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Guest Editorial

Coming into line: the EU's Court softens on cross-border health care

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The revolution started without anybody realising it. The finding, by the Court of Justice of the European Union (the Court), that two Italian nationals, Mrs Luisi and Mr Carbone, were entitled to travel to another member state to receive health services – unrestrained by capital movement or other restrictions – hardly alarmed people in the health sector: Luisi and Carbone were over-the-border service recipients paying, in private, for the services received. The drama unfolded over a decade later, when another over-the-border service recipient, Luxemburger this time, took things a step further: Mr Kohll sought to obtain a refund from his social insurance fund for treatment received abroad – and was found by the Court to be entitled to it. The great dismay of the health care sector did not stop the Court from going even further, holding that a system of prior authorisation (the standard practice to manage cross-border health care movements) could only exceptionally be tolerated, in relation to hospital treatments. The Court also held that, under some circumstances, patients could 'force' the delivery of an authorisation to go abroad. Over-the-border patients could even 'make money' from their social fund, if they could get an equivalent treatment more cheaply abroad. Subsequent judgments made clear that the right of patient mobility and the indispensable refund system should be made available by all health care systems, even where they are designed to offer primarily benefits-in-kind through taxation (Beveridge systems), rather than mere refund through social insurance (Bismarck systems). What is more, Beveridge systems have seen waiting lists, their core instrument for canalising health care expenses, brought under a case-by-case proportionality review.

This revolution at the European Union level, however, has not led to the immediate transformation of national health care systems [on the process of transformation of national health systems, see Obermaier A., *The End of Territoriality? The Impact of ECJ Rulings on British, German and French Social*

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Policy (London: Ashgate, 2009)]. Countries where a radical reform was already underway, such as the Netherlands and Germany, have been fast in embracing the new EU rules. In the United Kingdom, England and Wales have been 'modernising' their National Health Service and, to date, have reticently aligned national law to some basic requirements stemming from the above rulings – but never fully. France, on the other hand, has systematically and explicitly rejected the application of the above rulings in its internal legal order until fairly recently, prompting further litigation. Southern EU countries still resist, in practice at least, the effect of the above body of case law. In view of the above variations, of the fact that Court-based solutions are, by definition, reactive (as opposed to pro-active) and case-specific, and in order to further promote patient mobility, the European Commission decided to propose legislation. First, it attempted to include health care services in the Services Directive (2006/123). This move was fiercely opposed by the European Parliament, followed by the Council. However, a few months after the Services Directive was adopted, firmly excluding health care from its scope, the European Parliament, in Resolution 2006/2275 (INI), called on the Commission to codify the case law and, if appropriate, to propose measures, in order to clarify the legal situation. The Commission stepped in to propose legislation (COM 2008/414), but its enthusiasm was soon to fade away, as member states took over in the legislative process: it was their opportunity to contain the Court's perceived excesses. It should come as no surprise, therefore, that the negotiations were protracted and concluded only after compromise texts were tabled under several presidencies, including two who had openly declared themselves hostile to the Commission's initiative: the Spanish and Belgian.

There are several past examples, including in the field of health care, where member states have been 'pushed' to the negotiation table in order to overturn judicial decisions. The fundamental difference from past experience, however, lay in the fact that in this case the Court had not interpreted some text of secondary legislation (such as Regulation 1408/71, now 883/2004), but primary Treaty law itself. This notwithstanding, in Directive 2011/24, the legislature: reinstated prior authorisation for most major operations as it expanded the concept of 'hospital treatment' by adding treatments requiring the use of highly specialised and cost-intensive infrastructure and by inventing extra circumstances where an authorisation is allowed; expressly allowed member states to limit the list of treatments covered; and excluded top-up payments in favour of patients receiving treatment in cheaper countries. It may be said that several 'classic' patients' rights, stemming from the Court's jurisprudence, have been traded off against 'modern' rights, of information and quality, introduced for the first time by the new Directive.

Given the legislative intervention, it is not surprising that the Court's jurisprudence has taken a different line in recent cases, and the Court has backtracked on its former 'revolutionary' stance. In developing this new approach, the Court was able to draw on its power to interpret very broad terms in the Treaties (such as 'restriction') and on existing law on the question of when

a restriction on free movement of services is justified by an 'objective public interest'. In terms of legal methodology, this existing law is critical, as it allows the Court to change its position *de facto* without departing from the *de jure* consistency that the law values most highly and on which the rule of law and the role of Courts is based.

First, the Court's very wide interpretation of 'restriction' has been tempered in more recent cases. In 2010, the Court held that, where the patient has travelled to the host member state as a tourist or student or for some reason other than to receive health care services, reimbursement rules concerning emergency care that do not guarantee that the patient receives at least the same level of reimbursement as he would have if he had received the treatment in the home member state do not constitute a 'restriction' [Case C-211/08 *Commission v Spain (Emergency hospital care)* [2010] ECR I-5267]. This decision confines earlier rulings on the application of Article 56 TFEU to reimbursement of 'scheduled' treatment. The Court explicitly takes into account the coordinated arrangements of national health care systems, under Regulation 883/2004, noting that to find otherwise would 'undermine the very fabric of the system which Regulation [883/2004] sought to establish'.

Second, the Court has extended the application of its interpretation of 'objective public interest justifications'. The Court has long recognised that the social protection provided by national social security systems can be an 'objective public interest' justifying restrictions on the free movement of services. In this context, the Court had until 2010 in practice distinguished between 'extra-mural' and 'hospital' care, referring to the distinct characteristics of the hospital sector, in particular, the planning of the number of hospitals, their geographical distribution, the way in which they are organised, the equipment with which they are provided and the nature of the health services they are able to offer.

Although the *fact patterns* of the pre-2010 cases involve a distinction between hospital and non-hospital care, the Court's *reasoning* in these decisions did not limit its application to hospital care. On the contrary, the *rationales* of the decisions imply that objective public interest justifications are available, where they are made out and are non-discriminatory and proportionate, in accordance with the Court's general case law on the internal market. This interpretation of the pre-2010 cases was confirmed by the Court in Case C-512/08 *Commission v France (Major Medical Equipment)* [2010] ECR not yet reported, when the Court held that a prior authorisation rule applicable to treatment involving the use of major medical equipment, such as 'PET' (positron emission tomography) scanners, 'MRI' (magnetic resonance imaging) scanners, hyperbaric chambers and cyclotrons, outside hospital infrastructures, could be justified on the basis of the planning necessary to ensure a balanced range of high-quality treatment, and at the same time control costs by avoiding wastage of resources. This brings the case law into line with the legislative position in Article 8 (1) of Directive 2011/24.

The Court has also taken a different approach with respect to the relationship between Article 56 TFEU and Regulation 883/2004. The Court reconfirmed that nothing in EU law requires member states to extend their own reimbursable 'basket of care' [Case C-173/09 *Elchinov* [2010] ECR not yet reported]. The approach has been echoed by the EFTA Court [Cases C-11/07 and 1/08 *Rindal* (2008)]. However, both Courts took a different approach where treatment abroad is more medically advanced than in the home member state. In that context, if the treatment available in the other member state is more advanced, according to the internationally accepted views of the medical profession, then the state may no longer justify prioritising its own treatment but must interpret its list of types of treatment appropriately, taking into account available scientific data, and not simply refuse to authorise treatment on the basis that that particular treatment is not available in the home member state. In this narrow respect, the Court's case law continues the line of earlier decisions.

Finally, in its more recent case law [see e.g. Case C-169/07 *Hartlauer* [2009] ECR I-1721; Case C-490/09 *Commission v Luxembourg (Laboratory Analyses and Tests* [2011] ECR not yet reported], the Court has been stressing the wide margin of discretion left to member states in defining their health policies, in the absence of common or harmonised policies, provided they act in a coherent and systematic way.

The Court is not, of course, obliged to follow the legislature where it interprets Treaty provisions such as Article 56 TFEU, but in practice it usually does so. The recent case law suggests that the Court is likely to continue to do so, especially on the question of justification.

It is true that in these last few years many have accused the Court of being activist – or even of pursuing a neo-liberal agenda. It is also true that, if one is to follow the black-letter of the Court's case law, it would seem that member states need more discretion when they authorise gambling and gaming activities, rather than when they organise their health care systems. The discussion above, however, allows for a different, more coherent, understanding of the Court's approach. For one thing, it may be said with certainty that the Court is conscious of the difficulties of providing (social) health care. At a more general level, it may be that the Court acts as a 'broker', arousing the EU legislature and/or curbing member states' resistance. Once, however, the member states and the EU political institutions have come to grips with the issue raised by the Court, and have reached a clear position, the Court readily steps down from its proactive stance and aligns its own position with that of the political institutions. The revolution is over.

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Case C-211/08 *Commission v Spain (Emergency hospital care)* [2010] ECR I-5267.
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Cases C-447 & 448/08 *Sjöberg* [2010] ECR not yet reported.
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