohll argued that the national rules were incompatible with the EC Treaty provisions on the freedom to provide services. The matter was referred to the European Court of Justice. The arguments on both sides and the Court of Justice’s reasoning mirror those in Decker.73

The Court’s conclusions in Kohll were, firstly, that treatment provided by an orthodontist established in another Member States, outside a hospital infrastructure, for remuneration must be regarded as a service within the meaning of Article 50 EC, which expressly refers

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69 This is the view taken by Baeyens, A., ‘Free Movement of goods and services in health care: a comment on the Court cases of Decker and Kohll from a Belgian point of view’ (1999) 6 European Journal of Health Law 376-77.
70 A further ground for justification, that of public health, was put forward in Decker. This issue was examined by the Court at greater length in Kohll and will therefore be discussed below.
to “the activities of the professions.”\textsuperscript{74} Secondly, the Court held that the Luxembourg national rules on authorization did have the effect of deterring insured persons from seeking medical treatment in another Member State and were a barrier to the freedom to provide services.\textsuperscript{75} Thirdly it was found that “the risk of seriously undermining the financial balance of the social security system of a Member State may constitute an overriding reason in the general interest capable of justifying a barrier of this kind,”\textsuperscript{76} but that, as a matter of fact, the reimbursement of the costs of this treatment had no significant effect upon the financing of the Luxembourg social security system.

Apart from the financial argument, the Luxembourg government advanced a further ground for justification based on the protection of public health.\textsuperscript{77} Under the EC Treaty, derogations to the freedom to provide or receive services are permitted on grounds of public policy, public security and public health.\textsuperscript{78} The submission made in relation to the public health justification had two limbs.\textsuperscript{79} Firstly it was asserted that national rules of the kind in question were necessary to guarantee the quality of medical services. Secondly it was submitted that the rules were needed to protect the aim of the Luxembourg sickness insurance system which is “to provide a balanced medical and hospital service for all.”\textsuperscript{80}

The first argument is essentially one of quality assurance. It is predicated on an assumption that medical services (and in \textit{Decker}, goods) offered in other Member States may be inferior to those available nationally. In response to this point, Mr Kohll argued that there

\textsuperscript{74} Case C-158/96 \textit{Kohll} [1998] ECR 1-1931, para 29.

\textsuperscript{75} ibid., para 35. The threshold for breaching this principle is regarded by some commentators as low. Hatzopoulos believes that “the Treaty provisions on the free provision services...have greater impact...than the provisions on free movement and freedom of establishment” and notes that “the position is that, for article 49 to be violated by a national measure, this measure need only be liable to dissuade some categories of inter-State service-providers/recipients...” Hatzopoulos, V., ‘Recent Developments in the Case Law of the ECJ in the Field of Services’ (2000) 37 CMLRev 73-74.

\textsuperscript{76} Case C-158/96 \textit{Kohll} [1998] ECR 1-1931, para 41.

\textsuperscript{77} ibid., para 43. Once again, the Court of Justice treats the measure as non-discriminatory by considering the applicability of ‘overriding reasons in the general interest’.

\textsuperscript{78} Article 46, EC, applied to the freedom to provide services by Article 55, EC.

\textsuperscript{79} In relation to the first limb only, a similar argument was advanced in \textit{Decker}.

\textsuperscript{80} Case C-158/96 \textit{Kohll} [1998] ECR 1-1931, para 43.
was no scientific reason to conclude that treatment provided in Luxembourg would be more effective.\textsuperscript{81}

In both judgments the Court made reference to the relevant directives on the conditions for taking up and pursuing the regulated professions in question and, in particular, on the mutual recognition of the relevant qualifications.\textsuperscript{82} In \textit{Decker} the Court concluded that the effect of the directives was that the purchase of a pair of spectacles from an optician established in another Member State provides guarantees equivalent to those afforded by an optician established in the national territory.\textsuperscript{83} Similarly, in \textit{Kohll} the Court declared that:

"doctors and dentists established in other Member States must be afforded all guarantees equivalent to those accorded to [those] established on national territory for the purposes of freedom to provide services."\textsuperscript{84}

The Court therefore rejected the argument based on medical standards.\textsuperscript{85} The second limb of the Luxembourg government’s attempt to derogate from the freedom to provide services on the grounds of public health in the case of \textit{Kohll}, was that it was necessary to do so in order to ensure the provision of a balanced medical and hospital service for the benefit of all insured persons. Mr Kohll objected to this argument on the basis that it was an illegitimate economic aim designed to protect the insurers’ financial position. However, it is difficult to view this argument as purely economic. As Van der Mei explains:

"In order to provide adequate care, Member States must ensure that there are enough doctors, medical facilities and hospital beds available on their territory. Waiting lists and other problems of under capacity imply a limitation on the accessibility of the health care system and are to be avoided. At the same time, the number of available doctors, facilities

\textsuperscript{81} Case C-158/96 \textit{Kohll} [1998] ECR 1-1931, para 44.
\textsuperscript{82} In Case C-158/96 \textit{Kohll} [1998] ECR 1-1931, para 47, in Case C-120/05 \textit{Decker} [1998] ECR 1-1831, para 42.
\textsuperscript{83} Case C-120/95 \textit{Decker} [1998] ECR I-1831, para 43.
\textsuperscript{85} This reasoning demonstrates the relationship between the freedom to provide and the freedom to receive services. In particular, it is clear that the latter, expressed in \textit{Luisi} as the corollary of the former, at least in part depends upon the former being underpinned by the principle of the mutual recognition of qualifications.
and beds should also not be too large...Capacity planning, so it was argued, would be virtually impossible if patients were free to choose in which State they wished to obtain medical treatment."\(^{86}\)

This issue is clearly of great social importance in addition to its economic implications. In response to the arguments put before it, the Court of Justice held that the objective of maintaining a balanced medical and hospital service did indeed fall within the derogations on grounds of public health under Article 46 EC but concluded that it had not been established that the rules in question were necessary to achieving this aim.\(^{87}\) Thus the Court concluded that the Treaty rules on the freedom to provide services precluded national rules requiring prior authorization for the cost of dental treatment provided by an orthodontist established in another Member State.\(^{88}\)

The two judgments were highly significant and attracted widespread attention. The assumption that consistency with Article 22 of Regulation 1408/71 was a guarantee of legitimacy for national rules on the authorization of cross border treatment had been demolished. The judgments were widely perceived as creating a second, parallel route by which access to cross border treatment can be achieved, based directly on the enjoyment of freedoms under the Treaty.

The judgments have been described as landmark cases which have strengthened the legal status of patients\(^{89}\) and as having triggered a process, albeit in need of further refinement.\(^{90}\) However, a number of shortcomings in the judgments have also been identified. The first issue arising from the cases is the apparent side-lining of Article 22 of Regulation 1408/71.

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\(^{87}\) This was largely because no extra cost had been borne by the insurer than if Mr Kohll’s daughter had been treated by a dentist in Luxembourg.


Cabral comments that the Court abstains from any “substantial analysis”\textsuperscript{91} of Article 22 of the Regulation, noting that:

“it is striking that the Court’s rulings circumvent the difficulty of explaining how the outlawing of the Luxembourg prior authorization rules is to be reconciled with similar requirements laid down by Regulation 1408/71.”\textsuperscript{92}

He concludes that the Court preferred not to question the validity of Regulation 1408/71 and instead wait for a direct action to challenge Articles 22(1)(c) and 22(2).\textsuperscript{93} Hatzopoulos finds a way of explaining the apparent contradiction believing that:

“The Court, without invalidating the relevant Regulation provision, interpreted it in such a way as to eliminate its alleged restrictive effects... the Court treats Regulation 1408/71 as a specific application of the general Treaty rules on free movement and not as the only occasion in which social security funds may be called upon to reimburse expenses incurred in other Member States.”\textsuperscript{94}

This line of reasoning is problematic since the provision in question clearly requires that prior authorization for planned treatment abroad be obtained and he concedes that the importance of the provision is greatly undermined.\textsuperscript{95}

The Court’s reasoning on this point had two implications. Firstly, compliance with Article 22 of Regulation 1408/71 was now no longer conclusive proof of compatibility with Community law. This created uncertainty for Member States which could not now be confident that applying the Regulation would protect them from legal challenge. It also created uncertainty for the institutions charged with funding health care. If the requirement

\textsuperscript{92} ibid., p.392.
\textsuperscript{93} ibid.
\textsuperscript{94} Hatzopoulos, V., ‘Killing national health and insurance systems but healing patients? The European market for health care services after the judgments of the ECJ in Vanbraeckel and Peerbooms’ (2002) 39 CMLRev 696.
\textsuperscript{95} ibid.
to obtain prior authorization were no longer enforceable, such institutions would no longer have control over the selection of health care provider and this might have a variety of consequences.

Secondly, there was criticism of the apparent creation of a two track system in relation to cross border health care. In particular, concerns have been expressed about the complexity of the position and the danger of inequality arising from the fact that the two routes offer different scopes of protection.96

A third issue raised was the limited scope of the decisions in financial terms. The Court in *Kohll and Decker* ruled that the insurer in question had only to reimburse at the rate the patient would have received if the medical product or treatment had been provided in the home state. This differs from the position in relation to pre-authorized treatment under Article 22(1)(c), in relation to which reimbursement based on the actual cost of the product or treatment must be made.97 Cabral asks how, in the absence of similar tariffs for medical products and services in the different Member States, free movement can be assured regardless of the economic resources of the people concerned.98

He argues that free movement:

"seems to go only as far as the financial capacity of the patient will allow. It will to a large extent be only theoretical as far as low income persons are concerned since these will be unable to afford expensive treatment abroad."99

These concerns are echoed by Van der Mei. Noting that the difference between the price in other Member States and the national reimbursement rates is to be paid by the patient himself, he suggests that as public health insurance schemes are aimed at guaranteeing all

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96 For example, see Cabral, P., 'Cross-border medical care in the European Union – Bringing down a first wall' (1999) 24 ELRev 393.
99 Ibid.
residents equality of access to medical care regardless of their financial status, the same principle should apply to access to medical care in other Member States.\(^{100}\)

A fourth criticism leveled at the judgments is that they fail to take into account the position of a Member State to which patients go to exercise their freedom to receive medical services. Hervey believes that from this perspective nothing in the judgment appears to provide a mechanism by which such host states may protect the stability of their health service systems, as they may not lawfully refuse treatment to non-nationals.\(^{101}\) She speculates that, as a result, such states might ultimately be tempted to reduce the quality of their health care provision to discourage "medical tourism".\(^{102}\)

Hervey also notes that in Member States with a national health service, patients are not generally free to approach a private provider at public expense and that it would therefore be inconsistent if they were able to do so in another Member State. She suggests that the Court has forgotten that social security (including health care) is based on solidarity, rather than the market principles which underpin the free movement of services or goods, and has paid insufficient attention to upholding the values implicit in the European Social Model.\(^{103}\) This argument has since become even more important as the Court of Justice extends the principles established in \textit{Kohll} to patients coming from states with systems which arguably have an even greater element of social solidarity than the Luxembourg system.\(^{104}\)

A final point for consideration emerges from \textit{Kohll}. As in \textit{Decker}, the Court held that:

"Article [46] of the Treaty permits member States to restrict the freedom to provide medical services and hospital services in so far as the maintenance of a treatment facility or medical


\(^{102}\) ibid.

\(^{103}\) ibid.

\(^{104}\) In particular, the Netherlands, Spain and the United Kingdom.
service as national territory is essential for the public health and even the survival of the population.105

Whilst this precise argument had not been made by the parties, the Court’s statement indicated the stance it might wish to adopt in future cases. However the exact nature and scope of the public health derogation in relation to the free movement of services is unclear and commentators have been critical of the ambiguity of this application of Article 46 EC. In particular it is unclear whether this should be interpreted strictly, in the sense that the freedom to provide services may only be restricted when a certain facility might possibly have to be abolished altogether, or whether it means that Member States can impose restrictions on the free movements of services wherever the quality or accessibility of medical services is affected.106

3.4.2 Geraets-Smits and Peerbooms

The Court of Justice was to consider many of the issues raised in Kohll further in the joined cases of Geraets-Smits and Peerbooms.107 Both cases arose from challenges to the refusal of the relevant national authorities, two Dutch regional sickness insurance funds, to authorize treatment abroad. In the case of Mrs. Geraets-Smits this constituted a period of specialist assessment and treatment at a clinic in Germany, whilst Mr. Peerbooms had been sent to Austria, in a vegetative state, for special intensive neuro-stimulation therapy.

The sickness insurance funds applied the national law on authorizations for treatment abroad which comprised two conditions. Firstly, such treatment must be normal in the professional circles concerned. Secondly, it must be necessary for the health care of the person concerned.

The grounds for the refusal of authorization in the case of Mrs. Geraets-Smits were lack of necessity. Expert evidence confirmed that appropriate treatment was available in the Netherlands. In relation to Mr. Peerboom’s treatment, the ground of the refusal was that the treatment was regarded as experimental, and therefore not normal in Dutch medical professional circles. The Dutch Court referred the question of whether these grounds were compatible with the Treaty provisions on the free movement of services to the European Court of Justice.

Geraets-Smits and Peerbooms were to provide the Court of Justice with the opportunity to develop the principles expressed in Kohll and to clarify some of the questions hitherto left unanswered. Firstly, it is interesting to note that the Dutch Court’s reference did not mention Article 22 Regulation 1408/71, and instead refers directly to the relevant Treaty provisions. This demonstrates how far the former provision had been ‘left out of the loop’ by the Court of Justice in Kohll.

A second point of interest, discussed at length by the Advocate-General in his opinion, was that the Dutch health system was different in nature to that of Luxembourg, which had been at issue in Kohll. Furthermore, in both the present cases the treatments in question had been provided in hospitals – also differentiating these references from the earlier case. In particular, the Dutch system provided health care solely in the form of benefits in kind. No payments by or reimbursements to patients were made, unlike in the Luxembourg system. Furthermore, patients under the Dutch system were limited in terms of choice of health care provider to designated practitioners or institutions contracted to their fund, whereas in Luxembourg, patients have a free choice of provider within the territory of the state.

Due to these distinctions, the Advocate-General believed that there was no provision of ‘services’ under the system as the element of remuneration required by Article 50 of the Treaty was lacking. To support this view an analogy was made with national education

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109 ibid., para 29.
systems noting that in the case of *Humbel*\(^{110}\) the Court of Justice had held that only services ‘normally provided for remuneration’ fall within the meaning of Article 49 of the EC Treaty.

With regard to whether the national rules on the prior authorization of cross border treatment constituted a barrier to the free movement of services in light of the previous case law the Advocate General had no difficulty in finding the rules to be barriers in that they may deter patients from the Netherlands from approaching health care providers established in other Member States. For a number of reasons he found both conditions to be non-discriminatory.

The Advocate-General went on to consider the possibility of a justification based on overriding reasons relating to the general interest, noting that such reasons must be necessary and proportionate. A number of reasons were put forward both by the sickness funds and by Member States intervening in the proceedings. He summarized these as falling into three categories: maintaining the financial equilibrium of the compulsory sickness insurance scheme, providing a balanced medical and hospital service open to everyone without distinction, and ensuring the availability of the requisite health care and medical skills within the national territory, and concluded that the national rules in question were justified for the reasons stated.\(^{111}\)

The Court’s judgment in the cases of *Geraets-Smits and Peerbooms* bears little resemblance to the opinion of the Advocate-General. The Court began by noting that it was settled case-law that medical activities fell within the scope of Article [50] of the Treaty and that there was no need to distinguish between hospital and non-hospital care.\(^{112}\)

Significantly, the Court added that:

\(^{110}\) Case 263/86 *Belgian State v Humbel* [1988] ECR 5365.


\(^{112}\) *Case C-157/99 Geraets-Smits and Peerbooms* [2001] ECR I-5473, para 53.
"the fact that hospital medical treatment is financed directly by the sickness insurance funds on the basis of arrangements and pre-set scales of fees is not in any event such as to remove such treatment from the sphere of services within the meaning of Article 50 of the Treaty."\(^{113}\)

The Court noted that in the present cases, the payments made by the funds, albeit at a flat rate are regarded as consideration for hospital services and therefore represent remuneration. Having found the Treaty provisions on the free movement of services to be applicable the Court then went on to consider whether the barrier to free movement found to be created by the prior authorization rules can be justified, noting the availability of a public health derogation. In determining this issue, the Court’s approach was firstly to consider the legitimacy of the requirement for prior authorization for cross border hospital care and secondly to examine the conditions for authorization in turn.\(^{114}\)

It is recalled that in *Decker* and *Kohll* the Court held that the requirement for prior authorization in relation to the reimbursement of the cost of a pair of glasses and dental treatment, respectively, was not justified because it saw no threat posed to the Luxembourg social security systems which could justify such a requirement on grounds of public health.

In the present cases the Court accepted that:

"by comparison with medical services provided by practitioners in their surgeries..., medical services provided in a hospital take place within an infrastructure with...certain very distinct characteristics. It is thus well known that the number of hospitals, their geographical distribution, the mode of their organisation and the equipment with which they are provided, and even the nature of the medical services which they are able to offer, are all matters for which planning must be possible."\(^{115}\)

\(^{113}\) Case C-157/99 Geraets-Smits and Peerbooms [2001] ECR I-5473, para 56. It had previously been held in Case 352/85 Bond van Adverteerders and Others [1988] ECR 208 that it is not necessary for the remuneration for a service to be paid for by the recipient.

\(^{114}\) It appears from the reference to ‘overriding reasons...justifying barriers’ in para 71 of the judgment that the Court regards the measure as non-discriminatory. This is in line with its approach in *Decker* and *Kohll*.

The Court emphasised that such planning was necessary whatever the mode of funding applied, and held that a requirement that prior authorization must be obtained for cross-border hospital treatment appeared both “necessary and reasonable.”116

The Court then examined the conditions for the grant of authorization, taking firstly the condition that the proposed treatment be ‘normal’. The Court acknowledged that Community law did not require a Member State to offer a particular list of medical treatments. However to be compatible with Community law, any scheme of prior authorization must be based upon objective non-discriminatory criteria and be open to judicial or quasi-judicial review.117 The Court noted that the expression ‘normal in the professional circles concerned’ was open to a number of interpretations but concluded that only an interpretation on that basis of what is sufficiently tried and tested by international medical science satisfied the requirements of objectivity and non-discrimination.118

Furthermore the Court observed that:

“to allow only treatment habitually carried out on national territory and scientific views prevailing in national medical circles to determine what is or is not normal will not offer those guarantees and will make it likely that Netherlands providers of treatment will always be preferred in practice.”119

The Court also stated that where, for the purposes of prior authorization, it was necessary for national authorities to decide whether particular hospital treatment provided in another Member State was sufficiently tried and tested by international medical science, it must take into consideration all relevant information, including available scientific literature, expert opinion, and whether or not the treatment was covered by the sickness insurance system of the Member State in which it is provided.

117 ibid., para 90.
118 ibid., para 94.
119 ibid., para 96.
In relation to the second condition, that of necessity, the Court held that this was capable of justification provided that it:

"is construed to the effect that authorization...may be refused...only if the same or equally effective treatment can be obtained without undue delay from an establishment with which the insured person’s sickness insurance fund has contractual arrangements."\(^{120}\)

In assessing whether or not this is the case regard must be had to "all the circumstances of each specific case and...not only of the patient’s medical condition at the time...but also of his past record."\(^{121}\)

The Court added that whilst its approach was intended to strike a balance between the needs of Member States to control their hospital services and the free movement provisions of the Treaty, once it was clear that treatment covered by the national insurance system could not be provided by a contracted establishment, it was not acceptable for national hospitals not having any contractual arrangements to be given priority over hospitals in other Member States.\(^{122}\)

Here the Court appears to limit the obligation upon a Member State to fund care abroad to treatments offered within that State’s own system.\(^{123}\) This position is in line with the terms of Article 22 of Regulation 1408/71, but seems inconsistent with the earlier findings on the meaning of ‘normal treatment’. No reference is made in the judgment to Article 22 and it is unclear whether any link back to this provision by the Court is intended.

As with *Decker* and *Kohl*, the judgment in *Geraets-Smits and Peerbooms* was heralded as a significant step towards free mobility for patients within the European Union. The most important aspect of this progress was the stretching of the concept of remuneration, and

\(^{120}\) Case C-157/99 *Geraets-Smits and Peerbooms* [2001] ECR 1-5473, para 103.

\(^{121}\) *ibid.*, para 104.

\(^{122}\) *ibid.*, para 107.

\(^{123}\) The Commission has certainly interpreted the judgment in this way – see Commission Communication COM (2002)649 “Free Movement of workers – achieving the full benefits and potential”. See also Case C-385/99 *Müller-Faure v Onderlinge Waarborgmaatschappij OZ Zorgverzekeringen and van Riet v Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen* [2003] 1 - 4509.
thus of a service, within the meaning of Articles 49 and 50 to cover a benefits in kind health system. It can be questioned whether this is a sustainable interpretation and whether the distinction between health care and education is a sound one. Furthermore, the finding raised speculation about what approach the Court will take to a case arising from a Member State with a national health service funded out of general taxation.

Whilst many Member States may have been uneasy with this finding they may have found some consolation in the Court’s validation of the requirement for prior authorization for patients seeking cross border hospital care. The scope of treatments available subject to this condition is unclear. Nys believes that the setting by the Court of an international, or at least European, standard for the concept of ‘normal treatment’ would mean that if the rule were consistently applied:

“all European citizens [would] have the right to a package of comparable health services... Geraets-Smits and Peerbooms has paved the way for the harmonisation of the right to health services in Europe.”

However, it could be argued that the judgment applies only in the context of the particular national rules which required that treatment must be ‘normal’. If a Member State provides that the treatment must be one which is available nationally, there would be no room for an interpretation based on international standards.

3.4.3 Müller-Fauré and van Riet

The next major decision of the Court of Justice in relation to cross border treatment is that given in the joined cases of Müller-Fauré and Van Riet. Two issues were raised by the

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125 This issue was considered by the Court of Justice in Case C-372/04 The Queen on the application of Yvonne Watts v Bedford Primary Care Trust and Secretary of State for Health [2006] ECR I-4325, discussed later in this chapter.
cases: firstly whether the finding in *Geraets-Smits and Peerbooms* that the Dutch system requiring prior authorization for medical treatment abroad was compatible with European Community law, extended to out-patient treatment and, secondly clarification was sought of the scope and meaning of the concept of undue delay applied by the Court in the same case. The Advocate General expressed the view that the prior authorization requirement in question was objectively justified in relation to out-patient treatment. He further believed that the term undue delay should be assessed purely on medical grounds and without reference to the actual waiting time for the relevant procedure.

The Court of Justice's judgment contained a number of significant points. As in the earlier cases, the Court found the Dutch administrative requirement that prior authorization be obtained for treatment at a non-contracted establishment to be a barrier to the freedom to provide services under Article 49 EC. In considering whether the breach was justified, as in *Geraets-Smits and Peerbooms*, the Court distinguished between hospital and non-hospital treatment. The Court once again accepted the validity of the prior authorization requirement for hospital treatment in another Member State, subject to the conditions set out in the earlier case. In terms of the basis for justifying the restriction, the Court first mentioned the public health derogation found in Article 46 EC and then went on to hold that the risk of seriously undermining the financial balance of a social security system may have consequences for the overall level of public health and may also constitute in itself an overriding reason in the general interest, capable of justifying a restriction. It has been suggested that this represents a shift by the Court away from the use of the public health derogation, which it could be argued had been misapplied in this context in any event.

Confirming its earlier view that, in contrast, prior authorization cannot be required in relation to cross border non-hospital care, the Court added that whilst removing the prior

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129 ibid.
130 Hatzopoulos, V., 'Health Law and Policy: The Impact of the EU', in De Búrca, G., (ed), *EU Law and the Welfare State*, Oxford University Press, 2005, pp.140-142. The lack of clarity over which type of justification is being accepted is an example of the blurring of the distinction between discriminatory and non-discriminatory measures discussed earlier in the chapter.
authorization requirement in this latter instance curtails the ability of Member States to control their health expenditure the impact would not be significant as there is unlikely to be a high take up due to linguistic barriers, geographic distance, cost, lack of information, different cultural environment and the lack of a doctor-patient relationship.\textsuperscript{131}

Furthermore, the Court attached a number of conditions to the exercise of the freedom to receive cross border out-patient services. Firstly, patients can only claim reimbursement for types of treatment offered by their own health system.\textsuperscript{132} Secondly, Member States are free to fix tariffs for reimbursement provided that these are based on objective, non-discriminatory and transparent criteria.\textsuperscript{133} This means that concerns about inequality of access such as those expressed following Decker and Kohll are still valid. Finally, patients seeking cross border out-patient treatment may still be obliged to seek a referral from a general practitioner in their state of establishment.

These limitations are significant and will reduce the impact of the decision. Once again, the Court of Justice can be seen to be striking a balance between the rights of patients and the interests of Member States. This compromise is perhaps most evident in the division made between hospital and non-hospital treatment. Whether this distinction is rational is a moot point. Davies notes that:

"In the UK and the Netherlands many minor treatment and consultations take place within out-patient clinics within hospitals, where in other countries such as Belgium, they might more commonly be provided by specialists operating from their own premises."

He argues that any distinction should be based upon the type of procedure rather than the place where the treatment takes place as otherwise Member States will be encouraged to try

\textsuperscript{131} Case C-385/99 Müller-Fauré and van Riet [2003] ECR I-4509, paras 95 and 96.
\textsuperscript{132} ibid., para 98. This approach fails to take into account the issue of health care rationing i.e. would a particular patient have received a particular treatment under their own system, or would policy or spending requirements have precluded it?
\textsuperscript{133} ibid., para 107.
\textsuperscript{134} Davies, G., ‘Medical Treatment Abroad’ (2003) 153 NLJ 938.
to avoid free movement law by locating all their doctors in hospitals.\textsuperscript{135} Such an approach could be cemented by a Commission Recommendation, setting out lists of designated hospital and non-hospital treatments.\textsuperscript{136}

It is recalled that in \textit{Geraets-Smits and Peerbooms}\textsuperscript{137} the Court had declared that authorization for hospital treatment in another Member State could not be legitimately refused where the treatment was 'normal', necessary to the patient and could not be obtained without undue delay from a provider contracted to the health insurer. Here the nature or normality of the treatment was not in issue and the Court did not, therefore add to its earlier conclusions on this point.\textsuperscript{138} Attention was given, however, to the meaning of undue delay which was raised in the context of the existence of waiting lists within the Dutch health service.\textsuperscript{139} In light of its own difficulties in this regard, the United Kingdom government submitted that the use of waiting lists to set priorities for the treatment of patients is an aspect of the organisation of its health system. In particular it argued that patients did not have the right to demand a certain timetable for their hospital treatment and that if patients could circumvent waiting lists by seeking treatment abroad which had to be paid for by the National Health Service this would threaten the financial balance of the system.\textsuperscript{140}

The Court held that in assessing whether or not treatment can be provided without undue delay, national authorities are required to have regard to all the circumstances of each case and in addition to the patient's medical condition, to take account of the degree of pain suffered, and the extent of any disability interfering with the patient's ability to work. In response to the argument of the UK government, the Court stated that a refusal to grant

\textsuperscript{135} Davies, G., 'Medical Treatment Abroad' (2003) 153 NLJ 938.
\textsuperscript{138} There remains an apparent contradiction between the Court's definition of 'normal treatment' as treatment accepted as normal in international medical circles and the restrictive nature of the obligation on Member States by Article 22 of Regulation 1408/71 which requires that patients be sent abroad for treatment in cases of undue delay in the home state but only for treatments which would be available nationally but for that delay.
\textsuperscript{139} The referring court explicitly asked the Court of Justice whether undue delay must be assessed on a strictly medical basis, or also by reference to the waiting time for the particular treatment. See paras 34 and 35 of the judgment.
\textsuperscript{140} Case C-385/99 \textit{Müller-Fauré and van Riet} [2003] ECR I-4509, para 55.
authorization solely on the ground that there are waiting lists without taking the patient's particular circumstances into account would not be a properly justified restriction on the freedom to provide services. The desire to operate and manage a waiting list system was regarded by the Court as a purely economic matter which cannot be used to derogate from a fundamental freedom. Indeed the Court went further in describing the existence of a long or abnormal waiting time in itself as a restriction on access to hospital services.\textsuperscript{141}

These findings suggested that Member States with national health services and waiting list issues such as the Netherlands and the United Kingdom might have to alter their approach to requests for cross border treatment from patients on waiting lists, making it more difficult for national authorities simply to hide behind waiting lists as an easy way of managing such applications. This point will be considered further later in the chapter.

3.4.4 Inizan, Leichtle and Keller

Following the decision in Müller-Fauré, the Court of Justice gave three further rulings on particular issues arising in cases where patients have received cross border medical treatment in the cases of Inizan,\textsuperscript{142} Leichtle\textsuperscript{143} and Keller.\textsuperscript{144}

In Inizan the Court was asked directly whether the requirement for prior authorization to be obtained for cross border treatment in Article 22(1)(c) was valid in the sense of whether it was compatible with Article 49 of the EC Treaty. It is recalled that since the judgment in Kohl\textsuperscript{145} the status of the former provision had been somewhat undermined by the Court creating a second route to cross border treatment by permitting direct reliance on Article 49. In its judgment in Inizan the Court confirmed that Article 22(1)(c) was both valid and compatible with the Treaty.

\textsuperscript{141}Case C-385/99 Müller-Fauré and van Riet [2003] ECR I-4509, para 92.
\textsuperscript{142}Case C-56/01 Patricia Inizan v Caisse primaire d'assurance maladie des Hauts-de-Seine [2003] ECR I-12403.
\textsuperscript{143}Case C-8/02 Ludwig Leichtle v Bundesanstalt für Arbeit [2004] ECR I-2641.
\textsuperscript{144}Case C-145/03 Heirs of Annette Keller v Instituto Nacional de la Seguridad Social (INSS), Instituto Nacional de Gestion Sanitaria (Ingesa) [2005] ECR I-2529.
In *Leichtle* the issue arose as to whether a German health scheme for civil servants could withhold reimbursement for travel and accommodation expenses incurred in connection with cross border care, where these would have been met had the treatment been obtained in Germany. The reimbursement had been refused on the grounds that it had not been demonstrated that it had been necessary to go abroad for treatment on the basis of greatly increased prospects of success in the other Member State. The Court held that such discrimination was in breach of Article 49.

The case of *Keller* concerned a woman resident in Spain who fell ill whilst visiting Germany. Ms Keller sought and obtained authorization for treatment in Germany in accordance with Article 22(1)(c). In the course of her treatment her German doctors decided to transfer her to a Swiss hospital for specialist surgery. The Spanish authorities queried whether in these circumstances they were obliged to reimburse the costs of care received outside the EU. The Court held that having authorized the treatment of Ms Keller in Germany, the Spanish authorities had delegated the clinical responsibility for her treatment decisions to the German hospital. The latter was then obliged to treat her as if she were its own patient. This could include deciding to refer her to another hospital in Switzerland. The Court stated that the application of Article 22(1)(c) involves a sharing of responsibility between the doctors in the state of residence and those in the state of treatment, informed by the principle of mutual recognition of medical qualifications.\(^\text{146}\) Once cross border treatment has been authorized, the authorizing institution was obliged to accept the findings and choices of treatment made.

These interesting judgments shed further light on the scope of the right to cross border care in EU law. In *Inizan* the Court reinforces Article 22 and clarifies the status of the provision. It is unapologetic about the existence of a two track system for access to cross border care and presents the relationship between Articles 22 and 49 as a harmonious one. In *Leichtle* the paramount status of the non-discrimination principle is affirmed, whilst the case of *Keller* gave the Court an opportunity to consider the relationship between the body authorizing cross border care and the doctors providing the treatment. In this respect, the

\(^{146}\) Case C- 145/03 *Keller* [2005] ECR I-2529, para 50.
Court builds upon its earlier finding in *Kohll* that the principle of mutual recognition underpins cross border care by providing the assurance of quality. However, none of these cases raised the outstanding issues of the meaning of undue delay and whether the earlier case law would apply to a national health service. These questions both arose in a case referred to the Court of Justice by the English Court of Appeal, *Watts*.147

### 3.4.5 Watts

The case concerned an English patient’s challenge to the refusal of her local National Health Service (NHS) trust to authorize her to have a hip replacement operation in a French hospital. The refusal was based on the grounds that the time she was required to wait for treatment at her local hospital was consistent with Article 22(2) in that it was within the time normally necessary for obtaining a hip operation on the NHS. Mrs Watts argued that the waiting time, in fact, constituted an undue delay and that the decision to refuse authorization was in breach of her rights under European Community law. The novel issues raised in the case were whether Article 49 and the previous case law on cross border care applied to a tax-funded national health service which provides free care to patients and whether it was permissible for Member States to measure undue delay by reference to whether normal national waiting times had been exceeded.

The Court began by noting that both Article 49 EC and Article 22 of Regulation 1408/71 applied to the case and confirmed that a person can have rights under both provisions simultaneously.148 In addition, it cited Article 20 of the new social security Regulation 883/2004149 which states that there is a duty to authorize cross border treatment where it cannot be given in the State of residence within a time which is medically acceptable, taking into account the patient’s state and the probable course of their illness.150 The Court

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147 Case C-372/04 *The Queen on the application of Yvonne Watts v Bedford Primary Care Trust and Secretary of State for Health* [2006] ECR I-4325.
148 ibid., para 48.
149 Note that this Regulation is not yet in force.
150 Case C-372/04 *Watts* [2006] ECR I-4325. The phrase ‘within a medically acceptable time’ is used throughout the judgment, replacing ‘undue delay’. The concept is more fully elaborated in paragraph 79 of the judgment as a time “which does not exceed the period which is acceptable on the basis of an objective
of Justice then confirmed that the fact that the reimbursement in this case was sought from a national health service did not preclude the application of Article 49. All the grounds put forward to justify the refusal of authorization by the national health service, such as the fact that in the UK hospital treatment is free of charge or that it would entail the duty to make specific funds available for the purpose, were rejected by the Court which held that both Articles 49 of the EC Treaty and 22 of the social security Regulation place a duty on a national health service to provide mechanisms for the reimbursements of cross-border care.

In relation to the question of the role of waiting lists in determining undue delay, the Court held that where waiting lists are used by a health system, a refusal of authorization by the competent authorities cannot be based not upon these alone but must instead be founded upon an individual assessment of the patient’s condition. Authorization cannot then be refused where treatment cannot be given within a medically acceptable time for the particular patient. The Court confirmed that it was for the referring court to determine whether or not the refusal in this case was consistent with this principle.

Whilst the operation of a prior authorization scheme in relation to requests for cross-border care was found to be both necessary and reasonable the scheme itself had to be objective, non-discriminatory, transparent and not applied in an arbitrary manner. The Court found that the NHS had failed to put into place an authorization scheme which met these criteria and that the lack of a legal framework made it difficult to challenge refusals.

A further objection raised in the case by the UK was that imposing a duty to fund cross-border care on the NHS would be inconsistent with Article 152(5) EC, which provides that

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152 ibid., para 120.
153 ibid.
154 ibid., para 122.
155 ibid., para 79.
156 ibid., para 110.
157 ibid., para 116.
158 ibid., para 118.
Member States are fully responsible for the organisation and delivery of their health systems. On this point the Court held that the obligation to authorize cross border care in situations where the waiting time exceeds a medically acceptable period does not contravene Article 152(5) EC because the latter does not preclude the possibility that Member States may be required to make adjustments to their national systems under other Community legal provisions.159

The judgment raises a number of questions. Firstly, the concept of an objective medical assessment is of interest. Does the use of the term ‘objective’ imply independence of the waiting list managers? If so, this may prove difficult in a health service where the doctors are employees of the hospitals and are in effect responsible for operating waiting lists. Further problems could arise if there are conflicting medical opinions about how long a patient can be expected to wait for treatment. Secondly, whilst the Advocate General had suggested in his Opinion that services provided by the NHS in a cross border context would be very likely to be regarded as services within the meaning of the Treaty,160 the Court declined to address this point directly stating that there was no need to determine whether or not this was the case, since Mrs Watts had clearly paid for medical services in France.161

The question of whether health care provided by a national health service constitutes a service within the meaning of Article 49 EC remains a contentious one for many Member States as will be seen in Chapter 4. One of the reasons for this can be examined in a third observation on the judgment, namely that the issue of the social function and basis of a tax funded national health system founded on notions of social solidarity was not addressed. The Court has previously stated in cases such as Sodemare,162 that where an activity is based upon national social solidarity it will not be held to be a service within the meaning of the Treaty. Prior to the Watts judgment, Hatzopoulos had suggested that although the exact scope of the Sodemare judgment was unclear, it appeared that the closer a system is to a pure national healthcare system, the more likely it was that it will be treated leniently

160 ibid., para 58.
161 ibid., para 91.

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under the Treaty rules. However, Hervey believes that the Sodemare judgment is ambiguous, questioning whether its effect is to make social solidarity a test for whether particular activities fall within the Treaty or whether the notion simply provides a justification or exception from the normal application of Treaty principles such as the free movement of services. Whichever view is taken of the effect of the Sodemare judgment, the lack of attention paid to this issue in Watts and the other patient mobility cases will no doubt increase fears about the over-dominance of neo-liberalism in this area of social policy.

A final point which can be made in relation to the judgment is its failure to address concerns about the consequences of patient mobility upon the financial stability of health care systems. In his Opinion in Watts, Advocate General Geelhoed expressed the view, based on the Court’s previous judgments, that where a state can demonstrate that patient mobility has reached a level which threatens the viability of the national system, thereby undermining the provision of health care in its territory, it could justify measures to restrict incidences of cross border care to acceptable limits. The Advocate General argued that this approach would strike a balance between the freedom to receive cross border medical services and the budgetary concerns of Member States. However, in its judgment the Court seems unsympathetic to these concerns, stating that the achievement of the internal market fundamental freedoms inevitably requires Member States to make adjustments to their social security systems, with the implication that this would include increasing health care funding, if necessary, to cover the cost of cross border care. It appears from this latest

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166 Case C-372/04 Watts, Opinion of Advocate General Geelhoed of 15 December 2005, [2006] ECR I-4325, para 125. The Member States were divided on this point. France and Belgium, operating insurance based health systems, were satisfied that levels of cross border care were reasonable and did not pose a financial threat whilst Finland, Ireland and the United Kingdom argued that if they were obliged to fund cross border care for patients, this would have serious consequences for their tax funded national health systems.
judgment that the Court sees the obligation of a Member State to authorize cross border
treatment, where it cannot be provided within a medically acceptable time, as unqualified.

3.4.6 Conclusions to Part II

Having examined the development of the jurisprudence on patient mobility it can be seen
that the Court does not appear to have been particularly motivated by social policy
considerations and has not explicitly relied upon the notion of a right to health care to
underpin its decisions. Rather it has followed a familiar neo-liberal, deregulatory path,
removing obstacles to the receipt of health care which it regards as an economic service
within the meaning of the Treaty. It can be argued that the corresponding rights
recognised, arise as a spillover from internal market objectives. However, the Court has
also attempted to strike a balance between the fundamental freedom to receive services and
the interests of Member States in maintaining their health systems by declaring that certain
general interest reasons may be relied upon to justify restrictions on cross border care.
These reasons are all connected with the need for states to provide universal access to
health care, which is a crucial social entitlement as well as a fundamental right. In doing
so, the Court shies away from an exclusive promotion of economic integration by
acknowledging the importance of other, competing, social goals.

The impact of the free movement of services case law upon access to cross border
treatment for EU citizens is also highly significant in clarifying the scope and content of
rights to cross border care. The pre-existing possibilities for planned cross border treatment
under Article 22 of Regulation 1408/71 were on the whole operated very restrictively by
the Member States. By enabling patients to rely directly upon Article 49 of the Treaty, the
Court has increased opportunities for patient mobility, both by finding that reimbursement
can be sought outside of the regime of the Regulation and that prior authorization cannot be
required in relation to non-hospital care. However, due to the incremental nature of its
development, a number of issues remain to be addressed, both in terms of types of
treatment and types of system covered.
The Court has stated that waiting lists cannot be used to determine undue delay in individual cases and clarified the criteria to be taken into account in determining whether an undue delay has, or would occur. However, the concept is still difficult to pin down as it relies upon a consistent approach by clinicians to treatment timescales and is fraught with all the individual variables of each individual patient. The notion of what is a medically acceptable waiting time for a particular patient for a particular treatment may, furthermore, be conditioned by the realities of available provision within a particular Member State. Without a common understanding or approach to this matter it is difficult to see how consistency, and thereby, legal certainty can be achieved.\textsuperscript{168} In addition, it is submitted that Article 22 of the Regulation (and its successor, Article 20 of Regulation 883/2004\textsuperscript{169}) should be redrafted to reflect the latest jurisprudence with a detailed definition of undue delay. This would arguably empower patients to oblige Member States to send patients abroad for hospital treatment in many more instances than is presently the case.

The Court of Justice has distinguished between hospital and non-hospital treatment, holding that patients can undertake the latter type of cross border care without prior authorization from their national authorities. The distinction between in and out-patient treatment also raises concerns due to inconsistencies between Member States as to which types of treatment are available outside the realm of the hospital. A more specified approach would be welcome in this regard.

From an organisational point of view, availability of the facilities of a host state to patients from another state could be made subject to there being sufficient capacity. Both systems would stand to benefit from such arrangements and concerns about ‘health tourism’ (and a concomitant lowering of standards) could be met by monitoring incoming patients. Use could be made of the new European health insurance card, designed to “simplify access to care in the country visited, while providing a guarantee for the bodies financing the health

\textsuperscript{168} This issue is considered in Part III of this chapter.

system in that country that the patient is fully insured in his or her own country of origin and that they can therefore rely on reimbursement by their counterparts.\textsuperscript{170}

The Court of Justice has accepted that access to publicly-funded cross border care can be restricted to treatments provided in the home Member State of the patient, despite introducing the concept of an ‘international standard’ for whether a particular treatment is deemed ‘normal’. This can only perpetuate inequality in access to care in the European Union. So far this point has not been raised again before the Court of Justice but a future case may provide scope for further clarification. One possible approach to overcoming national differences in types of treatment available would be to apply the principle of mutual recognition in this area.\textsuperscript{171} This could surmount differences arising from variations in speed of medical advance and clinical preference but not the exclusion of particular types of treatment based on moral or ethical considerations. This latter category would have to remain subject to derogation based on public policy.\textsuperscript{172} In any event, cutting edge treatments are often controversial and so the two classes of objection may overlap.\textsuperscript{173}

Finally, the most serious consequence of patient mobility for Member States, particularly those with national health services, is the challenge the case law represents to their ability to contain costs and manage the rate at which health care is provided. Whilst economic reasons alone cannot be used to justify restrictions to the free movements, a threat to a state’s ability to provide a health service for the population as a whole has been accepted as an imperative reason in the general interest. The diversion of resources from a national system to fund cross border treatment may make sense as part of a worked out strategy but could otherwise threaten the stability of the health service. This, in turn, affects the main body of patients who are not seeking cross border care and may lead to longer waiting

\textsuperscript{170} Commission Communication concerning the introduction of a European health insurance card, Bulletin EU 1/2-2003. The card will gradually replace the various forms required under Regulation 1408/71/EEC. The introduction of the card began in June 2004.


\textsuperscript{172} Hervey and McHale suggest that the case law on patient mobility may ultimately undermine the ability of individual Member States to prohibit certain treatments, such as reproductive technologies and euthanasia, on ethical grounds. See Hervey, T. and McHale, J., ‘Law, Health and the European Union’ (2005) 25 The Journal of the Society of Legal Scholars 249 and 257.

\textsuperscript{173} The meaning of ‘normal treatment’ is examined further in Part III of this chapter.
times or even to cuts in the services available to them. The tension between the interests of the population as a whole and the individual rights and freedoms of small numbers of patients, which lies at the heart of the Watts case, remains to be addressed by the Court.

If in the future the Court extends the principles already established to cover treatment provided by national health service-type systems, as it appeared to suggest it would in Müller-Fauré, and finds that these provide a service under Article 49, this will in turn have an impact upon the ongoing debate over the regulation of services within the internal market which is examined in the next chapter. In particular, it will be seen that the debate surrounding the development of a policy on social services of general interest reflects unease about disregarding the social solidarity element in these systems and suggests that in treating health care as an economic service, the Court of Justice is out of step with the wishes of many Member States.

In addition to the issues arising directly from the cases themselves, the wider implications of the deregulatory activity of the Court of Justice in relation to patient mobility on the health systems of the Member States, must be considered. In particular, Chapters 4 and 5 will show that part of the wider impact of this body of case law has been to generate and contribute to legislative and policy developments at EU level in the field of health care.

Furthermore, the fact that the new ‘rights’ to cross border care arise as a spillover from the application of internal market principles, rather than as a result of a deliberately constructed rights-based policy, means that their effects have not been properly considered. It has been suggested that the classification of health care as an economic service for the purposes of Article 49 will lead to a cross-liberalisation of health services within the EU. Davies suggests that once a particular health system is required to adapt to permitting and funding cross border treatment, it comes under pressure to reorganise itself along economic lines.¹⁷⁴ This would have implications at a domestic level with greater opportunities for patient mobility within states as well as between states.

Finally, the absence thus far of consideration by the Court of the relevance of the fundamental right to health care in the context of patient mobility does not preclude future arguments based, for example, upon Article 35 of the EU Charter of Fundamental Rights in conjunction with Article 11 of the European Social Charter. In anticipation of such a discourse, Part III of this chapter will consider the extent to which international and regional human rights principles can inform the interpretation of the criteria set by the Court of Justice for access to cross border care. It will be argued that there is a significant resonance between the patient mobility case law and the fundamental right to health care as elaborated by relevant human rights bodies.

3.5 Part III - The fundamental right to health care and the cases on access to cross border care

In examining the relationship between the right to health care and the principles established by the Court of Justice in the patient mobility cases, three points must be noted at the outset. Firstly, the Court of Justice has not sought to create a right to cross border care as such, rather the Court has interpreted and applied Article 49 of the EC Treaty and Article 22 of Regulation 1408/71 in a particular way and the rights accorded are generally regarded as a spillover from this process. Secondly, the right in question in these cases involves access to cross border care and not to health care in the state of residence. The latter right to health care exists at national level in the domestic laws of the Member States,175 which also have international legal obligations to fulfil in this regard, as set out earlier in this chapter. In contrast, rights to cross border health care arise primarily at European Union level, although these too may be granted at national level for example in the creation of bilateral or multilateral agreements between states,176 or in national conditions governing access to health care which may offer patients the right to cross border treatment in

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175 The right to health care is enshrined within the constitutions of a number of Member States of the European Union including Belgium, Finland, Italy, Luxembourg, the Netherlands, Portugal and Spain, see Hervey, T. and McHale J., Health Law in the European Union, Cambridge University Press, 2004, p.8-9.
176 See, Palm, W., Nickless, J., Lewalle, H. and Coheur, A., 'Implications of recent jurisprudence on the coordination of health care protection systems', Association Internationale de la Mutualité, May 2000, for example between the Netherlands and Belgium (p.62) and the UK and Ireland (p.63).
particular circumstances. Finally, the content and scope of the right to cross border care is very much a 'work in progress' and the exact nature of the right is not fully elaborated at the present time.

The case law on cross border care has been extensively examined in Part II of this chapter. To provide a focus to the discussion in relation to the extent to which it reflects a right to health care, this analysis will concentrate upon the issues of 'normal treatment', which arose in the case of Geraets-Smits and Peerbooms, and 'undue delay' which is addressed by the Court in Geraets-Smits and Peerbooms, Müller-Faure, and Watts.

In summary, it is recalled that in Geraets-Smits and Peerbooms, two patients from the Netherlands had received hospital treatment in other Member States without obtaining prior authorization and were seeking reimbursement of their costs. The relevant EU legislation provides that authorization may not be refused where the treatment, which must be deemed to be medically necessary, is among the benefits provided for by the legislation of the home state and where it cannot be provided within the time normally necessary for obtaining the treatment in the home state taking account of the current state of health of the patient and the probable course of the disease. The Court examined the two main requirements for the authorization of cross border treatment of the Dutch scheme; firstly that the proposed treatment be regarded as 'normal in the professional circles concerned', and secondly that the authorization is required because adequate treatment cannot be provided within the Netherlands without undue delay. These criteria have helped to shape the nature and content of EU law on cross border care and will be examined in the light of the relevant human rights law principles.

177 For example Luxembourg.
179 ibid.

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3.5.1 The concept of 'normal treatment'

With regard to this requirement, it is recalled that the Court of Justice held that the national authorities must interpret 'normal treatment' on the basis of what is sufficiently tried and tested by international medical science. However, the finding seems to conflict with another part of the Peerbooms judgment in which the Court confirmed that Community law cannot in principle require a Member State to extend the list of medical services covered by its social insurance system. This raises the question of whether if it cannot do so in principle, it can nonetheless have that effect in practice. As the Court of Justice's interpretation of what constitutes 'normal treatment' seems inconsistent with the wording of Article 22(2) of Regulation 1408/71 it creates a degree of legal uncertainty. On one hand it can be argued that the judgment applies solely to the Dutch position and confirms that Member States have the right to set out limitative lists of available treatments. This would imply that 'normal treatment' is defined at national level. On this basis, states which develop such lists will be less vulnerable to challenge than those which leave the matter open. However, a contrary view which has been expressed is that the effect of the judgment is to create full cross border access to medical services in other Member States, including to treatments not available at national level. This would imply an international concept of 'normal treatment'. There is support for both views.

3.5.1.1 'Normal treatment' as a national concept

The first view of the effect of judgment is, as previously indicated, consistent with the wording of Article 22(2) of the Regulation on the co-ordination of social security. The

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184 ibid., 87.
view that 'normal treatment' is a national concept is also consistent with Article 152 of the EC Treaty which states that:

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

In practice the health systems of the Member States do not provide identical ranges of treatment. This is due to a number of factors including financial constraints and historical differences. If a state decides that its health system cannot or need not provide a particular treatment it is illogical if it is obliged to fund patients to have that treatment in another state. The term 'normal treatment' is in itself problematic as it appears rather subjective in nature. It could be interpreted as meaning treatments which are regarded as 'normal' per se or the treatment which would most commonly be given for a particular condition. The first meaning may act to preclude new or less usual forms of treatment. As medical science is constantly evolving, the rate of development of new therapies is unlikely to be identical in each Member State leading to inconsistencies in the ranges of treatment available. In the latter sense there may be an overlap with the concept of ‘necessary treatment’, which is an implicit criterion for prior authorization. There may also be differences between Member States in what is regarded as medical treatment – for example in relation to elective cosmetic surgery or gender reassignment surgery. No doubt Member States wish to retain control over their own definitions of treatment as well as over the range of treatment to be covered by their health systems.

A further basis for the exclusion of particular treatments lies in moral, social and political variations. An example of this is abortion which is illegal in a number of Member States, but is available, subject to time limits, in others. It would clearly be unacceptable to

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188 Article 152 (5), EC.
189 As with the treatment of Mr Peerbooms in Case C-157/99 Geraets-Smits and Peerbooms [2001] ECR I-5473, where authorization was refused partly on the grounds that the treatment in question was regarded as experimental.
those states which prohibit abortion, to be required to reimburse patients who have obtained this treatment in another state.\textsuperscript{191} Taking these considerations into account, arguably this cannot have been the result intended by the Court of Justice in \textit{Peerbooms}.\textsuperscript{192}

Related to this is the issue of health care rationing. Here a particular treatment, for example, infertility treatment, is provided but its availability is limited due to financial constraints and possibly also for moral, ethical or social reasons.\textsuperscript{193} Provision of IVF may be restricted, for example, to women under a certain age, or to married couples. Arguments here raise questions of cost containment versus rights to healthcare. Member States face a common problem of limited resources for health care juxtaposed with the legal rights of patients to such care.\textsuperscript{194} Roscam-Abbing believes that the effect of the primary focus of national health policies within Europe upon financial sustainability is to decrease the emphasis on the individual rights of patients.\textsuperscript{195}

In \textit{Peerbooms}, the Court of Justice accepted that Member States should be able to require patients to obtain prior authorization before undergoing cross border hospital care on the basis that a ‘free for all’ could threaten the ability of states to maintain their health systems. This is consistent with the international legal position as well as the ability to derogate under the Treaty or to justify obstacles to free movement on the basis of overriding reasons in the public interest. However, the Court then in effect goes on to limit the ability of

\textsuperscript{191} In any event, such a requirement would no doubt be resisted by Member States on grounds of public policy – another derogation from Article 49 available in the EC Treaty. In Case C-159/90 \textit{SPUC v Grogan} [1991] ECR I-4685 it was argued that Ireland could rely on the public policy derogation in relation to prohibiting the distribution of information about how to obtain an abortion in the United Kingdom.

\textsuperscript{192} It should also be noted that in a subsequent case regarding cross border treatment the Court of Justice stated that reimbursement could only be claimed “within the limits of the cover provided by the sickness insurance scheme in the Member State of affiliation.” Case C-385/99 \textit{Müller-Fauré and van Riet} [2003] ECR I-4509 para 98.

\textsuperscript{193} An example of national legal differences in relation to donor insemination was seen in \textit{R v Human Fertilization and Embryology Authority, ex parte DB} [1997] 2 CMLR 591, in which a British woman was permitted to ‘export’ her late husband’s sperm to Belgium for insemination on the basis of her European Community free movement rights, despite being precluded from having the treatment in the UK under national regulations.


Member States to refuse authorization seemingly without taking into account the resource implications. The tension between rights to treatment and resources is illustrated by the English case of Watts\textsuperscript{196} which raises the issue of whether the use of waiting lists legitimate. This case will be examined in the context of undue delay.

3.5.1.2 'Normal treatment' as an international concept

The main difficulty with this understanding of the Peerbooms judgment is that it appears inconsistent with the wording of Regulation 1408/71. In contrast, the main argument to support this view is that as the right to cross border care is based upon Article 49 of the EC Treaty, Article 22(2) is simply not engaged and therefore no conflict arises.\textsuperscript{197} The judgment in Peerbooms needs to be viewed in the light of the new route to cross border medical services first established in the case of Kohll.\textsuperscript{198} According to this reasoning, by using this route based on the freedom to receive services, the Regulation is avoided and any obstacle Member States place in the path of the service seeker must be justifiable either by a derogation under Article 56 or by an overriding reason in the general interest. The Court of Justice applied these principles in Peerbooms with the result that the criteria of a prior authorization scheme for reimbursement of costs of cross border hospital treatment were required themselves to comply with a number of conditions, in particular that they be based on objective, non-discriminatory criteria. It is argued that, as confining authorization to the range of treatments offered in the home state is likely to be discriminatory, such an obstacle cannot be justified.

This interpretation of the judgment suggests that a right to treatments which are not available nationally has, indeed, been created, reflecting the fact that one of the reasons for

\textsuperscript{196} See R (on the application of Yvonne Watts) v Bedford Primary Care Trust and Secretary of State for Health [2003] EWHC 2228 (Admin), 77 BMLR 26 and Secretary of State for Health v R on the application of Yvonne Watts [2004] EWCA Civ 166.

\textsuperscript{197} Hervey and McHale believe that the Court of Justice has circumvented Article 22 of the Regulation by applying Article 49 of the EC Treaty. Hervey, T. and Mc H ale, J., Health Law and the European Union, Cambridge University Press, 2004. Alternatively it can be noted that in Case C-56/01 Inizan v Caisse primaire d'assurance maladie des Hauts-de-Seine [2003] ECR I-12403, the Court of Justice held that the two provisions were not incompatible.

a patient to seek authorization for cross border care is a lack of provision of a particular
treatment in the home state. This reality is expressly catered for in the terms of the
authorization schemes of some Member States, for example Luxembourg where
authorization cannot be refused for necessary cross border treatment which is unavailable
in Luxembourg. In contrast, however, some Member States such as Belgium stick to the
letter of Article 22(2) and decline to authorize access to treatments which are not offered
nationally.

Support for an international basis for defining 'normal treatment' is seen in the promotion
by the European Commission of policies on the sharing of spare capacity, trans-national
care and centres of reference. This latter term refers to specialist medical facilities
dedicated to the care of patients with particularly complicated or rare conditions. It is
envisaged that access to such centres be trans-national as it is impractical for every Member
State to set up and maintain a full range of specialised facilities.

3.5.2 Human rights law and 'normal treatment'

The concept of 'normal treatment' does not appear explicitly in any of the relevant
international and regional human rights instruments. Examples of references to the types of
health care to which there is a fundamental right of access are found in the International
Covenant on Economic, Social and Cultural Rights which speaks of access to 'all
medical services', the WHO Declaration on the rights of patients in Europe, which refers
to the health care appropriate to the needs of the patient and in the Convention on Human
Rights and Biomedicine, which mentions health care of 'appropriate quality'.

199 Palm, W., et al., 'Implications of recent jurisprudence on the co-ordination of health care protection
200 ibid., p.81.
201 Communication from the Commission 'Follow-up to the high level reflection process on patient mobility
203 'A Declaration on the Promotion of Patients' Rights in Europe', World Health Organisation Regional
204 Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the
Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Council of Europe
Of greater assistance is an examination of the approach of the European Court of Human Rights, which is sometimes confronted with issues which relate to medical treatments that are regarded as 'normal' in some states but not in others. Two examples will be considered – gender reassignment and abortion. In the first of these it will be seen that an international view of what is established medical treatment is taken. However, the second example supports the national definition approach. This illustrates that there is no single path being followed in human rights law in relation to the understanding of normal treatment.

In the case of Van Kück the European Court of Human Rights heard a challenge by a post-operative transsexual to a refusal of her private health insurer to reimburse the costs of her treatment. The reimbursement had been declined on the grounds that the treatment had not been necessary in that there were other possible treatments available, and on the basis that there was no conclusive evidence that gender reassignment would relieve the applicant's physical and mental difficulties. This was tantamount to saying that it was not normal treatment.

Although the insurer refused to fund the treatment and this decision was upheld by the national courts, the applicant was able to meet the costs herself and went ahead with the treatment. In the case before the European Court of Human Rights, therefore, the issue was not of her right to have (future) treatment, for which she was waiting, but rather to be reimbursed for the cost of treatment she had already undergone. This placed the European Court of Human Rights in the same situation as the Court of Justice in cases such as Kohll, Geraets Smits and Peerbooms, Müller-Fauré and Van Riet. The parallels are striking. In all these cases access to treatment was not the issue, rather they concerned claims for reimbursement from the various bodies responsible for funding medical treatment. The difference between Van Kück and the other cases was that, in the former,

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there was no cross border dimension. The issue before the court was identical – whether the national legal position breached the European legal principles. Here, instead of a claim based on Article 49 of the EC Treaty (the free movement of services), the applicant alleged violation of Articles 6, 8 and 14 of the European Convention on Human Rights.

Of the three concepts identified in the Court of Justice’s jurisprudence, two were relevant here: necessity and whether the treatment was considered normal. The European Court of Human Rights elided the two concepts by combining the view that determining the medical necessity of gender reassignment measures is not a matter of legal definition with the assertion that transsexualism has wide international recognition as a medical condition for which treatment is provided to afford relief. This seemed to produce the result that the treatment was normal and therefore it was necessary and is an illustration of the overlap between ‘necessity’ and ‘normal treatment’. The European Court of Human Rights found that the German courts had not interpreted the term ‘medical necessity’ reasonably. This in part led to a finding that Article 6 had been breached. The alleged violation of Article 8 was also upheld on the grounds that the applicant’s right to respect for her sexual self-determination had not been sufficiently respected.

It is interesting to note the similarity between the conclusion that gender reassignment has wide international recognition as a medical condition for which treatment is provided to afford relief and the Court of Justice’s finding that national authorities must interpret ‘normal treatment’ on the basis of what is sufficiently tried and tested by international medical science. Faced with similar issues the two courts applied a very similar approach. However, it should be noted that in neither jurisdiction was the right to health care expressed to form part of the basis for the decision. Indeed neither court made any reference to such a right. This may tend to confirm the view that the right to health care is under-elaborated within the European regional human rights order.

209 Article 6 of the European Convention on Human Rights gives the right to a fair trial or hearing.
210 Article 8 of the European Convention on Human Rights gives the right to privacy and family life.
Whilst the European Court of Human Rights found gender reassignment to be a normal treatment, the same conclusion has not been reached with regard to abortion. In the case of Vo v France\(^{211}\) the question arose as to whether abortion was a breach of the right to life which is found in Article 2 of the ECHR.\(^{212}\) The Court noted that there was no consensus between the states covered by the ECHR on the nature and status of the embryo and no common position on the legality of abortion. Accordingly it concluded that the issue was not one which the Court could determine, instead it falls within the margin of appreciation accorded to states by the Court.\(^{213}\) A similar approach was seen in Grogan\(^{214}\) where the Court of Justice considered a case involving the dissemination, in the Republic of Ireland, of information about where abortions could be obtained in the United Kingdom. The Court of Justice held that, as a medical activity, abortion constituted a service within the meaning of the Treaty, despite the fact it was illegal in Ireland. It added that it was not for the Court to substitute its assessment for that of the legislature in those Member States where abortion is practised legally.\(^{215}\) Both courts, therefore, have left this question for individual states to determine, supporting a view that what is normal treatment should be decided at national level.

The issue of whether Member States can legitimately continue to restrict reimbursement to treatments offered by their own systems will only receive judicial clarification if an individual challenge to a national refusal of authorization on the basis that the treatment is not offered nationally were to become the subject of a preliminary reference to the Court of Justice. There is certainly scope for such a challenge to be made on the basis of the judgment in Peerbooms.

\(^{211}\) Vo v France (53924/00) [2004] ECHR 326 (8 July 2004).
\(^{212}\) This question had previously come before the European Commission of Human Rights in Paton v UK (8416/78) (1980) 3 EHRR 408 (13 May 1980), but had not been resolved.
\(^{213}\) Vo v France (53924/00) [2004] ECHR 326 (8 July 2004) para 82.
\(^{214}\) Case C-159/90 SPUC v Grogan [1991] ECR I-4685.
\(^{215}\) ibid., para 20.
3.5.3 The concept of undue delay

The issue of undue delay in receiving necessary health care is crucial because of its effect upon patients. A number of possible problems are described by Flood. Firstly, timeliness of treatment may have a significant impact on the patient's chances of a successful cure or even survival. Secondly, a patient may experience a significant decline in his/her quality of life whilst waiting for treatment. Thirdly, delays in receiving care can result in private costs in terms of lost days of work, lost income and reduced productivity. Finally, she believes that of greatest importance for most people, delays in treatment can cause great psychological stress, both for patients and their families.\footnote{216 Flood, C. and Epps, T., 'Can a Patients’ Bill of Rights Address Concerns About Waiting Lists?' Draft Working paper, Health Law Group, Faculty of Law, University of Toronto, 9 October 2001, p.2.} One of the most common reasons for a patient to seek cross border health care will be delays in receiving treatment in the home state. By finding that States must reimburse patients for cross border medical costs where necessary treatment cannot be provided in the state of residence without undue delay the Court of Justice may be regarded as echoing the international human rights provisions on the right to timely treatment. However, this right, such as it may be, can only be exercised if the patient is able and willing to go to another Member State for treatment.

The problem of domestic waiting lists is a matter wholly internal to Member States and as such does not fall within the competence of the EU. Article 152(5) of the EC Treaty confirms that Member States have control over their own health systems. It is only in situations with a cross border dimension that this limited right to be treated without undue delay arises.

Two related questions arise in relation to undue delay. The first of these is on what basis it is to be measured. The second is how a consistent approach to this might be achieved. With regard to the former question, it has been seen that in Peerbooms the Court of Justice upheld the condition that authorization must be granted where the patient would otherwise experience undue delay. Later, in Müller-Fauré, the Court added that in assessing whether or not treatment could be offered in the state of residence without undue delay, national authorities must have regard to all the circumstances of each individual case, taking due
account of certain factors, in particular, the patient’s medical condition at the time of the request,\textsuperscript{217} the degree of pain or nature of any disability which might make it impossible or very difficult for the patient to carry out a professional activity and the patient’s medical history.\textsuperscript{218} The Court rejected the arguments advanced by the Netherlands and the UK that waiting lists should be used as a measure of what was reasonable, on the grounds that it could not see that waiting lists were necessary other than for purely economic reasons which could not be used to justify a restriction on the free movement of services.\textsuperscript{219} These two sides of the argument can be characterised as medical and economic.

The approach that undue delay is to be judged purely on medical grounds is supported by the Court’s criteria for access to cross border care, all of which are medical in nature. It is also consistent with the principle that economic reasons cannot be used as a basis to derogate from the free movement of services.

This issue was revisited by the Court of Justice in the case of \textit{Watts}.\textsuperscript{220} Here the Court stated categorically that the determination of whether a patient faced an undue delay must be based upon an individual assessment of the patient’s condition rather than upon actual waiting times in the relevant Member State.\textsuperscript{221} This is a clear validation of the medical approach to determining whether an undue delay has occurred.

Despite the clarification given in \textit{Watts}, the problem of how medically to measure undue delay remains. In the event of litigation it then becomes the role of the Court to assess medical evidence as to whether undue delay has occurred which adds another layer to the determination. Between the clinicians and the Court, health service administrators will no doubt be called upon to participate in the assessment. However, at the base of the decision will be medical opinion.

\textsuperscript{218} Case C-385/99 Müllér-Fauré and van Riet [2003] ECR I-4509, para 90.
\textsuperscript{219} ibid., para 92.
\textsuperscript{220} Case C-372/04 Watts [2006] ECR I-4325.
\textsuperscript{221} ibid., para 120.
As previously indicated, the second problem which arises is how to achieve consistency in the medical assessment of undue delay since this cannot be an exact science. Excluding life and death emergencies, it may be impossible to determine what would constitute an undue delay. The term itself is mysterious. Clearly some delay is acceptable as the delay must be 'undue' to be unacceptable. It seems logical that the amount and pain and suffering experienced by the patient must be at the core of the assessment, but how should this be measured?

Even if it were possible to set an acceptable length of time (by medical standards) for the full range of treatments within a Member State there would still be a problem of inconsistency between Member States. At present, waiting times vary considerably depending on levels of health care provision. If the Court of Justice believes that undue delay has a single European Union-wide standard or meaning then it has been suggested that this would imply that British and Dutch patients would have an automatic right to cross border treatment in many cases.\textsuperscript{222} If, on the other hand, undue delay is to be determined on a state by state basis it is difficult to see how it can be based on objective clinical criteria alone.

It may be that a set of common waiting limits for different treatments, to which authorization bodies could refer, could be established by expert agreement. However, this would impinge on national competence for the organisation of health care provision which would be politically unpopular with the Member States. One possible way forward would be to deal with this issue either as part of the informal co-ordination of health care policy or under the OMC process, both of which are discussed in Chapter 5.

If common waiting times were agreed, the greatest impact would probably be felt within Member States, as most patients do not choose to go abroad for treatment. Setting common treatment times would also set expectations internally, thereby increasing pressure for resources to be made available to achieve these standard waiting limits. Arguably,

Member States may tolerate some increase in patient mobility, and the corresponding increase in costs this would bring, more easily than a direct interference in their domestic health policies, which would in any event conflict with Article 152 of the EC Treaty and Article 35 of the EU Charter. However from the perspective of the patient, the result may be the same either way as the indirect impact of the case law on cross border care may be to improve their enjoyment of the right to health care at national level by placing pressure on Member States to improve access by bringing down waiting lists (or increasing ranges of treatment) in order to avoid having to fund cross border care.

3.5.4 Human rights law and undue delay

Arguably, unreasonably delayed medical treatment constitutes a breach of the right to health care. The WHO Declaration on the Rights of Patients in Europe and the Convention on Human Rights and Biomedicine stress that access to health care must be equitable, whilst the International Covenant on Social and Economic Rights and the European Social Charter emphasise the right to timely treatment. As an aid to interpretation and an exercise in placing the 1966 Covenant provisions in a modern context, the Committee on Economic, Social and Cultural Rights of the United Nations issued a ‘General Comment’ on the right to health article in 2000. The General Comment begins by asserting that health is a fundamental human right indispensable for the exercise of other human rights. In relation to the right to medical treatment contained within the right to health, the Committee comments that this includes the provision of equal and timely access to basic preventative, curative, rehabilitative health services, to health education, screening and appropriate treatment of diseases, illness injuries and disabilities.

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226 ibid., para 1.
227 ibid., para 17.
In addition, the issue of undue delay in the provision of health care has been held to be an aspect of the right to health care covered by Article 11 of the European Social Charter (ESC) by the European Committee of Social Rights. Concern about the issue was expressed by the Committee in its conclusions on the United Kingdom’s state of compliance with Article 11.1 of the ESC. Both the length of waiting times, described as ‘long in absolute terms’ and the relatively low density of health professionals, found to be one of the two lowest in the OECD in 1996, were criticised. Whilst reserving its conclusions for the time being, the European Committee of Social Rights found that:

"the organisation of health care in the United Kingdom is manifestly not adapted to ensure the right to health for everyone.”

More recently the European Committee on Social Rights has criticised Poland for delays in access to health care, concluding that Poland is not in compliance with Article 11.1 on the grounds that waiting times for some treatments are excessive and waiting lists are not properly managed. When a breach of the Charter is found a procedure exists for the issue of a recommendation addressed to an individual State or States by way of a decision by the Committee of Ministers of the Council of Europe. In relation to waiting times for medical treatment, a Recommendation was issued to member states by the Committee of Ministers in 1999 stating that:

"the final objective of a health care system should be to eliminate both undue delays in access to health care and undue waiting lists altogether.”

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229 ibid.
231 See Bell, M, ‘Walking in the same direction? The contribution of the European Social Charter and the European Union to combating discrimination’ in de Búrea, G. and de Witte, H., (eds) Social Law and Policy in an evolving European Union, Oxford Hart, 2000, p. 15. Note that a further mechanism exists to enable certain types of representative bodies, such as trades unions and NGOs, to bring a ‘collective complaint’ against a state for failure to comply with the ESC – the mechanism is discussed by Bell at p.13
233 ibid., Appendix, para 5.

146
Noting that there were differences between member states in terms of the scale of the problem and approaches to waiting list management, the Committee of Ministers recommended that states develop comprehensive and coherent strategies to address this. The Recommendation refers to an attached appendix which contains a wide range of reflections on waiting list management. One of the principles stated therein is that:

"A goal of waiting times policies should be to ensure that access to treatment is based on transparent criteria...that address the risk of deterioration both in clinical (pathological) and quality of life (functional) terms."\(^{234}\)

It is also stated that waiting times should not be so long that the patients’ health is at risk of deterioration.\(^{235}\) This has resonances with the case of Watts where it was accepted that her condition had, in fact, deteriorated considerably while she was on the NHS waiting list. The reassessment of her condition led to a reduction in overall predicted waiting time, but not before she had had one of two necessary operations carried out in a French hospital.

There are further parallels between the Committee of Ministers’ Recommendation and the approach of the Court of Justice to the meaning of undue delay in Müller-Faure, which also encompassed clinical and functional considerations including the patient’s degree of suffering and the impact of their condition on their ability to work. It is also echoed in the EU legislative position where the ‘probable course of the illness’, a similar concept to ‘the risk of deterioration’, is a factor to be taken into account in determining whether or not cross border treatment must be authorized on the grounds of undue delay.\(^{236}\)


\(^{235}\) ibid., para 12.

3.5.5 Conclusions to Part III

The fundamental right to health care is found in various international and regional instruments and the relevant provisions contain some support for the propositions that there is a right to all types of treatment which are generally available and a right to receive treatment without undue delay. For example, the International Covenant on Economic and Social Rights refers to access to all medical services and the WHO Declaration on the rights of patients in Europe, to access to health care appropriate to the patient's needs. Both could be seen as supportive of the view that a patient is entitled to the widest possible range of treatment, which may mean not only those which are offered within a particular state. However, the EU Charter of Fundamental Rights reflects the alternate view; that it is for each state to define its own range of treatments. Furthermore, the International Covenant and the European Social Charter both expressly support the right to timely treatment. However, such wording is not found in the other provisions examined.

The right to cross border health care recognised by the Court of Justice is only applicable in specific circumstances and relies on the knowledge and ability of the individual to pursue it. The onus is on the patient to apply to his or her national authorities for authorization to go to another Member State for treatment. The obligation on the State is to consider the application and to grant it where the conditions of necessity, normal treatment and undue delay are met.237

The main objection of EU Member States to the granting or extension of rights to cross border care is the fear, real or perceived, that this will ultimately undermine the financial stability of their health care systems. This conflict between rights and resources raises the question of whether the right to health care is absolute or, in fact, subject to the economic ability of states to respect, provide and fulfil it, in terms of having the resources available to do so. A number of the international and regional provisions on the right to health care

237 In terms of the three types of obligations States are under in international law: to respect, protect and fulfil the right to health, the first seems most applicable to the exercise of the right to cross border care.
acknowledge such economic constraints.\textsuperscript{238} This would seem to support the view that it is legitimate for EU Member States to place a limit on the range of treatments which it is prepared to fund, and the speed at which patients will be treated, on the basis of cost containment. However, an alternative view is illustrated by Gevers who argues that:

"Where there are limitations in care due to capacity constraints, promotion of cross border care may help to share spare capacity and facilitate a more effective use of scarce resources."\textsuperscript{239}

The concept of resource sharing may help to vitiate concerns about the granting of cross border rights health care to individuals, to the detriment of the rights to health care of the majority at a national level. An example is seen in the Network of Independent Experts' (NIE) view of the decision in \textit{Müller-Faure}.\textsuperscript{240} Whilst acknowledging that neither the Charter nor a fundamental right to health was referred to by the Court of Justice, the NIE regards this judgment as an illustration of:

"the importance which the Community Court attaches to the right to health care where the concern of guaranteeing this right is invoked by a Member State in order to justify a restriction on the free movement of goods or the free provision of services."\textsuperscript{241}

The tension between individual rights to health on the one hand and collective entitlements on the other, manifested in the internal market litigation on cross border care is reflected in Article 35 of the EU Charter of Fundamental Rights, which covers both. Hervey has considered the possible consequences of Article 35 being raised in the context of internal market litigation.\textsuperscript{242} She argues that the right to health care could, for example, bolster a

\textsuperscript{240} Case C-385/99 \textit{Müller-Faure and van Riet} [2003] ECR I-4509.
claim by a UK national against a health authority or NHS trust for a refusal to give authorization or make reimbursement for cross border treatment. In such a case, the Court of Justice should interpret Article 35 in accordance with Article 11 of the European Social Charter. This would involve the Court taking into account the conclusions of the European Committee of Social Rights which has found the UK to be manifestly unadapted to ensure a universal right to health mainly due to excessive waiting times. On this basis such an argument might succeed. However, she cautions that:

"a strongly articulated right to health, if applied to entitlement to ‘cross-border beds’, might actually destabilise the financial arrangements for health care within the UK. If this were to occur, it would be at least arguable that the health protection and promotion of the health of citizens...had actually been undermined by a notion of the right to health."

It is interesting to note that the European Union’s own Charter of Fundamental Rights does not contain an explicit resources-based qualification to the right to health care. However, whilst there is no reference to resources, the provision recognises Member States’ control over the provision of medical treatment, forming a consistent approach with the public health Article 152 and Regulation 1408/71. Nonetheless, because health care has been held to be a service within the meaning of Article 49, Member State control is, in turn, subject to the conditions which attach to any interference by a Member State with one of the freedoms of movement which make up the internal market. This enables the Court to comment upon the manner in which Member States exercise such control, seen here in the use of prior authorization schemes. The Court has attached a number of conditions to the exercise of such mechanisms including in relation to the criteria for authorization. In particular, the Court has held that authorization should be given for necessary, ‘normal treatment’ where the patient would otherwise suffer an ‘undue delay’. These criteria have been examined in the light of international and regional human rights law and it has been shown that there is a significant degree of consistency between the approach of the Court of Justice and those of

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245 Article 35, EU Charter of Fundamental Rights.
the European Court of Human Rights to normal treatment, and of the European Committee of Social Rights to undue delay.

Two possible conclusions may be drawn from this. Firstly, it may add weight to the approach of the Court of Justice in that, arguably, it has not taken an isolated stance but one that sits quite comfortably with parallel conclusions drawn by the relevant institutions of the Council of Europe. Secondly, it can be contended that if the Court of Justice is consciously or unconsciously taking a position on the criteria for access to cross border care which reflects human rights law, this may be part of a shift away from a conception of patient mobility as a spillover from economic integration, towards a more rights-based approach to the exercise of these entitlements. Arguably, any such shift will be reflected in the nature of the impact of the case law upon the development of EU law and policy in relation to health care.

3.6 Overall conclusions

The purpose of this chapter has been to trace the evolution of the case law on cross border care, and to examine the key issues raised by the judgments, in order to lay the ground for the analysis of the impact of the case law upon the development of EU law and policy in relation to health care which follows. In particular, it has been shown that the case law lacks legal certainty in a number of respects and it will be seen in Chapter 4 that this has led to the pursuit of a number of different legislative strategies aimed at codifying the patient mobility principles. It will also be argued that the case law has been used as a justification for forging a wider policy role in relation to health care for the EU because it has so many implications for the delivery of health care at national level. This has been most evident in the steering by the Commission of two parallel policy co-ordination processes in the health care field which are considered in Chapter 5. Moreover, it will be seen that the latest policy paper from the Commission - a consultation on Community action on health services-raises the possibility of legislative action which goes beyond a mere codification of the case law into other areas of health care regulation.246

This chapter has also examined the relationship between the conditions for access to cross border care contained in the case law and the fundamental right to health care, and has concluded that there is considerable resonance between the two. It is suggested that whilst the case law starts from a market perspective on health care, it is nonetheless in tune with a rights-based approach. In terms of the impact of the case law upon the development of law and policy, it is argued that this is reflected in an overall shift within EU law and policy, from a neo-liberal conception of health care as an economic service towards a more rights-orientated view.
Chapter 4: The legislative response to the case law on patient mobility

4.1 Introduction

Having examined the background to the cases on patient mobility and the principles established by the European Court of Justice, the impact of the case law upon the development of law and policy in relation to health care at EU level will now be considered. In particular, this chapter will assess the legislative responses to the cases, whilst Chapter 5 will focus upon policy initiatives influenced by the case law.

In Chapter 3 it was seen that the Court of Justice’s jurisprudence on cross border care created new rights for patients as a spillover from the free movement of services. However, problems of non-compliance with the case law prompted the Commission to believe that there was a need to place these principles on a firmer footing through codification. This raises the question as to how and where the patient mobility principles fit into the existing framework of EU law and how best they can be incorporated into legislation. This can be related to the broader context of the choice of model of social policy for the EU.

Three different ways in which the case law could be codified have been proposed:

Firstly, and perhaps most obviously, the case law could be codified within the existing structure of Regulation 1408/71 and its successor. This would continue the historic association between the co-ordination of social security and access to cross border care.

A second approach would be to fit the required provisions within the wider framework of the regulation of services in the internal market. This is consistent with the Court of Justice’s conception of health care as a service. A modified version of this seeks to create a new legal framework for a new category of social services of general interest, such as health care.
Finally, a third suggestion is that the patient mobility principles should be the subject of specific legislation. This might be the most satisfactory route from the point of view of raising the profile of the new rights and providing clarity and legal certainty for patients and providers.

Whilst each approach has a certain logic, each also carries disadvantages. After outlining the concerns of the Commission about the failure of Member States to comply with the case law, this chapter will examine recent legislative attempts under the first and second approaches and consider the implications of the third approach, which has recently been adopted by the Commission.

4.2 Assessing compliance with the case law on cross border care

The European Court of Justice’s jurisprudence in relation to access to cross border care was based upon the finding that health services fell within the scope of Article 49 of the EC Treaty. Any barriers to patient mobility proscribed by the Court would henceforth constitute obstacles to one of the fundamental principles of the internal market – the free movement of services. It should be noted from the outset that there has been considerable resistance to a full application of internal market principles to health services. The approach taken by the Court of Justice has not been universally accepted. In this regard, following the judgments in the cases of Kohll,1 Decker,2 Smits and Peerbooms3 and Vanbraeckel4 the Commission received a number of complaints from individuals asserting that certain Member States were failing to abide by the conditions laid down in these cases.5 Accordingly, in July 2002 the Director General for the Internal Market launched a consultation process on the implementation of the case law by the Member States. This

4 Case C-368/98 Abdou Vanbracel v Alliance Nationale des Mutualités Chrétiennes (ANMC) [2001] ECR I-5363.
took the form of a questionnaire sent to each Member State designed to gain an overview of the compliance situation.\textsuperscript{6}

The exercise was referred to in the Commission’s Communication on “Internal Market Strategy 2003-2006”,\textsuperscript{7} the purpose of which was to examine how free movement of services generally within the Community could be improved. In relation to cross border health services the Commission believed that:

“A well managed application of Internal Market rules to the health care sector has the potential to help both patients and providers by allowing the most efficient possible use of the resources across the European Union.”\textsuperscript{8}

The Commission’s desire to engage the Member States in a discussion on compliance with the jurisprudence was consistent with its 2002 Communication on better monitoring of the application of Community law.\textsuperscript{9} It was also stated to be a parallel initiative to the High Level Process of Reflection on Patient Mobility launched jointly by the Commissioners for Public Health, Employment and Social Affairs and the Internal Market in 2002.\textsuperscript{10} The objective of both initiatives was to achieve greater legal certainty for patients and health professionals alike in the exercise of the fundamental freedom to provide or receive health services.\textsuperscript{11}

The results of the consultation process on the implementation by the Member States of the jurisprudence on cross border care were published in a Commission Staff Working Paper Report in July 2003.\textsuperscript{12} While the exercise was taking place, a further judgment in relation to cross border care, \textit{Müller-Fauré},\textsuperscript{13} had been given and this further defined the criteria.

\textsuperscript{8} ibid.
\textsuperscript{9} COM(2002)725.
\textsuperscript{10} This is examined in detail in Chapter 5.
\textsuperscript{12} ibid.
\textsuperscript{13} Case C-385/99 \textit{Müller-Fauré v Onderlinge Waaborgmaatschappij OZ Zorgverzekeringen} and \textit{van Riet v Onderlinge Waaborgmaatschappij ZAO Zorgverzekeringen} [2003] ECR I-4509.
which Member States must apply to requests for authorization and/or reimbursement for
treatment sought or received in another Member State. This additional decision was
therefore taken into account in the Report.\textsuperscript{14}

From its opening remarks onwards the Report revealed that Member States did not share a
common understanding of the jurisprudence and that the situation faced by patients seeking
cross border care therefore varied from one state to another.\textsuperscript{15} The Report looked firstly at
the application by Member States of the relevant case law. It then considered in particular
the extent to which their authorization procedures complied with the jurisprudence. Finally
it considered data on instances of cross border care provided by Member States and
attempted to analyse the relationship between the extent of compliance with the
jurisprudence and the volume of patient mobility.

As indicated above, the Commission found that application was very patchy. The response
of Member States to the early decisions in \textit{Kohll} and \textit{Decker} was very cautious, particularly
as it was widely believed that the judgments were only relevant to states operating systems
of reimbursement of health care costs, as opposed to those which provided health care free
at the point of delivery.\textsuperscript{16}

The Member States’ reaction to \textit{Smits and Peerbooms} and \textit{Müller-Fauré} appears to have
been equally mixed. Many Member States seem to have rejected the Court’s clear
distinction between the need to obtain prior authorization in relation to cross border
hospital care, and the lack of a corresponding requirement for non-hospital treatment,
believing that an inability to control access to any type of patient mobility would be
damaging to the financial viability of their health systems.\textsuperscript{17} In addition, there were
significant variances in the definition of hospital services.\textsuperscript{18} Similarly, a variety of

\begin{itemize}
\item\textsuperscript{14} SEC(2003)900, pp.2, 6, and 7.
\item\textsuperscript{15} ibid., p.2 This position, which indicates a lack of compliance and which has led to an increasing number of
complaints may prompt the Commission to initiate enforcement proceedings under Article 226 EC Treaty (p.6
para 3).
\item\textsuperscript{16} SEC(2003)900, p.8, para 9.
\item\textsuperscript{17} ibid., p.9, para 13.
\item\textsuperscript{18} ibid. In particular, it is noted that some Member States adopt a broad definition encompassing
establishments such as clinics, nursing homes and spas.
\end{itemize}
approaches were taken to the application of the Court’s ruling in *Vanbraekel*, which related
to establishing the appropriate level of reimbursement of cross border health care costs
incurred.

With regard to conditions for prior authorization for cross border care, Member States
relied upon the relevant legislative provisions – Article 22(1)(c) and 22(2) of Regulation
1408/71 - as their position. However, in its report the Commission took the opportunity to
remind Member States that the Court’s jurisprudence had in fact, reduced the significance
or at least the monopoly of these provisions, by stating that patients could receive
reimbursement for non-hospital treatment without having obtained prior authorizations.

In the final section of the Report, the Commission noted that the incidence of patient
mobility was very low, and argued that the attitude of national authorities was important for
the development of the free movement of health services. The evidence of the data
provided by Member States was that there is a correlation between the degree to which a
Member State has taken steps to implement the jurisprudence and the willingness of
patients from that state to seek cross border care. The Commission therefore concluded
that:

“legal certainty is an essential element in ensuring the effective right of patients to be
treated in another Member State.”

The Report concluded that the internal market in health services was not functioning
satisfactorily. Accordingly, the use of tools such as providing better information to
patients, health professionals and social security managers would be considered. However, no concrete proposals for improving the position were put forward beyond a
vague statement that:

\[20\] ibid.
\[21\] ibid.
\[22\] ibid., p.18.
\[23\] ibid.
"creating a Community legal framework could be another option."\(^{24}\)

This specific issue is an example of the problems which can occur in relation to the effectiveness of Court of Justice jurisprudence where there is no transposition into legislation at EU or national level. Whilst the case law forms part of the *acquis communautaire* it is suggested, at least in relation to cross border care, that as citizens do not have sufficient knowledge of case law unsupported by legislation, the codification of jurisprudential principles is essential.

The Report was significant in confirming and clarifying suspicions of a lack of compliance on the part of Member States with the jurisprudence on cross border care and was to form the backdrop to the introduction of two different sets of legislative proposals designed to ensure the legal certainty which it had been found to be lacking. The first approach was to include the provisions in the process of the reform of the co-ordination of social security. The second approach involved incorporating the principles within proposed legislation on the free movement of services.

**4.3 The first approach – codifying the case law in the new Regulation on the rules on the co-ordination of social security**

The need to overhaul Regulation 1408/71, which was highlighted by the case law on cross border care, had been recognised by the EU institutions for some time with the most recent reform initiative dating back to the 1992 Edinburgh Council and the later Commission Communication “An Action Plan for Free Movement of Workers.”\(^{25}\)

The proposal for a new Regulation to co-ordinate social security originated from a 1998 Commission white paper.\(^{26}\) The Commission’s stated reason for introducing the proposal was for the purpose of simplification; in particular, since 1971 the Regulation has been amended and updated numerous times and this has made it complex and lengthy. The new

Regulation 883/2004 was adopted in April 2004. A proposal for its implementation is currently being considered by the Council and the European Parliament.

There are a number of differences between the new Regulation and Regulation 1408/71. Firstly, it is much shorter and an effort has been made to “simplify and streamline concepts, rules and procedures. Nevertheless, in terms of its guiding principles and essential elements, the co-ordination system remains the same.”

Secondly, the new Regulation will apply to all persons covered by the social security legislation of a Member State including third country nationals. Thirdly, it brings new benefits, such as pre-retirement benefits, within the scope of the Regulation and lastly it gives increased benefit entitlements to unemployed persons who move to another Member State to seek employment.

The new Regulation is based on two simple principles: that the insured person is subject to the legislation of only one Member State at a time and that the insured person is insured in the Member State where he or she pursues a professional activity (lex loci laboris). However, in the case of insured persons who are no longer active or who do not pursue a professional activity, the applicable law is that of the State of residence.

4.3.1 The new articles on access to cross border treatment

It was initially proposed that Article 22 of Regulation 1408/71 would be replaced by two new provisions which were numbered Articles 16 and 18 in the draft legislation. In the final version these became Articles 19 and 20, respectively.

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The proposed articles were originally drafted before the case law on cross border care costs emanated from the Court of Justice. Article 16 would have dealt with access to emergency treatment required during a stay in a state other than the competent state thus replacing Article 22(1)(a). It provided that insured persons and their families:

"shall receive immediately necessary benefits in kind,...provided, on behalf of the competent institution by the institution of the place of stay...".

Pre-authorized cross border care was dealt with in Article 18, which sought to replace existing Article 22(1)(c) and 22(2). The wording differed from the pre-existing provisions in that it placed a positive duty upon states to grant authorization where the treatment is one offered in either the competent state or the state of residence and if the patient cannot be given the treatment ‘within the necessary time’, as opposed to the wording in Regulation 1408/71; ‘within the time normally necessary for obtaining the treatment in question in the Member State of residence.’ However, whilst it was intended to clarify matters, the new wording was criticised by the Economic and Social Committee on the grounds that it perpetuated the ambiguity of Article 22(1)(c). The Committee suggested adding the wording: “provided that this assessment is made on the basis of medical criteria”, to overcome this.

In response to the important set of judgments on cross-border care it was announced that:

"the Commission and the Member States will...think about the need to adapt the Regulation in the light of [recent] case law to make the present rules more transparent and more reliable for patients seeking medical treatment in another Member States."
Taking into account the new jurisprudence, in June 2003 the European Parliament issued its Report on the Proposed Regulation, proposing amendments to both draft Articles 16 and 18. In relation to Article 16 two main changes were suggested. The first of these involved a rewording of the circumstances giving rise to access to emergency treatment to include all benefits in kind which become medically necessary during a person's stay in another Member State, taking into account the nature of the benefits and the expected length of stay. This is clearly wider than 'immediately necessary' benefits.

Secondly, the Parliament proposed adding a second paragraph to Article 16 providing that:

"The Administrative Commission shall establish a list of benefits in kind which, in order to be provided during a stay in another Member State, require for practical reasons a prior agreement between the person involved and the institution providing the care."

With regard to draft Article 18, the Parliament proposed an amendment that Member States be required to grant authorization for non-emergency cross border care where the treatment was one offered in the patient's state of residence and "where he cannot be given such treatment within a time-limit which is medically justifiable taking account of his current state of health and the probable course of his illness." This new wording, which has been adopted reflects the case law and requires that the decision on authorization be made on purely medical grounds whereas the previous test was less specific and left open the possibility of a refusal for non-clinical reasons.

38 ibid., p.22.
39 ibid., pp.22-23.
40 ibid., p.24 On p.25 the Parliament states that this brings the Regulation in line with the Smits and Peerbooms case, Case C-157/99 Geraets-Smits and Peerbooms [2001] ECR I-4573, which raised the issue of 'undue delay'. For a full discussion see Chapter 3. This amendment was accepted by the Commission - see COM(2003)596.
41 This issue was discussed at length in the English case, R (on the application of Watts) v Bedford Primary Care Trust and the Department of Health [2003] EWHC 2228 (Admin). The case was subsequently referred to the European Court of Justice and is discussed in Chapter 3.
A further amendment which was put forward by the Parliament in September 2003 provided that:

"an insured person travelling to another Member State with the purpose of receiving benefits in kind during the stay shall seek authorization from the competent institution where such benefits involve in-patient treatment."\textsuperscript{42}

This proposed amendment, which reflects the judgment of the Court of Justice in\textit{Müller-Faure},\textsuperscript{43} was intended to open the door to full cross border access to out-patient treatment. Such a reformulation would have represented a significant step towards increasing cross border care. However, whilst the Commission approved the amendment, the Council declined to do so. The new Regulation will not, therefore, fully reflect the jurisprudential position. The Commission has commented on this discrepancy and has expressed regret that this particular advance could not be made within the new Regulation. However, the Commission has pointed out that according to the case law it is nonetheless possible to ask for reimbursement of the costs of cross border non-hospital treatment obtained without prior authorization on the basis of Article 49 EC.\textsuperscript{44}

The Commission has, in any event, expressed the view that the Regulations only apply to two situations: firstly in the case of hospital care for which prior authorization is necessary and secondly in the case of non-hospital treatment where a patient applies for authorization in order to benefit from the reimbursement mechanisms provided by the Regulations. These may provide a higher level of reimbursement than would otherwise be achieved. In any other situation the Commission believes that Article 49 is directly applicable.\textsuperscript{45}

\begin{footnotesize}
\textsuperscript{42} Amendment 53 to the proposal for a regulation on the co-ordination of social security systems adopted by the European Parliament on 3 September 2003, see COM(2003)596 p.4. This replaces the original amendment to Article 18, amendment 36.

\textsuperscript{43} Case C-385/99 \textit{Müller-Faure and van Riet} [2003] ECR I-4509.

\textsuperscript{44} COM(2004)44, p.5.

\textsuperscript{45} Explanatory note from the Commission Services on the provisions of the proposed Directive on services in the Internal Market relating to the assumption of healthcare costs incurred in another Member State with a particular emphasis on the relationship with Regulation No. 1408/71, 2004/0001(COD), 17.03.2005, p.6.
\end{footnotesize}
4.3.2 Comments on the new Regulation

Whilst the original purpose of reforming the social security regulation was to simplify the provision, the intervening case law on access to cross border care required a more radical review.

As far as the general criticisms set out in Chapter 2 are concerned, it is hoped that the new Regulation will be clearer and easier for Member States to apply than the existing legislation. However, two of its fundamental characteristics will remain – the approach will still be one of co-ordination rather than harmonisation and the state of employment principle is retained, at least until the point of retirement.

With regard to the specific criticisms of Article 22, whilst some are met, some remain unaddressed. In particular, the new formulation for planned treatment only partly reflects the recent jurisprudence of the Court of Justice and in this respect fails to take full account of the application of the free movement principles to the field of health care. Furthermore, many questions persist, such as how ‘medically necessary treatment’ will be defined and how the new conditions for authorization of planned care will be interpreted. There also remains an anomaly between the ranges of treatment available in each instance – for care which is required during a stay abroad this is unlimited, whilst in respect of planned cross border care the treatment must be one which is offered by the health system of the state of residence.

Under new Article 19, patients will be able to seek any medically necessary treatment during a stay in a Member State rather than only benefits which are ‘immediately necessary’. It is difficult to know exactly what the distinction is between these two concepts, and the widening of access does nothing to dispel concerns about abuse of the provision as a means of circumventing the need to gain prior authorization. In this regard it can be noted that the new formulation will put all insured persons in a position similar to

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46 These are examined in Chapter 2.
47 This would involve persons presenting for treatment abroad on the basis that they have become ill during a temporary stay, where in reality they have travelled for the purpose of obtaining medical treatment.
that previously only enjoyed by pensioners under Article 36 of Regulation 1408/71. In determining whether treatment has been legitimately sought under that provision, the decisive factor for the Court of Justice has been whether the visit to the Member State where the treatment was received was undertaken for that purpose, or was incidental to the visit. The Court of Justice has stressed that evidentially this is a matter for national courts to determine. It may be that a similar approach will be taken to new Article 19.

The reformulation of the authorization criteria in Article 20 should make it more difficult for Member States to refuse requests for treatment abroad in cases of delay. The wording which it replaces has been open to arguments based on the use of waiting lists. In particular, it had been suggested by the UK government that the wording “within the time normally necessary for obtaining the treatment in question in the Member State of residence” can be interpreted as meaning within normal waiting times for that type of procedure.48 The new wording, which requires that treatment be given within a time-limit which is medically justifiable, will make it very difficult for Member States to rely on non-clinical reasons for delay. This should benefit patients on lengthy waiting lists providing that they can produce a supporting medical opinion. The narrowing of the grounds for refusal to grant authorization will be welcomed by critics. However, it seems likely that in the absence of more detailed conditions there will continue to be significant disparities in national policies on authorizing cross border care.49

The failure to incorporate the principle that patients cannot be required to have sought prior authorization for cross border non-hospital treatment50 in Article 20 is difficult to justify. The reason given by the Council for the exclusion is that the effect of such a restriction on the ability of Member States to require that authorization be obtained for non-hospital

\[48\] This argument was put forward in R (on the application of Watts) v Bedford Primary Care Trust and the Department of Health [2003] EWHC 2228 (Admin). The interpretation was rejected by the Court of Justice on a preliminary reference of the case in para 60 of its judgment of 16 May 2006 in Case 372/04, The Queen on the application of Yvonne Watts v Bedford Primary Care Trust and Secretary of State for Health [2006] ECR I-4325.

\[49\] The provisions on authorization schemes contained in COM(2004)2, the draft Services Directive, sought to promote greater certainty and consistency in this regard.

treatment should have been the object of specific provisions. What this might entail will be considered later in the Chapter in the section on the third approach to codification. The result is that the legislative position remains inconsistent with the jurisprudence of the Court of Justice in this area. The new Regulation on the co-ordination of social security represents only a partial codification of the case law on cross border care. A further attempt to codify the principles will be considered in the next section.

4.4 The second approach – incorporating the principles within the services directive or within a special legal framework for social services of general interest

4.4.1 The draft services directive

In a second approach to codifying the case law on patient mobility a number of provisions including a definition of hospital care and setting out the conditions under which Member States must authorize reimbursement of cross border care costs, were included in the 2004 draft Directive on Services in the Internal Market, a wide ranging proposal aimed at removing remaining barriers to the free movement of services in numerous fields of activity.

It is recalled that the first issue for the Court of Justice to determine in the cases on cross border care was whether health services are services within the meaning of Articles 49 and 50 of the Treaty. Member States such as the United Kingdom argued that in relation to the National Health Service at least, this was not the case since the services in question were not economic in nature. However, the Court insisted that the fact a health service was publicly funded did not preclude it from being a service within the meaning of the Treaty because the remuneration for a service does not have to be paid by the recipient but can, for example, be paid by the state on their behalf.

52 COM(2004)2, Articles 4, 8-11 and 23.
The classification of health care as a service lies at the heart of the wider debate about the nature of the European social model. The draft directive on services in the internal market met with a huge level of opposition from trade unions and other social partners. The draft services directive can be regarded primarily as reflecting the neo-liberal market model of European social policy whereas the objections of its opponents that it will undermine the European social model and lead to social dumping, are supportive of the social cohesion model.\textsuperscript{53} The ideological tension between those who seek greater and greater deregulation of the internal market and those who want to see certain social services ring fenced from market effects has been played out in the controversy surrounding the draft directive.

In basic terms, the draft directive sought to remove many of the existing barriers to the free movement of services by adopting the ‘country of origin’ principle. This echoes the principle of mutual recognition which is applied to the free movement of goods (\textit{Cassis de Dijon})\textsuperscript{54}, stating that as long as service providers comply with any regulatory requirements in the state in which they are based, no further requirements can be imposed by other states in which they operate.

Explaining the need for the directive, the Commission argued that a liberalisation of the services market is essential for the realisation of the internal market and is part of the wider ‘Lisbon process’ aimed at increasing competitiveness in the EU. The Commission sought to counter fears of social dumping by drawing attention to the derogations from the country of origin principle which were included in the draft legislation. However, the circumstances in which these could be invoked were quite limited.\textsuperscript{55}

\textsuperscript{53} For example, British Trade Union leader Brendan Barber said of the draft directive that it “...would fire the starting gun on a race to the bottom. It would create flags of convenience across the whole of Europe, in every part of the services sector. It would undermine the very point of the European social model”, from “75,000 march in Brussels for a stronger social Europe”, http://www.tuc.org.uk/international/tuc-9587-f0.cfm, January 2006.
\textsuperscript{54}Case 120/78 Rewe-Zentrale AG v Budesmonopolverwaltung für Branntwein (Cassis de Dijon) [1979] ECR 649.
\textsuperscript{55} See Article 17 of the draft services directive, COM(2004)2.
The European Parliament was somewhat less enthusiastic about the draft directive. In her explanatory statement to the draft report on the directive,\textsuperscript{56} the rapporteur for the internal market and consumer protection committee, Evelyne Gebhardt, identified a number of problem areas including the scope of the directive, the country of origin principle and the compatibility of the directive with the \textit{acquis communautaire}.\textsuperscript{57} In terms of the question of the scope of the draft directive, Ms Gebhardt believed that its definition of services is insufficiently clear in that there should be a dividing line between services covered by the directive and services of general interest, which should come under separate legislation. With regard to the latter category she further argued that:

"In opening up the services market, it is crucial that the existing body of legislation on services of general interest, which represents a pillar of the European social model, be maintained."\textsuperscript{58}

On the country of origin principle Ms Gebhardt's view was that this is not an autonomous principle since it is not referred to in the treaties.\textsuperscript{59} She also argued that the principle is inconsistent with Article 50 EC, which provides that a cross border service provider has the right to equal treatment with national service providers from the state in which the service is being provided. She proposed that the country of origin principle be replaced by the principle of mutual recognition whereby the conditions laid down in one country could not duplicate equivalent conditions already satisfied in the country of origin.\textsuperscript{60}

The Commission proposal included health services within its ambit, whilst providing limited possibilities for derogation on grounds of public health and in relation to health personnel. It also covered certain other social services such as the provision of care to the elderly. The aim of including the assumption of health care costs in the draft directive has been stated to be threefold: to strengthen the rights of patients to receive cross border care, 

\textsuperscript{57} The existing body of European Community law.
\textsuperscript{59} ibid., p.95/96.
\textsuperscript{60} ibid., p.92/96.
to increase legal certainty and transparency and to take the opportunity to clarify certain points left open by the Court. The advantage of the approach is its consistency with that of the Court of Justice.

The proposed provisions covered four aspects of the conditions for access to cross border care: the definition of hospital treatment, the circumstances in which authorization must be granted, the nature of prior authorization schemes and the level of reimbursement of the costs of cross border medical treatment. However, ultimately the inclusion of health care related provisions proved unacceptable to the Parliamentary Committee which voted to exclude health from the draft directive altogether in November 2005, following the recommendation of the rapporteur of the internal market and consumer protection committee. To investigate this legislative attempt in more detail, the draft articles themselves will be considered, followed by an examination of the reasons for their removal from the services directive.

4.4.2 The draft provisions on patient mobility

The four areas covered in the draft directive will be examined in turn.

4.4.2.1 Defining hospital treatment

The Court of Justice has drawn a distinction between hospital and non-hospital care. The significance is that prior authorization need now only be sought in relation to the former.

In the draft directive, hospital care was defined as:

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61 Explanatory note from the Commission Services on the provisions of the proposed Directive on services in the Internal Market relating to the assumption of healthcare costs incurred in another Member State with a particular emphasis on the relationship with Regulation No. 1408/71, 17/3/2005, p.2.
62 Explanatory Statement, Draft Report on the proposal for a directive on services in the internal market, IMCO, 25/5/2005, p 94/96. The basis of the recommendation to exclude health from the directive on services was to avoid a contradiction with the division of competences laid down in Article 152(5), EC.
"medical care which can be provided only within a medical infrastructure and which normally requires the accommodation thereof of the person receiving the care, the name, organisation and financing of that infrastructure being irrelevant for the purposes of classifying such care as hospital care."

Although the need to define hospital and non-hospital care is vital for the correct application of the jurisprudence, this definition seems open to differences in interpretation. Whilst it overcomes the issue of the relevance of the name or type of the place of treatment it still leaves open the question of whether all health systems within the EU take a common position on which treatments can only be provided in a hospital and, if so, whether or not overnight accommodation will be provided. The use of the term ‘normally’ to qualify this latter point, if anything, creates greater uncertainty.

This issue was one of a number addressed by the Commission Services in an Explanatory Note on the provisions on patient mobility contained in the draft directive. In addition, the Commission Services recommended clarification to the effect that it is for the Member State where the person is normally entitled to health care (known as the state of affiliation) to determine what is considered hospital care, rather than the State where treatment takes place. The fact that the draft provision would apparently have permitted each Member State to have its own definition of hospital care seems problematic in so far as the overall objective of the provisions was to alleviate the present definitional inconsistencies. Whilst the Court of Justice recognised the difficulties in reaching a consensus on this point, arguably the distinction it made between hospital and non-hospital care can only be decisive if a common position is taken. Without this, arguably legal certainty cannot exist. However, the reality is that in light of the differences in the delivery of health care in different Member States, the concept of hospital care may in practice be incapable of precise definition. In any event, it seems unlikely that the proposed formulation would be sufficient to prevent problems for patients seeking reimbursement.

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64 COM(2004)2, Article 4(10).
65 Explanatory note from the Commission Services on the provisions of the proposed Directive on services in the Internal Market relating to the assumption of healthcare costs incurred in another Member State with a particular emphasis on the relationship with Regulation No. 1408/71, 17/3/2005, p.5.
66 ibid.
A further suggestion in the Explanatory Note was that the definition of hospital care be moved to the main article on the assumption for cross border care costs, to place it in its proper context.

4.4.2.2 The circumstances in which authorization for cross border health care must be granted

In line with Müller-Faure, the first paragraph of Article 23 of the draft directive provided that Member States may not oblige patients seeking non-hospital care in another Member State to obtain prior authorization in order to receive reimbursement of their costs in doing so. However, it did permit states to subject such patients to any other customary conditions and formalities applied to seeking treatment, such as the need to obtain a referral from a general practitioner (GP) in order to consult a specialist. Such a clause may act to restrain patients from certain states, such as the United Kingdom, from ‘leap-frogging’ GP referrals to seek specialist medical advice in another Member State. It is difficult to see how this limitation is compatible with the freedoms to provide and receive services.

The proposed formulation would arguably maintain the present barrier to reimbursement for cross border non-hospital care for patients from Member States whose systems have such requirements, such as the United Kingdom, to seeking care in states in which specialist physicians may be freely consulted, such as France. This could be regarded as a de facto limitation of the types of cross border treatment available to those which are provided by GPs, unless doctors in the state of affiliation are prepared to make referrals to specialists abroad. How restrictive the overall effect of Article 23 would be would depend upon the particular rules of each Member State.

The second paragraph of Article 23 related to hospital care and requires Member States to ensure that authorization for this be granted where:

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"the treatment in question is among the benefits provided for by the legislation of the Member State of affiliation and where such treatment cannot be given to the patient within a time frame which is medically acceptable in the light of the patient's current state of health and the probable course of the illness."69

This wording mirrors the case law and Article 20 of Regulation 883/200470 and it was suggested that Article 23 of the draft directive be altered to contain an express cross reference to that provision.71 The overlap raised the question of the relationship between the two pieces of legislation. This was addressed in the Explanatory Note which explained that Regulations 1408/71 and 883/2004 deal with situations where citizens ask for authorization in relation to seeking cross border care, in relation to either hospital or non-hospital treatment, as part of the overall co-ordination of social security systems for the benefit of persons exercising their free movement rights. In contrast, with regard to non-hospital treatment, the draft directive dealt with the situation where a patient claims reimbursement for non-hospital care received without prior authorization having been obtained. The draft directive also went on to cover the same ground as Article 22 of Regulation 1408/71 in relation to the question of when a state cannot refuse to authorize cross border hospital care "in order to ensure full coherence with [the Regulation]."72

It should be noted that, whilst under the case law patients are no longer required to seek prior authorization in order to claim reimbursement for non-hospital cross border care, they may nonetheless wish to do so under Regulation 1408/71 (and in future Regulation 883/2004) in cases where this would lead to a higher level of reimbursement. In cases where authorization is obtained, the level will be that of the state where treatment is received. Whether this will be higher or lower will simply depend upon the systems of the two states in question.73

69 COM(2004)2, Article 23(2).
71 Explanatory note from the Commission Services on the provisions of the proposal for a Directive on services in the internal market relating to the assumption of healthcare costs incurred in another Member State with a particular emphasis on the relationship with Regulation No. 1408/71, 17/3/2005, p.6, para 2.
72 ibid.
73 ibid., p.6, para 1.
4.4.2.3 The nature of authorization schemes

A further section of the draft directive had implications for the application of Article 22 of Regulation 1408/71. One of the problems with patient mobility has been shown to be the restrictive and closed manner in which many Member States operate their authorization schemes for the purposes of authorizing patients to go to another Member State for medical treatment. Section 2 of the draft directive on services set out conditions to be met by authorization schemes to which access to a service activity are subject.\(^74\) Article 23(4) requires that authorization systems for the assumption of cross border health care costs conform with this section.

Article 8 of the draft directive provided that authorization schemes must be non-discriminatory, objectively justifiable by an overriding reason relating to the public interest, necessary and proportionate. This reflected the jurisprudence on cross border care, and was crucial to the court’s finding that reimbursement for non-hospital treatment could not be made subject to prior authorization. These conditions were a restatement of existing principles and did not alter the position. However, the conditions set out for the granting of authorization could have prompted improvements in the operation of authorization schemes by Member States. The draft directive required that authorization schemes be based on criteria which ensure that decisions are not taken in an arbitrary or discretionary manner.\(^75\) Furthermore, in addition to fulfilling the conditions found in Article 9, criteria for authorization must be precise and unambiguous,\(^76\) objective\(^77\) and made public in advance.\(^78\) In addition, authorization must be granted as soon as it is established that the conditions have been met\(^79\) and full reasons for a refusal or withdrawal of authorization must be given, together with a right of appeal in judicial or quasi-judicial proceedings.\(^80\)

\(^{74}\) COM(2004)2, Articles 9-11.
\(^{75}\) ibid., Article 10 (1).
\(^{76}\) ibid., Article 10 (2)(d).
\(^{77}\) ibid., Article 10 (2)(e).
\(^{78}\) ibid., Article 10 (2)(f).
\(^{79}\) ibid., Article 10 (5).
\(^{80}\) ibid., Article 10 (6).
If health care had been included within the scope of the directive, Member States would have been forced to review and reform their authorization procedures. The greater transparency which would have resulted may have led to an increase in the number of authorizations which are granted for a number of reasons. Firstly, the authorization procedures might have become more widely publicised. Secondly, they may have been more easily challengeable. Finally, in combination with the reframing of the conditions under which a request for authorization for cross border hospital treatment may not be refused, more authorizations may have been granted anyway.

4.4.2.4 The level of reimbursement

Draft Article 23 covered one further area – that of the level of reimbursement. Here, Member States were required to ensure that the level of assumption of their social security system of cross border care costs is not lower than that which would be provided in respect of similar health care provided in their own territory. The Explanatory Note suggested that this provision was only intended to apply to situations in which a patient receives non-hospital treatment in another Member State without authorization, where reimbursement should be made in accordance with the tariff application in the Member State of affiliation. Reimbursement for hospital care, which remains subject to authorization, continues to be dealt with under Regulation 1408/71.

4.4.3 The removal of the provisions on health care from the services directive

Having examined the draft provisions, which were designed to give effect to the Court of Justice’s case law on access to cross border care, possible explanations for their removal from the directive will now be considered. There were a number of reasons why the inclusion of health care in the draft services directive was opposed. Firstly, the draft directive adopted an approach known as the ‘country of origin’ principle to the services

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81 COM(2004)2, Article 23(3).
82 Explanatory note from the Commission Services on the provisions of the proposal for a Directive on services in the internal market relating to the assumption of healthcare costs incurred in another Member State with a particular emphasis on the relationship with Regulation No. 1408/71, 17/3/2005, p.6, para 3.
which fall within its scope.  

This meant that service providers are only subject to regulation in the state in which they are established. Concern was expressed that this would ultimately lead to a lowering of standards or ‘race to the bottom’ in health care and other social services covered by the directive. There was a derogation available in relation to the country of origin principle whereby in exceptional circumstances a Member State may, in respect of a provider established in another state, take measures relating to, _inter alia_:  

“(a) the safety of services, including aspects related to public health;  
(b) the exercise of a health profession.”  

However, the ability to do so was subject to a number of conditions and it was thought that the Court would take a restrictive approach to permitting derogations from the main principle.  

Another concern relating to guaranteeing the quality of cross border services arose from the requirement that Member States take measures to encourage providers to take voluntary action to ensure the quality of service provision. It has been suggested that the adoption of a voluntary procedure in this field would be inadequate and that the directive would dilute governments’ powers to regulate businesses operating on their territories and protect the public sector.  

A further concern relates to the issue of competence for health services. The draft directive has been described as:  

“a significant attempt to increase the EU’s capacity to regulate health and social care within the framework of free-trade rules, [which] envisages the creation of a European-wide  

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84 European Public Health Alliance briefing note to members – Services, Health and the Internal Market, EPHA, July 2004, p.3.  
86 European Public Health Alliance briefing note to members – Services, Health and the Internal Market, EPHA, July 2004, p.5.  
market in health-care services. It is controversial because it raises but does not resolve, issues about the guardianship and direction of health policy in Europe.  

It was also suggested that by seeking to include health services within its scope, the draft directive undermines the reservation to Member States in Article 152 EC, of responsibility for the organisation and delivery of their health care systems. This view was shared by Evelyne Gebhardt who described the inclusion of health services as a contradiction with the division of competences laid down in the public health article. In response to this point the Commission has asserted that the directive does not aim to harmonise Member State’s regulation or mode of delivery of health services or challenge their competence to decide how these should be organised or financed. Despite this claim, fears of creeping competence seem well established.

Additional objections put forward focus on the practical problems of treating health as a service, subject to the rules of the internal market. Davies notes the difficulty in tinkering with the structures of health systems and asserts that, for example, the UK National Health Service is not organised in such a way as to facilitate funding UK patients to receive treatment in other Member States. He also argues that it is difficult for one State’s system to monitor foreign providers for fraud or cost-effectiveness and that allowing a free market in health services may undermine domestic funding arrangements since these are based on assumptions about the numbers of patients which will be treated. Related to this, it is suggested that financial and organisational problems could arise for states experiencing net exports or net imports of patients.

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89 ibid.
93 ibid., p.213.
94 ibid.
95 ibid., p.214.
With regard to these points it should be noted that all EU health systems must have reimbursement mechanisms in place for the purposes of Regulation 1408/71. Concerns about the possibility of fraud are just as relevant to reimbursements under the Regulation as to funding for cross border care under Article 49 of the Treaty, and do not seem to have caused a particular problem in the latter area. Arguments based on capacity planning have been raised in proceedings before the Court and are genuine. However, it can be argued that the incidence of patient mobility would have to increase significantly for the threat to materialise. The same argument applies to concerns about imbalances between health systems.

A final practical concern relates to the effective regulation of health services. At present this is organised on national lines and it has been suggested that it would be logistically difficult to adapt it to a Europe-wide market in health services. However, this is not insurmountable. Issues such as this have formed the basis of the work of the High Level Group on Health Services and Patient Mobility, which is examined in detail in Chapter 5.

Davies also advances a more philosophical objection to the classification of health care as a service, asking whether it is appropriate for a system based on compassion to be subject to economic regulation. This is the dimension which has so far been largely absent from the discussion about the classification of health as a service. In arguments submitted to the Court of Justice, opposition by Member States to the marketisation of publicly run health systems has been expressed mainly in economic terms and the Court has simply said that the special character of health care does not remove it from the scope of the Treaty. However, this may be in the process of changing with the advent of a debate about so-called ‘social services of general interest’ (SSGIs), which will be examined later in the chapter.

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97 ibid.
For all the reasons discussed, the attempt to codify the case law on patient mobility within the framework of the draft services directive failed.\textsuperscript{99} The rejection of the proposition that health care is a service raises serious questions. These include whether the Court of Justice is wrong to treat health care as an economic service, regardless of the basis upon which it is provided, whether the Commission and the Parliament are irreconcilably divided on this point, whether the Court will be influenced by the furore surrounding the inclusion of health care in the original draft of the services directive and how the institutions can ensure that Member States comply with the case law whilst it remains uncodified. One of the recitals to the amended draft directive states that:

"This directive does not affect the reimbursement of healthcare provided in a Member State other than that in which the recipient of the care is resident. This issue has been addressed by the Court of Justice on numerous occasions, and the Court has recognised patients' rights...".\textsuperscript{100}

Together with the expressed commitment to bringing forward separate legislation on patient mobility, this statement of the Commission seems imbued with frustration at being thwarted in its second attempt to fully codify the patient mobility case law. If the Commission is to fulfil its commitment in this regard it will need to find a new approach to doing so which is politically acceptable to Member States, the Council and the European Parliament. One possibility would be to develop a special legal framework for social services of general interest. This will now be considered.

4.4.4 Developing a new legal framework for social services of general interest

4.4.4.1 Services of general interest and social services of general interest

In addition to the introduction of the draft services directive, in a further initiative the Commission has sought to generate a debate about the role of the EU with regard to

\textsuperscript{99} Council Directive 2006/123/EC on services in the internal market was duly adopted and will come into force on 28 December 2009

\textsuperscript{100} COM(2006)160, Recital 10d, p.22.
services of general interest'. In the relevant White Paper these are described as both economic and non-economic services which are classed by the Member States as of general interest and which are as a result made subject to specific public service obligations.\(^1\)

The concept of 'general interest' may be understood as meaning 'in the interests of society or the community'. It has been suggested that whilst most services of general interest involve the implementation of activities of an economic nature, the key to differentiating them from normal economic services is that the objectives of the former activities are not purely economic.\(^2\) It is argued that because of the special nature of the effects of such services, they should not be subject to a market approach.\(^3\) The notion has been used to cover sectors such as transport, postal services, energy and communication and also social services such as health care and education. In relation to such services, the Commission has identified a consensus amongst Member States on the need to ensure:

"the harmonious combination of market mechanisms and public service missions."\(^4\)

Whilst economic services of general interest are covered by the draft services directive, non-economic ones are not. It is recalled that health care was included in the original draft directive as an economic service of general interest. However, the amended proposal removes health and social services from its ambit and clarifies its scope in relation to services of general interest.\(^5\) In particular, it is stated that the draft directive does not provide for liberalisation or privatisation of such services or address their funding or state aid.\(^6\)

In the White Paper on services of general interest, health care is described as a 'social service of general interest'\(^7\) (SSGI) and the Commission stated the intention to issue a

\(^3\) ibid., p.111.
\(^6\) ibid., p.3.
\(^7\) COM(2004)374, p.16
further communication on SSGIs in order to identify and recognise the specific characteristics of social and health services, the framework within which they operate and can be modernised.\textsuperscript{108} For example, social services are characterised by an informational asymmetry between the provider and recipient which means that procedures need to be in place to ensure the quality of the service.\textsuperscript{109} Furthermore, they are based on a series of cross-subsidies between different parts of the population such as the young and the old, the well and the ill and those in work and the unemployed; in other words upon social solidarity between groups.\textsuperscript{110} Due to these characteristics social services can be threatened by market forces, for example where cost containment policies restricting the supply of hospital treatment is undermined by patients seeking private or cross border care at the expense of their health system.\textsuperscript{111} The decision to focus on SSGIs suggests that the Commission might favour taking a different legal approach to such fields from that which applies to services generally. The removal of health and social services from the draft services directive is consistent with this view.

4.4.4.2 The reaction of the Member States

To facilitate the preparation of a communication on SSGIs the Commission issued a questionnaire on the subject to the Member States.\textsuperscript{112} The Public Health Working Party has described this exercise as necessary to clarify the relation between internal market rules and the national organisation of SSGIs.\textsuperscript{113} This view recognises the tension which has developed as a result of the Court of Justice's approach in treating certain social services, such as health, as economic services within the meaning of the Treaty.

\begin{itemize}
\item \textsuperscript{108} COM(2004)374, p.17. The Commission has since issued a Communication on social services of general interest, COM(2006)177, however, health services were in fact excluded from its remit and will instead be dealt with in a separate initiative during 2007, see COM(2006)122 p.11.
\item \textsuperscript{110} Mossialos, E. and McKee, M., EU Law and the Social Character of Health Care, P.I.E - Peter Lang 2002, p.207.
\item \textsuperscript{111} ibid. p.208.
\item \textsuperscript{112} http://europa.eu.int/comm/employment_social/social_protection/docs/questionnaire_en.pdf, June 2006.
\item \textsuperscript{113} Outcome of Proceedings of Public Health Working Party Meeting of 23/11/04, p.2.
\end{itemize}
The SSGI questionnaire was accompanied by a background document in which one of the aims of the exercise was stated to be a clarification of the difference between economic and non-economic service activities. In this regard, the distinction is drawn between the provision of health services on the one hand, and the bodies responsible for financing and organising that provision on the other, on the basis that the former is economic but the latter are not necessarily so. The implication is that it is the nature of a service rather than of its provider which brings it within the scope of internal market regulation. In addition, the background document asserted that:

"the presence of an element of solidarity, the pursuit of social objectives or the non-profit nature of the provider do not rule out the possibility of carrying out an economic activity."

A number of Member States have used their responses to the questionnaire to express concerns about the classification of health as an economic service. For example, the Belgian response seeks further clarification from the Commission as to whether free access to health services prevents them from being considered the object of remuneration. It further identifies as a problem the balance between the Treaty provisions on the freedom to provide services and the competence of Member States over the organisation of their social security and health systems. Concern is expressed that an unfettered application of internal market principles may affect the realisation of Member States' objectives in these fields. This view is shared by Ireland which argues that the classification of health services as an economic activity may create legal uncertainties which may interfere with the ability of Member States to meet their health policy goals.

The German response is robustly opposed to interference by the Community in non-economic services of general interest. The response states that the EU should recognise and ensure that social services, including health care, fall within the responsibility of the

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115 ibid., p.7.
116 ibid., p.5.
117 All the responses can be found at: http://europa.eu.int/comm/employment_social/social_protection/answers_en.pdf, June 2006.
Member States and that the delimitation between economic and non-economic services should be improved. Meanwhile, Poland believes that, due to their unique character, certain services of general interest such as education and health, should not be regulated by EU law. In addition it is argued that the considerable economic, social and cultural differences between states preclude strict Community legal regulation in the social sphere.

The Swedish response asserts that the jurisprudence on cross-border care has created problems for national health services, such as the Swedish system. In particular it is noted that to maintain a well-functioning publicly-funded health service the responsible agencies must be able to estimate care needs otherwise there is a risk that the system may experience over or under capacity. Furthermore, the reimbursement of cross border care costs is seen as an extra financial burden on the Swedish health care system.

Finally, the United Kingdom’s response is even more explicit in its opposition to the application of the principles established in the jurisprudence on cross border care to national health service-type systems, stating categorically that the NHS does not provide Treaty-regulated services. However, this issue is yet to be determined by the Court of Justice.118

4.4.4.3 The status of health services in EU law

The responses to the questionnaire on SSGIs once again demonstrate the degree of opposition to the classification of health care as an economic service. In doing so they reflect the clash between the neo-liberal and social cohesion models of social policy which, it has been argued, arises from the simultaneous pursuit at EU level of these two divergent

118 This was one of a number of questions referred to the Court of Justice in Watts. The rationale given for this assertion is that NHS bodies do not provide economic services within the meaning of Articles 49 and 50 EC because their services are provided on a not-for-profit basis, for no remuneration. The previous jurisprudence is distinguished on the basis that the NHS is financed out of general taxation rather than the insurance-based models found in the Member States concerned. In fact, the Court found it unnecessary to rule on this point. See Chapter 3 for a full discussion of the Court’s judgment in Case C-372/04 Watts [2006] ECR I-4325.
They also highlight definitional confusion in the initiatives and proposals emanating from the Commission in terms of the different descriptions for various kinds of service, and the relationship between the draft services directive and the White Paper on services of general interest. The present position leaves some doubt over the definition of health services as they appear to be regarded as being economic, social and of general interest at the same time. This difficulty is summarised by Jorens et al who note that:

"It would be contrary to the special status of health care in the Member States to characterise this sector as purely economic, as there is considerable consensus in the European Union that health care has specific characteristics to which the market is unable to respond accurately. On the other hand, qualifying health care as a genuinely non-economic service does not match reality either, as e.g. the Court confirmed several times 'health care provision' is an economic activity....".

The confusion about the status of health care which was raised by the overlap of the original draft services directive and the proposals on services of general interest was considered in a report on health services and the internal market by the European Health Policy Forum (EHPF).

The EHPF firstly noted that there is no clear definition either at national or EU level of the concept of services of general interest (SGIs) as applied to the health sector. It argued that health services have six special characteristics which must be taken into account by the EU institutions: access to health care is a fundamental right, health services have a clear general interest aim, the primary principle applicable to health services is solidarity, health

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121 This body, which is composed of representatives from public health non-governmental organisations, patient’s organisations, bodies representing health professionals, trades unions, health service providers and health insurers, was created in 2001 to advise the Commission on health matters.
services usually require the intervention of a third party, patients are not ordinary consumers and health providers are not ordinary service providers.\textsuperscript{123}

In relation to the jurisprudence on cross border care, the EHPF believes that as the judgments relate to exceptional situations, rather than the general way in which health care is accessed, the risk of undermining the financial stability of national health services should be avoided.\textsuperscript{124} It was suggested that health services should be excluded from the services directive and instead be considered within the debate on the framework for SGIs.\textsuperscript{125} Furthermore, any definition of SGIs should allow Member States to meet their public health objectives by protecting the viability of their health systems.\textsuperscript{126} However, it is also feared that the draft directive could limit the policy space available for any initiative on SGIs.\textsuperscript{127}

In relation to SGIs generally, the EHPF asserted that because these are linked to the function of welfare and social protection they are clearly a matter of national, regional and local responsibility. In terms of division of competence the role of the EU should be limited to promoting co-operation and co-ordination.\textsuperscript{128} The EHPF believes that the distinction between economic and non-economic SGIs is unhelpful, contending that:

"the all-encompassing definition of what constitutes ‘an economic activity’ is an over-application of Court of Justice rulings [which] results in the introduction of internal market principles into sectors and policies that have been firmly excluded from EU competence by the EU Treaty."\textsuperscript{129}

The observations and recommendations of the EHPF are one possible way to resolve the present confusion, however it is one which relies upon taking a somewhat circumscribed view of the Court’s judgments in the field of health care costs and fails to directly address

\textsuperscript{123} European Health Policy Forum, Recommendations on Health Services and the Internal Market, 2005, p.8.
\textsuperscript{124} ibid., p.15.
\textsuperscript{125} ibid., p.16.
\textsuperscript{126} ibid., p.12.
\textsuperscript{127} ibid., p.14.
\textsuperscript{128} ibid., p.11.
\textsuperscript{129} ibid.
the Court's view that health care is an economic service. However, the alternative approach suggests that there is a case for specific legal recognition of SGI's with a modified application of internal market rules.\textsuperscript{130} On this view it is possible for services such as health care to remain within the regulatory framework of the Treaty, whilst at the same time being distinguished from pure economic activity. The Platform of European Social NGOs has recently expressed support for the proposition that a specific legal instrument for social services of general interest should be developed, with the aim of setting out how social services should be dealt with in EU law.\textsuperscript{131} They suggest that one type of instrument which may be appropriate is an 'Interpretative Communication' giving guidance to the Court of Justice on how to apply EU law to social services. This proposal may indicate an underlying concern about the Court's approach to cross border care.

Whilst it had been anticipated that social and health services of general interest would be dealt with together by the Commission in a single communication, following the exclusion of health services from the draft services directive, the Commission decided to issue a policy paper on social services of general interest alone.\textsuperscript{132} It appears that the development of a policy on health services of general interest has now been tied in with the Commission's separate commitment to produce specific legislation codifying the case law on access to health care in 2007.\textsuperscript{133} This latest development, in relation to which a consultation process is underway, will now be considered in the next part of the chapter.

4.5 The third approach – specific legislation in the field of health care

The third approach is to introduce specific legislation to codify the case law on patient mobility. This course of action was suggested in a number of amendments tabled to the


\textsuperscript{131} Platform of European Social NGOs, 'Making the Communication on Social and Health Services of General Interest a tool for high quality social services in Europe: A contribution from the Social Platform', April 2006, p.6.

\textsuperscript{132} COM(2006)177.

\textsuperscript{133} ibid., p.3.
draft services directive by Committees and members of the European Parliament.\(^1\)

As previously noted, following the removal of the proposed provisions relating to access to cross border care from the draft services directive, the Commission has confirmed its commitment to producing a 'specific initiative' on health services\(^1\) and it is possible that the draft provisions may form the basis of this future legislation. However the choice of legal basis for the measure is less obvious. Any new legislation brought forth must be shown to be within the competence of the EU by having a clear legal base within the Treaty. The main question with this third approach to codification is that of its location within the overall legal framework of the EU.

The removal of health services from the ambit of the services directive demonstrates that it is politically unacceptable to the European Parliament to classify health care in this way. However, it must be noted that (ironically) it was the Parliament which attempted to add the full range of patient mobility rights to the new regulation on social security co-ordination and it is clear from this that the Parliament supports codification in principle. The unease of many Member States on the same issue is seen in comments on social services of general interest, assessed later in this chapter. This background may preclude not only Article 49 itself as a legal basis but also any other article which permits the introduction of legislation to facilitate the internal market such as Article 95.

Equally, the Council has vetoed the insertion of the new case law rights in respect of cross border non-hospital care into the regulation on the co-ordination of social security, maintaining that this should be dealt with in specific legislation. The reasons for this are not stated other than a reference to the fact that the new entitlement represents a restriction on Member States ability to control patient mobility. However, it can be argued that the case law does go beyond a mere co-ordination of social security systems and that it is inappropriate to simply add these into that legislation. There is nonetheless a contradiction

\(^{134}\) For example, in the Opinion of the Employment and Social Affairs Committee, 19/7/2005 and that of the Committee on the Environment, Public Health and Food Safety, 17/3/2005.

in this position as the other new principles have been incorporated into the new social security Regulation.\textsuperscript{136}

These two stumbling blocks have led the Commission to decide to pursue the third approach but this is not without its own problems. The fact that the Court has based its case law on Article 49 and, to some extent, Article 22 of Regulation 1408/71, may mean that it makes little sense for a codification of that case law to have an entirely different legal basis. One suggestion has been that, to overcome criticisms that the inclusion of health care provisions in the draft services directive constituted an attempt to extend the EU’s powers in the area in a manner incompatible with Article 152, the provision could be amended and form the legal basis of the new legislation. The merits of this approach will now be considered.

\textbf{4.5.1 Expanding the scope of EU competence under Article 152 EC}

The cases on patient mobility are seen as presenting a challenge to the reservation of competence over health care to Member States found in the fifth paragraph of Article 152 EC. It can be argued that, in the absence of Treaty powers, the Court of Justice has used the free movement of services to promote health care integration across the EU.\textsuperscript{137} This has produced an uncomfortable situation from the point of view of the demarcation of competence. Berman contends that whilst most Member States have misgivings about direct EU involvement in health care they recognise that Article 152’s limited focus on public health is not sufficient to cope with the aftermath of the Court of Justice’s rulings on access to cross border care.\textsuperscript{138} As the Court of Justice can only interpret the law as it stands, it is suggested that in order to achieve an outcome to such cases which pays more


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attention to issues such as solidarity and territoriality, the law itself must be changed in order to embed the social character of European health systems in the Treaty.\textsuperscript{139}

The political difficulty of extending the EU’s competence over health services is great. Member States are resistant to creeping competence in this area and when the opportunity arose to do so during the drafting of the Constitutional Treaty, this was not taken up. It can be argued that, as patient mobility is likely to affect only small numbers of people, it should not determine the expansion of EU competence and that it would be better for Member States to simply create bi-lateral or multi-lateral agreements between themselves on cross border care.\textsuperscript{140} However, there is also a strong counter argument. In particular, it can be claimed that the EU ‘adds value’ in terms of health protection and access to health care, and that the ring-fencing of health care cannot continue in the face of the reality of the impact of internal market regulation in the area. Rather, it is argued that it would be to better to accept this reality and amend the Treaty to reflect the valid aspirations of EU citizens to receive effective health services.\textsuperscript{141}

The advantage of using an amended Article 152 as the legal basis for codifying the case law on patient mobility is that it would overcome the problem of defining it as a service. Furthermore, it would mark a departure from patient mobility being a spillover from internal market regulation. Instead, in an expanded competence, the rights to cross border care would be autonomous, representing a shift to a rights-based approach in keeping with the increasing importance of fundamental rights within the EU legal order. It would also avoid pushing the regulation on the co-ordination of social security beyond its comfortable scope. The drawback is the inevitable resistance of Member States to such a course of action. Member States would need to be convinced that in order to protect health services from market forces they would need to permit an increase of EU competence in relation to them, that, paradoxically, expanding EU competence may protect national interests. In


\textsuperscript{140} Berman, P., ‘The EU, Health and Article 152: Present imperfect; future perfect?’ (2002/03) 8 eurohealth 7.

\textsuperscript{141} ibid.
support of this it may be argued that the inclusion of the fifth paragraph of Article 152 has not, in practice, had the desired effect of protecting the total autonomy of Member States over their health care systems and that a new approach is necessary to prevent further erosion. In particular, the deregulatory effects of the application of internal market principles have created a gap which needs to be filled by re-regulation through the reform of Article 152.

A further possibility put forward by the Commission in its recent Communication on Community action in relation to health services, is to base health care-specific legislation on Article 95. The Communication and the scope of the consultation process launched by it, will now be assessed.

4.5.2 The 2006 Communication regarding Community action on health services

The Commission consultation on action on health services was launched in September 2006 in a Communication issued by the Public Health and Consumer Affairs Directorate. In the introduction to this document, the Commission seeks to construct and justify a role for the EU in relation to health care by drawing support from a number of directions.

Firstly, it is asserted that health services are a priority for European citizens. Secondly, it is noted that rights to health care are recognised in Article 35 of the EU Charter of Fundamental Rights. Thirdly, the finding by the Court of Justice that Article 49 EC applies to health services regardless of how they are organised or financed at national level is rehearsed. A fourth observation is that a Community strategy on health services is consistent with the White Paper on services of general interest and the Communication on social services of general interest. Finally, the Communication cites reports of the European Parliament and the Council in support of action in the health field. Later in the

\[\text{SEC(2006)1195/4, Communication from the Commission, Consultation regarding Community action on health services, 26 September 2006. Responses to the consultation have been received from the national and regional authorities of the Member States, European institutions and national parliaments, national and international organizations, commercial organizations, universities and citizens and can be found at: http://ec.europa.eu/health/ph_overview/co_operation/mobility/results_open_consulation_en.htm#1, April 2007.}\]
Communication, reference is made to the two policy processes which have been applied to health care and which are discussed in Chapter 5 of this thesis, namely; the open method of co-ordination and the informal co-ordination led by the High Level Group on health services and medical care.

Thus, the Commission situates action on health services within the contexts of citizenship, fundamental rights, the free movement of services, and services of general interest, demonstrates cross-institutional support for it and links it to the relevant policy initiatives which have also been driven by the Commission. In bringing all these factors together, a case is made for an enhanced role for the EU in relation to health care. However, as the responses to the consultation on the regulation of social services of general interest discussed earlier in this chapter show, many Member States are highly resistant to interference with their competence over the organisation and delivery of their health services and the extent to which Member States will be receptive to these arguments remains to be seen.

The Communication contends that Community action in this field should be based upon two pillars; legal certainty and support for Member States. With regard to the question of legal certainty, the Commission believes that whilst the individual decisions of the Court of Justice on patient mobility are clear:

"...it is necessary to improve clarity to ensure a more general and effective application of freedoms to receive and provide health services".143

A number of areas which need such clarification are identified including: whether there are EU-wide shared values in relation to health care; how to reconcile greater choice for individuals with the financial sustainability of health systems; and how to enable patients to identify and assess the suitability of health care providers in other Member States.144

144 ibid.
In addition to focusing on issues relating to patient mobility the Commission asserts that:

"European action on health services will necessarily also contribute to the wider challenges facing health systems, beyond the specific case of cross-border healthcare itself."\textsuperscript{145}

The Commission argues that the usefulness of European co-operation in relation to health care is already seen in the sharing of resources in border areas, and in the practice of smaller states having arrangements with larger states for the use of specialist facilities. The Commission concludes that the lessons from existing forms of co-operation should be taken into account in future Community action.\textsuperscript{146} The Communication goes on to set out a series of questions which are to form the basis of the consultation exercise. The first of these seeks to ascertain the current impact of patient mobility on the accessibility, quality and financial sustainability of health care systems\textsuperscript{147} and to consider how this might evolve in the future.\textsuperscript{148} Questions 2 to 4 relate to the first pillar of legal certainty and revolve around the practical problems posed by patient mobility, such as what information is required by the parties to ensure safe, high quality and efficient cross border care,\textsuperscript{149} which state is responsible for issues such as clinical supervision and patient safety, and how can patients seek redress if they are injured.\textsuperscript{150}

In contrast, Question 5 addresses the concerns of Member States about maintaining the financial stability of their health systems,\textsuperscript{151} and Question 6 relates to the free movement of health care providers.\textsuperscript{152} The seventh question asks whether there are any other areas where legal certainty could be improved to facilitate patient mobility.\textsuperscript{153}

\textsuperscript{145} SEC(2006)1195/4, p.5.
\textsuperscript{146} ibid., p.5-6.
\textsuperscript{147} Note that these are the three areas which have been identified as the focus for the application of the open method of co-ordination to health care. This process is examined in detail in Chapter 5.
\textsuperscript{148} SEC(2006)1195/4, p.7
\textsuperscript{149} ibid.
\textsuperscript{150} ibid., p.8.
\textsuperscript{151} ibid.
\textsuperscript{152} ibid., p.9.
\textsuperscript{153} ibid.
Moving on to support for the Member States, the Communication sets out some of the ways in which co-operation is taking place in the field and asks, in an eighth question, how European action should be best be used to support the health systems of Member States and the different actors within them. With regard to supporting co-operation between Member States in the field of health care, the Communication notes the progress made under the auspices of the High Level Group on health services and medical care but suggests that:

"a more formal framework at the EU level is needed to ensure that these actions will be implemented effectively and on a sustained basis."

Finally, the Communication focuses on the means by which action on health services should be taken. The Commission clearly favours legislation, asserting that legal certainty would be best ensured by a binding legal instrument. In particular, it is proposed that either a regulation or a directive could be used. Interestingly the Commission also suggests that Article 95 EC, a provision which allows legislation to be introduced to facilitate the smooth running of the internal market, could be used as a possible legislative base. However, due to its market orientation, it can be argued that this approach may lead to similar problems to those encountered in the failed attempt to codify the patient mobility case law within the services directive. In addition, the suggestion raises questions about the scope of future legislation in the field of health care. Article 95 provides for the approximation of provisions laid down by law, regulation or administrative action in Member States, where the object of the approximating measure relates to the establishment and functioning of the internal market. This could include, for example, legislation codifying the patient mobility case law. Dashwood believes that whilst it should usually be possible to tell whether an approximation measure under Article 95 is genuinely designed to remove hindrances to free movement, it is in the use of Article 95 as a legislative base:

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155 The High Level Group on health services and medical care is responsible for overseeing an informal co-ordination process in which the Member States participate on a range of matters relating to the delivery of health services. This process is considered in detail in Chapter 5.
157 ibid., p.10.
In relation to the competence of the EU to enact legislation in relation to health care it should be noted that the public health Article 152 explicitly excludes harmonisation in relation to measures designed to protect and improve human health. However, Wyatt believes that, despite placing some limits on Community initiatives in the public health field, Article 152 does not limit the scope of Article 95. He further argues that a measure primarily concerned with health protection could be based on Article 95, provided that it made some contribution to the internal market, for example, by eliminating likely barriers to the free movement of services and suggests that such a measure could cover matters such as ranges of treatment offered, maximum waiting times and remedies against health care providers.

The question of the use of Article 95 as a base for a public health-related measure was addressed by the Court of Justice in the challenge brought by Germany to the Tobacco Advertising Directive. Here, the Court held that Article 152 did not preclude the adoption of harmonising measures which had some impact on the protection of human health, on the basis of other Treaty provisions, but added that, equally, other articles could not be used as a means of circumventing the exclusion of harmonisation set out in Article 152. Any legislation in the health field which goes beyond regulating patient mobility, would have to avoid falling into this trap.

The Communication also outlines possible non-legislative options highlighting the two co-ordination processes which will be examined in Chapter 5. However, whilst the

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159 Article 152(4)(c), EC Treaty.
161 ibid.
Commission describes these as valuable in taking forward the practical agenda, it believes that they will not provide the legal certainty needed by patients and health care providers.\(^{164}\)

Concluding this discussion, the Communication moots the possibility of a mixed approach, with some areas being addressed through legislation and others through soft law mechanisms and Question 9 seeks views on how such a division might be made.\(^{165}\)

The Commission has indicated that it will produce a summary report of the responses to the consultation. In the meantime, a brief preliminary survey of nine Member State responses is revealing.\(^{166}\) The Member States take the opportunity, once again, to affirm their competence in relation to health services as set out in Article 152(5). For example, the German response states that:

"Member States' exclusive responsibility for organising and financing their national healthcare systems must be respected and may not be eroded."\(^{167}\)

In a similar vein, Spain asserts that:

"it must be made clear that the principle of subsidiarity applies, that organisational responsibility lies with the Member States and that there is no question of harmonising health services in the EU treaties at present."\(^{168}\)

The UK goes even further, describing the responsibility of Member States for health care as a fundamental right.\(^{169}\)

\(^{164}\) SEC(2006)1195/4, p.11.

\(^{165}\) ibid.

\(^{166}\) All responses to the consultation on Community action on health services can be found at [http://ec.europa.eu/health/ph_overview/co_operation/mobility/results_open_consultation_en.htm#1, April 2007.](http://ec.europa.eu/health/ph_overview/co_operation/mobility/results_open_consultation_en.htm#1)

\(^{167}\) p.2, Response of the German government to the Consultation on Community action on health services, [http://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/health_services_co118_en.pdf, April 2007.](http://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/health_services_co118_en.pdf)


\(^{169}\) para 2, Response of the UK Government to the Consultation on Community action on health services, [http://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/health_services_co183.pdf, April, 2007.](http://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/health_services_co183.pdf)
The responses to the consultation studied generally show support for codifying the patient mobility case law, however, five states are unhappy with the present distinction between hospital and non-hospital care and believe that this requires further thought and clarification prior to any codification. In terms of how best the principles might be codified, various suggestions are made such as, incorporation into Regulation 1408/71, amendment of Regulation 883/2004 and the introduction of a specific framework directive. There appears to be little consensus on this point from the sample of states taken. Finally, although all nine states see value in informal co-operation in relation to health care matters, only two, Italy and Spain, seem prepared to countenance putting this on a legislative footing. The majority of states sampled favour continuing with the existing policy co-ordination mechanisms which are examined in Chapter 5.

Although the main thrust of the Communication relates to codifying the case law to increase legal certainty, there are clear indications that the Commission would like to see the development of a legislative framework in relation to health care which goes beyond a mere codification of the patient mobility principles. The brief survey of the responses of nine Member States gives an indication of some of the resistance the Commission faces in extending Community action in the health care field. Nevertheless, in conducting this consultation the Commission shows strong support for the ability of patients to access cross border treatment and explicitly links this to the fundamental right to healthcare. Overall, the Commission's desire to introduce health care-specific legislation can be regarded as a sign of a shift away from a neo-liberal conception of patient mobility as a spillover from internal market integration, towards a more rights-based approach in that it seeks to establish a separate legal framework for the rights of patients rather than leaving the area to be governed by a series of case law principles based upon the free movement of services.
4.6 Conclusions

In this chapter it has been seen that one of the effects of the case law on patient mobility has been to spark a series of legislative initiatives aimed at codification in order to increase legal certainty for patients and providers. The legislative initiatives examined in this chapter, in particular, the attempt to include draft provisions in the services directive codifying the various principles established by the Court of Justice in relation to obtaining reimbursement for the cost of cross border health care, and the new regulation replacing Regulation 1408/71, arose at least partly as a response to concerns about the lack of compliance by many Member States with the case law principles governing patient mobility. However, the situation of the cross border health service recipient has always sat uncomfortably within the context of social security co-ordination which is primarily for the benefit of those exercising less short-term free movement rights. Equally, it has proved politically impossible to codify the case law within the framework of the services directive. Instead it has been argued by the Commission that it would be a better legislative solution to introduce health-specific legislation drawing together all the provisions on patient mobility to provide a coherent legal framework for patient mobility.

The somewhat disjointed approach shown by the Commission in trying to introduce legislation in this area is explained by Greer in the following terms:

"The routes by which the three DG’s entered health care are...a testament to spillover. Employment and Social Affairs entered through its broader task of regulating the work place and DG Internal Market and Services through its broader regulation of buying and selling. DG Health...suffers from the fact that there is no significant EU health competence."\(^{170}\)

Any dedicated legislation in relation to health care must overcome limitations in competence. A number of possibilities have been examined. Firstly, the scope of EU

competence could be extended by amending Article 152, however this seems politically unlikely due to concerns about creeping competence. A second possible route considered would be to base such legislation upon principles being developed in relation to social services of general interest but this will require further work to be done in that area. Thirdly, it has been seen that the consultation on Community action in relation to health care suggests Article 95 EC as a possible legal basis for a regulation or directive in the field. However, this may be problematic in light of the controversy surrounding the attempt to include health care in the services directive and due to the need for legislation based on Article 95 to be tied to the aim of improving the functioning of the internal market.

A further problem identified in codifying the case law, highlighted in the responses of Member States to the consultation, is the lack of confidence in the meaning of particular aspects of the decisions on cross border care such as the distinction between hospital and non-hospital treatment, and the desire for further thought to be given to refining these points prior to their incorporation into legislation.

In the meantime, the failure thus far to fully codify the case law on patient mobility does not nullify the principles established by the Court of Justice in this area. The effect is to leave the Court of Justice in the driving seat as far as developing the law in relation to cross border care is concerned. So far, it has not shied away from this role and Cabral believes that:

"...one thing is certain: if the Community legislature does not take it upon itself to assume its responsibilities in this domain, then the Court itself must do so."172

Arguably, the incremental development of essentially individual rights as a spillover from internal market policy cannot, on its own, provide satisfactory legal certainty in relation to

171 Berman suggests removing the fifth paragraph of Article 152 to send a political signal to Member States. Berman, P., 'The EU, Health and Article 152: Present imperfect; future perfect?' (2002/03) 8 eurohealth 7.
cross border rights to health care. The movement to further develop and define a regulatory framework of services of general interest and, in particular, the advent of a new category of 'social services of general interest', demonstrates the existence of an ideological counterbalance to the neo-liberal goal of an unfettered opening up of the services market. This is invariably expressed in terms of the defence of the European social model and illustrates the discomfort surrounding the classification of public services such as health care which are based on notions of solidarity, as economic services within the internal market.

The case law on cross border care and the subsequent attempt to include related provisions in the services directive may have heightened divergence over whether or not health care should be treated as an economic service. As rights to cross border care epitomise the dichotomy between individual economic rights and collective interests based on social solidarity, this goes to the heart of the debate about the future direction of European social policy. It is suggested that the proposed introduction of specific legislation on cross border care may represent a shift away from seeing patient mobility as a spillover from internal market integration, towards a more rights-based approach. In particular, the Commission's consultation on Community action on health services sets out the case for a legislative framework which goes beyond a codification of the case law into the regulation of co-operation between Member States in this regard, and which acknowledges that access to health care is a fundamental right. Together with the policy developments examined in the next chapter, this forms a strategy to enhance the role of the EU in relation to health care, and to address it as a free-standing area of law and policy. However, the issue of limited competence remains a problem in pursuing this aim.

5.1 Introduction

In the last chapter, the impact of the case law on cross border care in the legislative field was examined. In addition to those developments, a series of policy initiatives relating to health care have emanated from the Commission in recent years and this chapter will assess the impact of the patient mobility case law in this regard. In particular, two areas will be considered. The first of these, a process of informal co-ordination in the field of health care co-operation, arose directly from the case law, initially in the form of a Commission-sponsored reflection process on patient mobility. The second initiative, namely, the application of the open method of co-ordination (OMC) to health care, had its roots in the modernisation of social protection in the EU, which became part of the strategic ‘Lisbon Process’, but has since been expressly linked to the process of informal co-ordination by the Commission.

It will be argued that the case law on access to cross border care has been a significant factor in the development of these policies on health care, by providing the Commission with the opportunity to become more involved in the area due to the cross border dimension and implications of patient mobility. Furthermore, the case law has been used as a way of justifying the need for a role for the EU in an area of activity, control over which the Member States have consistently indicated should be reserved to themselves. Despite this, it will be seen that the Member States are now participating in the two processes introduced above, under the leadership of the Commission. The nature and scope of these processes will now be examined.

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5.2 The informal co-ordination of health care policy

5.2.1 Responses to the case law on cross border care

The origins of this policy movement can be traced back to the preparation, on behalf of the Commission, of an extensive report on the implications of recent jurisprudence on access to cross border care, on the co-ordination of health care protection systems. The Report concluded that proactive policy measures on the part of the Member States with the support of the Commission would improve access to health care for European citizens. Three areas in which such policies could usefully be adopted were suggested; the first of these was that of cross border co-operation in border areas. The Report had studied certain existing cross border schemes and noted various features of these. It recommended that co-operation could be promoted between individuals and institutional health providers to ensure even levels of provision, underpinned by agreements setting criteria for authorization, quality, cost and reimbursement. Furthermore, co-operation could be encouraged between health care systems and action could also be taken at European level in the form of a recommendation on conditions for cross border care in border areas.

The second area in which the report recommended a proactive policy was in relation to so-called ‘centres of excellence.’ The term was used to denote hospitals or other medical institutions offering specialised or advanced treatments, often for relatively rare conditions. By its nature, such provision will usually not be widely available and the most advanced treatments may not be equally-well developed in all Member States. Questioning the extent to which “a rigorously applied principle of territoriality” would be able to meet the specific requirements of patients requiring such services the report recommended the development

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4 ibid., p.139.
5 ibid., p.67.
6 ibid., pp.140-141.
7 ibid., p.142.
8 ibid., p.143.
of a “European high-tech health care network”\(^9\) within the existing legal framework but with an increase in the use of bilateral agreements between Member States. One feature of such a network would be for health systems to require patients to use specialist facilities within other Member States where none existed nationally, rather than authorizing treatment outside the EU. Whether such a restriction would always make sense geographically is not discussed.

The final area where action was recommended was in relation to updating Regulation 1408/71.\(^{10}\) In addition to bringing it in line with the case law, the Report recommended raising awareness of the instrument.\(^{11}\) The conclusions of the report were fairly modest in terms of policy recommendations. None of the suggestions in the AIM Report could be described as radical or implied major legal developments. This may in part be due to the fact that report was produced by a health insurer, on behalf of the Commission, rather than by the Commission itself. It may also be attributed to two further factors: the recognition that there is no general Treaty basis for action at EU level in relation to health service provision, rather there is a reservation in Article 152(5) of responsibility for health service provision and delivery to the Member States, and the assessment that cross border care was, with the exception of Luxembourg, statistically insignificant for Member States, with most instances occurring in border regions.

At this point in time it appeared that the case law on cross border care would prompt no more than an adjustment to the legislation co-ordinating social security systems, and a continued, but isolated focus on border regions and cases where it was necessary for a Member State to send a patient abroad for specialist treatment unavailable at home. However, in practice a new emphasis was to be placed on health care by both the European Council and the Commission. On the basis of the Lisbon European Council’s declaration in March 2000 that the social protection systems of the EU were to be modernised, and to support the Council in meeting the subsequent request by the Goteborg European Council


that a report on orientations in the field of health care be prepared, the Commission put forward a Communication on the future of health care provision and long term care for the elderly in December 2001.\textsuperscript{12} In this document three major objectives were identified in relation to national health systems; the improvement of accessibility, quality and financial sustainability.\textsuperscript{13} These goals were subsequently approved by the Barcelona European Council in March 2002.\textsuperscript{14}

December 2001 also saw the publication of a report on the internal market and health services by the Commission's High Level Committee on Health.\textsuperscript{15} The report makes a number of recommendations for the development of EU health policy, which it describes as being in its infancy and in need of greater prioritisation.\textsuperscript{16} The rationale given for a proactive health policy is the need to push health care policy interests to the fore, rather than allowing economic considerations to dominate. Concern is also expressed that a:

"Lack of consensus and consequent inaction at a political level, mean that more and more issues have been decided by the European Court of Justice which is therefore put in the position not only of interpreting the Treaty but \textit{de facto} of making health policy by defining the influence of EU regulations on health care."\textsuperscript{17}

The Committee's conclusions and recommendations echoed those of the AIM report and contained a number of further suggestions. These include: promoting convergence and coherence between Member States in relation to cross border care, developing a common framework for quality standards and best medical practice, improving data protection in relation to the transfer of patient and clinical information in a confidential manner, making full use of the EC public health programme to underpin new health policy initiatives and

\textsuperscript{12} COM(2001)723 final.
\textsuperscript{13} ibid., p.9.
\textsuperscript{14} Presidency Conclusions of the Barcelona Council, March 2002, p.9.
\textsuperscript{15} 'The Internal Market and Health Services' Report of the High Level Committee on Health, European Commission, 17.12.2001. The High Level Committee on Health is a body composed of experts which advises the Commission services on matters of health policy.
\textsuperscript{16} ibid., p.22.
\textsuperscript{17} ibid., p.23.
obtaining the advice of the European Health Forum\textsuperscript{18} and ensuring the inclusion of the views of all the public health community in the development of EU health policy.\textsuperscript{19}

Furthermore, the Committee acknowledged that in addressing these issues, there may be a need to consider a reformulation of the EU competence in health, with the objective of moving all health-related powers into one Treaty Article as a means of further clarifying the respective roles and responsibilities of the EU and the Member States.\textsuperscript{20}

The report of the High Level Committee on Health thus contained a number of significant recommendations and challenged the assumption that the existing limited competence is set in stone. It should be noted that the ambit of the proposals made by the Committee constituted a very wide understanding of the issues arising from cross border care. The Committee was not interested merely in ensuring that the legal and administrative mechanisms are in place in a coherent policy shared by all Member States, but also in reaching a consistent position on the quality of care and protecting confidential medical information of patients. These are issues which will arise not only in cases where cross border treatment is received, but in relation to the experience of all patients treated by health services within Europe. A common standard of care would ensure no possibility of detriment to a cross border patient but should also assure quality for patients being treated in their own Member State. Such issues seem to lie clearly within the competence of Member States as part of their autonomy over the provision and delivery of health care. However, in a cross-border situation there is a European Community dimension because any anomalies may adversely impact upon the freedom to receive (medical) services in another Member State. It can be argued that examining the implications of the case law on patient mobility was, in fact, a way of opening up such areas for further policy action.

Whilst the report appeared capable of forming the basis for the Commission’s health policy initiative the Council and Commission decided to give the Member States a further

\textsuperscript{18} 'The Internal Market and Health Services' Report of the High Level Committee on Health', 17.12.2001, p. 26. The European Health Forum is an annual conference which provides a discussion platform for the various stakeholders in the field of public health and health care. It was founded in 1998.

\textsuperscript{19} ibid., pp.25-26.

\textsuperscript{20} ibid., p.26.
opportunity for input into the policy making debate by launching a high level process of reflection on patient mobility.\footnote{Conclusions of the Council and of the Representatives of the Member States meeting in the Council of 19 July 2002 on patient mobility and health care developments in the European Union, [2002] OJ C 183/01.} The High Level Reflection Process involved a number of meetings of the Health Ministers of the Member States and the Commissioners for Public Health and Consumer Protection, Employment and Social Affairs and the Internal Market. The High Level Reflection Group issued its Report in December 2003.\footnote{‘Outcome of the reflection process’, High Level Process of Reflection on Patient Mobility and Healthcare Developments in the European Union, European Commission, 9/12/2003, HLRP/2003/16.} Whilst there is some overlap between the recommendations of the High Level Reflection Process Group and those of the High Level Committee on Health, there are a number of differences. In general it is noted that the High Level Reflection Process group proposals cover a wide range of issues but are not radical in nature, rather many involve further study or assessment to be carried out, especially in the more controversial areas relating to cross border care. For example, the report recommends the evaluation of existing cross border health projects, despite the fact that there has already been work in this area such as the evaluation of pilot schemes in the UK\footnote{Lowson, K., West, P., Chaplin, S. and O'Reilly, J., ‘Evaluation of Treating Patients Overseas – Final Report’, York Health Economics Consortium, The University of York, July 2002.} and the AIM report.\footnote{Palm, W., et al, ‘Implications of recent jurisprudence on the co-ordination of health care protection systems’, Association Internationale de la Mutualité, May 2000, pp.62-68.} The report also suggests a study of the motivation for patients to seek cross border care, the specialities affected, the nature of bilateral agreements, patient experience and the information requirements of patients and clinicians. A further proposal is that the different access routes for cross border care in the different Member States are assessed. The effect of these recommendations is to postpone policy decisions on cross border care to a later date. However, arguably the policy process will nonetheless be advanced by such studies and assessments.

The High Level Reflection Group’s Report formed the basis of a Communication by the Commission described as a ‘follow-up’ to the reflection process.\footnote{COM(2004)301.} This significant policy document was far more decisive than the Report to which it responded. The Commission introduced its proposals by asserting that:
"A European strategy is needed to ensure that citizens can exercise their rights to seek care in other Member States if they wish, and that European co-operation can help systems to work together to meet the challenges they face."\(^{26}\)

The Communication went on to note that, beyond the consequences of patient mobility, health systems across Europe also faced additional common challenges and that there was great potential for co-operation at European level to benefit patients, health workers and health systems alike.\(^{27}\) This analysis linked patient mobility with the need for wider co-operation between Member States on health, without explicitly arguing that the latter is a necessary accompaniment to the former. There is no attempt to suggest that wider health policy should be brought within EU competence – rather there is express reference to the need to respect the responsibilities of Member States for their health systems enshrined in the fifth paragraph of Article 152 EC. The new policy is, instead, based on the second paragraph of Article 152, which allows co-operation between Member States to be supported by the Commission.\(^{28}\) The informal co-ordination of Member State co-operation under Article 152(2) is distinct from the OMC process. It also respects the responsibility of Member States for the organisation and delivery of their health systems as set out in Article 152(5). However, as the Commission says:

"Respecting national responsibility for health systems does not mean doing nothing at European level."\(^{29}\)

What is clear, is that the discussion of patient mobility, which was a result of the Court of Justice’s decisions on cross border care, has been used by the Commission as a route into a wider discussion of EU health policy, and as an impetus to hold that debate. It thus appears that the consequences of the jurisprudence on access to cross border treatment will go far

\(^{27}\) ibid., p.4.
\(^{28}\) The scope of the co-operation which can be supported by the Commission under this paragraph is somewhat ambiguous. Whilst it is stated to apply to “the areas referred to in this Article”, whether this was intended by the drafters to include the organization and delivery of health services and medical care, in relation to which para 5 requires Community action to “fully respect the responsibilities of the Member States”, is debatable.
\(^{29}\) COM(2004)301, p.16.
wider than may have been originally envisaged. One of the most significant examples of this widening of the ambit of health policy by the Commission is the proposal to consider reaching a consensus on the individual and social rights, entitlements and duties of patients at European level.\textsuperscript{30} Further examples of areas which could be made subject to a co-ordinated approach are given in the Communication, including the provision of timely and appropriate health care and the areas of informed consent, patient confidentiality and clinical negligence.\textsuperscript{31} The establishment of EU-wide standards in such areas would ensure legal certainty for patients seeking cross border care. It would also possibly have the effect of raising the standards of practice in certain Member States, thus benefiting all patients receiving treatment there. On the other hand it could be argued that the standards could be set at the lowest common denominator, thereby resulting in a lowering of standards in some Member States.

The Commission noted that before such steps could be taken, greater certainty in relation to existing rights to health care in Community law was needed.\textsuperscript{32} In terms of legal rights to reimbursement for cross border care, there was an unsuccessful attempt to address this within the draft directive on services in the internal market,\textsuperscript{33} which sought to clarify the relevant provisions of Regulation 1408/71 (itself now updated, and due to be superseded in the future by the new Regulation on the co-ordination of social security\textsuperscript{34}) on this point. The Commission has since confirmed its commitment to producing a specific initiative on health services and has launched a consultation paper on the subject.\textsuperscript{35}

In addition, the Commission proposed several further ways in which certainty about cross border care could be improved: these include providing clearer information about rights to cross border care, facilitating patient mobility through the streamlining of procedures and the use of the European health insurance card, improving information about patient

\textsuperscript{31} ibid.
\textsuperscript{32} ibid., p.7.
\textsuperscript{33} COM (2004)2, see Chapter 4 for a full discussion of this initiative.
mobility and health care developments and facilitating co-operation at European level by setting up a High Level Group on the Health Services and Medical Care. These proposals underline the Commission’s expressed desire to promote cross border care, as does the invitation to Member States to improve legal certainty by making any conditions for access to their own benefits clear and transparent.

As well as seeking to improve conditions for patient mobility, the Commission also addressed the mobility of health professionals in its follow-up to the High Level Reflection Process report. In particular, it noted that a new directive on the mutual recognition of professional qualifications has been introduced.

On the High Level Reflection Process Group’s suggestion of designating ‘centres of reference’, the Commission undertook to carry out the suggested mapping exercise as a first step. The purpose of such centres would be to treat patients with rare conditions or others requiring “a particular concentration of resources or expertise.” The concept of resource sharing in the provision of treatment is underpinned by the proposals referred to above with regard to the adoption of a common approach to various aspects of patient’s rights. Further confidence in cross border treatment is generated by a further area of action in relation to the notification of professional malpractice procedures. In particular, there is a focus on the best way of ensuring a confidential exchange of such information between the relevant agencies of the Member States.

In relation to improving conditions for both professional and patient mobility the Commission placed great emphasis on the need for information gathering and exchange for

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37 ibid., p.16.
38 ibid., p.8. Such rules must, of course, be non-discriminatory and not constitute an obstacle to the free movement of persons, services, goods or establishment.
42 ibid., p.9.
example on health care purchasing\textsuperscript{43} and health technology\textsuperscript{44}. A "health systems information strategy"\textsuperscript{45} was proposed entailing the creation of a framework for the systematic collection of information at the EU level, the movement of patients and health professionals.

\textbf{5.2.2 The High Level Group on Health Services and Medical Care}

The follow-up to the High Level Reflection Process represented a significant statement on the development of a European health policy. It also announced the creation of a mechanism to co-ordinate national health policies, in the form of the setting up of the High Level Group on Health Services and Medical Care (HLG), a group composed of health experts from the Member States\textsuperscript{46}. It is important to note that the work of the HLG does not form part of the open method of co-ordination (OMC) which has been applied to health and long term care via the Social Protection Committee. The creation of the HLG can be traced back to the high level reflection process on patient mobility and many of its areas of activity reflect this. Its working methods are practical and informal and its aim has been described as that of:

"developing concrete action bringing benefits to patients and helping to improve the effectiveness and efficiency of the health systems across the Union while respecting national responsibilities for health systems."\textsuperscript{47}

The HLG decided initially to focus on seven policy co-ordination areas; cross border health care purchasing and provision, health professionals, centres of reference, health technology assessment, information and e-health, health impact assessment and patient safety. Each area is the responsibility of a designated working group. In terms of patient mobility, the first and third areas are of most interest and will be considered in more detail.

\textsuperscript{44} ibid., p.11.
\textsuperscript{45} ibid., p.12.
\textsuperscript{46} The group started work in July 2004.
5.2.2.1 Cross border health care purchasing and provision

A number of aspects of this area have been identified by the HLG as suitable for policy co-ordination. In terms of concrete action the working group has drawn up guidelines providing a framework for health care purchasing to assist institutions in commissioning cross border care, and has invited the health ministers of the Member States to endorse these. The guidelines are not for use by individual patients and do not apply to matters regulated by the rules on the co-ordination of social security. Instead they are aimed principally at facilitating en bloc purchasing arrangements and contain guidance as to the contents of such agreements.

In addition to the guidelines on health care purchasing, the working group has made a number of recommendations. Firstly, the group has recommended further analysis of the financial impact of cross border care on health systems. Secondly, it has been proposed that a study of the motivation of patients seeking cross border health care is carried out.

On the issue of patients’ rights and responsibilities, it has been accepted that greater information is needed before exploring the possibility of working towards an EU-wide consensus, whilst in relation to the allied need for greater legal certainty for patients on rights to cross border health care, the working group has suggested that clarification should be sought on malpractice liability issues. Action has also been planned to increase the amount of information available to patients on how to access the various health systems of the Member States. Finally, with regard to co-operation in border areas the working group has proposed research into whether this should remain subject to bilateral agreements or would benefit from co-ordination at EU level.

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50. ibid., p.8.
51. ibid.
52. ibid.
5.2.2.2 Centres of reference

A separate working group has developed guidance in relation to centres of reference (COR). The benefits of such centres are seen as including improving access for EU citizens to specialist treatments, maximising the cost-effective use of resources and helping the smaller countries to provide a full range of health services and it has been argued that:

"The necessary complimentarity between people seeking treatment and facilities capable of treating them is an important part of the European integration process, in particular for achieving the EU goal of a minimum level of social cohesion."

The guidance consists of a definition and set of criteria to be met by centres of reference. The initial criteria issued stated that one of the characteristics of a COR should be having appropriate capacities to treat patients from other Member States. However, at a later stage some general principles were added, one of which states that, where possible, the expertise should travel rather than patients themselves. The apparent shift may be attributable to the fact that the principles were added after consultation with the Health Commission Task Force on Rare Diseases following the HLG's decision to use rare diseases as a trial area for centres of reference. Perhaps the addition of the principle reflects public health concerns in relation to infectious diseases, rather than a general change in the understanding of the role of COR.

The High Level Group co-ordination of co-operation on matters relating to the provision of health care seems to be a valuable process. It is able to focus in detail on specific issues and produce guidelines and recommendations in relation to them which represent a

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54 ibid., p.11.
consensus amongst the Member States. It is this concentration on the micro level which
gives it a role very distinct from the OMC process being conducted in parallel by the Social
Protection Committee. Operating outside the OMC process and on an entirely informal
basis, the HLG appears free to set its own agenda following the lead given by the
Commission in the follow-up to the reflection process Communication. Whilst its aims
may be fairly modest in nature, it appears capable of having a real impact upon the health
systems of the EU, in tandem with the OMC, which will now be examined.

5.3 The use of the open method of co-ordination in the field of European health policy

5.3.1 Background

Whilst the cases on cross border treatment provided the backdrop to the development of EU
health policy, the latter is not confined to the work of the High Level Group on Health
Services and Medical Care. A parallel process of applying the open method of co-
ordination (OMC) to health care and long-term care within the context of the modernisation
of social protection was launched in a companion policy document issued by the
Employment and Social Affairs Directorate of the Commission on the same day that the
“Follow-up to the high level reflection process on patient mobility” Communication58 was
published by the Health Commissioner.59

The choice of the OMC as a major policy instrument in this area has been dictated by
Treaty limitations. This is not an isolated situation – the OMC is often used to facilitate
policy making in areas of weak competence where regulation by law is impossible.60 The
Commission has stated that in the health policy context, the OMC will be a flexible tool

59 It should be noted that the application of the OMC to health care had been recommended by the High Level
Committee on Health in its 2001 report, ‘The Internal Market and Health Services’ Report of the High Level
60 See, for example, Schulte, B., ‘The new European ‘Buzzword’: Open Method of Co-ordination’ (2002) 4
European Journal of Social Security 351 and Bernard, N., ‘Between a Rock and a Soft Place: Internal Market
which respects the diversity of national positions,\textsuperscript{61} that it will offer an overall policy framework making transparent and highlighting the issues common to national systems,\textsuperscript{62} that the OMC will involve all the relevant social partners in this process\textsuperscript{63} and will provide integration of health policy by linking together the various instruments and policies in the area.\textsuperscript{64} Szyszczak believes that the purpose of applying the OMC to health care is twofold: both to implement the Lisbon objectives and:

"to handle erosion of the Member States’ sovereignty in the area of providing medical services as a result of the increasing opportunistic litigation before the Court of Justice."\textsuperscript{65}

Thus far in relation to health care, hard law has been used to govern conditions for access to reimbursement of medical costs, to underpin the free movement rights of patients and medical professionals, to prescribe the circumstances under which Member States must fund cross-border treatment and to facilitate the administration of claims between health providers and national authorities. The introduction of hard law provisions on professional and patient mobility has been necessary to address the economic implications of cross border care but is not intended to be an instrument of social policy. Instead it stems from Article 49 of the EC Treaty and Regulation 1408/71 which acts to co-ordinate the social security systems of the Member States to ensure that persons exercising free movement rights are able to access benefits including health care in host member states on the same basis as nationals in those states, a measure designed to underpin economic policy. The OMC is now to be applied to the wider context within which such ‘transactions’ take place. This marks a departure from traditional ‘hard law’ community methods such as harmonisation or mutual recognition to a ‘soft law’ approach. Initiatives to improve access, quality and financial sustainability in the delivery of health services through applying the OMC may improve conditions for patients generally. However, as noted in the previous section, it is difficult to predict the effect of the OMC process on patient mobility.

\textsuperscript{62} ibid., p.7.
\textsuperscript{63} ibid.
\textsuperscript{64} ibid.
\textsuperscript{65} Syzszczak, E., ‘The Open Method of Co-ordination’, Paper presented at Seminar on the OMC at Leicester University, 7 May 2003.
In order to assess the impact of the application of the OMC in relation to health care policy the nature of the process and its strengths and weaknesses will be considered.

5.3.2 About the process

The process now known as the OMC may not be a new, or exclusively European Community or European Union concept. It has been suggested that a similar process was used by the World Health Organisation in 1978 in relation to the Alma Ata Declaration. In terms of EU policy, the process which later became known as the OMC was first used in relation to the European employment strategy to overcome political differences in 1997. Its origins can be traced back further to the approach taken to Economic and Monetary Union – in particular to the use of Broad Economic Policy Guidelines to co-ordinate the fiscal policies of the Member States participating in the Euro project.

At the 2000 Lisbon European Council the agenda for creating a modern dynamic economy underpinned by the European social model was launched. In relation to the pursuit of certain specific social policy goals the Council declared that the process dubbed the ‘Open Method of Co-ordination’ would be used. This represented a formalisation of the process, elevating it in status to a designated mode of governance. It has been said that:

"With Lisbon, the former European ‘strategy’ was transformed into a proper ‘method’ of intervention."

Furthermore, the aim of the OMC has been described in terms of unleashing the EU’s social dimension from the constraints of the Community method.

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66 The term was first used at the Lisbon European Council in March 2000.
69 ibid., p.40-41.
The process of OMC consists of the setting of indicators or benchmarks, the comparison of best practice with timetables attached. It can also encompass short, medium or long term objectives.\textsuperscript{72}

Whilst overall policy objectives are set by the European Council, the practical implementation of the OMC is co-ordinated by the Commission which presents proposals on policies to be conducted under the process,\textsuperscript{73} co-ordinates the exchange of best practice, proposes indicators and benchmarks and provides general support by setting a framework for the application of the process in relation to particular policies.\textsuperscript{74} In practice much of this work is delegated to Committees such as the Social Protection Committee.

Whilst there is no direct intervention by the Community institutions in the Member States national policies under the OMC and in principle it is up to Member States to agree their own national and regional level targets to achieve the objectives defined at European level, it would be naïve to claim that they have a free rein in this regard. Syzsczak believes that:

"The framing of a Community policy through guidelines, indicators and benchmarking is not a soft or neutral process, but shapes the framework within which national policies, and actors must work. It is not only agenda setting but sets the parameters as to how policies should operate."\textsuperscript{75}

Since its formalisation, the process has been refined and can be applied in various ways as it is inherently flexible. The stated aim of the OMC is to share policy experience rather than to devise common policies with policy choices remaining at the national level. Crucially, though, these are no longer to be pursued in isolation, specific policy problems are designated ‘common concerns’, and governments are to agree to compare and evaluate


\textsuperscript{73} For example, COM(2004)304 in relation to the application of the OMC to health care and long term care.

\textsuperscript{74} De la Porte, C., ‘Is the Open Method of Co-ordination Appropriate for Organising Activities at European Level in Sensitive Policy Areas?’ (2002) 8 ELJ 44.

\textsuperscript{75} Syzsczak, E., ‘The Open Method of Co-ordination’, Paper presented at Seminar on the OMC at Leicester University, 7 May 2003.
them in “organised, iterative processes.” Commentators have identified two different views of the OMC. Some take the view that it is a ‘top-down’ process, with firm direction coming via the Commission from the European Council. Others see it more as a ‘bottom-up’ method, whereby a range of participants at regional and national level dictate the scope of policy co-ordination. It has also been argued that the type of OMC applied in different policy domains reflects this dichotomy, in particular, the Employment Strategy is essentially an example of a ‘top-down’ process, whilst the type of OMC used in relation to pensions, for example, is ‘bottom-up’.

The use of indicators or parameters to measure whether or not member States meet the agreed objectives is arguably a type of sanction despite the absence of penalties in the event of failure. As the progress of states is assessed by the Commission and the Council the pressure comes from the top down and it is reported that Member States are very uncomfortable with the resulting ‘finger pointing sessions’.

Applying the OMC to social policy development can be regarded as an intermediate tool. It rejects the two polar positions, that there should be no social policy intervention or conversely that there should be substantial harmonisation towards the creation of an EU welfare super state. Indeed, it has been argued that the use of the OMC in relation to social policy represents an acknowledgment that the latter is unlikely ever to be achieved. However, it does chime with the convergence model of social policy in that it aims to facilitate convergence through co-ordination. Furthermore, the OMC is often seen as a pre-

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cursor for further action eventually leading to a hard law measure. Wincott suggests that it may help to create conditions for a transfer of competence in a particular area.\textsuperscript{83}

5.3.3 \textit{Strengths and weaknesses}

It can be argued that the choice of the OMC, a soft law method, for the development of health policy, as opposed to legislative action in this field reflects the subordination of social policy to economic policy generally. De Börca believes that;

"The hierarchical relationship between the Treaty’s entrenched internal market norms and the softer powers in the social field forms a background to the operation of the OMC process."\textsuperscript{84}

In addition to being perceived as being a relatively weak instrument, the OMC is regarded as suffering from two further defects: a lack of democratic legitimacy and an insufficient focus on fundamental rights. The issue of democratic deficit in the EU is one which has received much attention in academic literature.\textsuperscript{85} For example, Douglas-Scott summarises the main areas of concern as ineffective parliamentary control over the political process, the executive nature of much Community decision-making and the use of comitology,\textsuperscript{86} a lack of transparency in the EU’s processes, and insufficient citizen participation in the EU.\textsuperscript{87}

Seeking to explain the existence of a democratic deficit, Weiler argues that:

\footnotesize{\textsuperscript{83} Wincott, D., ‘Beyond Social Regulation? New instruments and/or a new agenda for social policy at Lisbon?’ (2003) 81 \textit{Public Administration} 537.
\textsuperscript{85} However, it should be noted that some commentators have challenged the prevailing view that there is a democratic deficit in the EU. For example, see the discussion of the views of Moravcsik and Majone in this regard in Follesdal, A. and Hix, S., ‘Why there is a democratic deficit in the EU: A response to Majone and Moravcsik’ (2006) 44 JCMS 533-62.
\textsuperscript{86} ‘Comitology’ is the term used to describe the system whereby many technical regulations are made by committees acting under powers delegated by the Commission. Craig and De Börca explain that "Technocrats and national interest groups have dominated this sphere of decision-making to the exclusion of the more regular channels of democratic decision-making, such as the European Parliament..." , Craig, P. and De Börca, G., \textit{EU Law}, 3\textsuperscript{rd} ed., OUP, 2003, p.168.
"The process of integration – even if decided upon democratically – brings about at least a short-run loss of direct democracy in its actual processes of governance."\(^8\)\(^9\)

He believes that this needs to be compensated by social legitimacy which can be found both in an enhancement of the welfare of the citizenry as a result of integration and in ensuring that the integrated polity has democratic structures in place.\(^9\)

There are two main elements to the criticism that the OMC lacks democratic legitimacy. Firstly, it is argued that despite being characterised as an open process, in which a wider range of non-traditional actors are able to participate, this is not reflected in reality. As Member States control the application of the process, the degree to which non-state actors are involved is dependent upon a commitment to greater participation which may be lacking.\(^9\)

A second allegation of democratic deficit rests upon the absence of a role for the European parliament within the OMC.\(^9\)\(^1\) Traditionally arguments about democracy in EU law and policy making have been focussed on the powers of the Parliament within the legislative process, in relation to those of the other institutions. Whilst successive treaties have improved the Parliament’s position in this equation, the OMC which is perceived as a new alternative to the legislative process, does not involve Parliament. This issue has been noted in a recent Commission Communication on the new framework for the open co-ordination of social protection, which suggests that the Commission and the Member States should explore with the Parliament, ways of it becoming more involved in the process.\(^9\)\(^2\) It will be interesting to see how this is taken further. It has also been noted that whilst the OMC strengthens the role of the Council and, to some extent, the Commission, it excludes

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\(^9\) ibid.
not only the European Parliament but also the Court of Justice.\footnote{Borras, S. and Jacobsson, K., ‘The open method of co-ordination and new governance patterns in the EU’ (2004) \textit{Journal of European Public Policy} 199-200.} In this sense the process can be described as lacking judicial accountability as well as democratic input.


In relation to rights protection, De Búrca echoes widespread concern that the OMC contains:

“no mechanisms for checking against the dangers either of a race to the bottom or an undesirable slippage of protection, in respect of certain fundamental rights.”\footnote{De Búrca, G., ‘The Constitutional Challenge of New Governance in the European Union’ (2003) 28 ELRev 833.}

However, it is argued that this could be rectified in a number of ways in particular by using the process in conjunction with the Charter of Fundamental Rights as a way of giving “concrete contextual meaning”\footnote{ibid., p.834.} to the rights delineated therein. Whilst the OMC could be used to promote and progress Charter rights, the Charter could in return:

“operate as ideal norms in relation to which the outcome of the process would be appraised.”\footnote{ibid.}
This symbiotic relationship proposed by De Burca may help to overcome some of the concerns over the democratic legitimacy of the process. However, it is noted that whilst, like the European Parliament, the Court of Justice has yet to discover its role in the OMC, if the OMC is to be used in combination with the Charter it will become necessary for the Court to be involved to underpin the process.\(^\text{100}\)

The shortcomings of the OMC described do raise concerns in relation to the development of EU health policy. Issues about the quality of and access to health services do need to be openly debated with participation from the many relevant professional and patient interest groups. There is a risk of dominance of the process by designated experts with no real accountability and there seems no reason why the European Parliament should not have an input into this policy area. Applying the OMC to health policy will mean that Member States retain control over how information is collected, who is involved in preparing and presenting it and how open and thorough this turns out to be may vary from state to state. The Social Protection Committee has made a number of recommendations about the implementation of the OMC in relation to health and long-term care,\(^\text{101}\) which tend to support this concern. In particular, the Social Protection Committee (SPC) has stated that the OMC should not impose an excessive administrative burden on states, that the Committee will accommodate representatives of the Member States' health ministries within its own structure and that the process should be co-ordinated appropriately with parallel and related actions at EU level.

A further concern which has been expressed is that equal attention will not be given to all three objectives within the process. Specifically it is feared that access may not be given as much priority as quality and financial sustainability.\(^\text{102}\)

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\(^{101}\) Opinion of the Social Protection Committee on the Commission's Communication on "Modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care: support for the national strategies using the open method of co-operation" 14/9/04, SOC 399.

\(^{102}\) Tamsma, N., 'Are EU mechanisms for collaboration good for equity of access?' A contribution to the debate on health services at the Open EU Health Forum, Brussels, 8/11/05.

The positive aspects of the OMC are usually regarded as its relative flexibility in comparison to traditional methods and its ability to overcome political deadlock; and to bridge situations where there are significant national differences. In comparison to other ‘soft law’ mechanisms such as recommendations and opinions, the OMC may carry more weight as it is a process, not a provision and it is perceived that a process will generally result in policy development of some kind. Because of its voluntaristic nature, and emphasis on policy linkage, it is both attractive and non-threatening to Member States; fostering convergence in areas of common interest whilst respecting national diversity. Its core principle of promoting best practice through the setting of a common set of indicators may encourage states to improve national positions through a healthy form of peer pressure. However, it accommodates the different speeds at which various policies are developing at Member State level, giving more time and scope for natural evolution than a harmonising legislative provision. With regard to health policy, the OMC may prove effective in the long term in promoting convergence and thereby augmenting standards without the political difficulties of overcoming competency limitations in relation to Article 152.

The OMC is compatible with the principle of subsidiarity and it has been suggested that it may be a way of bypassing the principle altogether by allowing the EU to initiate co-ordination in areas which are within the Member State’s competence such as the provision of health care. In this field it has been argued that the OMC may help Member States to find a way out of the ‘subsidiarity dilemma’ which has existed since the Court of Justice’s

105 ibid., p.833.
106 ibid.
decisions in Decked\textsuperscript{110} and Kohll\textsuperscript{111} and that it could feed into developments on health in the internal market.\textsuperscript{112}

In terms of the wider context of the social dimension of the EU, the use of the OMC in essentially social policy areas has a number of interesting resonances. Firstly, it has been suggested that because it is neither primarily an EU or a national method, but rather, a process open to a wider range of actors and interests, the OMC:

"could constitute a means to develop and promote social and other forms of solidarity in Europe in a context where individual states' capacity to provide for public welfare has been weakened and where the EU lacks the authority, legitimacy and ability to pursue centralised policies of this kind."\textsuperscript{113}

Furthermore, the inclusive nature of the OMC based on participation of the relevant interest groups in the setting of objectives and indicators brings the process closer to society itself than traditional forms of governance. It has been argued that the OMC is more than merely a new, flexible tool, it forms part of a new social vision for Europe which embraces the Lisbon vision of a comprehensive modern economy underpinned by a robust social model.\textsuperscript{114} Schulte believes that the use of the OMC will give much needed definition to the concept of the European social model; translating it into a tangible set of agreed objectives.\textsuperscript{115}

Finally, the use of the OMC in relation to health policy may imply more fundamental structural changes for some Member States than for others. De la Porte observes that in the employment strategy most of the pressure to converge is on the states with continental and

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\textsuperscript{110} Case C-120/95 Deckev Caisse de Maladie des Employes Priv\`{e}s [1998] ECR 1-1831.
\textsuperscript{114} ibid., p.830.
Southern welfare states, whilst the OMC in relation to the social inclusion policy, the pressure is on the Southern and Anglo-Saxon welfare regimes. As the objectives for health policy emerge it will be interesting to see which type(s) of system they most closely reflect. It may, in practice prove difficult for objectives to be agreed in certain areas. Although the diversity of health care systems within the EU may make broad comparisons difficult, the Commission has sought to specify precise areas of action which lend themselves to co-ordination. In particular the focus will be on macro-level issues related to the principles of access, quality and financial sustainability. The application of the OMC to health care policy will now be considered in detail.

5.3.4 The application of the OMC to health care by the Social Protection Committee

As previously indicated, in addition to the informal co-ordination process discussed in the first section of this chapter, the Commission has also introduced the OMC in the field of health care, in a parallel process. In the relevant Communication it is noted that, whilst there has been an increase in patient mobility in addition to the Court of Justice’s decisions supporting access to cross border care, the area had never been the subject of a global strategy covering:

"the development and modernisation of the supply and funding of care, patient and health worker mobility in an enlarged Union, co-operation between health care regions and systems, as well as the mainstreaming of the main objective – providing a high level of human health protection – in all Community policies."

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118 COM(2004)304. The extension of the OMC to cover health and long term care was not entirely uncontroversial. For example, the United Kingdom House of Commons European Scrutiny Committee was not convinced that sufficient justification for applying the OMC was made by the Commission in the Communication introducing the process, querying: “why such exchanges of views as are required could not be achieved by a less intrusive means.” House of Commons European Scrutiny Committee, Eleventh Report of Session 2004-5, 15th March 2005, p.37.
The stated purpose of this Communication, together with the Follow-up to the high level reflection process on patient mobility, is to provide an overall strategy for developing a shared vision for the European health care and social protection systems. This parallel strategy, located within the context of EU policy on modernising social protection initiated at the Lisbon European Council, is to be achieved through the process of OMC, on the basis of the three objectives agreed in relation to health care and long term care by the Barcelona Council; access, quality and financial sustainability. In relation to access to care, the emphasis is on the universal provision of health care and the reduction of regional inequalities. Attention is paid to the need for some Member States to cut waiting lists where waiting times compromise patient's health and quality of life. The need to facilitate the mobility of medical professionals is also noted. However, somewhat surprisingly the section on improving access to care contains no direct reference to patient mobility, which instead is mentioned in relation to the quality of care. Here there are two relevant objectives, the first pertains to maximising health resources, in tandem with the proposal on the identification of centres of reference in the Communication on patient mobility. The second objective is to define the rights of patients and their families. The Communication on patient mobility is described as complementing this aim by proposing that information on individual rights, together with the European Community and national rules on billing for care, be brought together and made more visible.

On the specific question of the choice of the OMC as an instrument in this sphere, the Communication explains that it is a means of adding value to the individual health care policies of the Member States by identifying common challenges and supporting those reforms, whilst responsibility for the organisation and funding of the health care and elderly care sector rests primarily with the Member States, which are bound when exercising this
responsibility to respect the freedoms defined and the rules laid down in the Treaty.\textsuperscript{128} To describe the Member States as primarily responsible for health care policy suggests that they do not have exclusive control over the area. It is also implicit that the European Union is ‘secondarily responsible’, a contention which is not in fact supported by Article 152.\textsuperscript{129} This conceptualisation seems to represent an incursion into what has been seen as an area of exclusive Member State competence, based upon their obligation to respect, in particular, the free movement of services. However, observing the Treaty freedoms by, for example, funding a patient’s treatment in another Member States does not necessarily entail signing up to a host of joint policy action, albeit under the auspices of the OMC. It appears that Member States are expected to be willing to pursue a joint health policy over and above accepting the implications of the jurisprudence on access to cross border care.

The task of setting the OMC process in place has been given to the Social Protection Committee. This body was set up by the Council in 2000 to provide a means of co-operative exchange between the Commission and Member States in relation to the modernisation of social protection systems in the EU.\textsuperscript{130} In order to develop a framework for the application of the OMC in the fields of health care and long term care, the Indicators Sub-Group of the Social Protection Committee has been undertaking preparatory work by gathering data from the Member States in relation to the three objectives. The Member States have submitted preliminary reports which are examined in a Review published by the Social Protection Committee in November 2005.\textsuperscript{131}

Despite the initial links to patient mobility made in the Communication which introduced the process, it is evident from the Review that at this stage there is relatively little direct focus on cross border care within the process itself. One possible reason for this is a desire to avoid overlap with the work of the High Level Group on Health Care and Medical

\textsuperscript{128} COM(2004)304, p.11.
\textsuperscript{129} Article 152, EC.
\textsuperscript{131} Review of Preliminary National Policy Statements on Health Care and Long-term Care, Memorandum of the Social Protection Committee, 30/11/05.
Services described earlier in this chapter. A further point to be made is that the OMC is designed to complement, rather than duplicate hard law mechanisms and these latter have been the main forum for dealing with issues arising in relation to patient mobility, for example in the form of the case law on cross border care, the provisions contained in the regulation co-ordinating social security and the proposed provisions on cost reimbursement which were contained in the draft services directive.

There are two direct references to patient mobility in the Social Protection Committee’s Review, the first of which is found in the section on access to health care. Here it is noted in the context of concerns about undue waiting times for treatment that one Member State has adopted a policy of allowing patients the option to go abroad for treatment once a particular waiting time is exceeded. The second mention arises in relation to the discussion of issues surrounding the financial sustainability of health systems. Here it is reported that in its preliminary report, Spain highlighted concerns about the cost implications of patient mobility in particular with regard to the large number of people staying in the country for short periods and the number of nationals of other Member States taking up residence there.

There are, however, a number of further connections which can be made between the content of the OMC process and patient mobility. These arise in relation to each of the three goals of the process. On the issue of access to health care, a number of factors which may be causes of patient mobility were identified in the national preliminary reports. In particular, the lack of a comprehensive range of treatments is acknowledged by some Member States, as is geographical disparity in treatments available. These

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132 The desire to avoid overlaps, and the resultant need for close co-operation between the two bodies, is stressed in the Opinion of the Social Protection Committee on the Commission’s Communication on “Modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care: support for the national strategies using the open method of co-operation”, COM(2004)304.
134 Review of Preliminary National Policy Statements on Health Care and Long-term Care, Memorandum of the Social Protection Committee, 30/11/05, p.27.
135 ibid., p.7.
136 ibid., p.11.
shortcomings may prompt patients to seek cross border care. Two further problems highlighted by some states are staff shortages and waiting times, both of which restrict access to timely treatment and may also provide motives for patient mobility. Concerns about ensuring a consistently high quality of health care are also noted in the Review.137

With regard to the issue of financial sustainability, the Social Protection Committee contends that better-educated, wealthier and more demanding patients are increasingly desiring greater freedom of choice of care provider, timing and place of care and access to the latest medical technology.138 All these demands place cost pressures upon health care systems. Although requests for cross border treatment are not specifically mentioned in this context, they clearly form part of this trend.

There is an interesting contrast between the approach of the Social Protection Committee (SPC) to issues related to patient mobility and that of the High Level Group on Health Services and Medical Care (HLG). For instance, the SPC appears to believe that access problems should be tackled at national level whilst the HLG promotes the use of resource-sharing strategies and centres of reference by Member States. With regard to patient choice, the SPC suggests that it is necessary to raise patients’ awareness of the costs of health provision in view of scarcity of resources,139 whereas the HLG is keen to increase legal certainty for patients about their rights to health care. These examples demonstrate the difference in emphasis between the work of the two bodies: the HLG process is more focused on micro issues and individual rights, the scope of the OMC, as applied to health care, is concentrated upon the macro issue of the provision of health services as an aspect of social protection for the whole population.

The Commission has reiterated the goals of the application of the OMC in relation to health care in a Communication on the new framework on the open co-ordination for social

138 ibid., p.23.
139 ibid., p.24.
protection. This follows the re-launch of the Lisbon Process in March 2005 and is designed to streamline the OMC across the range of social protection areas to stimulate policy development, highlight common challenges and facilitate mutual learning. In relation to health care, the three aims of access, quality and sustainability are restated, with two allusions to cross border co-operation; firstly, there is a reference to establishing quality standards reflecting best international practice, and secondly, co-ordination between care systems is mentioned, although it is not absolutely clear whether this means health systems in different Member States.

The effect of the OMC process on patient mobility is difficult to predict. It could be argued that if the process has the effect of improving the supply, range and quality of health care at national level, the motivation for patients to seek cross border care will decrease. However, to achieve these goals Member States may have to work together, for example, in some of the ways being proposed by the HLG such as the publication of guidelines for the purchasing of cross border health care. This could lead to a formalisation, and possibly an increase, of patient mobility, with the state as the organiser rather than as a reluctant party to individual arrangements based on the free movement of services jurisprudence.

The wider effect of the application of the OMC to health care is to increase the involvement of the EU in this policy domain. It is suggested that the OMC can be regarded as a sort of 'assisted convergence' as it seeks to bring together national health care strategies through the use of a soft law mechanism. Furthermore, in a recent Commission Communication on the framework for the OMC, one of the overarching objectives given of the OMC in the various areas of social protection is to promote social cohesion, thereby reflecting the social cohesion model of social policy. These observations suggest that the OMC acts as an alternative to policies which reflect the traditionally prevailing neo-liberal market model.

141 ibid., p.3.
142 ibid., p.6.
143 ibid.
144 ibid., p.5.
The decision to apply the OMC in the health care field shows that the EU wishes to have a role in shaping the way health care is provided. Whilst certain aspects of this can be regulated through legislative measures, many fall outside EU competence and can only be addressed through processes such as the OMC. The SPC is optimistic about the process, reporting that some Member States have already declared that the OMC is producing positive effects. Further positive reactions can be seen in the responses to the Commission’s latest consultation on Community action on health services. The significance of this recent initiative to the future of the co-ordination of health care policy will now be considered.

5.4 The future of the co-ordination of health policy in the EU

The future of the co-ordination of health policy in the EU was touched upon in the Commission’s Communication on a consultation on Community action on health services, which has been examined in detail in Chapter 4 of this thesis. It was seen that the Commission has recently launched a debate with a view to introducing proposals on health-specific legislation which, whilst primarily aimed at codifying the case law on patient mobility, could also be used as a means of placing other health care-related matters on a firmer footing.

The communication makes a number of references to health policy co-ordination. It acknowledges the roles played by the informal co-ordination process under the HLG and the OMC as applied to health care by the SPC but asserts that more remains to be done to realise the potential for European co-operation in the health field. In particular, whilst both processes are said to be valuable in progressing the practical co-operation agenda, they are also regarded as incapable of providing legal certainty for patients and providers, an inherent consequence of the use of soft law tools.

147 ibid., p.6.
148 ibid., p.11.
In relation to the HLG-led process, specifically, the Commission argues that a more formal framework is required at EU level to ensure that the relevant actions will be implemented effectively and on a sustained basis.\textsuperscript{149} Finally, notwithstanding the earlier remarks, it is suggested that the processes could continue to form part of an “overall package of Community action”,\textsuperscript{150} together with legislation to be proposed by the Commission in 2007.

As observed in Chapter 4, a survey of a sample of responses of the Member States to the consultation revealed considerable support for the two co-ordination processes. One of the questions thrown open to debate by the Commission is whether some of the areas currently being explored under these processes could instead be brought within the scope of future legislative proposals. In this regard, the sample of responses studied showed little enthusiasm, with Member States preferring to maintain the present division between the use of soft and hard law mechanisms. The related problem of competence limitations was also noted.\textsuperscript{151} Any such move, were it to become a reality, would be a testament to neo-functionalist spillover. The scope of the planned legislative proposals is not yet known but, in the meantime, the attitude of Member States appears to confirm that the two co-ordination processes have become firmly embedded and will continue to be exploited to positive effect.

5.5 Conclusions

The case law on patient mobility has been an important influence in the introduction and pursuit of a strategy of co-ordination of Member States’ health policies by the Commission, by forming part of the background to, and rationale for, the two related strands of health policy co-ordination. The process of informal co-ordination in the field of health care co-operation under the High Level Group on Health Services and Medical Care arose after a reflection process on patient mobility launched by the Commission to consider the implications of the case law. This initiative was, in turn, linked to a parallel process

\textsuperscript{149} SEC(2006)1195/4, p.9.
\textsuperscript{150} ibid., p.11.
\textsuperscript{151} See Chapter 4.
involving the application of the open method of co-ordination to health care\textsuperscript{152} and the two processes are often referred to in conjunction with one another by the Commission.\textsuperscript{153}

Due to the differences in the organisation and funding mechanisms of health services within the EU, patient mobility poses many challenges. In particular, it raises specific issues about the ability of national health systems to co-ordinate with one another successfully where patients receive cross border care and a cross border patient's rights of recourse in the event of a medical accident, as well as wider concerns such as ensuring the quality of treatment across the EU and how to access information about treatments and health systems in different Member States.

The co-ordination of Member States' approaches to these sorts of issues is a useful strategy which is capable of having implications not just for cross border treatment, but for all patients. It also increases the involvement of the EU in the field of health which may be seen as undesirable by Member States in light of the reservation of competence contained in Article 152(5). However, the second paragraph of Article 152 permits a supporting role for the Commission in encouraging Member State co-operation and the pursuit of the two policy co-ordination processes may be regarded as justified on this basis.\textsuperscript{154} In any event, the use of policy co-ordination is more palatable to the Member States than hard law intervention. A survey of a sample of Member States' replies to the recent Commission consultation on Community action on health services shows support for the two co-ordination processes and a desire to confine Community action on health services to this type of activity.\textsuperscript{155}

It appears that whatever reservations Member States may have about issues of competence in relation to health care, their participation in the two processes outlined in this chapter shows a willingness to exchange views and practice about health provision. The use of policy co-ordination challenges the dominance of neo-liberalism and begins to shift the

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{152} See COM(2004)304.
\item \textsuperscript{153} See, for example, SEC(2006)1195/4, p. 6 and p. 11.
\item \textsuperscript{154} Although, as noted previously, the exact scope of the supporting role accorded to the Commission in this respect is difficult to determine.
\item \textsuperscript{155} See Chapter 4.
\end{itemize}
\end{footnotesize}
focus on health care away from its market conception as a service towards an approach more concerned with ensuring equitable access to, and the quality of, health care provision. In other words, the co-ordination of health care policy focuses on the rights of patients, rather than the economic freedom of service recipients.
Conclusion

The purpose of this research has been to explore the impact of the case law on patient mobility of the European Court of Justice upon the development of EU law and policy in relation to health care. The role of the EU in relation to health care has been set within the broader contexts of European integration and European social policy. It has been argued that of the range of integration theories, the approach which is of most assistance in addressing the research question is neo-functionalism. In particular, the circumstances in which the relevant principles have been introduced by the Court of Justice can be seen as consistent with the neo-functionalist notion of spillover, as is the way in which the Commission has used the case law both as a basis for formulating legislative proposals and to enhance its role in the promotion and co-ordination of policy in the health care field. The concept of integration through law, where law acts to advance and consolidate European integration through the creation of a uniform body of law, is also reflected in the various legislative initiatives which have stemmed from the patient mobility case law.

The development of European social policy is an aspect of the wider process of European integration. Two different approaches to explaining the existence of social policy initiatives at EU level have been examined. The first view is that these can be seen as occurring as a spillover from the neo-liberal aim of internal market integration. In this conception, social policy arises as an incidental effect to support economic integration. Alternatively, social policy development may be conceived as based upon an autonomous, rights-based strategy. This latter approach relies upon seeing the EU as having a function beyond the creation of a single market. These contrasting positions have been used as a way of examining the impact of the patient mobility case law, however, the view held by a number of commentators that the internal market is no longer an exclusively neo-liberal construct but incorporates a social dimension, has also been acknowledged.

It has been seen that the dominant philosophy underlying the case law on access to cross border care has been that of the free movement of services and the neo-liberal market model. While the case law is based upon market principles, it has had the effect of
enhancing individual rights. The rights which emerge from the case law can be regarded as a spillover both from the regime for the co-ordination of social security underpinning the free movement of persons and from the application of the regulation of the free movement of services within the internal market to the health care sector. Although the importance of the neo-liberal model in this area is consistent with its traditional dominance in EU policy generally, the application of internal market principles to health care has proved problematic. In particular, the case law has fuelled conflict around the definition of 'services', as evidenced by the controversy surrounding the failed attempt to include provisions on access to cross border health care within the services directive. The subjection of services with a social character, such as health care, to neo-liberal market principles is becoming increasingly politically sensitive, calling into question the approach the Court has taken and making it difficult to codify the case law on patient mobility.

**Legislative and policy developments in the area of health care following the case law on patient mobility**

Historically, limitations in competence has acted as a constraint on the ability of the EU to develop law and policy in relation to health care. In the field of public health a competence exists, with Member States realising that there are benefits of taking a common position in relation to major health threats and recognising that the EU should have regard to public health in all its activities. The provision of health care, on the other hand, has been an area over which Member States have wished to retain national control. Accordingly, when the public health article was redrafted to its present formulation, Member States attempted to ring fence their competence over health care provision through the insertion of a reservation to that effect in the provision,\(^1\) together with an exclusion of harmonisation of national laws and measures in the health field.\(^2\) The principles established by the case law on patient mobility have undermined this strategy because they impact directly upon health care systems by requiring that patients be reimbursed for cross border care. As a result of this, Greer argues that a 'dramatic case' of neo-functionalist spillover has occurred in the

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1 Article 152(5), EC.
2 Article 152(4)c), EC.
form of an emerging EU policy on health care. In other words, despite the competence limitations, action at EU level in relation to health care is increasing and it is concluded that the case law has played an important role in this.

The case law has prompted a number of legislative proposals which have met with varying degrees of success. The conflict over the classification of health care as a service by the Court of Justice, and the reluctance to move away from conceiving health related rights purely as a spillover from the free movement of services, has unquestionably hampered certain legislative efforts in the area of patient mobility. This is evidenced both in relation to the removal of provisions codifying the case law on access to cross border care from the draft services directive and the lack of consensus over the inclusion of similar provisions in the new regulation on the co-ordination of social security. Possible ways of overcoming these difficulties such as an extension of EU competence through the amendment of Article 152 EC, or a moderated regulatory approach within the developing framework on social services of general interest have been examined. Following the removal of the health care articles from the services directive, the Commission has declared its intention to introduce specific legislation in the field of health care and has launched a consultation process in this regard. Significantly, this latest strategy expressly envisages that Community action on health services will contribute to the wider challenges facing health systems, beyond those posed by patient mobility. This marks the latest step in the gradual construction of an increasingly wide-ranging agenda in relation to health care by the Commission which it has sought, in part, to justify by the need to improve conditions for cross border care.

In addition to the relevant legislative proposals, it has been seen that the Commission was able to use the case law to launch a policy debate in the form of the high level reflection process on patient mobility. This has led to a process of co-ordination of health policy at

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7 ibid., p.3.
micro level by the High Level Group on Health Services and Medical Care, complementing the parallel open method of co-ordination (OMC) process, which was already in the pipeline as part of the Lisbon process of modernising social protection in Europe. The co-ordination of Member States’ policies in relation to health care represents a form of ‘assisted convergence’. Areas of co-ordination which relate to patient mobility include a focus on cross border purchasing and provision of health care and the designation of specialised ‘centres of reference’ for rare conditions and diseases. Moreover, the scope of co-ordination is wider than patient mobility, covering a range of other areas such as the exchange of information on continuing professional development of health care professionals to ensure quality of care and on patient safety in an effort to improve the safe delivery of treatment and reduce the incidence of medical accidents. Such initiatives are intended to benefit all patients in the EU and apply generally rather than being confined to cross border situations.

It is concluded that the case law on patient mobility has been an important catalyst in relation to the co-ordination of health care policy led by the Commission which has the potential to benefit of all EU citizens. It has been argued that the most important reason for a common approach to patients’ rights is the principle of equality of treatment for all EU citizens. In this context it is becoming increasingly unacceptable for the legal rules governing the delivery of health services to differ from one Member State to another and it is argued that patient mobility will reinforce demands for common standards from the bottom up. Given the essential differences between health systems in the EU, it is unlikely that a complete convergence is achievable, or even desirable. However, it may be possible through policy co-ordination to work towards developing minimum standards in relation to the delivery of health care across the EU, without a formal harmonisation which is precluded by Article 152. It has been suggested in this regard that, as a soft law mechanism, the OMC may provide a framework within which the tensions between the economic and rights-based conceptions of health care may be resolved.

Signs of a shift towards a rights-based approach to the role of the EU in relation to health care

It is argued that, in having a significant impact on the development of law and policy in relation to health care, the case law has prompted a shift towards a rights-based approach to the role of the EU in this area.

It must first be noted that although the right to health care appears in the EU Charter of Fundamental Rights, both its uncertain scope and the non-binding status of the Charter have inhibited the development of this right by the Court of Justice. In particular, the Court has avoided using the language of rights in its patient mobility decisions, instead expressing the right to cross border care as an economic freedom, in line with the neo-liberal model of social policy. Nonetheless, analysis has shown that the criteria the Court has applied for access to cross border care broadly reflect the human rights law concept of the right to health care. In the lastest decision, Watts, the Court appears to recognise a right to receive necessary health care within a medically acceptable time frame and it is suggested that the absence of rights language does not diminish the importance of this principle.

As previously noted, the Commission has embarked upon a consultation process with a view to bringing forward specific legislative proposals in relation to health care in 2007 which may seek to go further than a simple codification of the case law into wider issues related to health provision. The scope and content of such proposals remain to be seen, however, it is suggested that the Commission’s continued desire to legislate in this area, and the apparent broadening of its agenda in this respect, reflects an underlying approach which goes beyond conceptualising it as a mere spillover from internal market integration and which seeks to recognise and promote autonomous rights for patients.

Furthermore, despite the characterisation of health care as an economic service by the Court of Justice, many of the recent policy papers on health care emerging from the Commission

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10 Article 35, EU Charter of Fundamental Rights.
11 Case C-372/04 The Queen on the application of Yvonne Watts v Bedford Primary Care Trust and Secretary of State for Health [2006] ECR I-4325.
make specific reference to health care as a fundamental right. The Commission has also proposed that the rights of patients in different Member States be identified and compared, with a view to achieving a common understanding of patients’ rights in the EU. These developments show signs of a rights-based approach, in contrast to the neo-liberal model.

These observations reveal a degree of inconsistency between the stance of the Court of Justice and that of the Commission in relation to the status of health care, with the former continuing to define it as a service and the latter seeing it also as a fundamental right. This can be explained in two ways. Firstly, the dominance of neo-liberal internal market ideology and the relatively limited competence of the EU in the areas of health and social policy mean that it has been logical for the Court of Justice to rely on the economic free movement principles rather than upon a fundamental right to health care in its decisions. Were the EU Charter of Fundamental Rights to become binding, it would perhaps be more likely that the Court would cite the right to health care as part of its reasoning in cases concerning access to cross border health care. However, the respect for fundamental rights is, in any event, enshrined in Community law. The real problem in relying on the right to health care may be the difficulty in determining the exact nature and extent of this right, which is rather ambiguous in nature. For example, in many conceptions and interpretations it appears to be subject to the reasonable financial constraints of states and their health systems.

If the right to health care is not regarded as unqualified, it may be that there would be limited benefit to individual litigants in trying to rely on it before the Court of Justice. Nonetheless, it can be argued that if the right to health care is to be fully respected and protected within the EU legal order, it cannot be seen simply in terms of an ability to exercise cross border freedoms at the request of individual patients. A stronger legal framework which places the onus upon Member States to guarantee the right to health care, if necessary by sending patients to other Member States for treatment, would increase pressure for common standards on quality of care, patients’ rights and the ranges of

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treatment available. An explicitly rights-based approach would also help to overcome difficulties surrounding the question of whether health care should rightly be regarded as an economic service.

A second explanation for the difference in position is found in the ability of the Commission, in formulating policy, to look beyond the scope of EU competence into broader areas of co-operation. It is possible that the Commission's relative freedom of vision may sometimes lead to the articulation of goals which, due to a lack of political support from the Member States, may prove difficult to realise in the short term. However, the expression of policy aims may ultimately, none the less, be persuasive and it has been noted that Commission communications can have significant influence upon the definition of the future scope of EU law.14

Final reflections

It is clear that the case law on patient mobility has been of crucial importance in the approach developed by the Commission on Community action in relation to health care. Furthermore, the case law has highlighted a number of issues. Firstly, it has illustrated the continuing conflict over the degree to which the EU should have competence in an area of social policy which has traditionally been a national domain, based on principles of solidarity and territoriality. Allied to this, responses to the case law have emphasised the tension which can arise between the operation of the internal market, seen here in the categorisation of health care as a service within the meaning of the Treaty, and the desire of Member States to protect social services, such as health care, from market effects. This tension, in turn, reflects the absence of a consistent theoretical basis for European social policy.

The future of the role of the EU in relation to health care holds many possibilities. Policy co-ordination in the field should yield closer co-operation between and, possibly, a degree

of convergence of the health systems of the Member States. In order to clarify the rights of patients and to place these on a firmer footing, the Commission is committed to bringing forward specific legislative proposals in relation to patient mobility in 2007.\textsuperscript{15} Whilst the nature and scope of the role of the EU in relation to health care remain the subject of vigorous debate, it is suggested that it may be time for an enhanced role, with a more rights-oriented basis to overcome the difficulties created by the clash between the social, solidarity-based, nature of health care and its status as an economic service for the purposes of the internal market. A way forward might be for the Member States to be persuaded that the best means of protecting their health systems from the effects of the internal market is to expand the role of the EU in relation to health care by revisiting Article 152 EC. In the meantime, the case law on patient mobility has been important in crystallising the tensions surrounding EU social policy, acting as a catalyst for legislative action and policy development, and, not least, in augmenting individual rights to timely medical treatment for patients in the EU.

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