Chapter 2
EU Health Care Law in a Constitutional Light: Distribution of Competences, Notions of 'Solidarity', and 'Social Europe'

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Contents

2.1 Introduction

> On one occasion an expert in the law stood up to test Jesus. "Teacher", he asked, "what must I do to inherit eternal life?"
> "What is written in the Law?" he replied. "How do you read it?"
> He answered: "'Love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind'; and, 'Love your neighbour as yourself'."
> "You have answered correctly", Jesus replied. "Do this and you will live."
> But he wanted to justify himself, so he asked Jesus, "And who is my neighbour?"In reply Jesus said: "A man was going down from Jerusalem to Jericho, when he fell into the hands

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> of robbers. They stripped him of his clothes, beat him and went away, leaving him half dead. A priest happened to be going down the same road, and when he saw the man, he passed by on the other side. So too, a Levite, when he came to the place and saw him, passed by on the other side. But a Samaritan, as he travelled, came where the man was; and when he saw him, he took pity on him. He went to him and bandaged his wounds, pouring on oil and wine. Then he put the man on his own donkey, took him to an inn and took care of him. The next day he took out two silver coins and gave them to the innkeeper. 'Look after him', he said, 'and when I return, I will reimburse you for any extra expense you may have'."
> Which of these three do you think was a neighbour to the man who fell into the hands of robbers?
> The expert in the law replied, "The one who had mercy on him."
> Jesus told him, "Go and do likewise."[1]

This parable of the 'Good Samaritan' may be claimed to have worked itself deeply into the European consciousness. It may be taken as one of the explanatory roots for the establishment of the modern sophisticated European public health systems, beginning as these often did back in history through Christian thinking, for example, in the shape of caring tasks in certain periods of time undertaken by monasteries and other organised institutions.[2]

Health care constitutes an essential element in a typical European welfare state. A welfare state in Europe is originally a nation-state, where contributions to a national health care system normally are provided through taxation or by payments of premiums into an insurance scheme. Although differing in many ways, all health care systems in the Member States of the EU provide near universal coverage based on solidarity.[3] However, generally there is an increasingly blurred line between such states and EU law as part of a more comprehensive multi-level legal system, where EU law and the national law of its Member States are mutually embedded.[4] Regarding more specifically healthcare, the same situation seems to have developed. Health care law used to be a nation-state matter, but, inter alia, the EU has altered this point of departure. Also, the market as such is having an increasing influence on the organisation of health care. Thus, there is a wave of liberalisation and privatisation, including the fact that cross-border health care has become a reality, which is changing the traditional way of setting up such systems. Also, certain basic values and principles, for example, non-discrimination, equality, social inclusion, and access to essential services, are becoming increasingly influential. These changes are largely, but not only, due to the influence of the EU.

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[1] The New Testament of the Christian Bible, Luke 10: 25–37. This quoted English version has been found on the internet. The present chapter constitutes a revised version of a paper presented at the Conference: 'Health Care and EU Law', 1–2 October 2009 (Radboud University Nijmegen). Generally, material which has come to my knowledge after 1 February 2010 has been left out of consideration.

[2] See also, for example, Manow (2004); or Østergaard (2010).

[3] Mossialos and McKee (2004), p. 21.

[4] See in this regard Neergaard et al. (2010).

Against this background, the present chapter has the purpose of analysing the changes of EU health care law in a more constitutional light, but limited to the following five issues: distribution of competences and the Treaty (Sect. 2.2), distribution of competences and free movement of services (Sect. 2.3), distribution of competences and SGEIs[5] in light of *BUPA* (Sect. 2.4),[6] notions of solidarity (Sect. 2.5), and Social Europe (Sect. 2.6).[7] Conclusions are brought forward in the final part (Sect. 2.7). The overall research aim is to achieve an understanding of which direction Europe takes with regard to health care on the basis of the five examined perspectives. The first three perspectives may be viewed as relating to the issue of competence, that is, who has the power (the Member State or the EU?). The last two perspectives may be viewed as relating more directly (compared with the first three perspectives) to which economic model the EU adopts in this area. At the same time, these two latter perspectives do in fact also throw some light on the understanding of distribution of competences. In other words, all five perspectives are inter-related. Taking this road, the changes occurring in this area are placed into a larger context. As a point of departure the approach taken is legal dogmatic, which results in the focus centred on what is valid law.[8]

2.2 Distribution of Competences and the Treaty

The issue of the distribution of competences is a concrete way of examining which direction European health law moves. By including this dimension it is possible to see at which level of governance the legislative competences in the area are placed, and in fact thereby also obtaining an indication of how much economic and/or social integration may be expected. On the one hand, if the legislative competences primarily are vested at the Member State level, they are more likely to be free to go ahead the way they so wish. On the other hand, if competences primarily are vested at the level of the EU, interference in this regard may be expected with an increased economic and social integration as the result.[9] Therefore, in this part, the purpose is to examine the role of health care primarily in the light of the Treaty of Lisbon 2009 with regard to distribution of competences.[10]

The Treaty of Rome, which entered into force in 1958, referred to health in principle only in Articles 36, 48(3), and 56(1) EEC, either as a reference to the

[5] The concept 'SGEIs' refers to 'services of general economic interest'.

[6] General Court, Case T-289/03 *BUPA* [2008] *ECR* II-81. See also General Court, Case T-289/03 (Order) *BUPA* [2008] *ECR* II-741.

[7] In other words, a full account of the subject is not possible here.

[8] See, for example, Hesselink (2009), pp. 20–45.

[9] In this regard, see further Sect. 2.6 *infra*.

[10] The Treaty of Lisbon 2009 entered into force 1 December 2009. Generally about distinction of competences in EU law, see, for example, Bribosia (2007), pp. 389–437; de Búrca and de Witte (2002), pp. 201–222; and Weatherill (2002), pp. 41–73.

'protection of health' or 'public health'.[11] Thus, the context in which health was placed in originally in principle only concerned the expressly stated derogations to the principles of free movement. Therefore, in the absence of harmonisation national measures could take precedence over free movement in the interest of health, of course provided that amongst others the principle of proportionality is fulfilled. As Barnard points out, the Court of Justice[12] has ruled that each Member State had the right to determine the level of health protection desired for its citizens, taking into account various factors such as the climate in the state, the normal diet of the population, and its state of health.[13] The seminal state of law could be seen as a strong indication of the Member States originally being in charge of health matters in a way that most likely not even the otherwise 'strong' free movement principles could disturb.

Today, the situation has changed radically. To date, the Treaty of Lisbon 2009 represents the final step in a rather long process of changes having taken place concerning the area of health in connection with Treaty amendments, but in fact also due to the interpretation of fundamental principles, launched by the progressive Court of Justice.[14] In the Treaty of Lisbon 2009, health issues still constitute an important derogation within the framework of free movement, but regarding legislative competences as such the picture is changed radically

[11] Now Articles 36, 45(3), and 52(1) TFEU. In addition to the three provisions mentioned, for the sake of completeness reference could also be made to the original Article 135 EEC.

[12] Pursuant to Article 19 TEU, the terminology regarding the European Courts now is: 'The Court of Justice of the European Union shall include the Court of Justice, the General Court and specialised courts…' This terminology is used throughout the present chapter, also in situations of reference to case law rendered before the entering into force of the Treaty of Lisbon 2009. Therefore, what often has been referred to as the European Court of Justice will here be referred to as the Court of Justice (except for references in footnotes to specific cases, where 'ECJ' is used), and what often has been referred to as the Court of First Instance will here be referred to as the General Court.

[13] Barnard (2007), p. 74. See further Sect. 2.3 *infra*.

[14] The evolution of the changes will not systematically be dealt with here. It is worth emphasising that the Proposal for a Directive of the European Parliament of the Council on the application of patients' rights in cross-border healthcare, COM(2008) 414, Brussels 2 July 2008 (hereinafter referred to as the 'Directive Proposal'), which was launched before the entry into force of the Treaty of Lisbon 2009 would have its legal basis in Article 95 EC (now Article 114 TFEU). It is stated at p. 8 that: 'This proposal respects the fact that health systems are primarily the responsibility of Member States and fully respects the responsibilities of the Member States for the organisation and delivery of health services and medical care in accordance with Article 152 TEC. Article 95(3) of the Treaty further stipulates that the Commission, in its proposals for the establishment and functioning of the internal market concerning health, shall take as a basis high level of protection of health, taking account in particular of any new development based on scientific evidence. In preparation of this proposal, the Commission took fully into account the most recent research results and the current best medical practice. Several expert studies, analyses and research reports were used in the preparatory work. The proposal will thus ensure that the necessary requirements for high-quality, safe and efficient healthcare are also ensured for cross-border healthcare.' Regarding the case law of the Court of Justice, see in particular Sect. 2.5.3 *infra*.

especially when compared with the original stance taken in the Treaty of Rome. Now, it is expressly stated in Article 4(1) and (2) of the TFEU that:

1. The Union shall share competence with the Member States where the Treaties confer on it a competence which does not relate to the areas referred to in Articles 3 and 6.
2. Shared competence between the Union and the Member States applies in the following principal areas:

   (a) internal market;

   (b) social policy, for the aspects defined in this Treaty; …

   (k) *common safety concerns in public health matters, for the aspects defined in this* Treaty. [emphasis added]

In Article 3 TFEU (to which reference is made in the quoted provision) areas where the Union has exclusive competences are mentioned. Health is not included therein. In Article 6 TFEU (to which reference is also made in the quoted provision) health is mentioned, as it is stated that:

> The Union shall have competence to carry out actions to support, coordinate or supplement the actions of the Member States. The areas of such action shall, at European level, be: (a) *protection and improvement of human health*; … [emphasis added]

It is thus expressly stated that the Union and the Member States share competences within the area of common safety concerns in public health matters, for the aspects defined in the Treaty. Also, it is expressly stated that the Union shall have competence to carry out actions to support, coordinate or supplement the actions of the Member States regarding the protection and improvement of human health. In other words, the Member States do not in any regard hold an exclusive competence in the area of health. Rather, sharing of competences in different variants is now dominant. It may be, first, added that pursuant to Article 2(1) TFEU, when the Treaties confer on the Union exclusive competence in a specific area, only the Union may legislate and adopt legally binding acts, the Member States being able to do so themselves only if so empowered by the Union or for the implementation of Union acts. Second, it may be added that pursuant to Article 2(2) TFEU when the Treaties confer on the Union a competence shared with the Member States in a specific area, the Union and the Member States may legislate and adopt legally binding acts in that area. Also, in this case, the Member States shall exercise their competence to the extent that the Union has not exercised its competence, and the Member States shall again exercise their competence to the extent that the Union has decided to cease exercising its competence. Third, it may be added that Article 2(5) TFEU provides that in certain areas and under the conditions laid down in the Treaties, the Union shall have competence to carry out actions to support, coordinate or supplement the actions of the Member States, without thereby superseding their competence in these areas. Although there is a distinction between concepts, this latter situation may in certain cases end up being close to the concept of shared competences.

Furthermore, Article 114 TFEU contains the general Internal Market legal base, and it is of some interest that Article 114(3) TFEU requires that

harmonisation measures adopted must guarantee a high level of protection of human health[15]:

> The Commission, in its proposals envisaged in paragraph 1 concerning *health*, safety, environmental protection and consumer protection, will take as a base a high level of protection, taking account in particular of any new development based on scientific facts. Within their respective powers, the European Parliament and the Council will also seek to achieve this objective. [emphasis added]

In addition, Title XIV concerns 'public health'. It consists of one provision, namely Article 168 TFEU. In general, this is a provision of importance here, but especially Article 168(7) TFEU should be given particular attention, as it is here stated that:

> Union action shall respect the responsibilities of the Member States for *the definition of their health policy and for the organisation and delivery of health services and medical care*. The responsibilities of the Member States shall *include the management of health services and medical care* and the allocation of the resources assigned to them. The measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.[16] [emphasis added]

The provision (in its earlier formulation) may (according to Hervey and McHale) be viewed as an explicit statement on the application of the principle of subsidiarity in the health field.[17]

In sum, the picture gained from this examination of particularly the Treaty of Lisbon 2009 definitely confirms the above-mentioned impression of a blurred line

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[15] See the chapter by Szyszczak.

[16] The predecessor in the Treaty of Nice 2000 was Article 152(5) EC where it was stated 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 particular, measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.' Especially, it is of interest that 'fully' has disappeared in the Treaty of Lisbon 2009. It is also of interest that in the Directive Proposal it is stated at p. 9 that: 'According to Article 152(5) of the EC Treaty Community action in the field of public health is to fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care. As confirmed by the Court, that provision does not, however, exclude the possibility that the Member States may be required under other Treaty provisions, such as Article 49 EC of the EC Treaty, or Community measures adopted on the basis of other Treaty provisions, to make adjustments to their national healthcare and social security systems. As the Court held, this does not mean that this undermines their sovereign powers in the field. In any event, Member States are responsible for the organisation and delivery of health services and medical care. They are in particular responsible for determining which rules will apply to the reimbursement of patients and to the provision of healthcare. This proposal changes nothing in this respect. It is important to underline that this initiative does not alter the Member States' choice of the rules which will be applicable to a specific case.' The provision was first introduced in the Treaty of Maastricht 1992 (as Article 129 EC).

[17] See further Hervey and McHale (2004), Chapter 3.

between Member States and the EU in the area of the regulation of health care.[18] Also, viewed over the time span of the existence of the EEC/EC/EU, health care has increasingly become an area of interest to this level of governance, having the unavoidable consequence of erosion of national competences.[19]

2.3 Distribution of Competences and Free Movement of Services

Within the area of free movement several important cases have been rendered by the Court of Justice. This area is in focus in what follows, at least with regard to the examined issue of distribution of competences, and only including services. As the judgments generally are rather complicated, but also already quite commented upon in legal discourse, the examination will focus on just the main consequences of this case law with regard to the issues at stake, rather than going into very technical details.[20] The most important cases will be analysed chronologically.[21] In general, the cases included in the examination constitute preliminary rulings and they are often decided by either eleven or thirteen judges as an indication in itself of the importance attached to the judgments by the Court of Justice itself.

Compared to the previous section, the level of focus is, in other words, changed here, because that part primarily took its point of departure in the more general understanding of legislative competences to be gained from a reading of the Treaty of Lisbon 2009. Thus, this was largely a matter of when the Institutions are given formal legal power to act. This Part takes its point of departure in the question of *when* Member States can legislate lawfully without contravening the general

[18] For the sake of completeness, it may be added that references to health (besides what has already been indicated) is also made in Articles 9, 114, 153, 169, 191, 202, 207 TFEU as well as Declaration on Article 168(4)(c) of the TFEU. In addition, see especially Article 35 of the Charter of Fundamental Rights of the European Union of 7 December 2000, as adapted at Strasbourg, on 12 December 2007. The Charter shall pursuant to Article 6 of the TEU have the same legal value as the Treaties. Also, besides the many mentioned provisions and the principles of free movement it should for the sake of completeness be emphasised that competition law provisions may be of relevance. Finally, other legal basis provisions and principles may be of relevance. Concerning legal base in the context of the Directive Proposal see the chapter by Szyszczak.

[19] See Hervey and McHale (2004), p. 80.

[20] See for one of the more recent contributions, for example, van de Gronden (2008), pp. 705–760. Also, several other chapters of the present volume deal with this case law in detail; see the chapter of Baquero Cruz.

[21] The analysis is limited to primary law issues, and will not include, for example, social security regulation, which may also be of significance, as a main theme. In this regard, see in particular the chapter of Pennings. Also, as indicated, only primary law concerning free movement of services is included. These delimitations of the analysis may have an impact on the conclusions reached, however, not fundamentally.

principles of free movement of services. The reason why this is of interest is, in somehow simplified terms, that even though a Member State formally has the legislative competence in a given area, most often this is limited as the competence will have to be used in a way not contravening these principles. Thus, a legislative competence in a given area may be thought of as 'vertical' in character, whereas free movement principles may be thought of as 'horizontal' as these principles often will function as cutting across all kinds of areas, and Member States are not protected there from, 'just' because they have a legislative competence in a given area pursuant to the Treaty. This—to some rather surprising—point of departure will be further understood from the following analysis.

Luisi and Carbone in 1984 is the first case to discuss because it paved the road to later case law of more specific importance.[22] In this case, it was established that not only the providers of services, but also the recipients, are included in the scope of protection. Although the case in hindsight is analysed for this new view of the scope of services, it in fact also concerned medical treatment.[23]

Gül decided in 1986 should be the next case to discuss.[24] Here, the importance of the Court of Justice ruling is seen in the statement that:

> … The right to restrict freedom of movement on grounds of public health is intended not to exclude the public health sector, as a sector of economic activity and from the point of view of access to employment, from the application of the principles of freedom of movement but to permit Member States to refuse access to their territory or residence there to persons whose access or residence would in itself constitute a danger for public health.[25]

In its entirety this case represents the somewhat 'older' regime of thinking, which now may be considered as too limited to be representative of today's thinking. The first part of this sentence is of importance, because the Court of Justice in the first case of essential importance, *Kohll*, finds pursuant to *Gül* that, although under Articles 56 and 66 EC (now Articles 52 and 62 TFEU) Member States may limit freedom to provide services on grounds of public health, that does not permit them to exclude the public health sector, as a sector of economic activity and from the point of view of freedom to provide services, from the application of the fundamental principle of freedom of movement.[26]

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[22] ECJ, Joined Cases 286/82 and 26/83 *Luisi and Carbone* [1984] *ECR 377*. See the chapter by Baquero Cruz.

[23] Para 16 states: 'It follows that the freedom to provide services includes the freedom, for the recipients of services, to go to another member state in order to receive a service there, without being obstructed by restrictions, even in relation to payments and that tourists, persons receiving medical treatment and persons travelling for the purpose of education or business are to be regarded as recipients of services.'

[24] ECJ, Case 131/85 *Gül* [1986] *ECR* 1573.

[25] Ibid., para 17.

[26] ECJ, Case C-158/96 *Kohll* [1998] *ECR* I-1931, paras 45–46. See also the related case, however, concerning free movement of goods, rendered on the same date: ECJ, Case C-120/95 *Decker* [1998] *ECR* I-1831. See for further discussion of this case, Chapter 4.

Kohll is in many respects of great importance regarding free movement of services and health care. On the surface, it has a certain degree of 'innocence' attached to it as it concerns a Luxembourg father stubbornly requesting authorisation for his daughter, who is a minor, to receive treatment from an orthodontist established in Germany. The case arises in proceedings between this father, Mr Kohll, and the Union des Caisses de Maladie, with which he is insured. Inter alia, the Court of Justice states that the fact that the national rules at issue in the main proceedings fall within the sphere of social security cannot exclude the application of Articles 59 and 60 EC (now Articles 56 and 57 TFEU). The Court of Justice holds that whilst the national rules at issue in the main proceedings do not deprive insured persons of the possibility of approaching a provider of services established in another Member State, they nevertheless make reimbursement of the costs incurred in that Member State subject to prior authorisation, and denies such reimbursement to insured persons who have not obtained that authorisation.[27] Also, costs incurred in the State of insurance are not, however, subject to that authorisation.[28] In the ruling of the Court of Justice, the measure is considered as constituting a barrier to freedom to provide services and it is thus examined whether it is objectively justified.[29] Although the Court of Justice in this regard finds that aims of a purely economic nature cannot justify a barrier to the fundamental principle of freedom to provide services it also importantly states that it cannot be excluded that the risk of seriously undermining the financial balance of the social security system may constitute an overriding reason in the general interest capable of justifying a barrier of that kind.[30] However, this is not the situation in the case at hand. In addition, the Court of Justice examines whether the measure in question can be justified on grounds of public health. The conclusion is that it cannot be justified on such grounds. More specifically, the Court of Justice finds in this regard first, that the measure cannot be justified on grounds of public health in order to protect the quality of medical services provided in other Member States.[31] Second, it finds that the objective of maintaining a balanced medical and hospital service open to all, that objective, although intrinsically linked to the method of financing the social security system, may also fall within the derogations on grounds of public health under Article 56 EC (now Article 52 TFEU), in so far as it contributes to the attainment of a high level of health protection.[32] However, the Court of Justice finds that this is not the situation in the measure at hand.

Overall, Articles 59 and 60 EC (now Articles 56 and 57 TFEU) are considered to be infringed, because these provisions preclude national rules under which reimbursement, in accordance with the scale of the State of insurance, of the cost

[27] Ibid., para 34.

[28] Idem.

[29] Ibid., para 35.

[30] Ibid., para 41.

[31] Ibid., para 48.

[32] Ibid., para 50.

of dental treatment provided by an orthodontist established in another Member State is subject to authorisation by the insured person's social security institution. With *Kohll*, it thus becomes clear that the path towards a more general right to have the costs of health treatment incurred in other Member States should in principle be reimbursed is initiated. Thus the case is of considerable significance.

The next case of primary interest, *Smits-Peerbooms*, rendered almost three years later, confirms this new path.[33] This time, the central issue is much more to the point as the case concerns reimbursement of hospital treatment costs. At the overall level, it concerns the issue of whether Articles 59 and 60 EC (now Articles 56 and 57 TFEU) are to be interpreted as precluding legislation of a Member State, which makes the assumption of the costs of care provided in a hospital establishment in another Member State conditional upon prior authorisation by the sickness insurance fund with which an insured person is registered, that authorisation being granted only in so far as two conditions are satisfied.[34] The first condition is that the proposed treatment must be amongst the benefits for which the sickness insurance scheme of the first Member State assumes responsibility, which means that the treatment must be regarded as 'normal in the professional circles concerned'.[35] The second condition is that the treatment abroad must be necessary in terms of the medical condition of the person concerned, which supposes that adequate care cannot be provided without undue delay by a health care provider which has entered into an agreement with a sickness insurance fund in the first Member State.[36]

Regarding the competence of the Member States to arrange their social security systems and the obligation to comply with EU law in exercising that competence, the Court of Justice states that:

> In order to answer the questions as thus reformulated, it should be remembered at the outset that, according to settled case-law, Community law does not detract from the power of the Member States to organise their social security systems… In the absence of harmonisation at Community level, it is therefore for the legislation of each Member State to determine, first, the conditions concerning the right or duty to be insured with a social security scheme… and, second, the conditions for entitlement to benefits… Nevertheless, the Member States must comply with Community law when exercising that power.[37]

In other words, free movement principles may, in a way, be viewed as 'superior' to the competence to organise social security systems, or at least as explained above, as having a 'horizontal' significance.

It is also of relevance to the understanding of distribution of competences in the area of health care that the Court of Justice considers whether the situations at issue in the main proceedings fall within the ambit of the freedom to provide services provided for in Articles 59 and 60 EC (now Articles 56 and 57 TFEU).

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[33] ECJ, Case C-157/99 *Smits-Peerbooms* [2001] *ECR* I-5473.

[34] Ibid., para 43.

[35] Idem.

[36] Idem.

[37] Ibid., paras 44–46.

More precisely, it is considered whether hospital services can constitute an economic activity within the meaning of Article 60 EC (now Article 57 TFEU), particularly when they are provided in kind and free of charge under the relevant sickness insurance scheme. The Court of Justice responded in the affirmative. Accordingly, medical activities fall within the scope of Article 60 EC (now Article 57 TFEU), there being no need to distinguish in that regard between care provided in a hospital environment and non-hospital care.[38]

The Court of Justice finds that rules such as those at issue in the main proceedings deter, or even prevent, insured persons from applying to providers of medical services established in another Member State and constitute, both for insured persons and service providers, a barrier to freedom to provide services.[39] In this regard, it is emphasised that treatment provided in contracted hospitals situated in the Member State itself, is paid for by the sickness insurance funds without any prior authorisation being required.[40]

Subsequently, the Court of Justice examines whether there are overriding reasons which can be accepted as justifying barriers to freedom to provide medical services supplied in the context of a hospital infrastructure. On the basis of *Kohll*, it acknowledges the following reasons: (1) the possible risk of seriously undermining a social security system's financial balance; (2) maintenance of a balanced medical and hospital service open to all, in so far as it contributes to the attainment of a high level of health protection; and (3) maintenance of treatment capacity or medical competence on national territory being essential for the public health, and even the survival of, the population.[41] Against this background, the Court of Justice concludes that in principle, the measure in question is justified, but under specified conditions.[42] When such conditions are satisfied, Member States are free to legislate.

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[38] Ibid., para 53.

[39] Ibid., para 69.

[40] Ibid., para 68.

[41] Ibid., paras 72–74.

[42] More specifically, the Court of Justice concludes that: 'Article 59 of the EC Treaty (now, after amendment, Article 49 EC) and Article 60 of the EC Treaty (now Article 50 EC) do not preclude legislation of a Member State, such as that at issue in the main proceedings, which makes the assumption of the costs of treatment provided in a hospital located in another Member State subject to prior authorisation from the insured person's sickness insurance fund and the grant of such authorisation subject to the condition that (i) the treatment must be regarded as 'normal in the professional circles concerned', a criterion also applied in determining whether hospital treatment provided on national territory is covered, and (ii) the insured person's medical treatment must require that treatment. However, that applies only in so far as—the requirement that the treatment must be regarded as 'normal' is construed to the effect that authorisation cannot be refused on that ground where it appears that the treatment concerned is sufficiently tried and tested by international medical science, and—authorisation can be refused on the ground of lack of medical necessity only if the same or equally effective treatment can be obtained without undue delay at an establishment having a contractual arrangement with the insured person's sickness insurance fund.'

Vanbraeckel was rendered on the exact same day as *Smits-Peerbooms*.[43] In principle, it builds on the same understanding as presented above. It is of central interest in the present context that the Court of Justice determines that Article 59 EC (now Article 56 TFEU) is to be interpreted as meaning that, if the reimbursement of costs incurred on hospital services provided in a Member State of stay, calculated under the rules in force in that State, is less than the amount which application of the legislation in force in the Member State of registration would afford to a person receiving hospital treatment in that State, additional reimbursement covering that difference must be granted to the insured person by the competent institution.[44]

In *Müller-Fauré*, decided in 2003, the Court of Justice considered whether Articles 59 and 60 EC (now Articles 56 and 57 TFEU) should be interpreted as precluding legislation of a Member State, which makes assumption of the costs of care provided in another Member State, by a person or an establishment with whom or which the insured person's sickness fund has not concluded an agreement, conditional upon prior authorisation by the fund.[45] This is answered in the negative, in principle.[46] In addition, the Court of Justice examined whether legislation, which has restrictive effects on the freedom to provide services, can be justified by the actual particular features of the national sickness insurance scheme, which provides not for reimbursement of costs incurred but essentially for benefits in kind and is based on a system of agreements intended both to ensure the quality of the care and to control the costs thereof.[47] In connection therewith, it is also examined whether the fact that the treatment at issue is provided in whole or in part in a hospital environment has any effect in that regard.[48] In principle, the

[43] ECJ, Case C-368/98 *Vanbraeckel* [2001] *ECR* I-5363.

[44] Ibid., para 53.

[45] ECJ, Case C-385/99 *Müller-Fauré* [2003] *ECR* I-4509, para 37.

[46] More precisely, the Court of Justice concludes that: 'Article 59 of the EC Treaty (now, after amendment, Article 49 EC) [now Article 56 TFEU] and Article 60 of the EC Treaty (now Article 50 EC) [now Article 57 TFEU] must be interpreted as not precluding legislation of a Member State, such as that at issue in the main proceedings, which (i) makes the assumption of the costs of hospital care provided in a Member State other than that in which the insured person's sickness fund is established, by a provider with which that fund has not concluded an agreement, conditional upon prior authorisation by the fund and (ii) makes the grant of that authorisation subject to the condition that such action is necessary for the insured person's health care. However, authorisation may be refused on that ground only if treatment which is the same or equally effective for the patient can be obtained without undue delay in an establishment which has concluded an agreement with the fund…'.

[47] Ibid., para 46.

[48] Idem.

Court of Justice answers this in the affirmative.[49] With this case, therefore, an important distinction between hospital and non-hospital care is introduced.

Inizan, also decided in 2003, may largely be viewed as a confirmation of its predecessors with regard to the understanding of free movement of health services.[50] More precisely, the Court of Justice holds that Articles 49 and 50 EC (now Articles 56 and 57 TFEU) must be interpreted as not precluding legislation of a Member State, such as that at issue in the main proceedings, which, first, makes reimbursement of the cost of hospital care provided in a Member State other than that in which the insured person's sickness fund is established conditional upon prior authorisation by that fund and, second, makes the grant of that authorisation subject to the condition that it be established that the insured person could not receive within the territory of the Member State where the fund is established the treatment appropriate to his condition.[51] However, the Court of Justice stresses that authorisation may be refused on that ground only if treatment which is the same or equally effective for the patient can be obtained without undue delay in the territory of the Member State in which he resides.[52]

Leichtle, decided in 2004 mainly constitutes a continuation of previously established principles.[53] For instance, it is stated that:

> Moreover, although it is not disputed that Community law does not detract from the power of the Member States to organise their social security systems and that, in the absence of harmonisation at Community level, it is for the legislation of each Member State to determine the conditions on which social security benefits are granted, it is nevertheless the case that, when exercising that power, the Member States must comply with Community law….[54]

It is of some interest that the Court of Justice stated that although travel costs and any visitors' tax are not medical in character, and are not as a rule paid to health care providers, they none the less appear to be inextricably linked to the cure itself, since, as previously stated, the patient is required to travel to and stay at the spa.[55] Therefore, a right to reimbursement of such related costs may also be in existence at times.

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[49] More precisely, the Court of Justice concludes that: '… Articles 59 and 60 of the Treaty [now Articles 56 and 57 TFEU] do preclude the same legislation in so far as it makes the assumption of the costs of non-hospital care provided in another Member State by a person or establishment with whom or which the insured person's sickness fund has not concluded an agreement conditional upon prior authorisation by the fund, even when the national legislation concerned sets up a system of benefits in kind under which insured persons are entitled not to reimbursement of costs incurred for medical treatment, but to the treatment itself which is provided free of charge.'

[50] ECJ, Case C-56/01 *Inizan* [2003] *ECR* I-12403.

[51] Ibid., para 60.

[52] Idem.

[53] ECJ, Case C-8/02 *Leichtle* [2004] *ECR* I-2641.

[54] Ibid., para 29.

[55] Ibid., para 35.

Watts, decided in 2006 contributes many new interesting aspects to the understanding of the area.[56] It is a rather long and detailed judgment. Inter alia, the Court of Justice was faced with the question of whether, given the particular characteristics of the National Health Service (hereinafter referred to as 'NHS'), a patient resident in the UK is entitled under Article 49 EC (now Article 56 TFEU) to receive hospital treatment in another Member State at the expense of that national service.

It is of significance that the case concerns national health services financed by the State, such as the NHS. In this regard, the Court of Justice states that:

> It must therefore be found that Article 49 EC applies where a patient such as Mrs Watts receives medical services in a hospital environment for consideration in a Member State other than her State of residence, regardless of the way in which the national system with which that person is registered and from which reimbursement of the cost of those services is subsequently sought operates.[57]

Regarding the distribution of competences, the Court of Justice emphasises that:

> Whilst it is not in dispute that Community law does not detract from the power of the Member States to organise their social security systems, and that, in the absence of harmonisation at Community level, it is for the legislation of each Member State to determine the conditions in which social security benefits are granted, when exercising that power Member States must comply with Community law, in particular the provisions on the freedom to provide services… Those provisions prohibit the Member States from introducing or maintaining unjustified restrictions on the exercise of that freedom in the healthcare sector.[58]

The Court of Justice decides that Article 49 EC (now Article 56 TFEU) applies where a person whose state of health necessitates hospital treatment goes to another Member State and receives such treatment for consideration, there being no need to determine whether the provision of hospital treatment within the national health service with which that person is registered is in itself a service within the meaning of the Treaty provisions on the freedom to provide services.[59]

It is of interest that the Court of Justice in connection with the answering of a question as to whether Article 49 EC (now Article 56 TFEU) and Article 22 of Regulation No 1408/71 must be interpreted as imposing an obligation on Member States to fund hospital treatment in other Member States without reference to budgetary constraints and, if so, whether such an obligation is compatible with Article 152(5) EC (now Article 168(7) TFEU), the Court of Justice reasserts its case law that the requirements arising from these provisions are not to be interpreted as imposing on the Member States an obligation to reimburse the cost of hospital treatment in other Member States without reference to any budgetary consideration

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[56] Case C-372/04 *Watts* [2006] *ECR* I-4325.

[57] Ibid., para 90.

[58] Ibid., para 92. See further the chapter by Baquero Cruz.

[59] Ibid., para 123.

but, on the contrary, are based on the need to balance the objective of the free movement of patients against overriding national objectives relating to management of the available hospital capacity, control of health expenditure and financial balance of social security systems.[60] The Court of Justice also emphasises that:

> Next, it should be noted that, according to Article 152(5) EC [now Article 168(7) TFEU], Community action in the field of public health is to fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care. That provision does not, however, exclude the possibility that the Member States may be required under other Treaty provisions, such as Article 49 EC [now Article 56 TFEU], or Community measures adopted on the basis of other Treaty provisions, such as Article 22 of Regulation No 1408/71, to make adjustments to their national systems of social security. It does not follow that this undermines their sovereign powers in the field…[61]

The judgment contains certain considerations regarding private hospitals which are of interest. Thus, after having held that the system of prior authorisation in question deters, or even prevents, the patients concerned from applying to providers of hospital services established in another Member State and constitutes, both for those patients and for service providers, an obstacle to the freedom to provide services, the Court of Justice establishes that[62]:

> That conclusion is not undermined by the fact, referred to in Question 1(b), that the NHS is not obliged to authorise and assume the cost of hospital treatment provided to patients in private non-NHS hospitals in England and Wales. In applying the case-law set out in paragraph 94 of the present judgment, the conditions for the NHS's assuming the cost of hospital treatment to be obtained in another Member State should not be compared to the situation in national law of hospital treatment received by patients in private local hospitals. On the contrary, the comparison should be made with the conditions in which the NHS provides such services in its hospitals.[63]

The Court of Justice considers the following three possible justifications: (1) the risk of seriously undermining the financial balance of a social security system; (2) the objective of maintaining a balanced medical and hospital service open to all may also fall within the derogations on grounds of public health under Article 46 EC (now Article 52 TFEU) in so far as it contributes to the attainment of a high level of health protection; and 3) the maintenance of treatment capacity or medical competence on national territory being essential for the public health, and even the survival, of the population.[64] Amongst the results of the examination of the measure in question is that Article 49 EC (now Article 56 TFEU) must be interpreted as meaning that it does not preclude reimbursement of the cost of hospital treatment to be provided in another Member State from being made subject to the grant of prior authorisation by the competent institution and that a refusal to grant

[60] Ibid., para 145.

[61] Ibid., paras 146–147.

[62] Ibid., para 98.

[63] Ibid., paras 99–100.

[64] Ibid., paras 103–105.

prior authorisation cannot be based merely on the existence of waiting lists intended to enable the supply of hospital care to be planned and managed on the basis of predetermined general clinical priorities, without carrying out an objective medical assessment of the patient's medical condition, the history and probable course of his illness, the degree of pain he is in and/or the nature of his disability at the time when the request for authorisation was made or renewed.[65] Furthermore, the Court of Justice finds that where the delay arising from such waiting lists appears to exceed an acceptable time having regard to an objective medical assessment of the above-mentioned circumstances, the competent institution may not refuse the authorisation sought on the grounds of the existence of those waiting lists, an alleged distortion of the normal order of priorities linked to the relative urgency of the cases to be treated, the fact that the hospital treatment provided under the national system in question is free of charge, the obligation to make available specific funds to reimburse the cost of treatment to be provided in another Member State and/or a comparison between the cost of that treatment and that of equivalent treatment in the competent Member State.[66]

Finally, it should be mentioned that in *Watts* it is determined that Article 49 EC (now Article 56 TFEU) must be interpreted as meaning that a patient who was authorised to go to another Member State to receive hospital treatment there or who received a refusal to authorise subsequently held to be unfounded is entitled to seek from the competent institution reimbursement of the ancillary costs associated with that cross-border movement for medical purposes provided that the legislation of the competent Member State imposes a corresponding obligation on the national system to reimburse in respect of treatment provided in a local hospital covered by that system.[67]

The last case selected in the present analysis is *Stamatelaki* a judgment rendered in the subsequent year, 2007.[68] The Court of Justice finds that Article 49 EC (now

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[65] Ibid., para 123.

[66] Idem.

[67] Ibid., para 143.

[68] ECJ, Case C-444/05 *Stamatelaki* [2007] *ECR* I-3185. However, see also ECJ, Case C-212/06 *Gouvernement de la Communauté francaise* [2008] I-1683, where it, amongst others, is held that: 'On a proper construction of Articles 39 EC and 43 EC, legislation of a federated entity of a Member State limiting affiliation to a social security scheme and entitlement to the benefits provided by that scheme only to persons residing in that entity's territory is contrary to those provisions, in so far as such limitation affects nationals of other Member States working in that entity's territory or nationals of the Member State concerned who have made use of their right to freedom of movement within the European Community.' In addition, see also ECJ, Case C-208/07 *von Chamier-Glisczinski*, 16 July 2009, *ECR* I-0000 (n.y.r)., para 76, where it is held, that Article 49 EC (now Article 56 TFEU) is not applicable because the person involved did not move to Member State in question, namely Austria, on a temporary basis, but rather that this person had fixed her residence on a stable basis in that Member State without a foreseeable limit to its duration. This decision contains important guidelines as to Article 18 EC (now Article 21 TFEU) in the context of health care. See in this regard in particular paras 80 et seq. For a discussion of this case, see the chapter by Baquero Cruz.

Article 56 TFEU) precludes legislation of a Member State which excludes all reimbursement by a national social security institution of the costs occasioned by treatment of persons insured with it in private hospitals in another Member State, except those relating to treatment provided to children under 14 years of age.[69] In reaching this conclusion, the Court of Justice puts emphasis on the absolute terms, with the exception of the case of children under 14 years of age, of the prohibition laid down by the scrutinised measure not being appropriate to the objective pursued, since measures which are less restrictive and more in keeping with the freedom to provide services could be adopted, such as a prior authorisation scheme which complies with the requirements imposed by EU law and, if appropriate, the determination of scales for reimbursement of the costs of treatment.[70] Also, it stresses that private hospitals located in other Member States are also subject, in those Member States, to quality controls and that doctors established in those States who operate in those establishments provide professional guarantees equivalent to those of doctors established in Member State involved.[71]

In sum, the principles of free movement of services have become of great importance to the area of health care. In fact, they have become one of the decisive factors as to the changes having taken place by now. From a point of departure where this area was thought of to be under no (or almost no) influence of these principles, today Member States cannot freely define or organise their health systems completely the way they wish. Most importantly and in simplified terms, Member States are supposed to take into account that patients are now in principle free to move to other Member States to obtain health care, and that patients may in many instances be free to bring the financing from the State of affiliation along. Member States may, however, under certain circumstances, demand a prior authorisation. In addition, Member States should take into account that health providers have gained an improved possibility of delivering health services to a wider group of patients than their 'own' nationals.

There may be situations where EU law will not interfere due to reasons such as: (1) the risk of seriously undermining the financial balance of a social security system; (2) the objective of maintaining a balanced medical and hospital service open to all in so far as it contributes to the attainment of a high level of health protection; and (3) the maintenance of treatment capacity or medical competence on national territory being essential for the public health, and even the survival, of the population. In other words, there may exist situations where such reasons may justify legislation which otherwise would be considered a barrier to the free movement of services, this being subject to the principle of proportionality.

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[69] Ibid., para 38.

[70] Ibid., para 35.

[71] Ibid., para 36.

Under all circumstances, national health care systems may no longer be viewed as 'closed' systems, which is why a kind of pressure may be perceived to have been placed on these health care schemes.[72] In the short run, this will by many be viewed as a positive development as for instance any seriously ill person will appreciate the possibility of choice, perhaps having the opportunity of finding the best hospital in Europe, perhaps having the possibility of escaping horrible waiting lists, and perhaps even having the possibility of having some, or all, of the costs covered from home. However, in the long run, this will by some be viewed as a negative development, as national health care systems will be challenged, amongst others, on their financing in a not completely predictable manner. However, more positively, they will also be challenged regarding the quality delivered. Altogether, the picture gained from the analysis of this corner of the case law also confirms the above-mentioned impression of a blurred line between Member States and the EU in the area of health care.[73]

2.4 The Distribution of Competences and SGEIs in the Light of *BUPA*

BUPA is one of the more interesting and important judgments which have been rendered in recent times regarding health care, and it will therefore be analysed with regard to the issue of distribution of competences within health care. Compared to Sect. 2.2 the level of focus is of the same reasons as were given above concerning Sect. 2.3 changed here. Section 2.2 primarily took its point of departure in the more general understanding of legislative competences to be gained from a reading of the Treaty of Lisbon 2009. This part rather takes its point of departure in the understanding of the EU concept of SGEIs, which now has an importance as to when Member States can legislate in areas such as competition law, state aid, and perhaps even free movement.[74] In simplified terms, the reason is that if a given health measure is to be considered to concern an SGEI, a possibility of 'immunity' from the requirements of EU law may often exist. This may have an impact on a Member State's rights for example, to grant exclusive or special rights, to establish public undertakings, grant state aid, etc.

Regarding the background and facts of the case as well as the general findings of the General Court, see the chapter by De Vries. I shall provide a more limited

[72] Therefore, it is rather surprising that the Danish Economic Councils in a recent report concerning health expenditure and financing in Denmark did not in any way include the present and future effect of EU law; see De Økonomiske Råd (2009).

[73] See also van de Gronden (2008), p. 759, who finds that the approach of the Court of Justice '… inevitably leads to the harmonization of several aspects of the organization of national health care systems.'

[74] See, however, for example, ECJ, Case C-567/07 *Sint Servatius*, 1 October 2009, *ECR* I-0000 (n.y.r.).

discussion of the concept SGEI and of the placement of the competence to decide what constitutes an SGEI.

2.4.1 The Concept of Services of General Economic Interest

In *BUPA*, the General Court declared that:

> [I]n Community law and for the purposes of applying the EC Treaty competition rules, there is no clear and precise regulatory definition of the concept of an SGEI mission and no established legal concept definitively fixing the conditions that must be satisfied before a Member State can properly invoke the existence and protection of an SGEI mission, either within the meaning of the first *Altmark* condition or within the meaning of Article 86(2) EC.[75]

The definition of SGEIs is as mentioned of concern regarding the distribution of competences between the EU and the Member States. The classification of various services, as for instance either 'market services', SGEIs, 'non-economic services of general interest',[76] or 'exercise of public authority', is of huge importance.[77] The reason is that the legal consequences vary a lot depending on which concept is involved, especially with regard to which degree market economic requirements will rule as well as the degree as to which Member State competence may be claimed. So far, for example, 'exercise of public authority' is largely a matter for the Member States. In contrast, 'market services' are largely completely within the competence of the EU. However, as indicated in the quotation, at present a lack of clarity dominates the definition of SGEI.[78]

BUPA contains certain important interpretational guidelines regarding the understanding of SGEIs. These are given in the context of the first condition of *Altmark,* where strictly speaking the concept 'public service' rather than SGEI is mentioned in the wording, as well as Article 86(2) EC (now Article 106(2) TFEU).[79] In this regard, it was held that the Commission was entitled to consider that the conditions for recognition of PMI services and obligations as relating to an SGEI mission were satisfied and that Ireland had made no manifest error in that regard.[80]

Importantly, pursuant to the General Court the point of departure is the following:

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[75] *BUPA*, para 165.

[76] Hereinafter referred to as 'NESGIs'.

[77] See for further details regarding these various concepts as well as the concept SGEI itself Neergaard (2009), pp. 30–57, and Neergaard (2009), pp. 191–224.

[78] See in the same direction, for example, Ross (2007), pp. 1057–1059.

[79] See in this context *BUPA*, para 162, where it is stated that: 'It is common ground between the parties that the concept of public service obligation referred to in that judgment corresponds to that of the SGEI as designated by the contested decision and that it does not differ from that referred to in Article 86(2) EC'.

[80] *BUPA*, para 207.

> … even though the Member State has a wide discretion when determining what it regards as an SGEI, that does not mean that it is not required, when it relies on the existence of and the need to protect an SGEI mission, to ensure that that mission satisfies certain minimum criteria common to every SGEI mission within the meaning of the EC Treaty, as explained in the case-law, and to demonstrate that those criteria are indeed satisfied in the particular case.[81]

In the opinion of the General Court, these so-called minimum criteria common to every SGEI mission are:

> … the presence of an act of the public authority entrusting the operators in question with an SGEI mission and the universal and compulsory nature of that mission… Furthermore, it follows from the case-law on Article 86(2) EC that the Member State must indicate the reasons why it considers that the service in question, because of its specific nature, deserves to be characterised as an SGEI and to be distinguished from other economic activities… In the absence of such reasons, even a marginal review by the Community institutions on the basis of both the first *Altmark* condition and Article 86(2) EC with respect to the existence of a manifest error by the Member State in the context of its discretion would not be possible.[82]

The General Court also holds that the provision of the service in question must, by definition, assume a general or public interest, implying that SGEIs are distinguished from services in the private interest, even though that interest may be more or less collective or be recognised by the State as legitimate or beneficial.[83] Furthermore, it is explained that the general or public interest on which the Member State relies must not be reduced to the need to subject the market concerned to certain rules or the commercial activity of the operators concerned to authorisation by the State.[84] In other words, the General Court states that, the mere fact that the national legislature, acting in the general interest in the broad sense, imposes certain rules of authorisation, functioning, or control on all the operators in a particular sector does not in principle mean that there is an SGEI.[85]

Furthermore, it is emphasised that the recognition of an SGEI mission does not necessarily presume that the operator entrusted with that mission will be given an exclusive or special right to carry it out.[86] According to the General Court, this follows from a reading of paragraph 1 together with paragraph 2 of Article 86 EC (now Article 106 TFEU), pursuant to which a distinction must be drawn between a special or exclusive right conferred on an operator and the SGEI mission which, where appropriate, is attached to that right.[87] The General Court views the grant of

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[81] *BUPA*, para 172.

[82] Idem.

[83] *BUPA*, para 178.

[84] Idem.

[85] Idem.

[86] *BUPA*, para 179.

[87] Idem.

a special or exclusive right to an operator merely as the instrument, possibly justified, which allows that operator to perform an SGEI mission.[88]

In addition, in the General Court's opinion both the first condition laid down by the Court of Justice in *Altmark* and the wording of Article 86(2) EC (now Article 106(2) TFEU), as such, require that the operator in question be entrusted with an SGEI mission by an act of a public authority and that the act clearly defines the SGEI obligations in question.[89]

On this basis, it may be summarised that at least the following descriptors—or in the wording of the General Court the minimum criteria, common to every SGEI mission pursuant to *BUPA* are important:

- the presence of an act of the public authority entrusting the operators in question with an SGEI mission and the universal and compulsory nature of that mission;
- the presence of an indication by the Member State of the reasons why it considers that the service in question, because of its specific nature, deserves to be characterised as an SGEI and to be distinguished from other economic activities; and
- the presence of a general or public interest, implying that the service is distinguished from services in the private interest.

In addition to this, the recognition of an SGEI mission does not necessarily presume that the operator entrusted with that mission will be given an exclusive or special right to carry it out.

2.4.2 Placing the Competence to Decide What Constitutes a Service of General Economic Interest

In the *Olsen* case, it was held that Member States have a wide discretion to define what they regard as SGEIs and that the definition of such services by a Member State can be questioned by the Commission only in the event of a manifest error.[90] This was upheld in *BUPA*.[91] In this regard, it is pointed out that:

> That prerogative of the Member State concerning the definition of SGEIs is confirmed by the absence of any competence specially attributed to the Commission and by the absence of a precise and complete definition of the concept of SGEI in Community law. The determination of the nature and scope of an SGEI mission in specific spheres of action which either do not fall within the powers of the Community, within the meaning of the

[88] Idem.

[89] *BUPA*, para 181.

[90] General Court, Case T-17/02 *Fred Olsen* [2005] *ECR* II-2031, para 216. What exactly could constitute a 'manifest error' is not yet developed.

[91] *BUPA*, paras 166–170. In addition, see General Court, Case T-442/03 *SIC* [2008] *ECR* II-1161, para 195. Finally, especially regarding this issue in the context of public broadcasting services, see General Court, Joined Cases T-309/04, T-317/04, T-329/04 and T-336/04 *TV 2/Danmark* [2008] *ECR* II-2935, especially paras 88–124.

> first paragraph of Article 5 EC, or are based on only limited or shared Community competence, within the meaning of the second paragraph of that article, remains, in principle, within the competence of the Member States. As the defendant and Ireland maintain, the health sector falls almost exclusively within the competence of the Member States. In that sector, the Community can engage, under Article 152(1) and (5) EC, only in action which is not legally binding, while fully respecting the responsibilities of the Member States for the organisation and provision of health services and medical care. It follows that the determination of SGEI obligations in this context also falls primarily within the competence of the Member States. That division of powers is also reflected, generally, in Article 16 EC, which provides that, given the place occupied by SGEIs in the shared values of the Union as well as their role in promoting social and territorial cohesion, the Community and the Member States, each within their respective powers and within the scope of application of the Treaty, are to take care that such services operate on the basis of principles and conditions which enable them to fulfil their missions.[92]

A lack of clarity could seem present in respect of the issue of where the competence to decide what constitutes an SGEI is situated.

On the one hand, this concept may be seen as an EU concept in the same way as it is the case with more or less any other Treaty-concept.[93] In fact, it has normally been considered as such,[94] in reality right from the very beginning.[95] One consequence normally following from this is that the definition of the concept in question is then common to all the Member States, independent of various definitions in national legal orders. Another consequence is that the competence to define the content of a given concept then is situated at the EU level rather than at the Member State level. This approach is more or less identical to what Buendia Sierra has designated as the 'Community approach'.[96]

On the other hand, by now it seems that the competence to define the content of the concept is situated at the Member State level. For instance, in the Services Directive, it is, amongst other things, stated in the second sentence of Article 1(3) that it does not affect the freedom of Member States to define what they consider to be SGEIs. This point of view is also expressed in several of the Communications of the

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[92] *BUPA*, para 167. See also the important para 172.

[93] See amongst others, Due (1997), p. 137. Also compare with ECJ, Case C-242/95 *GT-Link* [1997] *ECR* I-4449, para 50, where the Court of Justice states that: 'Since Article 90(2) [now Article 106 TFEU] is a provision which permits, in certain circumstances, derogation from the rules of the Treaty, there must be a strict definition of those undertakings which can take advantage of it (ECJ, Case 127/73 *BRT* v. *SABAM and NV Fonior* [1974] *ECR* 313, para 19)'. See also ECJ, Case 127/73 *Belgische Radio* [1974] *ECR* 313, para 23; ECJ, Case 41/83 *Italian Republic* v. *Commission* [1985] *ECR* 873, para 30; and ECJ, Case C-179/90 *Merci* [1991] *ECR* I-5889, para 27.

[94] See for instance Page (1982), p. 28.

[95] Papaconstantinou (1988), p. 84.

[96] Buendia Sierra (1999), pp. 280–283.

Commission.[97] This approach is more or less identical to what Buendia Sierra has referred to as the 'national approach'.[98] However, it should be pointed out that in the mentioned provision of the Services Directive, it is stressed that the definition has to be in conformity with EU law. In addition, it is of interest that the Court of Justice recently in *Federutility* has stated that Member States are entitled, whilst complying with the law of the Union, to define the scope and the organisation of their SGEIs, and that they may take account of objectives pertaining to their national policy.[99]

The General Court in *BUPA* focuses on the distribution of competences between the Member States and the EU. It seems to find, of more universal impact, that the absence of any competence specially attributed to the Commission and the absence of a precise and complete definition of the concept in EU law, point in the direction that the definition of SGEIs is the competence of the Member States. In addition, it seems that it is important that the case concerns the health sector, as the General Court points out that this sector falls almost exclusively within the competence of the Member States. This may be understood as indications in the direction, that under all circumstances this field of law will imply 'immunity', at least when viewed on the basis of the standing of the law before the entering into force of the Lisbon Treaty. It is emphasised by the General Court that a discussion of services of general interest is obviously not of relevance when the service in question belongs to a field of law which falls more or less exclusively within the competence of the Member States. Article 16 EC (now Article 14 TFEU) is additionally referred to as further support to the argument.

If assuming that the principle, amongst others stipulated in the Services Directive, that the competence to define what is considered to be SGEIs is vested at the Member State level, is universal in character, one may wonder how this principle may be unified with the characterisation of the concept as an EU concept, as well as with the principle, that the definition created by Member States has to be in accordance with EU law. Thus, it seems that the two principles are in conflict with one another and it may be questioned where the competence to define actually is situated, at the EU level or at the Member State level; or somewhere in between. Also, the exact definition of what constitutes a manifest error is at present completely unsettled.

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[97] See amongst others Commission, *Services of general interest in Europe* (96/C281/03), *OJ* C 281/3, Section 26; Commission, *Communication from the Commission. Services of general interest in Europe,* COM(2000) 580 (2001/C17/04), Section 22; Commission, *Green Paper on Services of General Interest*, COM(2003) 270, Sections 30–32; and Commission, *Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions. White Paper on services of general interest*, COM(2004) 374, Section 2.

[98] Buendia Sierra (1999), pp. 280–283.

[99] ECJ, Case C-265/08 *Federutility* 20 April 2010, *ECR* I-0000 (n.y.r.), para 29.

2.4.3 Preliminary Considerations

At present, it is not completely settled how health services and related activities shall be categorised in relation to SGEIs and related terms. Most likely, their categorisation will require a concrete evaluation of the exact activities involved, which will imply that the assessment of such activities often has to be carried out on a case-by-case basis.[100] On the basis of the above analysis, there are reasons to estimate that activities within the health sector often will be included within the concept of SGEI, or at times rather the related concepts SSGIs or NESGIs, inter alia, depending on the determination made by the Member States. At the present stage of development a large degree of uncertainty is related to this terminology and its concrete application. This of course is not optimal in relationship to traditional legal standards such as transparency and legal certainty. In the area analysed in the present part an impression of an increasingly blurred line between Member State and EU law may be observed.

2.5 'Solidarity'

This concept has an important role to play in *BUPA*. It is mentioned in paras 199, 200, 204, 292, and 293. The Commission refers to the concept several times in its Decision. In fact, one of the important reasons why the measure is approved of has to do with the fact that it is based on solidarity. For instance, the General Court points out that:

> … In effect, the purpose of community rating, namely that the young, healthy insured persons subsidise the premiums that would normally have to be paid by the elderly and sick insured persons, and, accordingly, *solidarity* between the generations, would be jeopardised if one PMI insurer, in an extreme situation, covered only young persons or

[100] See for example, Recital 34 of the Services Directive. See also Commission, *Commission Staff Working Document. Annexes to the Communication from the Commission on Social services of general interest in the European Union—Socio-economic and legal overview*—COM(2006) 177 final, SEC(2006) 516, Section 1.1.1., where it is stated that: 'It is in this context very important to note that 'social' does not necessarily mean "non-economic". The fact that the functioning is based on solidarity, that certain social objectives are pursued or the non-profit nature of the provider do not rule out that the activity in question is qualified as an *economic* activity. Some operators may agree to take aspects of solidarity into account in the light other benefits they may obtain from intervening in the sector under consideration. Conversely, non-profit-making entities may compete with profit-making undertakings and may, therefore, constitute undertakings within the meaning of Article 87 of the EC Treaty. As a general rule, Community case law classifies as an undertaking any entity engaged in an economic activity, regardless of its legal status in which it is financed [Footnote omitted]. It should also be noted that an entity carrying out primarily non-economic activities might be engaged in secondary activities of an economic nature. In such cases, classification as an undertaking within the meaning of the competition rules will be confined to the economic activities involved.'

> elderly, sick persons…. While such rating appears to be capable of significantly reducing the incentive to employ active risk selection… and, accordingly, of maintaining a certain equilibrium, it does not permit the other objective pursued by the open enrolment and community rating obligations to be achieved, namely *solidarity* between the generations, which ensures easier access to PMI—owing, in particular, to the cross-subsidy of premiums—by the elderly and the sick.[101] [emphasis added]

In Article 5(1) in the Directive Proposal, solidarity is mentioned in the following way:

> The Member States of treatment shall be responsible for the organisation and the delivery of healthcare. In such a context and taking into account principles of universality, access to good quality care, equity and *solidarity*, they shall define clear quality and safety standards for healthcare provided on their territory, and ensure that…[102] [emphasis added]

Solidarity has become one of the more 'fancy' terms in EU law, and it is generally important as to the organisation of healthcare. For instance, Hervey and McHale refer to solidarity as a fundamental value and point out that solidarity may be said to underpin all health regimes within the EU.[103] Mossialos and McKee also agree on this, and point out that the solidarity in the health sector often implies that contributions are made according to the ability to pay and benefits are received according to needs.[104] Thus, in the following part of this chapter some further guidance as to its understanding will be provided. With regard to the issue of distribution of competences, this has an interest because it is central whether certain solidarity mechanisms in Member States may be protected from interference of EU law. For instance, *BUPA* may in generalised terms be viewed as an indication of a certain degree of immunity in these instances to be realistic to obtain. More concretely, in what follows first the background of the concept is briefly stated (Sect. 2.5.1); second, solidarity in the Treaty texts is explained (Sect. 2.5.2); and third, solidarity in the case law of the Court of Justice is examined (Sect. 2.5.3).[105]

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[101] *BUPA*, paras 292–293.

[102] The concept is also mentioned other places in the Directive Proposal, see pp. 4, 9, and 23 (recital 12).

[103] Hervey and McHale (2004), p. 5. Also, at p. 392, the authors explain that: 'In the context of health law, this could refer to such matters as the cross-subsidisation that takes place within European national health systems (whether through compulsory insurance or taxation) allowing equality of access to health care and treatment, regardless of an individual patient's means; the interference with the normal operation of the market in setting prices for pharmaceuticals and other medical products; and the voluntary and unpaid donation of blood or organs.'

[104] Mossialos and McKee (2004), p. 34.

[105] For a more general account of solidarity in EU law health care law, see for example, Newdick (2006), pp. 1645–1668.

2.5.1 'Solidarity' in the Member States

Although the concept in the context of EU law at present is fairly 'immature', it has for long been a central subject in other disciplines such as for example, philosophy and sociology.[106] Due to the complex and ambiguous nature of the concept, a full account of the content thereof is not possible here. Therefore, the aim here is much more modest: to provide an impression of what it is more or less about.

Many of the welfare services, including health care, in the Member States are organised on the basis of certain solidarity mechanisms, at least with regard to some elements. Through a primarily tax-financed system, citizens may have the right of access to various welfare services, at most times based on certain criteria to be fulfilled.[107] They may be provided at the municipal, regional, or state level. They may largely be said to be based on a premise of the stronger supporting the weaker, but not only, as the system also is constructed as a way of the members of the society getting services which would not be possible for the individual to acquire, had each of us had to do everything ourselves. 'Belongingness' to the society is the main criterion to have the right to access of the services in question. Historically, citizenship has been the dominant determinant of belongingness, but nowadays residence or occupation appears as much more important. At times it may be sufficient just simply physically being there in order to take advantage of a given service. Also, being a member of the society, you will often not be able to escape contributing to it, primarily through tax contributions, but at times also otherwise.[108] Solidarity in national welfare systems are founded on the principle of territoriality.[109] The concept of solidarity may be for the present purposes loosely understood and as amongst others referring to such particular and often complex

[106] For an account, see for example, Ottmann (2008), www.icl-journal.com, p. 40.

[107] As explained by Hervey and McHale (2004), p. 125, national public health care systems in the EU may be seen as falling into two main categories: (1) social insurance systems and (2) national health services. About the former category, the authors point out that they are: '… based upon the compulsory insurance of categories of persons (now expanded to include all, or virtually all, the population). Insurance premiums are usually income related, and calculated on the basis of total annual expenditure. Administratively speaking, health care schemes are often integrated into the general social security system. The administration of health insurance may be entrusted to public or semi-public bodies, such as sickness funds. Social insurance schemes may be further subdivided into reimbursement schemes, in which patients have to pay for care, and are reimbursed subsequently by their sickness fund; and benefits-in-kind schemes, in which patients receive care essentially free (to them) from health providers, who are then paid directly by the relevant health insurance institutions.' [all footnotes in the quotation omitted] About the latter category, the authors state that these are: '… funded by public taxation, and operate according to benefits-in-kind system. They may be more or less centralised in terms of their administration.' [all footnotes in the quotation omitted].

[108] See, for example, Mau (2007), pp. 138–139, who points out that: '… the national welfare state represents a system of compulsory solidarity that does not rest on the voluntary contributions of the citizens, but on tax duties or compulsory social contributions…'.

[109] For an account, see, for example, Ottmann (2008), pp. 36–48.

structures in Member States, which are of central importance in holding institutionalised societies together.[110]

Weiler has expressed that:

> Europe prides itself on a tradition of social solidarity which found political and legal expression in the post-war welfare state, which all states of all political colours embraced as an ideal and as a pragmatic commitment for years. Universal health coverage, free education from kindergarten through to university, generous welfare for the less fortunate, notably the unemployed, have been the proud hallmarks of this commitment. This was not just a question of political choice. Like the eventual rejection of the death penalty, this commitment became a source of identity, even pride—especially in comparison with the United States.[111]

In the same direction, Mau points out that:

> Policy makers and social scientists have frequently referred to the nature of European society and the shared traits of the European nation states and people in order to justify the process of supranational community building. In their view, the European Union constitutes more than a random cluster of countries that have opted for a particular form of cooperation; it represents a particular identity and commonness that come together to support the integration process. Indeed, though the European continent has been the locus of the nation state and nationalism, it can also be argued that there is a common ground that unifies the European countries.[112]

Thus, Weiler stresses the importance of solidarity in Europe, and Mau the shared traits of the European nation states and people. But what is this European solidarity all about? One way to approach this question is to understand the results put forward by Karagiannis of her research on the subject.[113] This author provides a useful overview of what the features of European solidarity are characterised by. These are: the issue of inclusion/exclusion; the elusive nature of the centre of 'solidarity'; the issue of inequality; and the simultaneity of commitment and belonging.[114] These features may be further explained.

Regarding the first feature, Karagiannis explains that on the one hand inclusion is an important element in solidarity in the sense that solidarity federates, that is it makes social things come together and then hold together.[115] On the other hand, and perhaps more paradoxical is the widely observed fact that such inclusion entails exclusion.[116]

Regarding the second feature, that is the elusive nature of the centre of solidarity, Karagiannis explains that traditionally, solidarity federated previously

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[110] Multiple solidarities may be identified, see, for example, Karagiannis (2007), pp. 1–12.

[111] Weiler (2002), p. 569.

[112] Mau (2007), p. 129.

[113] For further details, see Neergaard (2010), pp. 99–140.

[114] Karagiannis (2007), pp. 4–5.

[115] Ibid., p. 5.

[116] Idem.

separate elements around a specific core of values, ideas or reified categories.[117] For example, western Christian solidarity, federated around entities such as 'God' or 'the Church', and working class solidarity was created around the central category of 'the workers'.[118] In other words, Karagiannis states, a normative commitment to solidarity as a value and a practice is on the one hand upheld, whilst on the other hand there is a recognition that this solidarity no longer has fixed points of reference, such as 'God', or 'the workers'.[119]

Third, the importance of the feature of inequality is explained as equality on the one hand being one of the fundamental traits of the received view of solidarity, together with reasonableness/rationality and abstraction, and on the other hand, solidarity can only exist where there already is inequality.[120] In other words, only if there are for example rich and poor can solidarity be inclusive; or only if there are for instance oppressed and oppressors can there be a dispassionate community; and finally, e.g. only if there are less powerful and more powerful classes can there be class-based solidarity.[121]

Finally, it is central in the understanding of the fourth feature, that is the simultaneity of commitment and belonging, that:

> [T]here is a hiatus between solidarity as a commitment or a value—that is, as something that is pursued—and solidarity as 'belonging', 'belongingness' or 'we-ness', something that is already there… In this sense, we are dealing with a different sense of solidarity when it is attached to particular world views about the good life, to autonomy and to freedom, and when it is viewed as endangered, dissolving or emerging. In the first case, solidarity is seen as the attribute that will keep the good polity together, and thus as an expression of the belief in the future of this polity as polity… In the second case, solidarity is seen as that which, having adequately described a social situation, no longer does so because the situation has become indescribable in social terms… The move from the second to the first case is always necessary before a new sense of 'belonging' can be ascribed to the social.[122]

Admittedly, it is rather difficult to sum up on the roots of solidarity in Europe. In addition to the four features put forward by Karagiannis, certain help from Wilde may be useful here. Thus, it may added that solidarity may largely be understood as the feeling of reciprocal sympathy and responsibility amongst members of a group which promotes mutual support.[123] Also, it is of importance that the difference between moral solidarity and legal solidarity may, with the words of Ottmann, be said to be that in the welfare state, solidarity is no longer seen as a voluntary act of charity, but rather as an obligatory act based on legal rights and duties.[124]

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117 Idem.

118 Idem.

119 Idem.

120 Ibid., p. 6.

121 Idem.

122 Idem.

123 Wilde (2007), pp. 171–172.

124 Ottmann (2008), p. 40.

2.5.2 'Solidarity' in the Treaty Texts

On the basis of the platform established in the previous section, the attention is now turned to the much more concrete level. In what follows, it will be explained what the explicit role of solidarity in primary EU law has been over the years.[125]

In general, a significant increase in the use of the word solidarity over the years can be observed. Also, a change from a more 'external' dimension to an 'internal' dimension has occurred so that a kind of protection or at least acknowledgement of the latter dimension with the Treaty of Lisbon 2009 and the Charter of Fundamental Rights now appears. The concept may thus be understood in light of which of the following words following it, namely either 'between' or 'among' following it. In other words, it is central to understand what relationship it is connected with. Thus, it can be observed that it is no longer only the relationship amongst Member States, amongst the peoples of the EU, and between the Member States and the EU, and between the EU and the wider world which are of interest. Solidarity 'internally' in Member States is becoming of interest in the sense that it is worthwhile protecting. However, it is not clear whether this protection is considered, e.g., only a domestic task or whether it, e.g., also has more European dimensions.

The concept of solidarity is not only to be understood in playing a role regarding these relationships. It also plays an important role in the definition of the European identity. Thus, it appears clear that solidarity is viewed as a special and important virtue of what Europe, including both the EU as such and the individual Member States, is about; something which apparently is viewed as distinguishing it from other continents.

At the same time, it may also be viewed as indicating an ideal, a programmatic commitment, an expression of a value or even an aspect of an ideology, which may be given weight. It seems as if the Treaty texts as a whole may be viewed as moving in the direction of a clearer commitment to the social responsibility of Europe over the years.

In sum, a rather significant re-orientation at the explicit level has taken place seen clearly in the Treaty of Lisbon 2009 and the Charter of Fundamental Rights. However, the exact content of the nature of the concept of solidarity cannot be deduced just on the basis of a reading of the Treaty texts. Therefore, the attention will now be moved to the case law of the Court of Justice.

[125] See for further details Neergaard (2010).

2.5.3 'Solidarity' in the Case Law of the Court of Justice

In a search on the EurLex database, the concept solidarity appears 113 times.[126] The first judgment dates back to 1969, some 11 years after the Treaty of Rome entered into force, and the context in which the concept is found in relates to Article 10 EC (previously Article 5 EEC; now repealed but replaced, in substance, by Article 4, paragraph 3 TEU).[127] In fact, in the first many years the references to the concept generally occurred in the context of a more 'external' dimension. This has changed over the years, so that the more 'internal' dimension has become of larger and larger importance. However, references to solidarity in a framework of identity or programmatic commitment, as were identified in the foregoing section, are not truly identifiable.

In general, the referrals to the concept have not surprisingly steadily increased strongly over the years, this also being so already when taking into account the increasing case load of the Court of Justice, which has occurred. It may, however, also be seen as an indication of the concept growing in importance. This may be exemplified in the following manner: from 1958 to 1970 (both years included) 1 reference was made; from 1971 to 1980 (both years included) 6 references were made; from 1981 to 1990 (both years included) 19 references were made; from 1991 to 2000 (both years included) 34 references were made; and from 2001 until 2010 53 references were made.[128]

The important legal areas may on the basis of the results of the query, and when focusing primarily on the 'internal' dimension of solidarity, roughly be limited to competition law,[129] internal market law, and Union Citizenship law as being the areas of possible interest. All of the cases identified have been rendered largely only from the end of the 1980s and onwards.[130]

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[126] See http://eur-lex.europa.eu (31 August 2009). The search undertaken was 'simple' and limited to judgments from the Court of Justice. The present section 21.5.3 presents only very the very general results of a previous study accomplished; see for further details Neergaard (2010), pp. 99–140.

[127] ECJ, Joined Cases 6 and 11–69, *Commission* v. *French Republic* [1969] *ECR* 523.

[128] 31 August 2009.

[129] For the present purposes here understood as not including state aid law.

[130] It should be stressed that other judgments than those in which the concept explicitly is mentioned may be of importance to national structures involving solidarity. However, these have largely been left out of the analysis, among others due to limitations of space, and that primary interest is taken in the explicit use of the concept rather than subjectively assuming that solidarity implicitly may be of concern. Also, several of the cases in which the term is mentioned, may be not of the least interest. This may for instance be the case, when the term is used in national legislation being reiterated by the Court of Justice or otherwise being an element in the account of the facts of relevance. Also, this may be the case when the more 'external' dimensions of solidarity are involved. In addition, a certain amount of cases concern the ECSC Treaty, which implies that they are also excluded from analysis. Also, cases, in which the reference to solidarity is to a relationship among workers or among trade unions in the context of solidarity actions, are also excluded. This in fact consists of a very large amount of cases.

An analysis of solidarity in its more 'internal' dimension shows that it at present holds a rather complex role and the degree of 'immunity' to be obtained there from is not very clear at present. Generally speaking, it has been observed that it is both used 'negatively' and 'positively'. This terminology has in the context of solidarity been introduced by Barnard whom refers to a 'negative' use of solidarity by the Court of Justice when social welfare policies are defended against erosion from single market principles.[131] Barnard views solidarity to have been used 'positively' when obligations are imposed on Member States.

The 'negative' function clearly dominates in the competition law regime. In the internal market law regime both functions have been seen. Finally, in the union citizenship law regime, the function is largely 'positive'. These findings are of interest to the area of healthcare, as health services in the Member States as mentioned most often are organised within a framework of solidarity mechanisms. The importance of this to those Member States being interested in as little interference of the EU in the organisation of their health services is that the 'negative' function may be viewed as a kind of optimism in that direction, whereas the 'positive' function may be viewed as a threat. Under all circumstances, it should be kept in mind that so far the case law in question is very limited with regard to what kind of solidarity mechanisms which have been under scrutiny by the Court of Justice.

The protection through the principle of solidarity may as mentioned be observed to be stronger in the competition law regime, than what may be observed in the residing regimes.[132] This may to a certain degree be explained by the circumstance that the competition law regime, if coming into force, might be considered to be more dominated by market economics and with fewer possibilities of exemptions. Also, it is an area which is not really constructed to a scrutiny of national legislation, but originally largely was developed with a primary eye on the activities of private undertakings. In addition, the competition law regime works in closer relationship to economic theory than the other regimes which may be a reason to explain the development: the understanding of the issues at stake may simply have been better perceived in this area. In contrast, the internal market and union citizenship law regimes constitute areas in which the individuals and their rights are the driving force. Although possible explanations may be suggested, this is not the same as implying that the difference in treatment between the

[131] Barnard (2005), p. 159.

[132] Pointing in the same direction, it was demonstrated above that the protection of health care in Member States is larger through the concept of SGEI, which is a concept which may be viewed as originating from competition law, than the justifications related to the concept public health and the like, in the area of free movement.

regimes is desirable.[133] The problem by ignoring economic theory in this area in a nuanced manner, and interfering in national systems, is in a nutshell that this sector from an economic point of view largely may be characterised as a public good,[134] which implies that imposing of a market economic ideology may create more problems than necessarily taken into consideration in the above-mentioned case law. In actual fact, it is a sector which is often characterised by market failures.[135] In other words, it is a sector where several factors constitute barriers to competition.[136] Amongst others, the amount of health providers will often be insufficient to ensure competition about demand and thereby prices which will mirror the marginal costs, which is often connected with the fact that health production is characterised with large-scale advantages.[137] In addition, it is seldom the consumers themselves who directly pay for the services, which will often imply an overconsumption of the services in question both by the consumers (often patients) and the producers (often the doctors).[138]

Generally speaking, there is a great deal of truth in the statement by Ross that an analysis of solidarity provides a rather frustratingly mixed picture to the extent that the concept is multifaceted and, as such, likely to send confusing or diluted messages as to its role.[139] In fact, at present transparency and predictability as to its use is not very apparent. Although responsibility for welfare provision based on

[133] See, for example, Szyszczak (2009), p. 192, who states: 'Finally the essay concludes with the view that EU law is inconsistent in its treatment of healthcare, finding that under the free movement rules there is a greater ease in accepting the economic nature of healthcare and patient mobility rights thus undermining the principle of solidarity upon which healthcare services were originally built. Whereas under the competition rules the Courts are generous towards national healthcare schemes using ideas of cohesion and solidarity to ring fence healthcare activities, even where such activities are explicitly commercial activities, protecting them from the full force of market principles. It is argued that this is the wrong approach and that the EU could play a role in defining an inner core of healthcare activities which are truly solidaristic in a different, EU-level, spatial setting and that there may be good and defensible reasons for protecting these activities from the full force of competition and market rules.' See also, for example, Hatzopoulos (2009), p. 228, who warns: 'The fully-fledged application of these same rules to public healthcare, a field based on the (non-market) principle of solidarity, could have undesirable—if not unacceptable—effects. Both the provision of health services and national healthcare and social systems themselves could suffer unintended negative consequences.'

[134] Mossialos and McKee (2004), p. 32. See also Chapter 14.

[135] See, for example, De Økonomiske Råd (2009), p. 271 et seq.

[136] Ibid., p. 271.

[137] Ibid., pp. 271–272.

[138] Ibid., p. 272.

[139] Ross (2007), p. 1069.

solidarity mechanisms for long has been considered primarily a domestic responsibility, EU law now has a severe impact thereon.[140]

In Recital 31 of the Directive Proposal it is stated that:

> The evidence available indicates that the application of free movement principles regarding use of healthcare in another Member State within the limits of the cover guaranteed by the statutory sickness insurance scheme of the Member State of affiliation will not undermine the health systems of the Member States or financial sustainability of their social security systems.

In the context of the present discussion of solidarity mechanisms, the prediction in the quotation does not seem completely convincing neither does it seem too correct to speak about 'evidence'. Changes are occurring and will continue to occur—with or without the adoption of the Directive Proposal, and solidarity at a wider scale, eventually at a European scale, will have to be established. As Szyszczak has pointed out the principle of solidarity upon which health care services were originally built on are being undermined.[141] A process towards a not completely known destination has been initiated already with especially the significant case law of the Court of Justice as explained above, this development perhaps to be further supported by such an adoption.

2.6 'Social Europe'

> The allegation made by the complainants re V. that European economic policy is a purely market-oriented policy without a social-policy orientation and that its functional approach restricts the possibilities of the legislature in the Member States to engage in a self-determined social policy is incorrect. Neither is the European Union without any social-policy competences, nor is it inactive in this area. At the same time, the Member States have a sufficient space of competences to take essential social-policy decisions on their own responsibility.[142]

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[140] This has been expressed by Dougan and Spaventa (2005), p. 181, as: '… the idea that the European Union now constitutes a multi-level welfare system characterized by a complex combination of local, national and Community policies. This is sometimes expressed in the notion that the Member States are now "semi-sovereign welfare states" whose choices about how to provide for the social well-being of their own citizens are increasingly constrained not only by obvious factors such as the demographic pressures posed by an aging population and the need to compete within the globalizing economy but also by the pervasive influence of the Union—which has not, however, evolved into a "newly sovereign welfare state" determining for itself the conditions under which we pay taxes and receive benefits. As a result, the idea of social solidarity can no longer be treated simply as a national or local monopoly. It also has a vital Community component. [footnotes omitted]'.

[141] Szyszczak (2009) at p. 192.

[142] 30 June 2009, para 393. See http://www.bundesverfassungsgericht.de/entscheidungen/es20090630_2bve000208en.html.

This quotation from the judgment of German Constitutional Court on the Treaty of Lisbon 2009 sums up one of the most complicated, controversial and fundamental problems which confronts the EU, namely how to understand and solve the problems of the tensions between economic and social integration. In the specific field of health care, the same characterisation may be given. In what follows, the concept of a European Social Model and the related concept of Social Market Economy will be touched upon and the findings established so far will be related to the scheme of Maduro on models of Social Europe.[143] By doing this, the development of the law on health care is placed into its larger context.

At the level of the EU, it is of significance that provision of welfare was for a long time the concern of, and within the competence of, the Member States. This point of departure has changed to some extent and continues to change further. In that context, it has now become a common theme to talk about a European Social Model as a point of reference. The concept of a European Social Model is several years old; it was applied for the first time by the Commission in 1994.[144] The most important step in this regard may be viewed as having been taken with the formulation of the Lisbon strategy in 2000, which may be interpreted as the result of a compromise between the neo-liberal and the more socially oriented governments of Member States.[145] Some authors have raised doubt as to whether the latter term really can be considered to exist.[146] One author has characterised the term as: '… a rather diffuse amalgam of ideas and principles constructed principally by the Commission to justify social policy interventions on the part of the EU.'[147] Others have characterised it as a concept that has '… an ambiguous and polysemic nature'.[148] Some emphasise the importance of a shared set of values that have given rise to the welfare state in the Member States, which are distinct from those in, for instance, the US.[149] Others again have pointed out that one cannot speak of a single 'European Social Model'. For instance, Kleinman points out that:

> Rather, there is a range of different European social models in existence. As there is no single European model, it logically follows that the idea that European Social Policy is about "defending" a European Social Model against, say, globalization, is logically

[143] Poiares Maduro (2006), pp. 125–141.

[144] Pursuant to Hatzopoulos (2005), p. 1600, whom refers to: Commission, European Social Policy—A Way forward for the Union—A White Paper, COM(94) 333. Here it is stated in the 'Preface': 'The objective in the coming period must be to preserve and develop the European social model as we move towards the 21st century, to give to the people of Europe the unique blend of economic well-being, social cohesiveness and high overall quality of life which was achieved in the post-war period.' See also, for example, Adnett and Hardy (2005).

[145] Hatzopoulos (2005), p. 1634.

[146] Ibid., pp. 1599–1635.

[147] Shaw (2000), p. 3.

[148] Jørgensen and Kongshøj Madsen (2007), p. 25, who point out that already in 1985 Jacques Delors introduced a social dimension of the EU.

[149] Mossialos and McKee (2004), p. 41.

> inconsistent. Rather, what European (supra-national) social policy seeks to do is to *create* a European social model—either by synthesising aspects of all four models or (more realistically) by imposing one model on all. In an analogous way to the national myths that create and sustain both nationalism and nations, the idea of a "European Social Model" should be considered perhaps as a founding myth which helps to create (not defend) the concept and reality of "Europeanisation" and a politically integrated Europe.[150]

Schiek agrees on this point, and states that the European Social Model should be defined as being based on commonalities between the Member States:

> It has been characterised as an "essence of a common political culture (…) which finds it difficult to accept the phenomena of exclusion and excessive inequality, which believes in the legitimacy of state intervention in redressing adverse consequences of the Market Economy in this respect and (…) in (…) a sufficient involvement of social partners", as a combination of "economic efficiency and generous social insurance" and as the "broad acknowledgement of three common features shared by every European state: (…) public commitment to social justice (…) the theoretical approach that social justice is not opposed to economic efficiency (…) and the value of interest representations and negotiations between social actors".[151]

The concept of Social Market Economy is closely related to the concept of European Social Model. In that context, it may be worth pointing out that the Court of Justice has ruled in *Laval* that:

> Since the Community has thus not only an economic but also a social purpose, the rights under the provisions of the EC Treaty on the free movement of goods, persons, services and capital must be balanced against the objectives pursued by social policy, which include, as is clear from the first paragraph of Article 136 EC, inter alia, improved living and working conditions, so as to make possible their harmonisation while improvement is being maintained, proper social protection and dialogue between management and labour.[152]

It is likely that these sentences, as well as for instance the judgment itself in its entirety and other sources of law including soft law, may be understood as an expression of a 'social market economy' as already, that is, before the entry into force of the Treaty of Lisbon 2009, being the actual objective for the EU to strive for.[153] After the Treaty of Lisbon 2009 entered into force, this objective is explicitly introduced, namely in Article 3(3) TEU:

> The Union shall establish an internal market. It shall work for the sustainable development of Europe based on balanced economic growth and price stability, a highly competitive social market economy, aiming at full employment and social progress, and a high level of protection and improvement of the quality of the environment. It shall promote scientific and technological advance. It shall combat social exclusion and discrimination, and shall promote social justice and protection, equality between women and men, solidarity

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[150] Kleinman (2002), p. 58.

[151] Schiek (2007), p. 26. Footnotes have been omitted from the quotation.

[152] Case C-341/05 *Laval* [2007] *ECR* I-11767, para 105. See also Case C-438/05 *Viking* [2007] *ECR* I-10779, para 79.

[153] See further, for example, Azoulai (2008), pp. 1335–1356; and Jacqueson (2009), no. 5–6.

> between generations and protection of the rights of the child. It shall promote economic, social and territorial cohesion, and solidarity among Member States. It shall respect its rich cultural and linguistic diversity, and shall ensure that Europe's cultural heritage is safeguarded and enhanced.

In other words, it is expressly indicated that the Union should work for 'social market economy'.[154] It is noteworthy that the term 'social market economy' will play an explicit and significant role. Thereby, a culmination of the development away from the original point of departure as a mere economic integrationist Community with a focus on, primarily, a system of undistorted competition, to a rather new situation, has explicitly taken place.[155] However, it may be of some significance and impact that it is a 'highly competitive' social market economy which the development should be based at.

The importance of the European Social Model and the Social Market Economy primarily lies in the function of indicating that Europe is now heading in a different direction. The social dimension of the EU will make the European integration project more acceptable to some than when it was primarily defined as an economic project. However, this change also unavoidably implies a larger impact, and at times limitations, on the national organisation of welfare and of interest here, health services, which will be perceived negatively by others. As it has been put forward by Damjanovic and De Witte, the EU's legitimacy to deal with welfare services is disputed and uneven.[156] The same seems to be the case regarding health care services.

The change may be further explained by reference to the work by Maduro, where he distinguishes between the following three models: (1) The model on economic freedom and social non-discrimination; (2) the model protecting the social model of the Member States; and (3) the social model of Europe.[157] However, first the content of these will be elucidated.

The three models presented by Maduro review the relationship between the constitutionalisation of the project of European integration and social values.[158] It is stressed that the models are heuristic devices rather than 'real-life' representations, and that elements of all are to be found to a greater or lesser extent, in the EU.[159] It is also stressed that they do not simply represent different understandings of the role and place that social values ought to have in the project of European integration, because they embody different processes of decision making

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[154] It should be noted that the former Article 3(1), litra g) EC, states that the activities of the Community shall include: '… a system ensuring that competition in the internal market is not distorted…' In the Lisbon Treaty this aim could be said to have been 'moved' to Protocol 27. See further, for example, Behrens (2008), p. 193; and Semmelmann (2008), pp. 15–47.

[155] See Joerges (2004), amongst others at pp. 16–17.

[156] Damjanovic and de Witte (2009), p. 55.

[157] Poiares Maduro (2006), pp. 125-141.

[158] Ibid., p. 125.

[159] Idem.

with respect to social values in the EU and these processes provide, in turn, different degrees of participation to different social groups.[160]

The first model more precisely is said to arise from the constitutionalisation of market integration.[161] Accordingly, in this model the focus is on the fact that market integration rules constituted the basis for the initial process of constitutionalisation of the project of European integration, and that they shaped its impact on the European social model.[162] Therefore, in this model both the impact of EU law on national social values and the development of European social values are linked to the logic of market integration and its focus on negative integration.[163]

The second model more precisely is said to have grown out of the policies of social harmonisation.[164] Here, the European social model is viewed as a set of basic social values and rules which are promoted or set by the European Union, but are mainly to be guaranteed and protected by the Member States.[165] Maduro points out that this model either aims at guaranteeing a level playing field in the social sphere so as to prevent social deregulation at the Member State level, or, in certain Member States, attempts to promote further social regulation by shifting the level of decision making of national social policies to what is perceived to be a more social-friendly political sphere.[166]

Finally, the third model assumes that the European social model must entail both a definition of genuinely European social values and mechanisms of distributive justice at the European level[167]:

> The underlying idea is that the European Union needs a political identity and that the latter requires a European definition of a core set of social values (including, in this respect, some core aspects of private law). It can also be argued that the increased redistributive consequences of some EU policies and its increased majoritarian character require a criterion and policies of distributive justice so as to legitimize and compensate for those redistributive consequences and to guarantee the necessary political loyalty of those in the minority. This model would require harmonization policies not as instruments of market integration (to guarantee a level playing field) but as instruments of a set of European social values that the Union ought to pursue. It would also require further instruments of distributive justice at the EU level (including taxation mechanisms).[168]

EU health care law seems to move more in the direction of the second model, but having its roots in the first model, whereas the third model still seems further

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[160] Ibid., p. 127.

[161] Ibid., p. 125.

[162] Idem, p. 125. Pursuant to Maduro this concept refers in this context both to the social model of the European States and that of the European Union itself.

[163] Ibid., p. 125.

[164] Idem.

[165] Idem.

[166] Ibid., pp. 125–126.

[167] Ibid., p. 126.

[168] Ibid., p. 126.

(perhaps forever) away.[169] In this respect, it is central that within the health care sector a right as such for the EU to legitimately establish and exercise an independent redistributive function is not recognised.

2.7 Conclusions

The 'Good Samaritan' has travelled a long way. Thus, the consciousness which may be claimed to have arisen from, amongst others, the parable may be considered to constitute an important element behind EU law, and thus no longer the domain solely of national law. The boundaries between the two levels of governance have become more blurred over the years. By reference to the different models of Social Europe, it seems clear that in a larger context, EU health care law at the general level is evolving and developing rapidly in recent years. It is now an important element of a newer agenda. The implementation of the understanding of the message inherent in, amongst others, the parable for the years to come will probably be less predictable. It is difficult to see how exactly the organisation will be influenced, whether for example, more privatisation will occur, more cross-border health care will arise, loss of well-functioning national solidarity mechanisms will evolve, negative changes as to the financing of health care will happen, and so on. It is certain that further changes are unavoidable. Hopefully, this process will eventually take into account the fact that health care is not a normally traded good, but has particular social traits, which need to be taken into consideration when deciding if a more market economically oriented ideology should rule, and if so, to what degree and how.

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[169] See in particular Poiares Maduro, ibid., p. 131: 'The need to protect the cross-border provision of health services has led the Court to recognize, in several circumstances, the rights of patients to choose the Member State where they wish to be treated. This allows citizens to choose from a broader array of treatments and also to benefit from a faster and better treatment than that which may be available in their country of residence. Some critics have pointed out, however, that this may impose too great a burden on the financial foundations of national health systems. So far, the Court has been careful in this regard but one must recognize that such a system involves a certain degree of cross-subsidization. That such forms of solidarity are inherent in the logic of an internal market which includes a dimension of citizenship appears obvious. The remaining question is how such solidarity should be organized.'

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