PATIENT CHOICE, MEDICAL ETHICS AND FREE MOVEMENT OF PATIENTS: THE "EMANCIPATION" OF THE CROSS-BORDER HEALTHCARE DIRECTIVE

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Abstract

As the free movement rights of patients are based on their entitlements under their national healthcare system, the exercise of these rights is not supposed to increase patient choice. Nevertheless, in the field of medical ethics, patients are likely to want to exercise patient choice. This article will show how, in its recent case law, the CJEU has interpreted the Cross-Border Healthcare Directive in such a way as to improve the exercise of patient choice in the internal market. In doing so, the Court has explicitly distinguished the aim of the Directive from the Social Security Regulation. As a result, more than a decade after its adoption, a process of "emancipation" of the Cross-Border Healthcare Directive may be observed. At the same time, the CJEU should develop and refine its approach towards identifying the limits on patient choice in the internal market. The current approach is based on a financial perspective, which is not suitable when Member States restrict free movement for reasons related to public policy or public morality. The process of emancipation of the Cross-Border Healthcare Directive does not just tell an important story about the relationship between primary and secondary EU law – it also shows the increasingly important role of the Charter of Fundamental Rights in free movement cases. The adoption of a non-discrimination "frame" based on the Charter shows how the CJEU is developing a more harmonious relationship between free movement rights and fundamental rights in the internal market.

Introduction

From the late 1990s, and based on Article 56 TFEU, the CJEU has developed a right for patients to be reimbursed by their home Member State for the costs of medical treatment in another Member State. The foundations of this right are based on a patient's entitlements under their home healthcare system or health insurance. The right to reimbursement is not an independent or self-standing free movement right – patients cannot be reimbursed for medical treatment which is not covered by their home Member State.[1] As a result, from the perspective of patient choice, the right to reimbursement broadens the potential *locations* where patients could receive medical treatment. However, it does not broaden the *scope* of their entitlements. The right remains intrinsically linked to the entitlements of patients under their home healthcare system. In 2011, the case law of the CJEU was codified in the Cross-Border Healthcare Directive ("the Directive").[2]

In the last twenty-five years, the right to reimbursement of medical treatment in another Member State has had a profound impact on the ability of patients to seek cross-border medical treatment. Two main scenarios can be identified in the case law of the CJEU. In the first scenario, patients applied to receive medical treatment in another Member State because the quality of the treatment provided would be higher than what could be provided in the home Member State.[3] This was either because the level of training and expertise of doctors in the Member State of treatment was more advanced than in the home Member State, or because the doctors in the Member State of treatment had more modern or advanced equipment to provide a certain type of treatment in a more effective way. In the second scenario, patients requested cross-border treatment because the treatment was not available in their home Member State, although it was covered by their home healthcare system. In many of these cases, the patient travelled abroad because of the long waiting

[1] Case C-158/96, *Kohll*, ECLI:EU:C:1998:171, and Case C-120/95, *Decker*, ECLI:EU:C:1998:167. See Hervey and McHale, *European Union Health Law: Themes and Implications* (CUP, 2015), pp. 73-74.
[2] Directive 2011/24/EU on the application of patients' rights in cross-border healthcare.
[3] See Case C-173/09, *Elchinov*, ECLI:EU:C:2010:581.

lists in their home Member State.[4] In these cases, patients were essentially seeking the same treatment in another Member State because it could be provided more quickly than in the home Member State. In other cases, there was another reason for the lack of availability of the treatment in the patient's home Member State. This could be because the doctors were not – or no longer – willing or able to provide a particular treatment in the circumstances of the patient's case.[5]

In both scenarios, the role of patient choice in decisions about cross-border treatment was limited. In the first scenario, the cross-border treatment provided an opportunity for a (more effective or complete) cure which was not available in the patient's home Member State. In many of the cases decided by the CJEU, the patient's clinical situation was very urgent and the chances of recovery were significantly better in the Member State of treatment. In these circumstances, it is difficult to argue that the patient was exercising choice.[6] Similarly, in the second scenario, patients were not exercising choice in deciding to receive treatment in another Member State, because the treatment was not available in their home Member State. Again, the choice between no or delayed treatment in the home Member State and treatment in another Member State cannot be regarded as a genuine choice. Overall, while free movement law has significantly improved the possibilities for patients to receive a higher quality of care in another Member State, or to receive speedier treatment in another Member State, it is difficult to characterise the exercise of free movement rights by patients in the case law of the CJEU as an exercise of patient choice.[7]

The aim of this article is to analyse the role of free movement law, and the right to reimbursement of cross-border medical treatment, in a field in which patients do seek to exercise genuine choice: the field of medical ethics.[8] In cases with an ethical dimension, the decisions that are made by

[4] See Case C-372/04, *Watts*, ECLI:EU:C:2006:325.
[5] Case C-157/99, *Peerbooms*, ECLI:EU:C:2001:404.
[6] De Witte, 'The constitutional quality of the free movement provisions: looking for context in the case law on Article 56 TFEU' (2017) 42 *EL Rev* 313, 328-329.
[7] Van Leeuwen, 'The Patient in Free Movement Law: Medical History, Diagnosis and Prognosis' (2019) 21 *CYELS* 162, 176-177.
[8] See Glenn Cohen, *Patients with Pas.ports: Medical Tourism, Law, and Ethics* (OUP, 2015) and Hervey and McHale, above n 1, 90-96.

patients are strongly determined by their own considerations about what the appropriate treatment should be. Although the views of doctors play an important role in the decision-making process, patients are more likely to defend their autonomy and to want to exercise choice in decisions about their treatment. At the same time, their ability to exercise patient choice can be significantly restricted by their entitlements under the home healthcare system. It is possible that the treatment which they are seeking to receive abroad is unlawful in the home Member State, or that it is unavailable in the home Member State because it is deemed to be unethical. In these circumstances, it is unlikely that the proposed cross-border treatment is covered by the home healthcare system, and that the patient will be able to claim reimbursement for this treatment.

Against this background, the number of free movement of patients cases with an ethical dimension is very low. *Grogan* could be seen as a free movement of patients case *avant la lettre*.[9] However, this case was not about the right to reimbursement of medical treatment in another Member State – it focussed on the right of patients to access medical treatment in another Member State which was unlawful in the home Member State. More recently, in *A v Veselibas Ministrija*, the CJEU had an opportunity to analyse the interaction between free movement of patients and medical ethics.[10] In doing so, the CJEU has made some fundamental statements about the role of the concept of patient choice under the Cross-Border Healthcare Directive. Although the Member States had to implement the Directive by October 2013, it took until 2020 before the first cases on the Directive were decided by the CJEU.[11]

In *A v Veselibas Ministrija*, the CJEU has, for the first time, identified the aims and scope of the Directive, and distinguished the role of the Directive from the Social Security Regulation 2004/883,[12] which provides a separate and additional right to reimbursement of cross-border

[9] Case C-159/90, *Grogan*, ECLI:EU:C:1991:378.
[10] Case C-243/19, *A v Veselības Ministrija*, ECLI:EU:C:2020:872.
[11] A second case decided in 2020 was Case C-777/18, *WO*, ECLI:EU:C:2020:745.
[12] Regulation 883/2004/EC on the coordination of social security systems.

treatment. It has characterised the Directive as an instrument to facilitate patient choice.[13] In doing so, the CJEU has recognised that the Directive is not just a codification exercise of the grounds of justification which Member States can rely on in restricting the right to reimbursement of cross-border medical treatment. The Directive specifically aims at improving the rights of patients in receiving cross-border treatment. This process of "emancipation" of the Cross-Border Healthcare Directive has important implications for the ability of patients to exercise patient choice and to seek cross-border healthcare in situations with a strong ethical dimension. Furthermore, in "shaping" the concept of patient choice in free movement law, the CJEU has not just relied on the aims and provisions of the Directive – it has analysed the scope of the Directive through the "lens" of the Charter of Fundamental Rights of the EU ("the Charter"). This reliance on the Charter as a frame for free movement of patients cases has significantly strengthened the position of patients who are seeking to access cross-border medical treatment for ethical reasons.

The argument of this article is twofold. First, the CJEU has now given a clear "identity" to the Cross-Border Directive. In doing so, it has sought to distinguish the aim of the Directive from the Social Security Regulation. As such, we can observe a process of "emancipation" of the role of the Cross-Border Healthcare Directive in the internal market. The CJEU has relied on the Directive to develop a right for patients to exercise patient choice in situations with an ethical dimension. This right puts patients in a more powerful position vis-à-vis their doctors and their home healthcare systems. Therefore, the judgment in *A v Veselibas Ministrija* should be regarded as a significant "boost" for the exercise of patient choice in the internal market. However, this increase of patient choice comes with certain risks, which will have to be addressed by the CJEU.

Second, a number of open questions about this process of emancipation of the Directive remain. In *A v Veselibas Ministrija*, the CJEU made a rigid distinction between the exercise of patient choice and the clinical assessment of the patient's medical situation. The suggestion that the exercise of

[13] *A v Veselibas Ministr ja*, above n 10, paras. 75-85.

patient choice can and should be entirely separated from the doctor's assessment of a patient's medical situation creates risks for the patient-doctor relationship. In most free movement of patients cases decided by the CJEU, the patient was strongly supported by their treating doctor in seeking cross-border treatment.[14] The exercise of free movement rights by patients was a co-operative project between the patient and their treating doctor. In placing more emphasis on patient choice, the CJEU should be cautious not to force a "break" in the patient-doctor relationship. Ultimately, this break could result in a development from patient choice to consumerism, which is precisely what many academics warned against after the first series of free movement of patients cases in the early 2000s.[15]

Moreover, the current limits on the exercise of patient choice set by the CJEU have a purely financial focus. However, in cases with an ethical dimension, Member States may want to rely on justifications which are not exclusively based on the protection of the financial stability of the social security system.[16] In these circumstances, Member States should be able to rely on justifications related to public morality or public policy. Finally, the role of the Charter in free movement of patients should be developed further. The CJEU's current approach is based on a non-discrimination perspective. However, the situations in which patients might want to rely on fundamental rights could extend beyond non-discrimination. For that reason, the approach developed in *A v Veselibas Ministrija* should also be applied to other Charter rights, such as the right to private and family life in Article 7 of the Charter.

The structure of the article will be as follows. First, the interaction between patient choice, medical ethics and free movement of patients will be explored in more detail. A distinction will be made between unlawful and unavailable treatment. This distinction has implications for a patient's ability

[14] See Van Leeuwen, above n 7, 176-178.
[15] See Newdick, 'Citizenship, Free Movement and Healthcare: Cementing Individual Rights by Corroding Social Solidarity' (2006) 43 *CML Rev* 1645; Hatzopoulos, 'Some thoughts on the fate of poorer Member States' healthcare systems after the ruling in Petru' (2016) 41 *EL Rev* 424; Sokol, 'Rindal and Elchinov: An (Impending) Revolution in EU Law on Patient Mobility' (2010) *CYELP* 167.
[16] Hervey and McHale, above n 1, pp. 91-96.

to rely on the right to reimbursement of cross-border medical treatment. Second, the article will analyse the case law before the adoption of the Cross-Border Healthcare Directive. The focus will be on *Grogan*, in which the CJEU laid down a right to access medical treatment abroad which is unlawful in the home Member State, and *Peerbooms*, in which the CJEU confirmed the role of the medical profession as a "gatekeeper" to access to cross-border treatment in cases with an ethical dimension.[17] Third, the CJEU's judgment in *A v Veselibas Ministrija* will be analysed in detail. In particular, the focus will be on the distinction made by the CJEU between the concept of patient choice and the objective medical assessment of a patient's situation. Fourth, the implications of the process of emancipation of the Cross-Border Healthcare Directive will be analysed in more detail. The focus will be on the distinction between the Directive and the Social Security Regulation, and on the role of the Charter as a "frame" for free movement of patients cases. Finally, the article will conclude by placing the above developments in a broader constitutional perspective.

The relationship between patient choice, medical ethics, and free movement of patients

Unlawful treatment and non-reimbursement cases

The field of medical ethics is usually connected to medical treatment in situations that are closely linked to the start or end of life. Medical ethics play an important role in complicated decisions around fertility, abortion and end-of-life decisions, such as palliative care, assisted suicide or euthanasia.[18] Some of the decisions that have to be made are inherently less medical. They are based on our ethical beliefs, and our decisions are influenced by factors such as our own (family) history, (lack of) religion and the views of our family. As such, patients are likely to defend their

[17] *Peerbooms*, above n 5.
[18] Herring, *Medical Law and Ethics* (OUP, 2018), 202-208. See also Foster, *Choosing Life, Choosing Death* (Hart Publishing, 2008), 3-15.

autonomy more strongly in cases with an ethical dimension.[19] From this perspective, cases with an ethical dimension provide an important "testing ground" for an analysis of the interaction between patient choice and the exercise of free movement rights by patients.

Despite the strong emphasis on patient choice in ethical cases, the patient's ability to exercise choice is restricted by a number of factors. First, the treatment (or lack thereof) is always provided by a doctor. As such, a patient will have to be supported in their decision by a doctor – whether in their home Member State or abroad.[20] Second, from a broader perspective, patient choice can be restricted by the legislation in the home Member State. The treatment that the patient would like to receive may be unlawful in the home Member State. In these circumstances, even if a doctor might be willing to provide the treatment, they are prohibited from doing so under the home Member State's legislation.[21] Alternatively, although the treatment may be lawful in the home Member State, it could be unavailable to patients. This could be because, for ethical reasons, the treating doctors are unwilling to provide it, or because the home healthcare system is unable to provide a certain type of treatment for technical or financial reasons.

This distinction between unlawful and unavailable treatment is important to the free movement right that patients are likely to rely on in seeking access to and reimbursement of cross-border treatment. In the first category, the treatment that a patient is seeking to access in another Member State is prohibited in the home Member State. As a result, the treatment is unlikely to be covered by the patient's home healthcare system. This does not mean that free movement law has no more role to play in unlawful treatment cases. Article 56 TFEU provides a general right to patients to access and receive medical treatment in another Member State.[22] This right is not just limited to receiving reimbursement from the home Member State. The home Member State can restrict the

[19] Miola, *Medical Ethics and Medical Law* (Hart Publishing, 2007), 167-200. McLean, *Autonomy, Consent and the Law* (Routledge, 2010), 98-127.
[20] See Glover-Thomas, 'Getting the Balance Right: Medical Futility, Scientific Advancement, and the Role of Law' (2020) 28 *Med LR* 573.
[21] Herring, above n 18, 558-559.
[22] See Berki, *Free Movement of Patients in the EU* (Intersentia, 2018), pp. 25-32.

rights of patients under Article 56 TFEU in three main ways. First, Member States could prevent patients from travelling abroad to receive cross-border treatment.[23] Second, it could be made more difficult for patients to receive treatment abroad – for example, by limiting the patient's access to information about a certain type of treatment. Third, the home Member State could take action against a patient after they received the treatment.[24]

Unavailable treatment and reimbursement cases

A second category of cases are cases in which the treatment which the patient would like to receive is not unlawful in the home Member State. However, it is not provided to the patient and, as a result, is unavailable to them. In this scenario, all the rights under Article 56 TFEU discussed above are still applicable and can be relied on by patients. The main difference for unavailable treatment cases is that it is possible that the treatment which the patient is seeking to access in another Member State is covered by the home healthcare system. For example, doctors in the home Member State may no longer want to provide a certain type of treatment to a patient for ethical reasons.[25] Second, although the type of treatment is covered by the home healthcare system, it would be provided in a way which is not acceptable to doctors in the home healthcare system.[26] Third, it may be that the patient's entitlements under their home healthcare system are determined on a case-by-case basis, and that the treatment in the other Member State is held not to be covered by the home healthcare system for ethical reasons.[27] In each of these scenarios, the treatment is or could be covered by the patient's home healthcare system, but it is not or no longer available to them.

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[23] Van Leeuwen, 'Euthanasia and the Ethics of Free Movement Law: The Principle of Recognition in the Internal Market' (2018) 19 *German Law Journal* 1418, 1434-1435.
[24] See Glenn Cohen, above n 7, pp. 315-370.
[25] See, for a (pre-Brexit) English example of such a case, *Tafida Raqeeb v Barts NHS Foundation Trust* [2019] EWHC 2531 (Admin) and [2019] EWHC 2530 (Fam).
[26] See *A v Veselibas Ministrija*, above n 10.
[27] See *Peerbooms*, above n 5.

In these scenarios, it is possible for patients to argue that they are entitled to receive reimbursement from their home healthcare system. Therefore, it is important to set out the basics of the rules on reimbursement under the Social Security Regulation ("the Regulation") and the Cross-Border Healthcare Directive. Before the adoption of the Directive in 2011, the CJEU had developed the scope of the right to reimbursement under Article 56 TFEU.[28] Free movement of patients cases were decided either under the Regulation or under Article 56 TFEU. After the adoption of the Directive, the role of Article 56 TFEU as an independent source of the right to reimbursement has become less important. The two main routes for reimbursement are now the Directive and the Regulation. Both routes are based on the starting point that the treatment must be covered by the patient's home healthcare system.[29] The right to reimbursement under the Regulation is more advantageous than under the Directive.

Under the Regulation, patients are entitled to reimbursement of the complete costs of the treatment in the other Member State.[30] It is not relevant whether the treatment may be more expensive than the costs of the treatment in the home Member State. Moreover, the process of reimbursement is managed directly by the patient's home healthcare system or health insurer. Under the Directive, the patient is only entitled to reimbursement of the costs of treatment at the rate of the home Member State's healthcare system.[31] If the treatment abroad is more expensive, they will receive reimbursement up to the costs of the same treatment in the home Member State. Moreover, patients are expected to pay for the treatment themselves, and then seek reimbursement from their home healthcare system.

The additional benefits of the Regulation come at a "price": patients must always apply for prior authorisation from the home healthcare system (or health insurer) before they receive the medical

[28] For an overview, see Hervey and McHale, above n 1, pp. 88-91.
[29] Berki, above n 22, pp. 30-32.
[30] Article 20(2) of the Social Security Regulation.
[31] Article 7(4) of the Cross-Border Healthcare Directive.

treatment in another Member State.[32] Their right to reimbursement is dependent on having received prior authorisation before they travel abroad for the treatment.[33] This is different for reimbursement under the Directive: for treatment which does not require an overnight stay in hospital, there is no need for patients to apply for prior authorisation before they travel abroad.[34] They can simply claim reimbursement of the costs on their return to the home Member State. Nevertheless, for treatment which requires an overnight stay in hospital, Member States are allowed to impose a requirement of prior authorisation.

The main ground on the basis of which prior authorisation can be refused under both the Regulation and the Directive is that the same or equally effective treatment is available in the home Member State.[35] This ground is likely to be relied on by home healthcare systems in cases in which patients would like to receive medical treatment in another Member State which is equally effective to what can be provided in the home Member State, but which is provided in a way which is compatible with their ethical or religious views. Under the Directive, Member States are also explicitly allowed to refuse prior authorisation in cases in which they have concerns about the quality or safety of the medical treatment in another Member State.[36] This could again be relevant to ethical cases, if doctors in the home Member State have concerns about the way in which the treatment in another Member State would be provided. Finally, at the systemic level, Member States can refuse to provide prior authorisation for "planning requirements relating to the aim of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned".[37]

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[32] Article 20(1) of the Social Security Regulation.
[33] There are two situations in which a patient is entitled to reimbursement under the Regulation without having received prior authorisation before travelling abroad: (1) their treatment was so urgent that they could not reasonably have waited for the outcome of their request for prior authorisation; (2) the patient had applied for prior authorisation and the Member State's refusal was later found to be unlawful. See *WO*, above n 11, paras 46-48.
[34] Article 8(2)(i)(a) of the Cross-Border Healthcare Directive.
[35] Article 8(6)(d) of the Cross-Border Healthcare Directive.
[36] Article 8(6)(a)-(c) of the Cross-Border Healthcare Directive.
[37] Article 7(9) of the Cross-Border Healthcare Directive.

Medical ethics and free movement of patients before the Cross-Border Healthcare Directive

Unlawful treatment and the right to information: Grogan

Grogan is the main case which focussed on unlawful medical treatment and the right for patients to access information about medical treatment which is unlawful in their home Member State. At the time, abortion was still prohibited in Ireland.[38] Irish women who wanted to have an abortion had to travel to an abortion clinic in England, where abortion could lawfully be provided. Several national and local student unions provided information to students about abortion clinics in England. The Society for the Protection of Unborn Children ("SPUC") was a private company whose main purpose was to prevent the de-criminalisation of abortion.[39] SPUC brought proceedings against several officers of the student unions and applied for an injunction to prevent them from providing this kind of information to students at Irish universities.

Mr Grogan and the other officers argued that granting an injunction would breach the right of Irish women to receive abortion services in England. As such, it constituted a breach of Article 56 TFEU. As a starting point, the CJEU held that the fact that abortion services were lawfully provided in the UK meant that Irish women had a right under Article 56 TFEU to receive this service.[40] The fact that abortion was prohibited in Ireland did not mean that the free movement provisions were not applicable. This conclusion is fundamentally important to the exercise of patient choice in ethical cases. The fact that a medical treatment is unlawful in the home Member State does not prevent patients from having a right under Article 56 TFEU to access this treatment in another Member State, where it can lawfully be provided. However, the CJEU also ruled that Article 56 TFEU could not be relied on by the unions in this case. This was because there was no

[38] *Grogan*, above n 9, paras 3-4.
[39] Ibid., para 6.
[40] Ibid., paras 18-21.

"economic link" between the unions and the abortion clinics.[41] Article 56 TFEU is only applicable when remuneration is provided, and the unions were not paid for the provision of information. On that basis, the CJEU concluded that the case did not come within the scope of application of Article 56 TFEU.[42]

From the perspective of the interaction between free movement of patients and medical ethics, *Grogan* is important in protecting the right of patients to receive information about medical treatment, and their ability to find relevant information to make a choice about the treatment they would like to receive. This right to information is necessary for patients to be able to provide consent to treatment and to be able to exercise patient choice.[43] The effect of the judgment is that Member States can restrict the provision of information to patients about treatments that are unlawful in the home Member State. At the same time, this restriction was only outside the scope of "control" of free movement law because of the absence of an economic link between the information provider and the information recipient. The situation would have been different if one of the potential patients had relied on their right to freely receive abortion services in the UK. Similarly, if Article 56 TFEU had been relied on directly by a UK clinic that wanted to provide information to potential patients from Ireland, the situation would have come within the scope of application of free movement law.

Overall, even if *Grogan* was heavily criticised on the basis that it failed to provide adequate protection to the free movement rights and fundamental rights of Irish women,[44] its broader impact is that patients do have a right to reach out to doctors, clinics or hospitals in other Member States to discuss the possibility of receiving medical treatment which is unlawful or unavailable. The ability of patients to receive information about medical treatment in another Member State –

[41] Ibid., paras 24-26.
[42] Ibid., para 27.
[43] See De Ruijter, *EU Health Law and Poli y* (OUP, 2019), pp. 172-174. See also Van Kolfschooten, 'EU Regulation of Artificial Intelligence: Challenges for Patients' Rights' (2022) 59 *CML Rev* 81, 85-87.
[44] O'Leary, 'The Court of Justice as a reluctant constitutional adjudicator: an examination of the abortion information case' (1992) 17 *EL Rev* 138, 145-146.

including ethically controversial treatment – has now been strengthened by the creation of national contact points in the Cross-Border Healthcare Directive.[45] The Directive explicitly recognises the importance of the right to information for patients in making decisions about accessing cross-border medical treatment.[46]

The ethics of evidence-based medicine: Peerbooms

In *Peerbooms*, Mr Peerbooms fell in a coma after a road traffic accident in the Netherlands. He was in a vegetative state, and no further treatment could be provided to him in the Netherlands. As a result, he was likely to die in the near future. However, his treating neurologist discovered that a hospital in Innsbruck, Austria, provided neuro-stimulation treatment to patients in Mr Peerbooms' situation. This treatment was provided in the Netherlands, but only on an experimental basis and only to patients below the age of 25. Mr Peerbooms was in his mid-thirties. His doctor applied for prior authorisation for Mr Peerbooms to receive this treatment in Austria. In determining whether this treatment was covered by his Dutch health insurance, the health insurer applied two conditions. First, the treatment had to be "normal in the professional circles concerned".[47] Second, the treatment had to be "necessary" in light of the patient's individual circumstances.[48] The health insurer decided that the proposed treatment was not evidence-based, and, as a result, Mr Peerbooms was not entitled to it. There was insufficient scientific support to establish that the treatment was successful – in particular, in patients of Mr Peerbooms' age. Therefore, prior authorisation was refused.

When the case reached the CJEU, the focus was on the conditions applied by the Dutch health insurer. The necessity requirement was allowed under Article 56 TFEU. The CJEU emphasised that all the circumstances of Mr Peerbooms' individual case had to be taken into account, and that

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[45] Article 6 of the Cross-Border Healthcare Directive.
[46] Article 4(2) of the Cross-Border Healthcare Directive. See Nys, 'The Right to Informed Choice and the Patients' Rights Directive' (2012) 19 *European Journal of Health Law* 327.
[47] *Peerbooms*, above n 5, para 10.
[48] Ibid., para 6.

due regard should be had to his current and past medical record.[49] The CJEU's analysis of the requirement that the treatment be "normal" was more interesting. It held that this requirement could be justified and was proportionate, but only if the concept of normality was based on "what is sufficiently tried and tested by international medical science".[50] As such, when the case returned to the referring court, the national court had to verify whether the expert opinion on the basis of which Mr Peerbooms' request for prior authorisation had been refused was based on international scientific evidence.

From this perspective, it could be argued that *Peerbooms* was primarily about medical *science* and not about medical *ethics*. After all, the case focussed on the definition of evidence-based medicine.[51] However, there is a close relationship between evidence-based medicine and ethics. The underlying question in *Peerbooms* was to what extent Member States could set an age limit on a particular type of treatment, which provided the only possibility of a cure to the patient. In these circumstances, the definition of evidence-based medicine became a decisive factor in determining whether the patient could be offered any further treatment. The case provoked a discussion in the Netherlands about the evidence-based nature of the treatment provided in Austria.[52] Mr Peerbooms' neurologist argued that he should be entitled to receive it, and he was supported by an independent expert instructed by the referring court. However, the doctor instructed by Mr Peerbooms' health insurer had concluded that the treatment was not evidence-based. This decision was ultimately upheld, but only after they had explicitly confirmed that this assessment had taken place based on *international* scientific evidence.[53]

Overall, *Peerbooms* confirmed the key position of the medical profession in providing access to potential treatment options in other Member States. In this case, the initiative for cross-border

[49] Ibid., para 104.
[50] Ibid., paras 94-98.
[51] Van Leeuwen, 'The doctor, the patient, and EU law: the impact of free movement law on quality standards in the healthcare sector' (2016) 41 *EL Rev* 638, 642-643.
[52] Van Leeuwen, above n 7, 177-178.
[53] Judgment of the Centrale Raad van Beroep of 20th July 2004, ECLI:NL:CRVB:2004:AQ6215.

treatment was taken by Mr Peerbooms' treating neurologist. Furthermore, the request was supported by the independent expert instructed by the Dutch court.[54] As a result, a significant body of medical opinion argued that Mr Peerbooms should be entitled to receive the treatment in Austria. The doctors in Austria (unsurprisingly) agreed with this position. The reason why Mr Peerbooms was not authorised to travel abroad was because there was a difference of opinion between doctors in his home Member State. The refusal was justified because the doctors were required to base their assessment on international scientific evidence.

The CJEU's emphasis on the concept of evidence-based medicine has restricted the ability of patients to exercise patient choice if they would like to receive treatment that is not evidence-based. It is not sufficient for patients to be supported by their treating doctor – the position of their doctor must be based on international scientific evidence. Therefore, if they want to be reimbursed for their treatment, the patient cannot independently make decisions about where they would like to receive treatment. The assessment of whether there is sufficient and convincing scientific evidence to establish the effectiveness of a particular type of treatment cannot be made by the patient. The medical assessment is dependent on the evidence that is available in the international scientific literature at the time of the request for prior authorisation. This focus on the role of doctors in acting as "gatekeepers" to cross-border medical treatment was developed further in *A v Veselibas Ministrija* through the CJEU's emphasis on the patient's "objective medical assessment". This will be analysed in detail in the next section.

Medical ethics and free movement of patients after the Cross-Border Healthcare Directive

Religion and medical ethics: A v Veselibas Ministrija

[54] *Peerbooms*, above n 5, para 39.

While, in *Peerbooms*, the patient – or rather, their family – and the treating doctor were both supportive of cross-border treatment, the case of *A v Veselibas Ministrija* involved a disagreement between the patient's family and the treating doctors. This disagreement was to a significant extent based on the religious convictions of the patient's family. For the first time, in *A v Veselibas Ministrija*, the role of religion in medical ethics and reimbursement cases was discussed through the lens of the Social Security Regulation and the Cross-Border Healthcare Directive.

A was a Latvian citizen and the father of a young son. His son had to have open-heart surgery for a congenital heart condition. This kind of surgery could be provided in Latvia. However, it would inevitably involve a blood transfusion. Because Mr A was a Jehovah's witness, he did not want his son to have a blood transfusion.[55] He discovered that the same kind of surgery could be provided in Poland without the need for a blood transfusion, and he applied for prior authorisation from the Latvian healthcare system for his son to receive surgery in Poland. Prior authorisation was refused on the basis that the same or equally effective treatment was available in Latvia.[56] The Latvian healthcare system argued that religion should play no role in the assessment whether the same or equally effective treatment was available in Latvia. The assessment should remain a medical assessment – it should not be based on the patient's personal religious choices or preferences.[57] Mr A appealed the refusal before the Latvian courts, and the Latvian Supreme Court submitted a number of preliminary questions to the CJEU.

The CJEU's starting point was to confirm that the assessment of the question whether the same or equally effective medical treatment could be provided in the home Member State is an objective medical assessment, which cannot be influenced by the personal choice of a patient.[58] Latvia was entitled to find that an equally effective treatment could be provided in the home Member State. This assessment would be identical under the Social Security Regulation and the Cross-Border

[55] *A v Veselibas Ministrija*, above n 10, para 14.
[56] Ibid., para 14.
[57] See the Request for a preliminary ruling in *A v Veselibas Ministrija*, above n 10, para 13.
[58] *A v Veselibas Ministrija*, above n 10, para 30.

Healthcare Directive. However, the CJEU then adopted a fundamental rights perspective under the Charter. It held that the application of the rules of the Social Security Regulation and Cross-Border Healthcare Directive by the Latvian healthcare system could result in discrimination on the ground of religion, which would be prohibited by Article 21 of the Charter.[59] If discrimination could be established, this could be justified by the Latvian healthcare system by the need to maintain "an adequate, balanced and permanent supply of quality hospital care on the national territory and by protecting the financial stability of the social security system".[60] These were essentially the same justifications that could be relied on to justify a prior authorisation requirement.

In the analysis of the proportionality of the restriction of Article 21 of the Charter, the CJEU focussed on the extent to which national healthcare systems could be required to facilitate patient choice. It made a distinction between the Social Security Regulation and the Cross-Border Healthcare Directive. Under the Social Security Regulation, the home healthcare system is required to reimburse the full costs of the treatment abroad. The CJEU held that this could result in an additional financial burden for the home Member State, because the treatment abroad might be more expensive than in the home Member State.[61] It concluded that such an additional financial burden would be too much to ask of the home Member State in circumstances where the patient's choice was exclusively based on their religious convictions, and where equally effective medical treatment could be provided in the home Member State.[62] On this basis, the Latvian healthcare system could justify the discrimination as far as the Social Security Regulation was concerned.

However, the CJEU's conclusion was different for the Cross-Border Healthcare Directive. The main reason for this difference was that, under the Directive, the home Member State is only

[59] Ibid., paras 36-42. See also De Federico, 'When Medical Treatment and Religious Beliefs Intersect: The Case of *Veselības Ministrija*' (2021) 6 *European Papers* 6.
[60] Ibid., para 44.
[61] Ibid., paras 50-54.
[62] Ibid., paras 55-56.

required to reimburse the costs of the treatment in another Member State up to the amount that it would have cost under the national healthcare system. Therefore, the home Member State would not incur any additional financial burden.[63] The ground of justification based on the financial stability of the social security system was not available in these circumstances. The only justification that could be relied on was based on "the risk for the planning of hospital care" in the home Member State.[64] As a result, Latvia's ability to justify the discrimination was more limited under the Cross-Border Healthcare Directive.

The distinction between patient choice and an objective medical assessment

The CJEU has made a very clear distinction between the assessment of a patient's medical situation, which is an objective medical assessment made by doctors, and a patient's choice about their treatment based on their personal convictions or preferences. This is consistent with the approach taken in *Peerbooms*, in which the CJEU confirmed that Member States were entitled to restrict reimbursement of cross-border treatment based on international scientific evidence. There is a clear link between evidence-based medicine and an objective medical assessment. Nevertheless, the distinction between patient choice and an objective medical assessment creates certain risks. By making such a rigid distinction, the CJEU has prevented the "integration" of patient choice into the medical assessment. In doing so, it protected the "monopoly" of doctors to decide what is best for their patient from a medical point of view. This monopoly is protected under the Social Security Regulation, but not under the Directive. This approach could be regarded as inconsistent with the recent emphasis on the importance of dialogue in the patient-doctor relationship.[65] Moreover, the distinction is based on the presumption that a patient's personal preferences can and should be kept separate from the clinical assessment. In practice, the assessment of a patient's

[63] Ibid., paras 75-78.
[64] Ibid., paras 78-84.
[65] See Montgomery, 'Patient No Longer? What Next in Healthcare Law?' (2017) 70 *Current Legal Problems* 73. See also Herring, Fulford, Dunn and Handa, 'Elbow Room for Best Practice? Montgomery, Patients' Values, and Balanced Decision-Making in Person-Centred Clinical Care' (2017) 25 *Medical LR* 582.

medical situation is *never* exclusively clinical or scientific. A doctor will always take the position of the patient into account in deciding what the best course of treatment would be.[66] From this perspective, the distinction made by the CJEU is too rigid.

The distinction can be justified in circumstances in which a patient wishes to make a decision about their treatment which the doctors believe goes against their best interests. In cases of a conflict between the medical assessment and the patient's choice, a clear distinction between the responsibility of the doctor and the patient can be made. However, in most circumstances, the doctor will do their best to accommodate their patient's wishes as much as is clinically responsible and possible. It should be emphasised that, in A's case, the Latvian doctors or healthcare system had not expressed any (explicit) concerns about the safety or the quality of the treatment provided in Poland. Their justification of the restriction on free movement was exclusively based on systemic grounds. If the Latvian doctors had raised concerns about the safety of the treatment, this would have been a legitimate ground to refuse reimbursement under the Cross-Border Healthcare Directive.[67] In line with *Peerbooms*, the assessment of the quality and safety of the treatment would have had to be based on international scientific evidence.

The CJEU's separation of patient choice from the objective medical assessment makes it easier for patients to ignore the views of their treating doctor and to refuse to engage in a dialogue with their doctors in identifying and deciding on the most appropriate treatment. Therefore, the emphasise on patient choice under the Directive could reduce the need for dialogue and co-operation between patients and doctors. As a result, it could lead to more emphasis on consumerism on the part of patients. This is precisely one of the key risks that was identified in the academic literature after the judgments in the first "wave" of free movement of patients cases decided by the CJEU.[68] Another risk is that, in identifying the boundaries of the concept of patient choice in free

[66] See Herring et al., above n 65.
[67] Article 8(6)(a) of the Cross-Border Healthcare Directive.
[68] See Newdick, above n 15.

movement law, the CJEU has adopted an exclusively financial perspective. This approach is consistent with the general logic of the Directive.[69] If the patient's preference is opposed to or different from the opinion of the doctors in the home Member State, the national healthcare system would never have to pay more than the costs of the treatment the patient would have received in the home Member State. Member States cannot be required to incur an "additional financial burden" in facilitating the exercise of patient choice.[70] This financial focus of the CJEU is also understandable in light of the justifications that were relied on by Latvia. The main grounds of justification which Latvia relied on were maintaining the financial stability of the social security and protecting the planning of healthcare provision under the Latvian healthcare system.

However, in ethical cases, Member States may want to rely on a broader range of justifications to restrict a patient's right to reimbursement, such as public morality or public policy.[71] The key question is what role the concept of an "additional burden" should play in these circumstances. If public morality or public policy were relied on as the ground of justification, this would not be a financial assessment – it would go to the heart of the question of how patient choice can be balanced with fundamental ethical choices that have been made by the home Member State.[72] The Recitals of the Directive confirm that the Directive does not "undermine the fundamental ethical choices of Member States'.[73] Therefore, cases in which Member States would seek to rely on the protection of fundamental ethical choices would have to be assessed separately under Article 56 TFEU.[74]

The approach developed by the CJEU in *A v Veselibas Ministrija* cannot easily be applied to cases with a public policy or public morality justification. As a result, in future cases, the CJEU will have

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[69] De La Rosa, 'The Directive on Cross-Border Healthcare or the Art of Codifying Complex Case Law' (2012) 49 *CML Rev* 15; De Ruijter, above n 43, pp. 160-175.
[70] *A v Veselibas Ministrija*, above n 10, para 54.
[71] See Hervey and McHale, above n 1, 91-96. See also Glenn Cohen, above n 8.
[72] Ibid., 91-92. For an earlier perspective, see Hervey, 'Buy Baby? The European Union and Regulation of Human Reproduction' (1998) 18 *CJLS* 207. See also L. Catchpole and A. Barav, 'The Public Morality Exception and the Free Movement of Goods: Justification of a Dual Standard in National Legislation?' (1980) 7 *LIEI* 1-21.
[73] Recital 7 of the Cross-Border Healthcare Directive. See De Ruijter, above n 43, pp. 187-188.
[74] See, more generally, Hatzopoulos, *Regulating services in the European Union* (CUP, 2012), 148-150 and 159-161.

to address how home healthcare systems should deal with patient choice cases in which the ground of justification relied on is not linked to the financial stability of the social security system. The CJEU will have to provide more guidance on how the concept of an additional burden should operate outside a financial context. In doing so, it will have to achieve a balance between the rights of patients to choose to receive a type of treatment which is compatible with their own ethical views, and the ability of Member States and national healthcare systems to protect their own ethical positions.[75] This balancing exercise creates a strong link to the protection of fundamental rights.[76] As such, a clear link can be made to role of the Charter, which will be analysed in more detail in the next section.

The "emancipation" of the Cross-Border Healthcare Directive

"Identity-building" for the Cross-Border Healthcare Directive

In 2012, shortly after its adoption, De La Rosa characterised the adoption and the substance of the Cross-Border Healthcare Directive as a balancing exercise on at least two levels.[77] First, the Directive had to achieve a balance between protecting the free movement rights of patients and the rights of Member States to protect the financial stability of their social security systems and to plan the delivery of healthcare on their territory.[78] Second, the adoption of the Cross-Border Healthcare Directive constituted a balancing exercise between codifying the existing case law of the CJEU and adding a number of new patient rights, which focussed primarily on the right to information.[79] In developing patient rights under the Directive, Article 168(7) TFEU remained a fundamental obstacle.[80] This article provides that the EU does not have the competence to regulate

[75] See De Witte, 'Sex, Drugs & EU Law: The Recognition of Moral and Ethical Diversity in EU Law' (2013) 50 *CML Rev* 1545, 1565-1578.
[76] See Hatzopoulos, above n 74, 161-165; Hervey and McHale, above n 1, 164-166.
[77] De La Rosa, above n 69, 17-18.
[78] Ibid., 39-45.
[79] Ibid., 30-39.
[80] Ibid., 27-28.

the delivery of healthcare services at the national level. As a result, the EU was limited in the type and number of patient rights that could be included in the Directive.

This balancing background to the Directive made it difficult at the time of its adoption to assess what the additional benefits of were going to be – apart from improving legal certainty for patients and national healthcare systems. For almost ten years, the Directive suffered from a lack of "character" or "identity". However, it is now possible to say that a process of "emancipation" of the Directive has taken place. The CJEU has used the judgment in *A v Veselibas Ministrija* to provide a self-standing and independent identity to the Directive. This new identity is founded on the concept of patient choice. In his Opinion, Advocate General Hogan had already argued that the core provisions of the Directive are "guided, in principle, by free choice on the part of the person receiving cross-border healthcare".[81] He had even referred to the "primacy of patient choice under Directive 2011/24".[82]

In identifying patient choice as one of the core foundations of the Directive, the CJEU has created a sharper distinction between the aims and scope of the Social Security Regulation and the Directive.[83] Assessments and decisions made under the Regulation are exclusively based on the objective medical assessment of the patient's medical situation.[84] This assessment is conducted by the home healthcare system and cannot be influenced by patient choice. As a result, the right to reimbursement under the Regulation remains conditional on the cross-border treatment being supported and approved by the patient's home healthcare system. In practice, this means that patients will often be supported by their treating doctors, or by other doctors in their home Member State. This level of support and control by the medical profession in the home Member

[81] Opinion of Advocate General Hogan in *A v Veselibas Ministrija*, above n 10, ECLI:EU:C:2020:325, para 91.
[82] Ibid., paras 95-97.
[83] Slokenberga, 'Case C-243/19, A v Veselibas Ministrija, Judgment of the Court (Second Chamber) of 29 October 2020' (2021) 28 *European Journal of Health Law* 285, 295. For a more detailed analysis of the interaction between the two regimes before *A v Veselibas Ministrija*, see Berki, above n 22, pp. 138-152. See also Hervey and McHale, above n 1, pp. 199-202.
[84] Paju, 'Case C-243/19 A v Veselibas Ministrija' (2021) 28 *Maastricht Journal of European and Comparative Law* 900, 905.

State is not required by the Directive, which enables patients to make choices which are genuinely independent from their home healthcare system. As a result, patients can take responsibility for their own treatment. As such, the judgment in *A v Veselibas Ministrija* has not only resulted in a process of emancipation of the Directive, but also in a process of emancipation of the position of patients vis-à-vis their treating doctors and national healthcare systems.

The role of the Charter of Fundamental Rights as a "frame" for free movement of patients cases

The interaction between the Cross-Border Healthcare Directive and the Charter formed an important foundation of the judgment in *A v Veselibas Ministrija*. The non-discrimination "frame" of the case restricted the ability of the Latvian healthcare system to justify the restriction on Mr A's free movement rights. The process of emancipation of the Directive could not be completed without the support of another source of rights in EU law: the Charter. The role of the Charter is visually represented in the structure of the judgment, because the CJEU adopted a non-discrimination "lens" for its analysis. As a result, the structure of the judgment looks fundamentally different from a "regular" free movement of patients case.

In developing the role of the Charter, the CJEU did not rely on the provision in the Charter which is directly linked to the provision of medical treatment. Not once did the CJEU refer to Article 35 of the Charter, which provides that "[e]veryone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices". More generally, Article 35 of the Charter has never been relied on by the CJEU in free movement of patients cases.[85] It has only been referred to in cases in which the CJEU had to interpret secondary EU law which aimed at protecting public health.[86] This confirms the nature of Article 35 as a principle, which must be given effect through the adoption of secondary legislation

[85] See De Ruijter, above n 43, pp. 41-43.
[86] See Case C-547/14, *Philip Morris Brands*, ECLI:EU:C:2016:325; Case C-151/17, *Swedish Match*, ECLI:EU:C:2018:938; Case C-160/20, *Stichting Rookpreventie Jeugd and Others*, ECLI:EU:C:2022:101.

by the EU.[87] It does not in itself provide a directly effective that can be relied on by patients. In any event, the scope and potential of Article 35 of the Charter is limited in the context of free movement of patients, because it is explicitly limited to what is provided "under the conditions established by national laws and practices".[88] This is a confirmation of the limited competences of the EU in the field of healthcare provided by Article 168 TFEU.

In *A v Veselibas Ministrija*, the main right that was relied on was the right to non-discrimination in Article 21 of the Charter. This right did not just limit the discretion of Latvia in relying on justifications under the Directive. The CJEU framed the case as a potential example of discrimination on the ground of religion. Such discrimination is prohibited by Article 21. It could potentially be justified on the ground of the protection of the financial stability of the social security system. However, because Latvia would never have to pay more under the Directive than what Mr A's son's treatment would have cost in Latvia, there was no financial risk to Latvia. In these circumstances, the justification for the discrimination on the ground of religion would not be proportionate.

As such, the non-discrimination frame under the Charter limits the ability of Member States to rely on the grounds of justification included in the Directive. The judgment provides a good example of the important role of the Charter in interpreting secondary EU law, and in limiting the discretion granted to Member States by secondary EU law. This development can be observed in other recent free movement cases with a link to national social security systems. In these cases, the CJEU also relied on the Charter to limit the discretion of the Member States in derogating from free movement rights granted by secondary EU law. In *CG*,[89] the CJEU confirmed the strict approach it had taken in *Dano*[90] and *Alimanovic*[91] to the rights of non-economically active EU

[87] Lock, 'Rights and Principles in the Charter of Fundamental Rights' (2019) 56 *CML Rev* 1201, 1213-1216.
[88] Second sentence of Article 35 of the Charter.
[89] Case C-709/20, *CG v The Department for Communities in Northern Ireland*, ECLI:EU:C:2021:602.
[90] Case C-333/13, *Dano*, ECLI:EU:C:2014:2358.
[91] Case C-67/14, *Alimanovic*, ECLI:EU:C:2015:597.

citizens who did not satisfy the conditions for residence under Article 7 of the Citizens' Rights Directive. These citizens did not enjoy a right to equal treatment under Article 24 of the Directive. As a result, Member States could refuse to provide social assistance to them. However, the CJEU then relied on Articles 1, 7 and 24(2) of the Charter to limit the discretion of the Member States to refuse to provide social assistance. Member States would have to verify that EU citizens would be able to live in dignified conditions and ensure that the best interests of the EU citizens' children were protected.[92] The main difference with *A v Veselibas Ministrija* is that, while the Charter was relied on as an "add-on" by the CJEU in *CG*, towards the very end of the judgment, the Charter provided the frame of analysis in *A v Veselibas Ministrija*.[93] This resulted in a much more decisive role for the Charter in determining the outcome of the case.

This role of Article 21 of the Charter provides a particularly powerful tool to patients in cases with an ethical dimension. This can be seen in cases in which there is direct interaction between medical ethics and religious views. However, the potential of Article 21 extends beyond cases with a religious dimension. Article 21 could similarly be relied on cases in which a national healthcare system might discriminate against patients who, for cultural reasons, would like to receive a certain type of medical treatment in another Member State. As such, the right to non-discrimination on the ground of race could also be relevant. The non-discrimination frame can also be powerful tool for patients with a disability – in particular, when a patient has a very rare disease which can only effectively be treated in a limited number of Member States. Although the Directive expressly encourages co-operation between Member States in the field of rare diseases, patients with a rare disease might struggle to access cross-border medical treatment.[94] Member States might be more reluctant to accept that medical treatment in another Member State could be more effective. In

[92] *CG*, above n 89, paras 84-92.
[93] O'Brien, 'The great EU citizenship illusion exposed: equal treatment rights evaporate for the vulnerable (CG v The Department for Communities in Northern Ireland)' (2021) 46 *EL Rev* 801, 811-813; Haag, 'The coup de grâce of the Union citizen's right to equal treatment: *CG v The Department for Communities in Northern Ireland*' (2022) 59 *CML Rev* 1081, 1101-1103.
[94] Article 13 of the Cross-Border Healthcare Directive.

such cases, relying on the right not to be discriminated against on the ground of disability could put patients in a stronger position vis-à-vis their national healthcare system or health insurer.[95]

Although this non-discrimination frame will assist many patients in seeking cross-border medical treatment, it does not help all patients who would like to access cross-border medical treatment for ethical reasons. After all, some of our ethical views are not based on (non-)religion, race or disability. These ethical cases would be difficult to frame as non-discrimination cases. For example, a patient may want to access cross-border treatment because most of their family members live in another Member State. Alternatively, a well-known couple may want to access assisted reproductive treatment in another Member State for privacy reasons. In these cases, patients would not be able to rely on the right to non-discrimination under Article 21. However, they may be able to rely on alternative Charter rights. In particular, Article 7 of the Charter, which protects the right to private and family life, could also be relied on as a frame for free movement of patients cases. As a result, it is important that the Charter frame adopted in *A v Veselibas Ministrija* is not just relied on for Article 21, but that it could also be applied to other Charter rights. For example, the refusal of a Member State to provide prior authorisation for cross-border medical treatment could be "framed" as a restriction on the right to private and family life. If this frame were adopted, the CJEU would not just protect patients whose ethical views are based on their religion, race or disability, but it would bring a broader range of free movement of patients cases within the scope of the Charter.

The future of the Cross-Border Healthcare Directive

Finally, we will return to the relationship between patient choice and the concept of consumerism. So far, this article has analysed the strengthening of patient choice in the internal market as a positive development – in particular, in circumstances in which patients want to make decisions

[95] See also Kilpatrick and Eklund, 'Article 21 – Non-Discrimination' in Peers, Hervey, Kenner and Ward (eds.), *The EU Charter of Fundamental Rights: A Commentary* (Hart Publishing, 2021), p. 615.

based on their ethical convictions. However, there is a risk that the process of emancipation of the Directive will ultimately be counterproductive for the rights of patients. This risk must be addressed by the CJEU to ensure that the exercise of patient choice in the internal market does not develop into consumerism.

After the first series of free movement of patients cases, Newdick warned about the potential of free movement of patients to threaten the integrity of national healthcare systems, because the exercise of free movement rights undermined the choices made by national healthcare systems.[96] Ultimately, the approach developed by the CJEU prioritised individual rights over solidarity between patients covered by the same healthcare system. This principle of solidarity forms the foundation of most national healthcare systems in the EU.[97] Similar warnings were made by Hatzopoulos – in particular, about the ability of newer Member States to cope with the financial burden of reimbursing cross-border medical treatment.[98] The case law in the last ten years or so has confirmed that the CJEU has managed to strike a balance between the rights of patients to access cross-border healthcare and the ability of Member States to protect their national healthcare systems.[99] However, the increased emphasis on patient choice under the Cross-Border Healthcare Directive means that attention should be paid to how this balance is maintained.

In the last decade, a more nuanced perspective has been taken on the relationship between consumerism and free movement of patients.[100] Free movement of patients is not just about patients acting as consumers. In many cases, free movement law provided an "escape" to very ill and desperate patients to receive an opportunity to a cure which simply did not exist in their home Member State.[101] Even if the exercise of free movement rights by patients is usually for

[96] Newdick, above n 15, 1658-1664.
[97] See Ter Meulen, *Solidarity and Justice in Health and Social Care* (CUP, 2017).
[98] Hatzopoulos, above n 15, 427-430. See also Frischut and Fahy, 'Patient Mobility in Times of Austerity: A Legal and Policy Analysis of the Petru Case' (2016) 23 *European Journal of Health Law* 36.
[99] Van Leeuwen, above n 7, 185-186. See also De Witte, above n 6, 329-331.
[100] Hervey and McHale, above n 1, 83-96.
[101] Van Leeuwen, above n 7, 184-185.

individualistic motives, these patients confronted their home healthcare system with new or more advanced treatments in other Member States, or with a higher quality of care provided in other Member States.[102] As such, free movement law has become a learning process for national healthcare systems. This has also benefited patients who do not exercise free movement rights. In these learning processes, patients and doctors often acted in a joined or co-operative manner – as a team.

The increased emphasis on patient choice under the Directive puts at risk this co-operative and dialogical relationship between patients and doctors. The distinction between patient choice and the objective medical assessment laid down in *A v Veselibas Ministrija* creates a potential division between the position of patients and doctors. It makes it easier for patients to insist on a different type of treatment in another Member State. On the one hand, such a process of patient empowerment is important. On the other hand, it creates a risk that patients will simply see the possibility of cross-border medical treatment as an example of a second opinion, which is not too different from the possibility of receiving a second opinion in another hospital in the same Member State. The difference between "regular" second-opinion cases and most of the free movement of patients cases is that a second opinion is usually "speculative", in the sense that the patient is hoping to receive a new diagnosis elsewhere.

Such a process of "normalisation" of the aims of the Directive should be avoided. One of the unique characteristics of free movement of patients is that it has done a lot more than enabling dissatisfied patients to receive a second opinion in another Member State. In most of the free movement of patients cases decided by the CJEU, the patient's request for cross-border treatment was not based on a challenge of their treating doctor's diagnosis, but on the identification of a

[102] Van Leeuwen, above n 51, 652-653.

specific treatment or cure that was available in the Member State of treatment. These cases are fundamentally different from regular requests for a second opinion by dissatisfied patients.[103]

The special characteristics of free movement of patients cases should be protected under the Directive. They require a more nuanced approach by the CJEU to the relationship between the objective medical assessment and patient choice. Patients and doctors should be encouraged to see the exercise of free movement rights of patients as a "project" in which both the patient and the doctor play an important role. In cases with an ethical dimension, patients are in a stronger position if they can "frame" their case as a conflict of opinion between doctors, or if they have a doctor on their side.

Conclusion

The process of emancipation of the Cross-Border Healthcare Directive may be linked to two broader constitutional developments in free movement law.

First, it provides a good example of the CJEU relying on a piece of secondary EU law to revitalise and develop the free movement rights granted under the Treaty provisions. This is a broader phenomenon which can be observed in recent years: rights granted by secondary EU legislation, which was initially regarded as little more than a codification exercise of the existing case law of the CJEU, were relied on to develop free movement rights in a way which went significantly beyond the original rights granted under the Treaty provisions. This process of emancipation had not been anticipated when the secondary EU law was adopted.[104] The adoption of harmonisation provided a "constitutional momentum" to develop the substance of the free movement rights. The concept of patient choice was not present in the CJEU's case law before the adoption of the Directive. The structure and the wording of the Directive enabled the CJEU to provide substance to the concept of patient choice in free movement law. The adoption of secondary EU law

[103] See also De Witte, above n 6, 329-331.
[104] Velyvyte, *Judicial Authority in EU Internal Market Law* (Hart Publishing, 2022), pp. 199-201.

provided the constitutional legitimacy to the CJEU to develop the scope and substance of free movement rights of patients.[105]

A parallel could be made to other pieces of secondary EU law in the field of services, such as the Services Directive.[106] After the initial Bolkestein proposal had been rejected, the Services Directive was regarded as having been "stripped" of most of its novel features.[107] Nevertheless, despite this modest start, in recent years, the CJEU has relied on the provisions of the Services Directive to develop some fundamental concepts of free movement law.[108] For example, under the Services Directive, the requirement of a cross-border element has been eliminated for cases which fall within the Directive's provisions on establishment.[109] Furthermore, the CJEU has held that the sale of retail goods should be considered a "service" under the Services Directive.[110] This has created a significant degree of fluidity in maintaining the distinction between free movement of goods and services in the internal market. As a result, it undermines the effect of the CJEU's approach in *Keck* to remove "certain selling arrangements" from the scope of application of Article 34 TFEU.[111] As such, the Services Directive has enabled the CJEU to develop some well-established principles in free movement law.

All these developments in the case law of the CJEU were made based on secondary EU law. Against this background, the interaction between primary and secondary law in resolving free movement cases requires new and more detailed attention.[112] For the Cross-Border Healthcare, a

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[105] Nys, 'The Transposition of the Directive on Patients' Rights in Cross-Border Healthcare in National Law by the Member States: Still a Lot of Effort to Be Made and Questions to Be Answered' (2014) 21 *European Journal of Health Law* 1.
[106] Directive 2006/123/EC on services in the internal market.
[107] Barnard, 'Unravelling the Services Directive' (2008) 45 *CML Rev* 323, 327-330. See also Weatherill, *The Internal Market as a Legal Concept* (OUP, 2017), pp. 218-219.
[108] Snell, 'Independence Day for the Services Directive: Visser' (2019) 56 *CML Rev* 1119, 1119-1120.
[109] Case C-360/15, *Visser Vastgoed Beleggingen BV*, ECLI:EU:C:2018:44, paras 104-110. See Maletic, 'Servicing the Internal Market: The Contribution of Positive Harmonization through the Services Directive and Its Interaction with Negative Integration' (2021) 48 *LIEI* 251, 264-266.
[110] Ibid., paras 88-97.
[111] Snell, above n 108, 1123-1129.
[112] Although the focus is exclusively on free movement of goods, see, for a detailed recent analysis, Ni Chaoimh, *The Legislative Priority Rule and the EU Internal Market for Goods* (OUP, 2022). See also Velvyte, above n 104.

particular risk which has been identified in this article is that, in cases with an ethical dimension, Member States are likely to want to rely on grounds of justification with a non-economic focus. These grounds are not directly linked to the protection of the financial balance of the social security system, but rather focus on the protection of public morality or policy choices made by the Member State. No such grounds are currently included in the Directive, unless it is possible for a Member State to link public morality and public policy to the quality of care that would be provided in another Member State.[113] Although the Directive seems to give Member States the opportunity to rely on a broader range of public interest requirements in restricting the right to reimbursement of patients,[114] the case law on non-economic justifications will have to developed under Article 56 TFEU.[115]

Second, the process of emancipation of the Cross-Border Healthcare provides an example of the role of the Charter in free movement law. This role has been reinforced and strengthened through the CJEU's adoption of a frame of analysis which is based on the structure of Charter rights. This frame has an important impact on the way in which free movement cases are resolved. It is not just a *presentational* frame (to refer to the term used by Weatherill).[116] Instead, the application of the Charter makes a *substantive* difference to the outcome of the case. This process of emancipation of the role of the Charter in free movement cases sheds a new light on the interaction between free movement rights and Charter rights. The traditional perspective of the interaction between free movement rights and fundamental rights is that Member States can rely on fundamental rights as a ground of justification to restrict free movement rights.[117] In addition, fundamental rights impose limits on the ability of Member States to restrict free movement rights.[118] This second

[113] Article 8(6)(a)-(c) of the Cross-Border Healthcare Directive.
[114] Article 7(9) of the Cross-Border Healthcare Directive.
[115] See Velvyte, above n 104, p. 122.
[116] Weatherill, above n 107, p. 106.
[117] Barnard, *The Substantive Law of the EU* (OUP, 2022), pp. 192-193.
[118] Case C-368/95, *Familiapress*, ECLI:EU:C:1997:325.

application of fundamental rights in free movement law has received new impetus under the Cross-Border Healthcare Directive.

In cases such as *A v Veselibas Ministrija*, the reliance on the Charter was intended to strengthen the exercise of free movement rights by patients. The application of Article 21 did not undermine the ability of patients to seek cross-border medical treatment – its intention was to provide an additional "boost" to the exercise of free movement rights by patients. However, the case should not just be characterised as a case in which the Charter was relied on to reinforce and strengthen the exercise of free movement rights. In parallel, the exercise of free movement rights reinforced the ability of citizens to exercise their rights under the Charter. For Mr A, the ability to seek cross-border treatment strengthened his right to manifest his religion under Article 10 of the Charter. As such, the case provides a good example of a "harmonious" relationship between free movement rights and Charter rights – a relationship of mutual reinforcement.[119] More broadly, it could be argued that these cases show that free movement rights should be characterised as fundamental rights, or as integral to the exercise of fundamental rights, as confirmed by Articles 15 and 45 of the Charter.[120]

This "harmony" between Charter rights and free movement rights is easier to achieve in cases in which the Charter right relied on is an individual right, such as the right to private life, the right to non-discrimination or the right to religion. A fundamental challenge which remains for the CJEU is to strengthen the interaction between collective Charter rights, such as the right to collective action, and free movement rights.[121] In these cases, as shown by the CJEU's judgments in *Viking*[122] and *Laval*,[123] it is much more challenging to balance fundamental rights with the exercise of free

[119] See Weatherill, above n 107, 135-141.
[120] See De Cecco, 'Fundamental Freedoms, Fundamental Rights, and the Scope of Free Movement Law' (2014) 15 *German Law Journal* 383, 384-385.
[121] Weatherill, above n 107, 125-129.
[122] Case C-438/05, *Viking*, ECLI:EU:C:2007:772.
[123] Case C-341/05, *Laval*, ECLI:EU:C:2007:809.

movement rights.[124] Given the fact that Article 35 of the Charter is included in the Solidarity chapter, this balancing exercise is equally important to the interaction between national healthcare systems and free movement rights. In *A v Veselibas Ministrija*, this question was directly linked to the broader question of how the CJEU should balance respect for the free movement of rights of individual patients with the ability of Member States to protect their ethical position and national legislation. Such cases cannot be considered exclusively from a financial or efficiency-based perspective. The judgment in *A v Veselibas Ministrija* provides an important template for how free movement cases can be assessed under a Charter frame, in a way which provide more opportunities to protect the harmony – and equality – between free movement rights and Charter rights.

[124] De Witte, above n 6, 324-326.