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Cross-Border Movement of Patients in the EU: a Re-Appraisal

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The national welfare state, so it seems, has come under attack by European integration. This article focuses on one facet of the welfare state, that is, health care and on one specific dimension, that is, cross-border movement of patients. The institution which has played a pivotal role in the development of the framework regulating the migration of patients is the European Court of Justice (ECJ). The Court's activity in this sensitive area has not remained without critics. This was even more so since the Court invoked Treaty (primary) law which not only has made it difficult to overturn case law but also has left the legislator with very little room for manoeuvre in relation to any future (secondary) EU law. What is therefore of special interest in terms of legitimacy is the legal reasoning by which the Court has made its contribution to the development of this framework. This article is a re-appraisal of the legal development in this field.

Health care, solidarity, ECJ, free movement of services

Boundaries are of pivotal importance when it comes to health care systems. They are necessary because partial solidarity,² which forms the basis of the welfare state, requires boundaries.³ If boundaries are essential for the functioning of the welfare state, then the connection between the welfare state and nation state only becomes obvious because with the advent of the nation state, societies have been transformed into highly bounded entities.⁴ The range of impact the health care framework of the EU can have on boundaries reaches from making them more

¹ Academic Fellow, University of Lancaster. I gratefully acknowledge the award of a British Academy Mid-Career Fellowship. I am thankful to Sonja Puntcher-Riekman for hosting me during parts of the summer 2013 at the Salzburg Centre of European Union Studies where a first draft of this article was written. I am grateful to Professor Gareth Davies and Professor Steven Weatherill and, as always, Lisa Warren for their comments on an earlier draft. All errors remain mine. The author can be contacted at <c.rieder@lancaster.ac.uk>.

² This is to be contrasted with the solidarity of the Good Samaritan.

³ M Ferrera, *The Boundaries of Welfare. European Integration and the New Spatial Politics of Social Protection* (Oxford University Press 2005) 2.

⁴ A Giddens, *The Consequences of Modernity* (Polity 1990) 14.

permeable which means that the individual health care systems become *coordinated* to *integration* which means that boundaries are dissolved or redrawn.⁵

Generally it seems fair to say that patients wish to exit their system of affiliation predominately for two reasons: first, they prefer to have access to the treatment they need as quickly as possible; I will call this the ‘vector of time’. Secondly, patients hope for better treatment which can either mean that the same treatment is performed more skilfully elsewhere or patients seek to gain access to treatment which is not even available in their system of affiliation; I will refer to this as the ‘vector of treatment’. It is therefore of no coincidence that the authorisation regime of the EU, which regulates the terms and conditions when patients become allowed to exit their system of affiliation, focuses on the above mentioned vectors of ‘time’ and ‘treatment’. In particular, secondary EU law and here most notably, Article 20 of Regulation No 883/2004,⁶ gives a rather detailed account of the two vectors as will be outlined below.

The Court, beginning implicitly with *Luisi and Carbone*⁷ and explicitly continued in the seminal case of *Kohll*⁸ decided to link health care with free movement of services (Article 56 et seq. TFEU). This move by the Court turned out to be rather ‘controversial’⁹. The Court, has been criticised on various occasions for its ‘activism’, especially in relation to its interpretation of Treaty provisions.¹⁰ However, activism in relation to the Treaty is a particularly sensitive matter because it is relatively easy for the Court to transform itself into

⁵ Ferrera, op. cit. *supra* note 3, 3.

⁶ Regulation (EC) No 883/2004/EC of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems [2004] O.J. L 166/1.

⁷ Joined Cases 286/82 and 36/83 *Luisi and Carbone*, EU:C:1984:35, para 16.

⁸ Case C-158/96 *Kohll*, EU:C:1998:171, para 29.

⁹ A. G. Sharpston, C-512/08 *Commission v France*, EU:C:2010:427, para 1 (reference omitted).

¹⁰ Cf J Snell, ‘The Legitimacy of Free Movement Case Law: Process and Substance’ in M Adams *et al.* (eds.), *Judging Europe’s Judges. The Legitimacy of the Case Law of the European Court of Justice* (Hart Publishing 2013) 109, 111-112.

an agenda setter which is capable of limiting options available not only for the national but also the EU legislator.¹¹ The most recent evidence in this regard is Directive 2011/24 which regulates the rights of patients in cross-border health care. The EU legislator – as a consequence of the Court’s case law – was *de facto* left with only limited choices to make.¹² These considerations award a reappraisal of the existing case law.

The aim of this article is to give a reconstructive account regarding the legitimacy of the Court’s case law in the field of patient migration. In contrast to the existing literature this article seeks to justify the use of primary EU law in the field of health care by making reference to secondary EU health care law, that is, most notably Article 20 Regulation 883/2004. Conceptually this approach is based on Dworkin’s idea which treats law as integrity. Briefly stated, respecting the integrity of law requires one to look back in history in order to establish whether principles have been applied consistently over time. This will be the focus of section 1 of this article. Yet integrity in law also makes it necessary to ‘look across’ in order to study whether principles are established consistently across the law. This will be the focus of sections 2 and 3.¹³ Law as integrity means that every judge interprets the law in accordance with its best possible reading.¹⁴

1. The Meaning of Free Movement of Services

¹¹ M Dougan, ‘The Bubble that Burst: Exploring the Legitimacy of the Case Law on the Free Movement of Union Citizens’ in M Adams *et al.* (eds.), *Judging Europe’s Judges. The Legitimacy of the Case Law of the European Court of Justice* (Hart Publishing 2013) 127, 129-130; G Davies, ‘Legislative Control of the European Court of Justice’ 51 *Common Market Law Review* (2014) 1579, 1603.

¹² Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the Application of Patient’s Rights in Cross-Border Health Care [2011] O.J. L88/45.

¹³ R Dworkin, *Law’s Empire* (Hart Publishing 1998) 227-228.

¹⁴ *Ibid.*, 360.

In order to establish whether health care constitutes a service in accordance with the Treaty the starting point is Article 57 TFEU which stipulates that '[s]ervices shall be considered to be "services" within the meaning of the Treaties where they are normally provided for remuneration.' In legal positivist thinking the provision clearly constitutes an example of 'open texture', that is, one finds 'duality of a core of certainty and a penumbra of doubt'.¹⁵ The existence of doubt is also evidenced by the disagreement which is usually rare to find between the Court and its Advocate Generals. Yet it surfaced on the question as to whether free movement of services ought to be applicable in relation to health care. The two Advocate Generals developed their (dissenting) arguments in the light of the Court's (earlier) case law in the field of education. Such mutual references are plausible because health care and education are both public services for which 'many of the same arguments apply'.¹⁶ Yet in *Humbel*¹⁷ the Court had found that education does not constitute a service which is provided for remuneration, whereas in health care the Court arrived at the opposite conclusion.

Two preliminary observations can be made about the relationship between education and health care. First, and based on the involvement of solidarity, Somek argues that the Court should have pursued the same approach it had chosen in public education and decided that health care is beyond the reach of the Treaty.¹⁸ This is in line with Hervey who considers solidarity to be 'a buttress against market law'.¹⁹ Second, Shuibhne argues that the two strands of case law are not only conflicting but evidence of the Court's 'incompleteness of reasoning

¹⁵ H L A Hart, *The Concept of Law*, 3rd ed. (Oxford University Press 2012) 123.

¹⁶ J Le Grand, *The Other Invisible Hand: Delivering Public Services through Choice and Competition* (Princeton University Press 2000) 96.

¹⁷ Case 263/86 *Humbel*, EU:C:1988:451, para 20; also N Bernard, 'Between a Rock and a Soft Place: Internal Market versus Open Co-ordination in EU Social Welfare Law' in M Dougan and E Spaventa (eds.), *Social Welfare and EU Law* (Hart Publishing 2005) 261, 270-275.

¹⁸ A Somek, 'Solidarity Decomposed: Being and Time in European Citizenship', 32 *European Law Review* (2007) 787, 788-789.

¹⁹ T K Hervey, 'Social Solidarity: a Buttress against Internal Market Law', in J Shaw (ed.), *Social Law and Policy in an Evolving European Union* (Hart Publishing 2000) 31-47.

and the selective citation of existing authority.’²⁰ If her finding is persuasive this presents a serious problem for the Court because legal reasoning and legitimacy are interconnected.²¹ It is therefore necessary to examine whether a plausible argument can be made which allows for treating health care and education differently or, alternatively, whether it must be concluded that one was decided wrongly. One can argue that judges are faced with hard cases when it comes to health care.

INTERPRETATION THROUGH TEXTUALISM

The story of cross-border movement begins – as is well known – with Mr Kohll’s daughter who was insured in Luxembourg but had received dental treatment by an orthodontist established in Germany. In line with Luxembourg national law but also Article 22 of Regulation No 1408/71 Mr Kohll had asked for prior authorisation from the competent national authority but was denied on grounds that his daughter’s dental treatment was neither urgent (vector of time) nor unavailable (vector of treatment) in Luxembourg. However, the legal journey did not end there. Advocate General Tesouro considered ‘medical activities’ to constitute a service in accordance with Article 57 TFEU.²²

When the case reached the ECJ it found without offering further justification that the treatment by the German dentist constituted a service in accordance with the Treaty.²³ The consequence of this ruling was that health care treatment, more specifically non-hospital treatment, became part of free movement law. It is submitted that the character of legal

²⁰ N N Shuibhne, *The Coherence of EU Free Movement Law. Constitutional Responsibility and the Court of Justice* (Oxford University Press 2013) 66.

²¹ Cf. G Beck, *The Legal Reasoning of the Court of Justice of the EU* (Hart 2012) 92-95.

²² A.G. Tesouro, Cases C-120/95 (*Decker*) and C-158/96 (*Kohll*), EU:C:1997:399, paras 15-25.

²³ *Kohll*, op. cit. *supra* note 8, para 29.

reasoning applied by the Court and its Advocate Generals can be best categorised as textualism. According to US Supreme Court Justice Antonin Scalia, one of its chief proponents, the core characteristic of this method is that '[t]he text is the law, and it is the text that must be observed.'²⁴

Yet the consensus between the Court and its Advocate Generals that had still existed in *Kohll* came to an abrupt end with the subsequent cases of *Geraets-Smits and Peerbooms*²⁵ and *Vanbraekel*.²⁶ Judgments for both cases were delivered on the same day. Despite some factual changes about the way treatment was delivered in *Kohll* – hospital treatment instead of non-hospital treatment, and the organisation of the system, benefits in kind instead of reimbursement – the basic question remained the same, namely whether services offered by public health care systems are provided for remuneration? The Court – in both cases – only made brief reference to the ‘settled case law’ of *Luisi and Carbone* and *Kohll* before it found, without hesitating, that medical services would fall indeed under the provisions of free movement of services.²⁷ The Court simply argued that the mere fact that fees are pre-set and paid by a third party, i.e. the public insurance system, does not rule out the application of Article 57 TFEU.²⁸

In contrast to the Court, Advocate General Saggio in his Opinion in *Vanbraekel* found ‘that services which, on the one hand, are an integral part of the public health-care system, in the sense that they are established and organised by the State, and, on the other hand, are financed by public funds, *must be excluded* from the provisions on freedom of movement’.²⁹ The same conclusion was reached by Advocate General Colomer in *Geraets-Smits and*

²⁴ Antonin Scalia, *A Matter of Interpretation* (Princeton University Press 1997) 22.

²⁵ Case C-157/99, *Geraets-Smits and Peerbooms*, EU:C:2001:404.

²⁶ Case C-368/98, *Vanbraekel*, EU:C:2001:400.

²⁷ *Geraets-Smits and Peerbooms*, op. cit. *supra* note 25, para 53; *Vanbraekel*, *ibid.*, para 41.

²⁸ *Geraets-Smits and Peerbooms*, op. cit. *supra* note 25, paras 56-57.

²⁹ A.G. Saggio, *Vanbraekel*, EU:C:2000:271, para 21 (emphasis added).

Peerbooms,³⁰ who also highlighted the organisational differences between the Luxembourg health care system in *Kohll* and the Dutch system in *Geraets-Smits and Peerbooms*. The Advocate General concluded that only the Dutch system is ‘free for insured persons’.³¹ The reasoning of the Advocate General, arguably, was inspired by the earlier case law on education. In the earlier case of *Gravier*, Advocate General Slynn had already addressed the question of whether education could possibly constitute a service which falls under the umbrella of the Treaty.

The Advocate General thought that education could amount to ‘economic activities’³² which were then to be governed by Article 57 TFEU. At the same time he also found that in the specific case of state education this was not the case because its aim was not to make economic profit. The Advocate General argued instead, that education forms part of the social policy of the state which covers all or most of its costs.³³ In the later (education) case of *Humbel* the Court endorsed the reasoning of Advocate General Slynn albeit with a slightly further developed definition about the meaning of ‘remuneration’. For a service to be covered by the law on free movement of services, according to the Court, the service must, first, engage ‘in *gainful activity*’, secondly must not simply be the *fulfilment of duties* which a state has in relation to its own people and thirdly, must not be ‘*funded from the public purse*’.³⁴ Applying these criteria in the context of public education the Court concluded that education did not constitute a service which is provided for remuneration.³⁵

³⁰ A.G. Colomer, *Geraets-Smits and Peerbooms*, EU:C:2000:274, para 33.

³¹ *Ibid.*, paras 25 (emphasis added); a rather similar argument was made in Case C-372/04 *Watts*, EU:C:2006:325 which originated from the English National Health Service (NHS).

³² A.G. Slynn, C-293/83 *Gravier*, EU:C:1985:69, 602.

³³ *Ibid.*, 603.

³⁴ *Humbel*, op. cit. *supra* note 17, para 18 (emphasis added).

³⁵ *Ibid.*, para 20.

The important question which then needs to be addressed is whether these criteria, developed in the field of education, are at all helpful and can be meaningfully translated into the area of health care. The ‘profit-argument’, invoked by the Court, generally does not seem particularly useful in order to determine whether a respective service is provided for remuneration. Even in competition law, where the identification of economic activity is essential, the marker of ‘profit-making’ is absent.³⁶ Also, it appears that the Court in the meantime has forgone of the profit argument altogether because it has been absent in the Court’s later case law on education.³⁷ In addition, the ‘duty-argument’, which was also mentioned by the Court, does not necessarily constitute a helpful marker either because all actions of a state, as Davies rightly points out, are – one way or another – a fulfilment of its duties.³⁸

For a ‘transaction’ to be commercial, arguably, it is necessary that payer and recipient of the service are sufficiently distinct. This is not necessarily the case if ‘[t]he payer and the provider are essentially working together to provide a single service, rather than exchanging that service for money.’³⁹ In order to illustrate this point Davies uses state universities as an example which most likely are organised as part of the Ministry of Education.⁴⁰ The overall problem with this argument, which is based on ‘separateness’ of entities, is that it appears to operate less with absolute but more relative categories. This naturally begs the question: how much separateness is needed or what is considered to be too close? Closely related with transaction is the ‘funding-argument’.

³⁶ G Davies, ‘Welfare as a Service’, 29 *Legal Issues of Economic Integration* (2002) 27, 29-30.

³⁷ Case C-76/05 *Schwarz*, EU:C:2007:492, para 39.

³⁸ Davies, op. cit. *supra* note 36, 32.

³⁹ *Ibid.*, 35.

⁴⁰ *Ibid.*, 34-35.

It is this argument which seems conceptually most closely connected to ‘remuneration’. For this reason alone, it is presumably the most interesting and promising one. Consequently, it deserves to be addressed in more detail. Davies undertakes an elaborate attempt to conceptually distinguish education from health care depending on how funding is organised. With an emphasis on the transaction aspect, Davies argues that a service is provided for remuneration when a private insurance company pays for a hospital but also if, for example, the state pays a private company in order to provide a specific service. Under these circumstances a service will undoubtedly be offered for remuneration. Also, a service is provided for remuneration when the state specifically ‘sells’ this service to the public.⁴¹

In the context of health care we find a specific version of the transaction problem. In the English case of *Watts*,⁴² the Court found – in line with its earlier case law – free movement law to be applicable; the English National Health Service (NHS) is tax funded and delivers its services free of charge.⁴³ The Court in its legal reasoning in *Watts* focussed exclusively on the cross-border dimension of the transaction, that is, a patient pays a health care provider directly in another Member State and is then reimbursed by the system of affiliation.⁴⁴ In other words, the private individual is reimbursed by the state. This in turn allowed the Court to come to the conclusion that there was no need in the case of *Watts* ‘to determine whether the provision of hospital treatment in the context of a national health service such as the NHS is in itself a service within the meaning of those provisions’.⁴⁵ Accordingly, Spaventa accuses the Court of

⁴¹ G Davies, ‘The Process and Side-Effects of Harmonisation of European Welfare States’ (2006) *Jean Monnet Working Paper No 02/06 (2006)* 17.

⁴² The case of *Watts* was about an English patient who jumped the NHS waiting lists and went to France in order to receive a hip replacement.

⁴³ On the organisation of the NHS see C Newdick, *Who Should We Treat? Rights, Rationing, and Resources in the NHS*, 2nd ed. (Oxford University Press 2005) Chapter 4.

⁴⁴ Cf. W Gekiere, R Baeten and W Palm, ‘Free Movement of Services in the EU and Health Care’, in E Mossialos et al. (eds), *Health Systems Governance in Europe: The Role of European Union Law and Policy* (Cambridge University Press 2010) 461, 467.

⁴⁵ *Watts*, op. cit. *supra* note 31, para 91.

using a ‘hermeneutic “trick”.’⁴⁶ *Watts* clearly shows that attempts of conceptualising the Court’s case law along the lines of textualism does not deliver convincing results. It is therefore necessary to find an alternative approach which provides more persuasive answers.

LAW AS INTEGRITY

It is submitted that law as integrity offers a promising alternative in order to conceptualise the case law of the Court. Dworkin explains the character of integrity through an analogy in which novelists meet in order to write a chain novel. Each of the novelists involved in this project is responsible to write one specific section or chapter of that novel. They are only able to do this in a meaningful way, if they interpret the story that has been written so far.⁴⁷ Their task but also their technique compares with the one applied by a common law judge⁴⁸ who needs to engage with history as a consequence of the practice of *stare decisis*.⁴⁹ The judge

must interpret what has gone before because he has a responsibility to advance the enterprise in hand rather than strike out in some new direction of his own. So he must determine, according to his own judgment, what the earlier decisions come to, what the point or theme of the practice so far, taken as a whole, really is.⁵⁰

Looking at the problem from this perspective one question to ask is whether health care and education share similar historical ‘chains of law’⁵¹ and are therefore at all comparable to

⁴⁶ E Spaventa, *Free Movement of Persons in the European Union: Barriers to Movement in Their Constitutional Context* (Kluwer Law International 2008) 56.

⁴⁷ R Dworkin, ‘Law as Interpretation’, 9 *Critical Inquiry* (1982) 179, 193.

⁴⁸ Dworkin applies the concept of integrity also in relation to statutory and constitutional law: Dworkin, *supra* n. 13, Chapters 9 and 10.

⁴⁹ S Herschovitz, ‘Integrity and Stare Decisis’ in S Herschovitz (ed.), *Exploring Law’s Empire. The Jurisprudence of Ronald Dworkin* (Oxford University Press 2006) 103, 104.

⁵⁰ Dworkin, *op. cit. supra* note 47, 193-194.

⁵¹ Dworkin, *op. cit. supra* note 13, 228.

or relevant for each other in the context of integrity. The legal history regarding the migration of patients in EU law shows that Chapter 1 of Regulation No 3/58, which belonged to the first laws ever passed by what was then the European Economic Community, had already included laws regulating the cross-border movement of patients.⁵² The legal basis of Regulation No 3/58 was Article 51 EEC⁵³ (now Article 48 TFEU) whose aim was to facilitate the free movement of workers by providing them with social security. Welfare in general and health care in particular therefore constitute an ‘accessory’ to the internal market. Hence the law is an acknowledgement of the special nature of the free movement of workers with its social dimension.⁵⁴

In comparison, the legal history of education has developed differently. Originally there was neither any mentioning of education in the Treaty nor was education covered by secondary legislation.⁵⁵ At first sight, it may be somehow surprising that neither primary nor secondary EU law deemed it necessary to bring together education and the internal market. Yet at the beginning of European integration the value of knowledge (*Wissensgesellschaft*) for the individual and a society was not as obvious and compelling as it is today.⁵⁶ In fact, it was the field of agriculture – evidenced by the Common Agricultural Policy – which was considered to be the most prominent economic factor.⁵⁷ In the light of this development it does not come

⁵² Verordnung Nr 3/58 (EWG) vom 16. Dezember 1958 über die Soziale Sicherheit von Wanderarbeitnehmern (ABl 1958, 30/561, text only available in DE, FR, IT, NL) Kapitel 1.

⁵³ Treaty Establishing the European Economic Community, Rome 25 March 1957.

⁵⁴ Cf P C de Sousa, *The European Fundamental Freedoms. A Contextual Approach* (Oxford University Press 2015) 68-71.

⁵⁵ A P van der Mei, *Free Movement of Persons within the European Community. Cross-Border Access to Public Benefits* (Hart Publishing 2003) 333.

⁵⁶ Cf U Beck, *Risk Society. Towards a New Modernity* (Sage 1992; transl. by M Ritter) 46-48.

⁵⁷ A Moravcsik, *The Choice for Europe. Social Purpose and State Power from Messina to Maastricht* (Cornell University Press 1998) 89 (Table 2.2).

as a surprise that the Maastricht Treaty finally included Article 126.1 TEU⁵⁸ [now Article 165.1 TFEU] which specifically addresses the issue of (higher) education.

The analysis seems to have reached a point where it is possible to bring together the different threads and provide a preliminary answer to the question which stood at the beginning of this first part: is health care a service provided for remuneration? Clearly the analysis of the legal history showed that health care has received considerable attention by the EU legislator already from the beginning of European integration. As suggested, one of the earliest pieces of secondary legislation covered aspects of cross-border movement of patients even if only as an accessory to and in order to improve the functioning of the internal market. In comparison, education (legally) had a somewhat slow(er) start than health care.⁵⁹ Therefore, it would appear – from the perspective of integrity – that a different treatment of education and health care is justifiable.

And yet, when it comes to integrity, it is not enough to simply ‘look back’ in time. It is also necessary to ‘look across’ and examine as to whether there exists consistency horizontally in relation to the relevant principles, that is, ‘across the range of the legal standards the community now enforces’.⁶⁰ The point which therefore needs to be developed further in this article is whether the Court’s activity in the field of health care has created some incoherence with the established principles. The framework of reference which will be used is based on the principles of integration and coordination. Only once consistency of these principles is established horizontally, is it possible to have a satisfactory answer to the question, which is at

⁵⁸ Treaty on European Union [1992] O.J. 191/23.

⁵⁹ van der Mei, *op. cit. supra* note 55, 340-347.

⁶⁰ Dworkin, *op. cit. supra* note 13, 227.

the centre of this article: did the judges of the ECJ behave in an Herculean manner and read EU health care law in the best possible light?

2. The Principle of Coordination

The characteristic of the principle of coordination is that it preserves the substance of boundaries, but additionally seeks to make boundaries more permeable. One consequence of the preservation of boundaries is that the authority of Member States, which is to be found within these boundaries, remains.⁶¹ From a constitutional perspective therefore it can be argued that integration, which will be discussed in more detail below, is linked to sovereignty and the authority to act,⁶² whereas coordination impacts only on the autonomy, that is, the capacity to act.⁶³ Coordination can be categorised into perfect and imperfect coordination. The cases of *Pierik*⁶⁴ suggest that perfect coordination and integration can come rather close in terms of their effects.

In the two *Pierik* cases the Court interpreted a predecessor version of Article 20 Regulation No 883/2004, that is, Article 22.2 Regulation No 1408/71⁶⁵ which stipulated that '[t]he authorisation required ... may not be refused where the treatment in question cannot be

⁶¹ Cf. A Hurrell, 'International Law and the Making and Unmaking of Boundaries' in A Buchanan and M Moore (eds.), *States, National, and Borders. The Ethics of Making Boundaries* (Cambridge University Press 2003) 275, 279.

⁶² S Leibfried and P Pierson, 'Semisovereign Welfare States: Social Policy in a Multitiered Europe', in S Leibfried and P Pierson (eds.), *European Social Policy. Between Fragmentation and Integration* (The Brookings Institution 1995) 43, 44.

⁶³ Cf. K A Armstrong, *Governing Social Inclusion. Europeanization through Policy Coordination* (Oxford University Press 2010) 41.

⁶⁴ Case 117/77 *Pierik*, EU:C:1978:72; Case 182/78 *Pierik (No 2)*, EU:C:1979:142.

⁶⁵ Regulation (EEC) No 1408/71 of the Council of 14 June 1971 on the Application of Social Security Schemes to Employed Persons and their Families Moving within the Community, English Special Edition: Series I Chapter 1971(II) 416.

provided for the person concerned within the territory of the Member State in which he resides.’ The ECJ, when interpreting the wording of that said norm concluded that it would cover two scenarios: first, the treatment which is provided in the destination state is ‘more effective’⁶⁶ than the one available in the home state. Secondly, a particular treatment is unavailable in the home state altogether. One consequence of the Court’s interpretation of the norm was that patients were given access to the best treatment available in Europe.

The Court justified its interpretation of the relevant provision by arguing ‘that it was the *intention* of the regulation to give *medical requirements* a decisive role’.⁶⁷ I do not intend to discuss the problems related with intentional interpretation.⁶⁸ Member States responded to the Court’s ruling by amending Article 22 of Regulation 1408/71. They added two criteria, the primary aim of which was to regulate the impact the health care framework of the EU has on national systems. Member States clarified that authorisation to patients only has to be given for treatment which is ‘*among the benefits provided*’ (vector of treatment) and if provided, ‘*within the time normally necessary* for obtaining the treatment in question in the Member State of residence, taking account of his current state of health and the probable course of the disease’⁶⁹ (vector of time).

While secondary EU law allows for authorisation which is an essential feature of coordination, Article 56 TFEU stipulates that ‘[w]ithin the framework of the provisions set out below, *restrictions* on freedom to provide services within the Union shall be prohibited.’⁷⁰ Yet even the free movement provisions of the Treaty do not entitle patients to exit their system of

⁶⁶ Case 117/77, *Pierik*, EU:C:1978:72, para 22.

⁶⁷ Case 182/78, *Pierik (No 2)*, EU:C:1979:142, para 12 (emphasis added).

⁶⁸ J Waldron, *Law and Disagreement* (Oxford University Press 1999) Chapter 6.

⁶⁹ Article 22.2 Council Regulation (EEC) No 2793/81 of 17 September 1981 amending Regulation (EEC) No 1408/71 on the application of social security schemes to employed persons and their families moving within the Community and Regulation (EEC) No 574/72 fixing the procedure for implementing Regulation (EEC) No 1408/71.

⁷⁰ Emphasis added.

affiliation under all circumstances. Member States remain entitled to put in place certain restrictions of free movement law. According to Article 52 TFEU, derogations are possible based on public policy, public security or public health. In addition, the Court has developed ‘mandatory requirements’ which provide grounds of justifications in order to limit the free movement law.⁷¹ The difficult question that remains, however, is to establish what type of regulatory framework constitutes an acceptable or legitimate restriction on freedom?

In order to develop a legitimate balance of such a framework the Court usually draws on the principle of proportionality. The principle needs to address the impact the framework of the EU has on waiting lists and the scope of treatment. In health care it is the concept of solidarity which is ‘submitted to one or the other version of a proportionality test’.⁷² The aim of proportionality is to protect specifically recognised interests.⁷³ The principle of proportionality is especially useful because it allows to balance ‘a liberal rights-based constitutional rationality with a strong commitment to a welfare state’.⁷⁴ Yet the essential problem with the proportionality test is that the various versions of it are all based on an ‘open-ended formula’.⁷⁵ Therefore, the proportionality test is sometimes considered to simply conceal political decisions behind a veil of verbose, albeit substantively weak, legal reasoning.⁷⁶ In order to establish whether the Court upheld the principle of coordination to a similar degree in comparison to the Regulation, the pivotal question to consider is how the proportionality test deals with the two critical parameters of time and treatment.

⁷¹ D Chalmers *et al.*, *European Union Law*, 3rd ed. (Cambridge University Press 2014) 899-901.

⁷² Somek, *supra* n. 18, 6.

⁷³ G de Búrca, ‘The Principle of Proportionality and its Application in EC Law’, 13 *Yearbook of European Law* (1993) 105, 106.

⁷⁴ T-I Harbo, ‘The Function of the Proportionality Principle in the EU’, 16 *European Law Journal* (2010) 158.

⁷⁵ G Conway, *The Limits of Legal Reasoning and the European Court of Justice* (Cambridge University Press 2012) 218.

⁷⁶ Sousa, *op. cit. supra* note 54, 45.

THE VECTOR OF TIME

In relation to the first parameter, that is, ‘waiting times’ the Court in *Inizan*⁷⁷ interpreted Article 22.2 of Regulation No 1408/71 with reference to and in analogy with the cases *Geraets-Smits and Peerbooms*⁷⁸ as well as *Müller-Fauré and Van Riet*;⁷⁹ all of which addressed ‘time’ in the context of the Treaty. Advocate General Villalón in the very recent case of *Elchinov* reasoned that since the Court repeats the same statement of law, irrespectively of whether it is dealing with a case based on the Treaty or the Regulation, the only sensible conclusion to be drawn is that it ‘[is] placing the interpretation of the Treaty and the interpretation of secondary law on an equal footing in case-law.’⁸⁰

Arguably, in a rather unusual way the ECJ filled the ‘open-ended formula’ of the proportionality test by drawing on *lex specialis*, i.e. Regulation, which thereby became a ‘controlling factor’.⁸¹ Because the Court cannot rule out, as will be argued subsequently, that EU health care law impacts on the national systems, it fills the gaps with existing secondary law and thereby upholds the integrity of the law. Thus, the Court ensured that it transferred the principle of coordination, which is in operation in the context of the Regulation, as approximate as possible from the Regulation context, into the Treaty context. According to Article 20.2 of Regulation No 883/2004 the maximum waiting time is based on whatever is ‘medically justifiable’ which seems however, to limit the authority of Member States.

⁷⁷ Case C-56/01, *Inizan*, EU:C:2003:578.

⁷⁸ *Geraets-Smits and Peerbooms*, op. cit. *supra* note 25, para 103.

⁷⁹ Case C-385/99, *Müller-Fauré and Van Riet*, EU:C:2003:270, para 89.

⁸⁰ A.G. Villalón, Case C-173/09, *Elchinov*, EU:C:2010:336, para 77; cf. also A.G. Geelhoed, C-372/04, *Watts*, EU:C:2005:784, para 101; he was followed by the Court in the subsequent judgment (paras 60-64); but see van der Mei writing a few years earlier (*supra* n. 55) 305.

⁸¹ Conway, *supra* n. 75, 275.

Yet, the question of whether a specific treatment is ‘medically justifiable’ constitutes no longer a problem of interpretation but, if we apply MacCormick’s framework, one of ‘classification’.⁸² This finding goes beyond pure semantics because the question whether specific factual circumstances fit a described class, transforms a problem of interpretation into one of fact.⁸³ While generally a court needs to make a decision about facts and law in one judgment, in the EU context we encounter a strict ‘division of functions’⁸⁴ between the national courts and the ECJ. This means that the ECJ at most wields the authority of persuasion to impose its preferences on Member States.⁸⁵

In the Dutch case of *Geraets-Smits and Peerbooms* the specific treatment in question was not covered by national insurance rules. According to the Dutch decree on sickness insurance benefits in kind, medical and surgical care, the treatment provided by a general practitioner and a specialist is only covered if it is considered ‘*normal* in the professional circles concerned’.⁸⁶ There are two ways how to interpret the word ‘normal’ in this context: it can be understood either with reference to the ‘national’ or alternatively ‘international’ medical circles.⁸⁷ While the Court accepted that the phrase in question ‘[was] open to a number of interpretations’,⁸⁸ it concluded nevertheless that it needed to be interpreted as ‘sufficiently tried and tested by *international medical science*’.⁸⁹ If the relevant norm were to be interpreted in a way that it only covers ‘treatment habitually carried out on *national territory* and scientific

⁸² N MacCormick, *Rhetoric and the Rule of Law. A Theory of Legal Reasoning* (Oxford University Press 2005) 43.

⁸³ *Ibid.*, 141- 142.

⁸⁴ G Davies, ‘Activism Relocated. The Self-Restraint of the European Court of Justice in its National Context’, 19 *Journal of European Public Policy* (2012) 76, 78.

⁸⁵ *Ibid.*, 79.

⁸⁶ *Geraets-Smits and Peerbooms*, op. cit. *supra* note 25, para 10 (emphasis added).

⁸⁷ *Ibid.*, paras 96-97.

⁸⁸ *Ibid.*, para 92.

⁸⁹ *Ibid.*, para 94 (emphasis added); also C Kopetzki, ‘Behandlung auf dem “Stand der Wissenschaft” ’ in W J Pfeil (ed.), *Finanzielle Grenzen des Behandlungsanspruchs* (MANZ 2010) 9, 14.

views prevailing in national medical circles to determine what is or is not normal’,⁹⁰ it would be quite likely that generally Dutch providers were to be preferred. While the effects of the Court’s judgment seem to fall along the correct lines, its reasoning – based on the language of discrimination – does not persuade fully.

A better approach seems the one chosen by Advocate General Colomer who rejects any of the territorial references by arguing that ‘[t]he criterion of what is normal in professional circles, ... is determined on *objective medical grounds* and without regard to the place where the treatment is provided.’⁹¹ The gist of the reasoning of the Advocate General also resonates in the submission by the Dutch Government which was of the opinion, and this may come with little surprise, that ‘professional opinion in the Netherlands is also based on the *state of the art and on scientific thinking at international level* and depends on whether, in the light of the state of national and international science, the treatment is regarded as normal treatment’.⁹² One reason as to why the judges may have invoked the language of discrimination may be a consequence of the fact that the ECJ cannot rule on the meaning of national law, whereas the issue of discrimination gives them a better handle on the substance.

THE VECTOR OF TREATMENT

With regard to the second factor, scope of treatment, the Court held on more than one occasion that EU law ‘*cannot, in principle, have the effect of requiring a Member State to extend such lists of medical benefits.*’⁹³ Consequently, ‘the fact that a particular type of medical treatment

⁹⁰ *Geraets-Smits and Peerbooms*, op. cit. *supra* note 25, para 96 (emphasis added).

⁹¹ A.G. Colomer, op. cit. *supra* note 30, para 43 (emphasis added).

⁹² *Geraets-Smits and Peerbooms*, op. cit. *supra* note 25, para 93 (emphasis added).

⁹³ For example: Case C-173/09 *Elchinov*, EU:C:2010:581, para 58 (emphasis added).

is covered or not covered by the sickness insurance schemes of *other Member States* is irrelevant in this regard'.⁹⁴ Both statements of the Court suggest that the EU health care framework is rather deferential to national law. The Court, in *Müller-Faurè and Van Riet*, echoed this finding when it held that the 'achievement of the fundamental freedoms guaranteed by the Treaty inevitably requires Member States to make some *adjustments* to their national systems of social security. It does not follow that this would undermine their *sovereign powers* in this field.'⁹⁵

In this context the Bulgarian case of *Elchinov* is of interest. The Bulgarian health care system offers a mix between definitive lists of covered benefits but also describes what constitutes such benefits in rather generic wording.⁹⁶ Mr Elchinov, having been diagnosed with a malignant oncological disease, requested authorisation from the competent Bulgarian authority in order to receive treatment in a specialist clinic in Germany. The considerable advantage of the treatment in Germany was that Mr Elchinov's eye was saved. The relevant section of the Bulgarian health insurance law stipulates that treatment covered by the public health care system includes in No 136 'other operations on the eyeball' and in No 258 'high technology radiotherapy for oncological and non-oncological conditions'.

In a preliminary ruling to the ECJ the Bulgarian national court wanted to know, among other things, whether the fact that this specific, less invasive, treatment offered in Germany, not available in Bulgaria, yet covered by Bulgarian national law, would qualify as 'treatment in question' in accordance with what was then Article 22.2 of Regulation 1408/71. The Court in *Geraets-Smits and Peerbooms* had already held that 'treatment in question' refers to 'the

⁹⁴ *Geraets-Smits and Peerbooms*, op. cit. *supra* note 25, para 87 (emphasis added).

⁹⁵ *Müller-Faurè and Van Riet*, op. cit. *supra* note 79, para 102 (emphasis added).

⁹⁶ A.G. Villalón, op. cit. *supra* note 80, para 60.

same or equally effective treatment’.⁹⁷ Consequently, if Bulgarian national law, as was the case in *Elchinov*, decides to cover less invasive treatment, arguably, the more ‘effective treatment’ – this means that the more invasive treatment actually available in Bulgaria – can no longer be considered to amount to the ‘treatment in question’. Whether the treatment is more effective, however, is ultimately a question of fact. Thus again, this means that the ECJ does not have the authority to make a decision.

Nevertheless, the Bulgarian case appears to constitute an example where an increase in national solidarity is required as a consequence of EU law, that is, as a consequence of the interpretation of what constitutes ‘treatment in question’. Yet a different, more accurate, interpretation of the legal practice seems to be that the Bulgarian legislator can simply adjust the law to its realities and remove from the list of covered treatments the wording ‘other operations on the eyeball’ and ‘high-technology radiotherapy for oncological and non-oncological conditions’ if the health care system only intends to offer treatment which amounts to a complete removal of the eyeball (‘enucleation’).⁹⁸ Therefore it seems obvious that the Bulgarian legislator has retained its authority.

Davies has made the observation that often because of the direct application of free movement rights of the Treaty they can provide a useful and powerful tool for the court to foster integration ‘where secondary legislation does exist, but does not grant the rights desired’.⁹⁹ At least in the field of health care this finding is not supported. In fact, the conclusion must be the other way around. The examples studied suggest that the Court draws on secondary

⁹⁷ *Geraets-Smits and Peerbooms*, op.cit. *supra* note 25, para 103.

⁹⁸ AP van der Mei, ‘Case C-512/08, *Commission v. France*, Judgment of the European Court of Justice (Grand Chamber) of 5 October 2010, nyr, and Case C-173/09, *Georgi Ivanov Elchinov v. Natsionalnadravnoosiguritelna kasa*, Judgment of the Court of Justice (Grand Chamber) of 5 October 2010, nyr’ 48 *Common Market Law Review* (2011) 1297, 1305-1306.

⁹⁹ Davies, op. cit. *supra* note 11, 1602.

legislation as a form of *lex specialis*. The Regulation covering free movement of patients in relation to the proportionality test in particular is used in order to interpret the more general law, that is, the Treaty. With regard to the integrity of law it can be concluded that the Court has invoked the Regulation even in the context of the Treaty and thus applies existing principles consistently. In other words, the degree of coordination is the same in the context of the Regulation and the Treaty. Finally, the discussion turns to the most controversial aspect of EU health care law, namely the integration of health care systems and the question of how this can be justified by a Herculean judge.

3. The Principle of Integration

Above it has been argued above that education and health care come from a different chain of EU law and also that health care law coordinates, whereas education integrates systems. However, to the extent that the Court removes any barriers to free movement of patients, arguably, health care is based on the principle of integration. And yet it would appear that there remains a difference between integration in health care and education. Integration in education has abolished the boundaries of membership, whereas integration in health care has only abolished the functional boundaries of health care systems. Therefore it does not come as a surprise that that education is no longer based on the law on free movement of services but on non-discrimination/citizenship law, whereas health care law is still exclusively driven by the law on free movement of services.¹⁰⁰

¹⁰⁰ Cf A Somek, *Individualism. An Essay on the Authority of the European Union* (Oxford University Press 2008) 201-204.

Thus, it is still necessary to establish whether the principle of coordination can be accommodated with the principle of integration as developed by the Court in health care. In the discussion about coordination in health care, the requirement of authorisation constitutes a focal point because depending on its nature it can either preserve or undermine the integrity of existing boundaries. This in turn then either fosters or hinders integration. While boundaries or the ruins of them are not necessarily an absolute barrier to free movement, they are nevertheless an obstacle to it. It therefore comes with little surprise that the ECJ considered the legal requirement of prior authorisation – imposed on patients who intend to undergo health care treatment in another EU Member State – to constitute a restriction on free movement of services which can only be upheld if justifiable.¹⁰¹

In this context an oddity regarding the qualification of what constitutes an obstacle to free movement law needs to be examined. While for some types of treatment, i.e. non-hospital treatment, the Court found national laws, which require prior authorisation, to be in conflict with the Treaty, it refused to come to the same conclusion in relation to secondary EU law, i.e. Article 20.2 of Regulation 883/2004. The Court tried to justify the difference by arguing that Article 42 EC Treaty (now Article 48 TFEU), which is the legal basis for Regulation 883/2004, ‘does not prohibit the Community legislature from attaching conditions to the rights and advantages which it accords in order to ensure freedom of movement for workers.’¹⁰² Yet one would think that the requirement of prior authorisation in health care amounts either to a violation of the free movement principle, or it does not.¹⁰³

¹⁰¹ *Kohll*, op. cit. *supra* note 8, paras 31-36.

¹⁰² *Inizan*, op. cit. *supra* note 77, para 23.

¹⁰³ P Cabral, ‘The Internal Market and the Right to Cross Border Medical Care’, 29 *European Law Review* (2004) 673, 679.

It appears that Cabral's conclusion is less compelling if one analyses the matter from the perspective of the 'no-impact-approximation'; by this I mean that the health care framework of the EU has no or rather limited impact on the national health care systems. Needless to say, that the nature of legal reasoning becomes now consequentialist.¹⁰⁴ Article 20 Regulation No 883/2004 reimburses patients in accordance with the tariffs of the Member State where the patient receives the treatment.¹⁰⁵ This can create either more or fewer costs for the Member State of affiliation but is counterbalanced, it is submitted, by the requirement for authorisation. Thus Member States, it has been argued, retain formally the legal authority of making the decision even if their autonomy to act may in fact be rather limited because the terms and conditions are predetermined – to a considerable degree – by the supranational level.

THE STATE OF PARETO-EFFICIENCY

The situation is different when it comes to the application of the Treaty. In *Kohll* the Court held that national laws which stipulate the need for prior authorisation are in conflict with the Treaty.¹⁰⁶ Thus Member States have lost the formal authority to grant permission. It is argued, that to the extent Member States have lost the formal legal authority to decide, this can only be justified if the migration of patients does not violate the no-impact-approximation. In other words, nobody is made worse off and at least one person, here the patient, is better off because

¹⁰⁴ Cf. M-B Dembour, *Who Believes in Human Rights? Reflections on the European Convention* (Cambridge University Press 2006) 78.

¹⁰⁵ Article 20.2 of Regulation No 883/2004: 'An insured person who is authorised by the competent institution to go to another Member State with the purpose of receiving the treatment appropriate to his/her condition shall receive the benefits in kind provided, on behalf of the competent institution, by the institution of the place of stay, in accordance with the provisions of the legislation it applies, as though he/she were insured under the said legislation.'

¹⁰⁶ *Kohll*, op. cit. *supra* note 8, para 54.

of the Court's intervention.¹⁰⁷ Pareto-efficiency embodies another important demand of integrity, namely that a government has 'equal concern' for the treatment of its citizens.¹⁰⁸ It may be disputed, from an empirical perspective, whether the case actually achieves this result but it is nevertheless important to note that both the Court and the Advocate General seem to make their arguments in this contextual framework.

Clearly, Advocate General Tesauro made reference to the possible effects EU health care law, based on free movement of services, could have on national solidarity and found: '[t]he only effect I can conceive of is that ... [the] orthodontist established in the same State [Luxembourg] will have lost one patient. It is therefore the individual practitioners who are adversely affected and *not the system itself*.'¹⁰⁹ The Court followed its Advocate General and added that 'it is clear that reimbursement of the costs of dental treatment provided in other Member States in accordance with the tariff of the State of insurance has *no significant effect* on the financing of the social security system'.¹¹⁰

The Court in its consequentialist reasoning in health care also acknowledged the necessity for an 'overall approach'. The judges considered it to be 'self-evident that assuming the cost of one isolated case of treatment, carried out in a Member State other than that in which a particular person is insured with a sickness fund, can never make any significant impact on the financing of the social security system.'¹¹¹ The Court thereby seemed to pursue an altogether different strategy in health care in comparison to the doctrine of 'unreasonable

¹⁰⁷ Cf M Maduro, *We the Court: The European Court of Justice and the European Economic Constitution* (Hart Publishing 1998) 152.

¹⁰⁸ Dworkin, op. cit. *supra* note 13, 222.

¹⁰⁹ A.G. Tesauro, op. cit. *supra* note 22, FN 90 (emphasis added).

¹¹⁰ *Kohll*, op. cit. *supra* note 8, para 42 (emphasis added).

¹¹¹ *Müller-Faurè and Van Riet*, op. cit. *supra* note 79, para 74.

financial burden'¹¹² which it had applied in education cases such as *Baumbast*¹¹³ and *Grzelczyk*.¹¹⁴ The obvious criticism raised against the Court then was that the micro-level findings were simply scaled up to the macro-level when the kernel of the problem would be that 'one *Baumbast* and one *Grzelczyk* cannot really constitute an unreasonable burden upon the public purse – but ten-thousand *Baumbasts* and ten-thousand *Grzelczyks* might well have some more appreciable effect on the welfare resources of the host state.'¹¹⁵

While the Court was of the opinion that free movement of patients would have no considerable effects on solidarity in the context of non-hospital care, it reached a different conclusion in relation to hospital care. The judges assumed that '[i]t is well known that the number of hospitals, their geographical distribution, the way in which they are organised and the facilities 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.'¹¹⁶ The Court consequently accepted, without the need for further detailed evidence,¹¹⁷ that the requirement of authorisation constitutes a necessary tool in order to control costs but also avoid wastage of resources.¹¹⁸

And yet critics of the Court are nevertheless of the opinion that free movement of patients would amount to the 'Killing of National Health and Insurance Systems' or the 'Corroding [of] Social Solidarity.'¹¹⁹ The issue is important and therefore needs to be studied

¹¹² What is created as a consequence of this imprecision is a paradox: cf TA O Endicott, *Vagueness in Law* (Oxford University Press 2000) 33-36.

¹¹³ Case C-184/99 *Grzelczyk*, EU:C:2001:458.

¹¹⁴ Case C-413/99 *Baumbast*, EU:C:2002:493.

¹¹⁵ M Dougan and E Spaventa, 'Educating Rudy and the non-English Patient: a Double Bill on Residency Rights under Article 18 EC', 28 *European Law Review* (2003) 699, 707.

¹¹⁶ *Müller-Faurè and Van Riet*, op. cit. *supra* note 79, para 77.

¹¹⁷ Cf N N Shuibhne and M Maci, 'Proving Public Interest: The Growing Impact of Evidence in Free Movement Case Law', 50 *Common Market Law Review* (2013) 965, 997-998.

¹¹⁸ *Müller-Faurè and Van Riet*, op. cit. *supra* note 79, para 80.

¹¹⁹ See for detailed references: E Szyszczak, 'Patients' Rights: A Lost Cause or a Missed Opportunity', in J W van de Gronden et al. (eds), *Health Care and EU Law* (TMC Asser Press 2011) 103, 110.

in more detail. The gist of the argument critics make is based on the planning argument. According to them the case law of the Court undermined Member States' ability to assign resources and control costs through, e.g., the use of waiting lists.¹²⁰ The Court, through its focus on the individual patient ignores, so argue the critics, the 'opportunity costs' which accumulate whenever limited resources are used in one way instead of another.¹²¹ The reasons for their scepticism may also have to do with the fact that in the real world there are relatively few Pareto-superior situations.¹²² Nevertheless, in the remainder of this Chapter it will be argued that their concerns appear to be unfounded for two reasons.

THE ANOMALY OF THE EXCEPTION

In contrast to critics of the Court it is argued that patients, while being on a waiting list, can develop additional health conditions which can increase the overall 'costs-per-patient.' And yet quite possibly only some of these additional costs will exclusively affect the health care budget, whereas other costs will simply be externalised to other budget posts, such as welfare, or alternatively they are 'privatised', e.g. to the members of a family who takes care of a patient. Furthermore, poor health of a population, due to long waiting lists, can even have macro-economic consequences because a population becomes, for example, overall less productive.¹²³ In *van Riet* the Court made reference especially to this point when it argued that

¹²⁰ C Newdick, 'Citizenship, Free Movement and Health Care: Cementing Individual Rights by Corroding Social Solidarity', 43 *Common Market Law Review* (2006) 1645, 1661-1664.

¹²¹ C Newdick, 'The European Court of Justice, Transnational Health Care, and Social Citizenship – Accidental Death of a Concept?' 26 *Wisconsin Journal of International Law* (2009) 844, 865.

¹²² S Guest, *Ronald Dworkin* 3rd ed. (Stanford University Press 2013) 151.

¹²³ P Baldwin, *The Politics of Social Solidarity. Class Bases of the European Welfare State 1875-1975* (Cambridge University Press 1990) 5.

‘the degree of pain or the nature of the patient’s disability ... might, for example, make it impossible or extremely difficult for him [the patient] to carry out a *professional activity*’.¹²⁴

Without developing these points fully, this much is obvious: if one does not take adequately into account the costs of waiting lists, this necessarily distorts the findings made in relation to opportunity costs. Consequently not each and every shortening of waiting lists necessarily amounts to increased costs of a health care system. And yet, there obviously comes a point, however difficult to locate, where a health care system with longer waiting times is cheaper to run in comparison with a system that operates with shorter waiting lists. It is then that the no-impact-approximation, as outlined above, is violated because Member States find themselves in a situation in which unless they pour more funds into the system – which increases the quantity of solidarity – some other patients will have to live with extended waiting times and this will impact on their welfare.

A different way of looking at the same issue would be that there comes a point where EU health care law has used up all its ‘efficiency-savings’ which means that either more solidarity is needed or EU health care law is beginning to have an impact on how national health care systems have to be managed. The probability for this scenario to happen increases the broader the anomaly of integration is defined. The rarity of Pareto-superior circumstances may have been one contributing factor for the Court to decide upon abolishing the requirement of prior authorisation only in relation to non-hospital treatment.¹²⁵ This marks the second reason as to why the argument of the critics is of limited persuasiveness. It would appear that

¹²⁴ *Müller-Faurè and Van Riet*, op. cit. *supra* note 79, para 90 (emphasis added).

¹²⁵ Cf also Somek, op. cit. *supra* note 100, 208-211.

the conceptual approach of the Court upholds the idea of equality, namely, that the rights of those who wish to exit are not taken more seriously by the ECJ than those who do not.¹²⁶

However, one obvious consequence of the Court's case law was that it became necessary to distinguish between hospital care and non-hospital care which is, however, difficult to do at times. The Court drew the following line: 'certain services provided in a hospital environment but also capable of being provided by a practitioner in his surgery or in a health centre could for that reason be placed on the same footing as non-hospital services.'¹²⁷ This approach suggests, without offering absolute clarity, that the decisive criterion regarding hospital treatment did not necessarily depend on where the treatment *took place* but where the treatment *could have taken place*.

The new Directive 2011/24, which regulates aspects of cross-border movement of patients, continues to distinguish between treatment for which prior authorisation is imperative and treatment for which no authorisation is needed. According to Article 8.2 of the Directive the requirement of prior authorisation may be 'limited' (which could be understood as a cynical choice of word) to treatment which 'involves overnight hospital accommodation of the patient in question for at least one night' or (alternatively) which 'requires use of highly specialised and cost-intensive medical infrastructure or medical equipment.' To what extent this second aspect leaves room for interpretation can be seen if one compares the Opinions of the Advocate Generals Bot and Sharpston in the cases *Hartlauer*¹²⁸ and *Commission v France*.¹²⁹

In *Hartlauer*, Advocate General Bot chose a rather extensive reading of hospital treatment. He considered even dental care, if it goes beyond most basic care (e.g. plaque

¹²⁶ Cf Guest, op. cit. *supra* note 122, 184-188.

¹²⁷ *Müller-Faurè and Van Riet*, op. cit. *supra* note 79, para 75.

¹²⁸ Case C-169/07 *Hartlauer*, EU:C:2009:141.

¹²⁹ C-512/08 *Commission v France*, EU:C:2010:579.

control or polishing) and requires some qualified staff,¹³⁰ to amount to hospital treatment. In turn, for Advocate General Sharpston the decisive parameter whether a certain treatment qualifies as hospital treatment or not depends on the costs of the equipment involved in the treatment.¹³¹ Clearly, Advocate General Sharpston seems to prefer a slightly narrower understanding of what constitutes hospital treatment if compared to Advocate General Bot. Nevertheless, it is possible to notice a tendency that has developed over time which appears to limit the circumstances when a patient is entitled to treatment in another Member State without the need for authorisation.¹³² Overall Advocate General Sharpston's cost-focussed approach appears to be conceptually preferable because it is in line with the no-impact approximation and the Court seems to follow.¹³³ Overall it seems that the anomaly of integration created by the Court has been gradually reduced in its scope.

To conclude: the abolition of the authorisation mechanism constitutes an anomaly which has led to the integration of health care systems by abolishing functional boundaries. However, in contrast to education, in health care the membership boundaries have remained intact. The relationship between the coordination and integration in health care can be accommodated with the no-impact-approximation: the framework of the EU work must not have any (significant) impact on the quantity of national solidarity. The narrowing down or fine tuning of the anomaly of integration in the Court's case law is an acknowledgement of the difficulties to firmly establish, that is, beyond pure speculation, to what extent integration of health care systems has an effect on national solidarity. The Court thereby operates with the following approximation: the cheaper the treatment involved in cross-border health care, the

¹³⁰ A.G. Bot, *Hartlauer*, EU:C:2008:478, para 92.

¹³¹ A.G. Sharpston, *op. cit. supra* note 9, para 73.

¹³² Cf also V Hatzopoulos and T Hervey, 'Coming into Line: the EU's Court Softens on Cross-Border Health Care', 5 *Health Economics, Policy and Law* (2012) 1, 4.

¹³³ *Commission v France*, *op. cit. supra* note 129, paras 37-42.

less likely the migration of patients has any impact on the quantity or degree of national solidarity

4. Conclusion

Over the last decade or so the law on cross-border movement of patients has gained some momentum. One critical factor in this development has been the Court. The interpretation of the law on the free movement of services resulted in its application in the field of migration of patients. In reaction to its jurisprudence the Court has faced some considerable criticism over the years. The aim of this article was therefore to undertake a (re-)appraisal of this criticism through an in-depth conceptual analysis of the Court's legal reasoning. The approach chosen for this article was based on Dworkin's conceptual idea which treats law as integrity. Consequently it was necessary to examine and accommodate the 'consistency' of the Court's treatment of the education cases in relation to health care. Furthermore, it became also necessary to examine the consistency of the two strands of health care law, namely secondary EU law, here in particular Regulation 883/2004, and the case law which is based on the Treaty.

The argument made was that there are no conflicting principles at work between health care and education. In contrast to health care, and based on vertical consistency, education was not an area which was regulated in some way by EU law. This is very much in contrast to health care which was considered important for the functioning of the internal market and also suggests that free movement of people is somewhat different from the other free movement laws. It is a relatively recent development that education, broadly understood, is important for the functioning of the internal market. However, the consequence of this observation is that the

chains of law in health care and education are different in their character and the law on education does not predetermine the 'fit' for health care.

The other dimension, that is, horizontal consistency, was established between the principles upheld by the Regulation and those of the Treaty. The Court applied the 'open-ended-formula' of the proportionality test in a rather unusual way. As such the Court filled the vague terms of the proportionality test with the relevant provisions of Regulation 883/2004. In this way the Court made sure to achieve the correct level of restriction/coordination between the different health care systems and consequently achieved horizontal consistency. To the extent the Court abolished boundaries through free movement of services and integrated systems it did so in a rather limited way. Despite the fact that the Court integrated systems, which would normally mean that Member states lose their authority, it only allowed this to the extent that circumstances change from Pareto-inefficient to Pareto-efficient. Thus, even if the judges of the ECJ sit in rather mundane Luxembourg and not on top of the more glamorous mount Olympus, overall, they seem to follow Hercules' method of interpretation in the field of health care.