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The Application and Interpretation of the EU Charter in the Context of Cross-Border Movement of Patients

Rieder, C. M. (2017). The Application and Interpretation of the EU Charter in the Context of Cross-Border Movement of Patients. *Columbia Journal of European Law*, 22(3), 451-482.

Published in:

Columbia Journal of European Law

Document Version:

Peer reviewed version

Queen's University Belfast - Research Portal:

[Link to publication record in Queen's University Belfast Research Portal](#)

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The Application and Interpretation of the EU Charter in the Context of Cross-Border Movement of Patients

*Clemens M Rieder*¹

Cross-border movement of patients in the EU has been traditionally linked to and analyzed from the perspective of the internal market. This article seeks to introduce human rights, namely the European Convention on Human Rights and the EU Charter of Fundamental Rights, into the discourse about the cross-border movement of patients. The aim of this article is to address—now that the EU Charter has become binding—whether the application of human rights law in the context of cross-border movement of patients has the potential to deepen integration in this emerging area of law. For patients, this could mean that it becomes easier to exit their home system and receive health care in another Member State. For Member States, it would amount to a (further) reduction of their sovereignty in a sensitive field.

Key words: health care, human rights, EU Charter, solidarity

It does not come as a surprise that one strategy used by Member States in order to fend off European integration involves citing the needs of the Welfare State.² The welfare state needs boundaries in order to “[gate] access to the resources and opportunities of both the in-space and

¹ A first preliminary draft of this article was written during my stay at the Salzburg Centre of European Union Studies (Austria) in 2013. An earlier version of this article was presented at the 45th UACES Annual Conference in Bilbao 2015; I gratefully acknowledge the comments I received there. I am also grateful to Professor Chris Hilson, Professor David Sugarman and Lisa Warren for their comments on an earlier draft. All errors remain mine.

² See for examples in the case law: Tamara K Hervey, *Social Solidarity: a Buttress against Internal Market Law*, in *SOCIAL LAW AND POLICY IN AN EVOLVING EUROPEAN UNION* 31-47 (Jo Shaw ed., 2000),

the out-space, and [facilitate] bonding dynamics among insiders.”³ Concerning boundaries, “[v]irtually no pre-modern societies were as clearly bounded as modern nation-states.”⁴ Consequently, a perceived threat to the composition of the nation-state—be that either European integration or globalization—seems to be almost automatically considered (rightly or wrongly) a danger to the welfare state. After all, European integration “can be understood as a large-scale operation of boundary redrawing.”⁵

This article focuses on one important aspect of the welfare state: providing public health care. So far, jurisprudence has addressed cross-border movement of patients exclusively in the context of the internal market.⁶ Regarding the relationship between health care and free movement law, Hatzopoulos and Hervey conclude that “[t]he revolution is over” after evaluating the existing case law on the cross-border movement of patients.⁷ While it is arguable whether a revolution ever took place in the field of cross-border movement of patients, this article explores if the application of human rights law, most notably the European Charter of Fundamental Rights (“EU Charter”),⁸ has the potential of either triggering or continuing the revolution. The article thereby addresses a gap that exists in the current literature by analyzing

³ MAURIZIO FERRERA, *THE BOUNDARIES OF WELFARE. EUROPEAN INTEGRATION AND THE NEW SPATIAL POLITICS OF SOCIAL PROTECTION* 3 (2005).

⁴ ANTHONY GIDDENS, *THE CONSEQUENCES OF MODERNITY* 14 (1990).

⁵ Ferrera, *supra* note 3, at 3.

⁶ E.g. WOLF SAUTER AND HARM SCHEPEL, *STATE AND MARKET IN EUROPEAN UNION LAW. THE PUBLIC AND PRIVATE SPHERES OF THE INTERNAL MARKET BEFORE THE EU COURTS* 37 (2009)

⁷ Vassilis Hatzopoulos and Tamara Hervey, *Coming into line: the EU’s Court softens on cross-border health care* 8 *HEALTH ECONOMICS, POLICY AND LAW* 1, 4 (2013).

⁸ Charter of Fundamental Rights of the European Union, 2012 O.J. C 326/391 [hereinafter EU Charter].

whether the EU Charter has—as argued by some—potential that remains “yet unrealised in Union law.”⁹

In the legal history of the cross-border movement of patients, human rights law neither played a prominent role in the scholarly discussion¹⁰ nor featured at all in case law of the European Court of Justice ("ECJ" or “Court”) on cross-border movement of patients.¹¹ This absence of human rights law is somewhat surprising because the link between human rights and health care is by no means unusual in international law.¹² While this article focuses on the potential role of the EU Charter in the cross-border movement of patients, the article will also discuss provisions of the European Convention on Human Rights and Fundamental Freedoms¹³ ("ECHR" or “Convention”) and the case law of the European Court of Human Rights ("ECtHR"). This seeming diversion results from Article 52.3 of the EU Charter, which stipulates that “[i]n so far as this Charter contains rights which correspond to rights guaranteed by the Convention for the Protection of Human Rights and Fundamental Freedoms, the meaning and scope of those rights shall be the same as those laid down by the said Convention.”¹⁴ The

⁹ Tamara Hervey and Jean McHale, *Article 35 – Health Care* in THE EU CHARTER OF FUNDAMENTAL RIGHTS. A COMMENTARY, ¶35.17 (Steve Peers *et al* eds., 2014).

¹⁰ Among the few exceptions are Tamara Hervey, *The ‘Right to Health’ in European Union Law* in ECONOMIC AND SOCIAL RIGHTS. A LEGAL PERSPECTIVE 193 (Tamara Hervey and Jeff Kenner eds., 2003); Sabine Michalowski, *Health Care Law* in THE EUROPEAN UNION CHARTER OF FUNDAMENTAL RIGHTS 287 (Steve Peers and A Wards eds., 2004); Hervey and McHale, *id.*; Jean McHale, *Fundamental Rights and Health Care* in HEALTH SYSTEMS GOVERNANCE IN EUROPE. THE ROLE OF EUROPEAN UNION LAW AND POLICY 282 (Elias Mossialos *et al.* eds., 2010)

¹¹ The special case of *Stamatelaki* (*Stamatelaki v NPDD Organismos Asfaliseos Eleftheron Epangelmaton*, Case C-444/05, [2007] E.C.R. I-3185) will be addressed later in this article.

¹² For a more detailed account on international law, human rights and health see THÉRÈSE MURPHY, *HEALTH AND HUMAN RIGHTS* Chapter 1 (2013).

¹³ Rome, 5. Nov 1950.

¹⁴ EU Charter, *supra* note 8, art 52.3.

Explanatory Note¹⁵ on Article 52.3 specifically point out that the provisions of the EU Charter are also “determined”¹⁶ by the case law of the ECtHR.

The conceptual approach chosen in this article is based on Dworkin’s understanding of law as integrity, which is a plausible point of departure.¹⁷ It is well known that Dworkin’s proverbial Hercules interprets not only the text of a statute “but [also] its life, the process that begins before it becomes law and extends far beyond that moment.”¹⁸ Yet, if we aim for integrity in law, then it becomes necessary—to the extent the ECJ has not adjudicated on specific rights of the EU Charter—to draw on the case law of the ECtHR. The ECtHR and Convention provide some interpretative guidance, since the Convention constitutes the forerunner and linkage to various provisions of the EU Charter.¹⁹

ECtHR jurisprudence cites the following provisions in the context of health care. First, Article 2 of the Convention,²⁰ containing the “right to life,” corresponds to Article 2 of the EU Charter.²¹ Article 3 of the Convention²² prohibits “inhumane and degrading treatment,” and it

¹⁵ Explanations to the Charter of Fundamental Rights, 2007 O.J. C303/17 (hereinafter Explanatory Note); on the nature of these Explanatory Notes *cf.* Sacha Prechal, *Rights v Principles, or how to Remove Fundamentals Rights from the Jurisdiction of the Courts in THE EUROPEAN UNION. AN ONGOING PROCESS OF INTERGRATION. LIBER AMICORUM AFRED E KELLERMANN 177, 181-183* (Jaap W d Zwaan *et al* eds., 2006).

¹⁶ Explanatory Note, *supra* note 15, art 52.3.

¹⁷ *Cf.* GEORGE LETSAS, *A THEORY OF INTERPRETATION OF THE EUROPEAN CONVENTION ON HUMAN RIGHTS* 30 (2007).

¹⁸ RONALD DWORKIN, *LAW’S EMPIRE* 348 (1998); see also Scott Hershovitz, *Integrity and Stare Decisis in EXPLORING LAW’S EMPIRE. THE JURISPRUDENCE OF RONALD DWORKIN* 103 (Scott Hershovitz ed., 2012).

¹⁹ EU Charter, *supra* note 8, art 52.3; see also for a detailed analysis of the link Stephen Brittain, *The Relationship Between the EU Charter of Fundamental Rights and the European Convention on Human Rights: an Originalist Analysis* (11) *EUROPEAN CONSTITUTIONAL LAW REVIEW* 482, 495-504.

²⁰ Convention, *supra* note 13, art 2

²¹ EU Charter, *supra* note 8, art 2.

²² Convention, *supra* note 13, art 3.

has a mirroring provision in Article 4 of the EU Charter.²³ In addition, there is Article 8 of the European Convention²⁴ (the “right to private and family life”), which the EU Charter also protects under Article 7 of the EU Charter.²⁵ Finally, Article 35 of the EU Charter (“health care”) is relevant but different from the other provisions because no corresponding right exists in the Convention.²⁶

While the primary aim of ECJ is to deal with “economic matters” and to foster integration to facilitate movement across borders,²⁷ the ECtHR seeks to protect individuals against the abuse of authority by the state.²⁸ Therefore, the ECJ in contrast to the ECtHR, has only a modest record of human rights case law.²⁹ While over the years the ECtHR ruled on some high profile cases in the field of health law,³⁰ this article's exclusive focus on the cross-border movement of patients considerably reduces the amount of relevant case law to analyze. Before addressing whether applying the EU Charter to the cross-border movement of patients changes the character of the existing EU health care framework by deepening integration,³¹ — it is useful to briefly introduce the current legal framework.

²³ EU Charter, *supra* note 8, art 4.

²⁴ Convention, *supra* note 13, art 8.

²⁵ EU Charter, *supra* note 8, art 7.

²⁶ *Id.*, art 35.

²⁷ Gráinne de Búrca, *After the EU Charter of Fundamental Rights: the Court of Justice as a Human Rights Adjudicator*, 20 MAASTRICHT JOURNAL OF EUROPEAN AND COMPARATIVE LAW 168, 171 (2013)

²⁸ CHARLES R BEITZ, *THE IDEA OF HUMAN RIGHTS* 14-27 (2009)

²⁹ de Búrca, *supra* note 28, 171.

³⁰ E.g. *Pretty v the United Kingdom*, App No 2346/02 (ECtHR, 29 April 2002); and also *cf.* Jean McHale, *Fundamental Rights and Health Care in HEALTH SYSTEMS GOVERNANCE IN EUROPE. THE ROLE OF EUROPEAN UNION LAW AND POLICY* Chapter 6 (Elias Mossialos et al eds., 2010).

³¹ Haas defined political integration to be a ‘process whereby political actors in several distinct national settings are persuaded to shift their loyalties, expectations and political activities toward a new centre, whose institutions

1. A Brief Overview of the Framework Regulating Cross-Border Movement of Patients

"Cross-border movement of patients," for the purposes of this article, refers to a specific type of situation in which patients decide to exit their Member State of affiliation in order to receive planned treatment in another Member State. What makes cross-border movement of patients in the EU context rather unique is the fact that patients want their Member State of affiliation to pay for treatment received in another Member State.³² However, "there is little globalization of *public* healthcare, which tends to stop at national borders."³³ The issue of the cross-border movement of patients is very sensitive for Member States because EU health care law may have a direct impact on the organization of their health care systems.³⁴

The matter of health care in the context of European Union integration has been traditionally linked to the internal market.³⁵ Verordnung 3³⁶ and 4³⁷ belonged to the first laws ever passed by what was then the European Economic Community ("EEC").³⁸ Their legal basis

possess or demand jurisdiction over the pre-existing national states.' (ERNST B HAAS, *THE UNITING OF EUROPE. POLITICAL, SOCIAL, AND ECONOMIC FORCES, 1950-1957* 16 (2004)).

³² I GLENN COHEN, *PATIENTS WITH PASSPORTS. MEDICAL TOURISM, LAW, AND ETHICS* 36 (2014).

³³ *Id.*

³⁴ Opinion of AG Colomer, *Stamatelaki*, *supra* note 9, ¶ 67 and FN 42; cf. Stefano Giubboni, *Free Movement of Persons and European Solidarity*, 13 *EUROPEAN LAW JOURNAL* 360, 366-367 (2007)

³⁵ THORSTEN KINGREEN, *SOZIALE RECHTE UND MIGRATION* 23-24 (2010).

³⁶ Verordnung Nr 3/58 (EWG) vom 16. Dezember 1958 über die Soziale Sicherheit von Wanderarbeitnehmern, 1958 ABl. 30/561 (text only available in DE, FR, IT, NL).

³⁷ Verordnung Nr 4/58 (EWG) vom 16. Dezember 1958 zur Durchführung und Ergänzung der Verordnung Nr. 3 über die Soziale Sicherheit der Wanderarbeitnehmer, 1958 ABl. 30/597 (text only available in DE, FR, IT, NL).

³⁸ TREATY ESTABLISHING THE EUROPEAN ECONOMIC COMMUNITY, Rome 25 March 1957.

was Article 51 of the EEC³⁹ (now Article 48 of the Treaty on the Functioning of the European Union (“TFEU”)), which allowed Member States “[to] adopt such measures in the field of social security as are necessary to provide freedom of movement for workers.”⁴⁰ Regulation 1408/71⁴¹ and its implementing Regulation 574/72⁴² superseded these two early Regulations.⁴³ Under this framework, patients seeking treatment in another Member State needed permission from their Member State of affiliation, which was ultimately expected to pay their bill, from which they wished to exit.⁴⁴ Article 22.2 of Regulation 1408/71, which dealt with the matter of authorization, stipulated that “[t]he authorisation required . . . may not be refused where the treatment in question cannot be provided for the person concerned within the territory of the Member State in which he resides.”⁴⁵

Interpreting the meaning of Article 22.2 in *Pierik*, the ECJ held that it “covers both cases where the treatment provided in another Member State is *more effective* than that which the person concerned can receive in the Member State where he resides and those in which the treatment in question *cannot be provided* on the territory of the latter State.”⁴⁶ Effectively, the Court’s ruling gave patients access to the best treatment available in Europe. This ruling had

³⁹ *Id.*

⁴⁰ Consolidated versions of the Treaty on European Union and the Treaty on the Functioning of the European Union, 2012 O.J. C 326/1 [hereinafter TEU and TFEU].

⁴¹ Regulation (EEC) No 1408/71 of the Council of 14 June 1971 on the Application of Social Security Schemes to Employed Persons and their Families Moving within the Community, English Special Edition: Series I Chapter 1971(II) 416.

⁴² Regulation (EEC) No 574/72 of the Council of 21 March 1972 fixing the procedure for implementing Regulation (EEC) No 1408/71 on the application of social security schemes to employed persons and their families moving within the Community (English special edition: Series I Chapter 1972(I), 159).

⁴³ Regulation (EEC) No 1408/71, *supra* note 41, recitals 3-4.

⁴⁴ *Id.*, art 22.2.

⁴⁵ *Id.*

⁴⁶ *Bestuur van het Algemeen Ziekenfonds Drenthe-Platteland v G. Pierik*, Case 117/77, [1978] E.C.R. 825, ¶ 22 (emphasis added) [hereinafter *Pierik I*].

far reaching consequences for national health care systems. Member States lost direct control over whom could exit their systems, in turn making planning difficult, and possibly augmenting the cost of national health care systems.⁴⁷ Nevertheless, the Court was of the opinion “that it was the *intention* of the regulation to give *medical requirements* a decisive role in the decision . . . to grant or refuse” (prior) authorization.⁴⁸

In a rare direct reaction to the Court’s rulings in *Pierik*, the European legislator added two amendments to the original version of Article 22.2.⁴⁹ The purpose of the amendments, arguably, was to operate as a safeguard against the undesired result of the *Pierik* rulings and to re-emphasize the coordination character of the Regulation.⁵⁰ The amending clause inserted into Article 22's text stipulated that the “treatment in question is *among the benefits provided* for by the legislation of the Member State on whose territory the person concerned resides.”⁵¹ The amendment's first part undermined the Court’s jurisprudence by no longer obliging Member States to offer the most effective treatment since it prevented access under EU law to treatments unavailable to patients under national law. At the same time, these amendments made Member

⁴⁷ Cf. Christopher Newdick, *The European Court of Justice, trans-national health care, and social citizenship: accidental death of a concept?* Wisconsin International Law Journal, 26 WISCONSIN INTERNATIONAL LAW JOURNAL 844, 852-857 (2008)

⁴⁸ Bestuur van het Algemeen Ziekenfonds Drenthe-Platteland v G. Pierik, Case 182/78, [1979] E.C.R. 1978, ¶ 12 (emphasis added).

⁴⁹ Cf. generally Gareth Davies, *Legislative Control of the European Court of Justice*, 51 COMMON MARKET LAW REVIEW 1579 (2014).

⁵⁰ DORTE SINDBJERG MARTINSEN, AN EVER MORE POWERFUL COURT? THE POLITICAL CONSTRAINTS OF LEGAL INTEGRATION IN THE EUROPEAN UNION 139 (2015).

⁵¹ Council Regulation (EEC) No 2793/81 of 17 September 1981 amending Regulation (EEC) No 1408/71 on the application of social security schemes to employed persons and their families moving within the Community and Regulation (EEC) No 574/72 fixing the procedure for implementing Regulation (EEC) No 1408/71, 1981 O.J. L275/1) (emphasis added).

States (once again) the ultimate decision-maker on what treatments to offer and pay for. Thus, Member States regained authority to control the allocation of resources.⁵²

The amendment added a second element, which referenced the factor of time.⁵³ While the original version of Article 22 did not address timing, the amended provision made clear that authorization must be granted if treatment could not be provided “*within the time normally necessary* for obtaining the treatment in question in the Member State of residence, taking account of his current state of health and the probable course of the disease.”⁵⁴ The amendment clarified the maximum waiting time for a patient before a Member State needed to authorize the requested treatment. Eventually, Regulation 883/2004⁵⁵ and its implementing Regulation 987/2009⁵⁶ replaced Regulation 1408/71.⁵⁷ The structure of Article 22, with its above-mentioned limitations on waiting times as well as the range of treatment, still exists in Article 20.2 of Regulation 883/2004.⁵⁸

Therefore, if patients wish to receive planned treatment in another Member State at the expense of their Member State of affiliation—according to Article 20 of Regulation 883/2004—then patients must seek authorization.⁵⁹ The competent national institution must grant this authorization to a patient when “the treatment in question is *among the benefits*

⁵² Jonathan Montgomery, *Law and the Demoralisation of Medicine*, 26 LEGAL STUDIES 185, 196 (2006).

⁵³ Regulation No 2793/81, *supra* note 51, art 22. 2.

⁵⁴ *Id.*

⁵⁵ Corrigendum to Regulation (EC) No 883/2004/EC of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems, 2004 O.J. 2004 L166/1 (as amended).

⁵⁶ Regulation (EC) No 987/2009 of the European Parliament and of the Council of 16 September 2009, laying down the procedure for implementing Regulation (EC) No 883/2004 on the coordination of social security systems, 2009 O.J. L284/1.

⁵⁷ Regulation 1408/71, *supra* note 41.

⁵⁸ Regulation 883/2004, *supra* note 55, art 20.2.

⁵⁹ *Id.*, art 20.2.

provided for by the legislation in the Member State where the person concerned resides” and if the patient “cannot be given such treatment *within a time limit* which is medically justifiable, taking into account his/her current state of health and the probable course of his/her illness.”⁶⁰ The level of reimbursement corresponds to the tariffs of the Member State in which the treatment took place.⁶¹

In addition to the secondary EU law framework, around 15 years ago—beginning with the early case of *Luisi and Carbone*⁶² and more prominently with *Kohll*⁶³—the Court linked health care with the free movement of services Articles of the TFEU. Article 56 of the TFEU stipulates that “restrictions on freedom to provide services within the Union shall be prohibited in respect of nationals of Member States who are established in a Member State other than that of the person for whom the services are intended.”⁶⁴ Health care based on the Treaty, as acknowledged by General Advocate Sharpston in the recent case of *Commission v France*, has been rather “controversial.”⁶⁵

In the prominent case of *Kohll*, Mr. Kohll’s daughter, who was insured in Luxembourg, received dental treatment by an orthodontist established in Germany. In line with Luxembourg national law and Article 22 of Regulation 1408/71, Mr. Kohll asked for prior authorization from the competent national authority.⁶⁶ But, the competent national authority denied Mr. Kohll's

⁶⁰ Emphasis added.

⁶¹ Regulation 883/2004, *supra* note 55, art 20.2.

⁶² *Graziana Luisi and Giuseppe Carbone v Ministero del Tesoro*, Joined cases 286/82 and 26/83, [1984] E.C.R. 377, ¶ 16.

⁶³ *Raymond Kohll v Union des caisses de maladie*, Case C-158/96, [1998] E.C.R. I-01931.

⁶⁴ TFEU, *supra* note 40, art 56.

⁶⁵ Opinion of AG Sharpston, *European Commission v France*, Case C-512/08, [2010] E.C.R. I-8833, ¶ 1 (reference omitted).

⁶⁶ Opinion of AG Tesouro, *Cases C-120/95 and C-158/96, Decker and Kohll*, [1998] E.C.R. I-01831, ¶ 8.

authorization on the grounds that his daughter's dental treatment was neither urgent nor unavailable in Luxembourg.⁶⁷ When the case reached the ECJ, it simply held “[t]hat service [treatment by a German dentist], provided for remuneration, must be regarded as a service within the meaning of Article 60 of the Treaty [now Article 57 TFEU], which expressly refers to activities of the professions.”⁶⁸

The Court also held that the requirement of prior authorization in national laws, such as the one in existence in Luxembourg, “[deters] insured persons from approaching providers of medical services established in another Member State and [constitutes], for them and their patients, a barrier to freedom to provide services.”⁶⁹ As a consequence of this ruling, national laws requiring prior authorization—but surprisingly not Regulation 883/2004 itself,⁷⁰ which required the same authorization—violated free movement law.⁷¹ The amount reimbursed to a patient under *Kohll*, in contrast to Regulation 883/2004, was no greater than the amount to which a patient would have been entitled in the Member State of affiliation.⁷² Thus, arguably, the framework developed by the Court, at least *prima facie*, does not have any impact on the overall costs of the national health care systems. Yet in *Kohll*, the Court acknowledged that derogation from the free movement of services provision was possible in order to pursue “the

⁶⁷ *Id.*

⁶⁸ *Kohll*, *supra* note 63, ¶ 29.

⁶⁹ *Id.*, ¶ 35.

⁷⁰ The Court justified this anomaly by arguing that Article 42 EC Treaty (now Article 48 TFEU), which is the legal basis for Regulation 883/2004, ‘does not prohibit the Community legislature from attaching conditions to the rights and advantages which it accords in order to ensure freedom of movement for workers.’ (*Patricia Inizan v Caisse primaire d'assurance maladie des Hauts-de-Seine*, Case 56/01, [2003] E.C.R. I-12403, ¶ 23).

⁷¹ Pedro Cabral, *The Internal Market and the Right to Cross Border Medical Care*, 29 EUROPEAN LAW REVIEW 673, 679 (2004).

⁷² *Kohll*, *supra* note 63, ¶ 54.

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.”⁷³

A different category of treatment, hospital care, was at stake in the case of *Geraets-Smits and Peerbooms* in which the two applicants were insured in one Member State (the Netherlands) but received treatment in another.⁷⁴ Ms. Geraets-Smits obtained specific and multi-disciplinary treatment in a hospital in Kassel, Germany, for Parkinson’s disease.⁷⁵ The second applicant, Mr. Peerbooms, fell into a coma after a traffic accident and was taken to Innsbruck, Austria, for special treatment at the local University Clinic.⁷⁶ The pivotal question in both cases was whether the Court would follow its reasoning in *Kohll* and abolish the authorization required by national law, even for hospital treatment.⁷⁷

The Court focused on whether abolishing the need for authorization would have any impact on the allocation of health care resources and ultimately, the costs of a health care system.⁷⁸ As in *Kohll*, the Court found that the requirement of prior authorization under national law restricts the free movement of services.⁷⁹ Yet, with regard to hospital treatment, the Court accepted the planning argument made by various intervening states, without demanding any

⁷³ *Id.*, ¶ 50.

⁷⁴ B.S.M. Geraets-Smits v Stichting Ziekenfonds VGZ and H.T.M. Peerbooms v Stichting CZ Groep Zorgverzekeringen, Case C-157/99, [2001] E.C.R. I-05473, ¶¶ 25-26 and 31-34.

⁷⁵ Opinion of AG Colomer, *id.*, ¶ 3.

⁷⁶ *Id.*, ¶ 7.

⁷⁷ Geraets-Smits and Peerbooms, *supra* note 74, ¶ 43.

⁷⁸ *Id.*, ¶¶ 76-82 and 86.

⁷⁹ *Id.*, ¶ 69; also Gareth Davies, *Welfare as a Service*, 29 LEGAL ISSUES OF ECONOMIC INTEGRATION 27, 37 (2002).

empirical evidence.⁸⁰ It simply agreed with their concerns that “the number of hospitals, their geographical distribution, the mode of their organisation and the equipment with which they are provided, and even the nature of the medical services which they are able to offer, are all matters for which planning must be possible.”⁸¹ So, the Court permitted (prior) authorization as an instrument “to control costs and to prevent, as far as possible, any wastage of financial, technical and human resources.”⁸² The Court believed that as a costs control mechanism, prior authorization allowed “sufficient and permanent access to a balanced range of high-quality hospital treatment in the State concerned.”⁸³

The Court’s case law thus required distinguishing between hospital care and non-hospital care in order to establish whether a national law could legitimately prescribe an authorization requirement. The Court acknowledged that “the distinction between hospital services and non-hospital services may sometimes prove difficult to draw.”⁸⁴ Nevertheless, the Court offered a guiding principle: if a specific treatment is capable of being provided both in and outside a hospital environment, then it should be treated as a non-hospital treatment irrespective of the treatment's actual location.⁸⁵ In other words, the decisive criterion regarding hospital treatment is not where the treatment *took place* but where the treatment *could have taken place*, which—as a result—amounted to a rather expansive reading of *Kohll*.

⁸⁰ See generally Nicolas de Sadeleer, *The Precautionary Principle in EC Health and Environmental Law*, 12 EUROPEAN LAW JOURNAL 139 (2006) and Niamh Nic Shuibhne and Marsela Maci, *Providing Public Interest: the Growing Impact of Evidence in Free Movement Case Law*, 50 COMMON MARKET LAW REVIEW 965 (2013).

⁸¹ Geraets-Smits and Peerbooms, *supra* note 74, ¶ 76.

⁸² *Id.*, ¶ 79.

⁸³ *Id.*, ¶ 78.

⁸⁴ V.G. Müller-Fauré v Onderlinge Waarborgmaatschappij OZ Zorgverzekeringen UA and E.E.M. van Riet v Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen, Case C-385/99, [2003] E.C.R. I-04509, ¶ 75.

⁸⁵ *Id.*

The new Directive 2011/24⁸⁶ on patients' rights in cross-border health care, which consolidates the Court's treaty-based case law, continues to distinguish between treatments for which prior authorization is imperative and those for which it is not in Article 8.2.⁸⁷ Article 8.2 limits prior authorization to treatment which "involves overnight hospital accommodation of the patient in question for at least one night" or which "requires use of highly specialised and cost-intensive medical infrastructure or medical equipment."⁸⁸ To what extent this second limitation leaves room for interpretation is exemplified by the differing interpretations in the Opinions of the Advocate Generals in *Hartlauer*⁸⁹ and in *Commission v. France*.⁹⁰

In *Hartlauer*, Advocate General Bot chose a rather expansive interpretation of the provision.⁹¹ He argued that even in the context of dental care, authorization may be required if the treatment goes beyond "basic services, such as radiography or preventive care (plaque control, polishing), but . . . takes the form of actual surgery, such as extractions, the elimination of aesthetic deformations or certain orthodontic care, which requires qualified staff."⁹² In contrast, Advocate General Sharpston argued in *Commission v France* that prior authorization is not justified for treatment that involves "standard, relatively inexpensive, equipment" such as an x-ray machine.⁹³ According to her reasoning, expensive equipment includes, for example,

⁸⁶ Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the Application of Patients' Rights in Cross-Border Healthcare, 2011 O.J. L 88/45.

⁸⁷ *Id.*, art 8.2.

⁸⁸ *Id.*

⁸⁹ *Hartlauer Handelsgesellschaft mbH v Wiener Landesregierung and Oberösterreichische Landesregierung*, Case C-169/07, [2009] E.C.R. I-01721.

⁹⁰ *European Commission v French Republic*, Case C-512/08, [2010] E.C.R. I-08833.

⁹¹ He made reference to the provision which was then still non-binding: Opinion of AG Bot, *Hartlauer*, *supra* note 89, ¶ 92 (FN 44)

⁹² *Id.*.

⁹³ Opinion of AG Sharpston, *Commission v France*, *supra* note 90, ¶ 73.

a nuclear magnetic resonance imaging or spectrometry apparatus for clinical use or hyperbaric chamber.⁹⁴ Advocate General Sharpston prefers a more limited interpretation of the provision than Advocate General Bot—the latter expands the Article to require prior authorization for more treatments. In spite of Advocate General’s reading of the provision, one can identify a tendency to limit the circumstances which allow patients to exit their system of affiliation without prior authorization to receive treatment in another Member State.⁹⁵ Notably, the shift in reasoning no longer focuses as much on “the location where the medical service is received” as on costs.⁹⁶ This reasoning indicates the health care framework's goal to be cost-neutral in its effects on national health care systems. In its judgment, the Court appears to favor Advocate General Sharpston’s more limited interpretation of the provision.⁹⁷ Both the novelty of the Directive and the scarcity of case law make it difficult to provide a final judgment on the matter.

In conclusion, the EU health care framework regulating the cross-border movement of patients (originally Regulation 1408/71⁹⁸ and now Regulation 883/2004⁹⁹) requires patients seeking treatment in another Member State to request authorization under all circumstances.¹⁰⁰ Authorization must be granted if the treatment is covered by the system of the Member State of affiliation and cannot be provided within a particular time-frame.¹⁰¹ Simultaneously, the

⁹⁴ *Id.*; *cf.* also Commission v France, *supra* note 90, para 40.

⁹⁵ *Cf.* also Hatzopoulos and Hervey, *supra* note 2, at 4.

⁹⁶ Opinion of Advocate General Sharpston, Commission v France, *supra* note 90, ¶ 69.

⁹⁷ Commission v France, *supra* note 90, ¶¶ 37-40.

⁹⁸ Regulation (EEC) No 1408/71, *supra* note 41, art 22.2

⁹⁹ Regulation 883/2004, *supra* note 55, art 20.2.

¹⁰⁰ *Id.*, art 20.2.

¹⁰¹ *Id.*

Court began to use the Treaty to further develop the then-existing EU health care framework.¹⁰² Patients no longer need to receive an authorization by the competent national authority when they want to undergo treatment in another Member State.¹⁰³ Yet, the Court somewhat limits this judicially-created exception to non-hospital treatment, and since its inception, the distinction between hospital and non-hospital treatment has been unclear.

The more recent case law of the Court suggests that this exception from prior authorization for non-hospital treatment is losing relevance. Arguably, one explanation for this development is that the cross-border movement of patients may make planning for Member States more difficult and it has the potential to undermine their protected prerogative to allocate resources.¹⁰⁴ Yet, does the EU Charter have the authority to alter the character of the current EU health care framework? To address this question, it is necessary to establish whether the EU Charter is applicable to the cross-border movement of patients, and if so, to determine to what extent.

2. The Scope of the EU Charter

The founding Treaties—the Treaty constituting the European Coal and Steel Community¹⁰⁵ and the Treaty establishing the European Economic Community¹⁰⁶—were economic in nature, so

¹⁰² TFEU, *supra* note 40, art 56.

¹⁰³ E.g. Kohll, *supra* note 63, ¶¶ 33-34.

¹⁰⁴ TFEU, *supra* note 40, art 168.7.

¹⁰⁵ Treaty of Paris, 1951.

¹⁰⁶ Treaty of Rome, 1957.

it seemed unnecessary to put a human rights regime in place.¹⁰⁷ In the early days of European integration, however, the Court in *Stauder*¹⁰⁸ and *Internationale Handelsgesellschaft*¹⁰⁹ found “fundamental human rights enshrined in the general principles of Community law.”¹¹⁰ With *Nold*, the European Convention on Human Rights made its appearance in EU law.¹¹¹ The ECJ held that “international treaties for the protection of human rights on which the Member States have collaborated or of which they are signatories, can supply guidelines which should be followed within the framework of community law.”¹¹²

Finally, in 2000, the EU adopted its own human rights framework. At the European Council of Nice, the EU Charter was “solemnly proclaimed.”¹¹³ Yet only under the Lisbon Treaty did it become a binding instrument.¹¹⁴ One of the most contentious issues in the drafting process of the EU Charter was the role of social rights.¹¹⁵ While some delegates considered social rights necessary to absorb the side-effects of “negative integration” propelled by the

¹⁰⁷ PAUL GRAGL, THE ACCESSION OF THE EUROPEAN UNION TO THE EUROPEAN CONVENTION ON HUMAN RIGHTS 51 (2013).

¹⁰⁸ *Erich Stauder v City of Ulm*, Case 29/69, [1969] E.C.R. 419.

¹⁰⁹ *Internationale Handelsgesellschaft mbH v Einfuhr- und Vorratsstelle für Getreide und Futtermittel*, Case 11/70, [1970] E.C.R. 1125.

¹¹⁰ *Id.*, ¶ 4; *Stauder*, *supra* note 108, ¶ 7.

¹¹¹ *Siemens AG v Henry Nold*, Case 4/73, [1974] E.C.R. 491, ¶ 13.

¹¹² *Id.*

¹¹³ Charter of Fundamental Rights of the European Union, 2000 O.J. C 364/5.

¹¹⁴ Article 6.1 TEU: ‘The Union recognises the rights, freedoms and principles set out in the Charter of Fundamental Rights of the European Union of 7 December 2000, as adapted at Strasbourg, on 12 December 2007, which shall have the same legal value as the Treaties. The provisions of the Charter shall not extend in any way the competences of the Union as defined in the Treaties. The rights, freedoms and principles in the Charter shall be interpreted in accordance with the general provisions in Title VII of the Charter governing its interpretation and application and with due regard to the explanations referred to in the Charter, that set out the sources of those provisions.’

¹¹⁵ Koen Lenaerts, ‘Exploring the Limits of the EU Charter of Fundamental Rights’ 8 EUROPEAN CONSTITUTIONAL LAW REVIEW 375, 399 (2012).

internal market, others—such as the UK and the Netherlands—found it unimaginable that the EU Charter would provide enforceable social rights.¹¹⁶ Given these tensions among the delegates, the scope of the Charter unsurprisingly became a contentious issue.¹¹⁷

Article 51.1 establishes the scope of the EU Charter by stipulating that “[t]he provisions of this Charter are addressed to the institutions and bodies of the Union with due regard for the principle of subsidiarity and to the Member States only when they are implementing Union law.”¹¹⁸ Because the EU does not have exclusive competence in the area of health care, the analysis focuses on Member States.¹¹⁹ To what extent are Member States “implementing” EU law in the specific context of cross-border movement of patients? This much is clear: even the most generous reading of the phrase “implementing Union law” excludes using the EU Charter on a stand-alone basis in the process of judicial review. Instead, “[t]here must be a provision or a principle of Union primary or secondary law that is directly relevant to the case.”¹²⁰

Both a narrow and a wide understanding of the phrase “implementing Union law” are possible.¹²¹ The narrow interpretation refers to Member States which “act as agents of the

¹¹⁶ Jasper Krommendijk, *Principled Silence or Mere Silence on Principles? The role of the EU Charter’s Principles in the Case Law of the Court of Justice*, 11 EUROPEAN CONSTITUTIONAL LAW REVIEW 321, 323-328 (2015).

¹¹⁷ Lenaerts, *supra* note 115, 399.

¹¹⁸ EU Charter, *supra* note 8, art 51.1.

¹¹⁹ Tamara Hervey and Bart Vanhercke, ‘Health Care and the EU: the Law and Policy Patchwork’ in HEALTH SYSTEMS GOVERNANCE IN EUROPE. THE ROLE OF EUROPEAN UNION LAW AND POLICY 84-133 (Elias Mossialos *et al.* eds., 2010).

¹²⁰ Allan Rosas, *When is the EU Charter of Fundamental Rights Applicable at National Level?*, 19 JURISPRUDENCE 1271, 1277 (2012).

¹²¹ Cf. Michael Dougan, *Judicial Review of Member State Action under the General Principles and the Charter: Defining the ‘Scope of Union Law’*, 52 COMMON MARKET LAW REVIEW 1201, 1210-1219 (2015).

Union, enforcing EU rules.”¹²² Two acts of secondary EU law, Regulation 883/2004¹²³ and Directive 2011/24,¹²⁴ play an important role when it comes to the cross-border movement of patients. First, Regulation 883/2004 stipulates that patients who wish to receive treatment in another Member State need to obtain authorization from their Member State’s competent national authority.¹²⁵ According to Article 20.2 of Regulation 883/2004, authorization must be granted if the treatment cannot be provided “within a time-limit which is medically justifiable, taking into account his current state of health and the probable course of his illness benefits.”¹²⁶ In addition, the treatment in question needs to be “among the benefits provided for by the legislation in the Member State where the person concerned resides.”¹²⁷

Second, Article 9.3 of Directive 2011/24 requires Member States—when they consider requests for cross-border health care—to “take into account: (a) the specific medical condition; (b) the urgency and individual circumstances.”¹²⁸ In the light of the EU Charter, Directive 2011/24—whose main purpose has been to consolidate, clarify, and maybe legitimize the existing case law of the ECJ¹²⁹—receives some added (doctrinal) value. As a consequence of the EU-level codification process, any national law transposing the Directive “implements” EU

¹²² Daniel Sarmiento, *Who is Afraid of the Charter? The Court of Justice, National Courts and the New Framework of Fundamental Rights Protection in Europe*, 50 COMMON MARKET LAW REVIEW 1267, 1274 (2013).

¹²³ Regulation 883/2004, *supra* note 55, art 20.2

¹²⁴ Directive 2011/24, *supra* note 86, art 9.3.

¹²⁵ Regulation 883/2004, *supra* note 55, art 20.2.

¹²⁶ *Id.*

¹²⁷ On the difficulty to establish what kind of treatment is offered *cf.* Christopher Newdick, *Citizenship, Free Movement and Health Care: Cementing Individual Rights by Corroding Social Solidarity*, 43 COMMON MARKET LAW REVIEW 1645, 1661-1662 (2006).

¹²⁸ Directive 2011/24, *supra* note 86, art 9.3.

¹²⁹ Stephane De La Rosa, *The Directive on Cross-Border Healthcare or the Art of Codifying Complex Case Law*, 49 COMMON MARKET LAW REVIEW 15, 18 (2012)

law, even when reading the phrase narrowly.¹³⁰ While the Regulation provides a rather detailed account regarding the conditions under which authorization has to be granted, the Directive is vaguer in its word choice. This is in line with the general purpose of Directives which are “binding, as to the result to be achieved, . . . , but shall leave to the national authorities the choice of form and methods.”¹³¹ When Member States transpose Directive 2011/24 into national law,¹³² this needs to be in accordance with the EU Charter.

Yet, the Court also held that national laws, which require patients to request authorization before receiving health care in another Member State, amount to a limitation of the free movement of services principle.¹³³ The question then becomes whether Member States are still “implementing Union law” even when they derogate from EU law.¹³⁴ This constitutes the wide interpretation of the phrase “implementing Union law.”¹³⁵ In the *ERT* case, the Court held that “where a Member State relies on the combined provisions of Articles 56 and 66 [now 52 and 62 of the TFEU] in order to justify rules which are likely to obstruct the exercise of the freedom to provide services, such justification, provided for by Community law, *must be interpreted in the light of the general principles of law and in particular of fundamental rights.*”¹³⁶ The *ERT* line of case law, however, predated the EU Charter, leaving unclear at the

¹³⁰ Steve Peers and Sacha Prechal, *Article 52 – Scope of Guaranteed Rights*, in *THE EU CHARTER OF FUNDAMENTAL RIGHTS. A COMMENTARY*, ¶ 52.193 (Steve Peers *et al* eds., 2014).

¹³¹ TFEU, *supra* note 40, art 288.

¹³² Directive 2011/24, *supra* note 86.

¹³³ Kohll, *supra* note 63, ¶ 35.

¹³⁴ Cf Leonard F M Besselink, *The Member States, the National Constitutions, and the Scope of the Charter*, 8 *MAASTRICHT JOURNAL OF EUROPEAN AND COMPARATIVE LAW* 68, 78 (2001).

¹³⁵ Angela Ward, *Article 51 – Scope*, in *THE EU CHARTER OF FUNDAMENTAL RIGHTS. A COMMENTARY*, ¶ 51.39 (Steve Peers *et al* eds., 2014).

¹³⁶ *Elliniki Radiophonia Tiléorassi AE and Panellinia Omospondia Syllogon Prossopikou v Dimotiki Etairia Pliroforissis and Sotirios Kouvelas and Nicolaos Avdellas and others*, Case C-260/89, [1991] E.C.R. I-2925, ¶ 43 (emphasis added).

time of adoption of the EU Charter whether the case law would still be good law once the EU Charter became binding law.¹³⁷ The use of the word “only” in Article 51.1¹³⁸ appears to limit its applicability to situations in which Member States “implement” EU law in the narrow sense of the phrase.¹³⁹ The phrasing of the Article presumably reflects the concerns of some Member States that the Charter could be (ab)used as a “federalising device.”¹⁴⁰

In *Pfleger*, after the EU Charter was already in force, the Court addressed whether the EU Charter also applies—in the wide sense—whenever national law derogates from EU law.¹⁴¹ It needs to be noted that the case of *Pfleger* was not about health care but rather addressed the legality of restrictions in the Austrian law on gambling.¹⁴² However, some of the findings are of relevance for the discussion in this article. The Court in *Pfleger* held that “the national rules in question can fall under the exceptions provided for only if they are compatible with the fundamental rights the observance of which is ensured by the Court.”¹⁴³ Therefore, if a Member State runs a national health care framework that regulates the terms and conditions of when patients may exit their system of affiliation, then the national framework must also meet the standards of the EU Charter.

¹³⁷ *But see* Explanatory Note, *supra* note 15, art 51.1.

¹³⁸ EU Charter, *supra* note 8, art 51.1: “The provisions of this Charter are addressed to the institutions, bodies, offices and agencies of the Union with due regard for the principle of subsidiarity and to the Member States *only* when they are implementing Union law. They shall therefore respect the rights, observe the principles and promote the application thereof in accordance with their respective powers and respecting the limits of the powers of the Union as conferred on it in the Treaties” (emphasis added).

¹³⁹ Ward, *supra* note 135, ¶ 51.28.

¹⁴⁰ Koen Lenaerts, *Fundamental Rights to be included in a Community Catalogue*, 16 EUROPEAN LAW REVIEW 367, 374 (1991).

¹⁴¹ Robert Pfleger and Others, Case C-390/12, Judgment of 30 April 2014, ¶¶ 31-36. [nyr]

¹⁴² *Id.*, ¶¶ 2-8.

¹⁴³ *Id.*, ¶ 35.

Yet, in *Pfleger*, Advocate General Sharpston argued, regarding the Freedom to Choose an Occupation (Article 15 of the EU Charter) and the Right to Property (Article 17 of the EU Charter), that “the Charter impose[s] no greater obligations to be satisfied for a restriction on the freedom to provide services to be permitted than is already established by the case law of the Court in relation to Article 56 TFEU.”¹⁴⁴ Van der Mei rightly points out that there exists a “substantive overlap between the TFEU’s economic freedoms, [on] the one hand, and the freedoms to choose an occupation and conduct a business and the right to property, on the other hand, [which] are so great that it is hard to see why a separate review under the Charter is necessary or why the outcomes of a review under the TFEU and the Charter would (have to) differ.”¹⁴⁵ The same, however, cannot be concluded about the EU Charter provisions relevant to health care.¹⁴⁶

To conclude, the fulcrum controlling whether the EU Charter is applicable is the word “implementing.”¹⁴⁷ For secondary EU law—Regulation 883/2004 and Directive 2011/24—a narrow understanding of the word is sufficient in order for the EU Charter to become operative. For national law that derogates from EU free movement law, however, a wider understanding of the word “implementing” is needed. The recent case law seems to indicate that the Court considers the word “implementing” to also cover this somewhat wider meaning.¹⁴⁸ Therefore, the EU Charter applies when the Court reviews a Member State's derogation from the Treaty,

¹⁴⁴ Opinion of AG Sharpston of 14. November 2013, *id.*, ¶ 70.

¹⁴⁵ Anne Pieter van der Mei, *The Scope of Application of the EU Charter of Fundamental Rights*, 22 MAASTRICHT JOURNAL OF EUROPEAN AND COMPARATIVE LAW 432, 438 (2015).

¹⁴⁶ See, *supra*, at 5-6.

¹⁴⁷ EU Charter, *supra* note 8, art 51.1.

¹⁴⁸ *Pfleger*, *supra* note 141, ¶¶ 31-36

which, as shown, is often a contentious issue in the context of cross-border movement of patients.

Thus, there exists legal space to apply the EU Charter in the context of cross-border movement of patients. Whether the application of the EU Charter makes any significant difference in comparison to the *status quo*, however, depends on the substantive interpretation of the provisions defining the standard applied through judicial review. Therefore, the Article shifts away from considerations about scope to a substantive discussion regarding the provisions of the EU Charter that are relevant to the cross-border movement of patients. Only then is it possible to better understand whether applying the EU Charter would make any significant changes to the current legal framework regulating the free movement of patients. As already suggested earlier, the European Convention and its interpretation through the ECtHR will play an important role in the discussion to follow.

3. The Right to Life

Among the rights protected in the EU Charter, “the right to life” has considerable potential in the context of cross-border movement of patients.¹⁴⁹ So far, the ECJ has no developed case law on the cross-border movement of patients based on Article 2 of the EU Charter. But, the ECtHR’s interpretation of Article 2 of the ECHR is important because Article 2 of the EU Charter has “the same meaning and scope as Article 2 ECHR.”¹⁵⁰ In the health care context,

¹⁴⁹ Elizabeth Wicks, *Article 2 – Right to Life*, in THE EU CHARTER OF FUNDAMENTAL RIGHTS. A COMMENTARY, ¶ 2.02 (Steve Peers *et al* eds., 2014).

¹⁵⁰ *Id.*, ¶ 2.15.

the case law on the "right to life" is of interest in particular when it addresses either of two scenarios, which are recurring themes in the field of the cross-border movement of patients. First, patients cross borders in order to reduce waiting times for treatment.¹⁵¹ Second, patients seek to gain access to treatment which would not normally be covered by their system of affiliation.¹⁵² In the case law of the ECtHR, three cases are particularly noteworthy because they all address the rather sensitive issue of access to treatment.

In the first case, *Scialacqua v Italy*, the applicant received a herbal treatment for his deteriorating hepatitis B, which—in the end—was cured by the treatment.¹⁵³ Unfortunately for the patient, the Italian public health care system, to which the patient was affiliated, did not recognize and did not cover the treatment.¹⁵⁴ In his submission to the ECtHR, the applicant invoked Article 2 of the ECHR, which stipulates that “[e]veryone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.”¹⁵⁵

The now-abolished European Commission of Human Rights,¹⁵⁶ however, rejected the submission based on Article 2 of the ECHR and considered it to be “manifestly ill-founded.”¹⁵⁷ This may hardly come as a surprise since hepatitis B normally does not constitute a life

¹⁵¹ For example: *The Queen, on the application of Yvonne Watts v Bedford Primary Care Trust and Secretary of State for Health*, Case C-372/04, [2006] E.C.R I-4325, ¶¶ 24-31.

¹⁵² For example: *Geraets-Smits and Peerbooms*, *supra* note 74, ¶¶ 25-39.

¹⁵³ *Scialacqua v Italy* App. No 34151/96 (Eur Comm’n H.R. 1 July, 1998) (1998) 26 EHRR CD164).

¹⁵⁴ *Id.*

¹⁵⁵ ECHR, *supra* note 13, art 2.

¹⁵⁶ On the role of the European Commission of Human Rights: MARIE-BENEDICTE DEMBOUR, WHO BELIEVES IN HUMAN RIGHTS? REFLECTIONS ON THE EUROPEAN CONVENTION 22-24 (2006).

¹⁵⁷ *Scialacqua*, *supra* note 153.

threatening illness. According to the World Health Organization, “more than 90% of healthy adults who are infected with the hepatitis B virus will recover naturally from the virus within the first year.”¹⁵⁸ Yet, the Commission provided some general guidance regarding the interpretation of Article 2 of the ECHR particularly relevant in relation to the cross-border movement of patients. In the eyes of the Commission, the Convention “cannot be interpreted as requiring States to provide financial covering for medicines which are not listed as officially recognised medicines.”¹⁵⁹

More recently the ECtHR endorsed the core findings of the European Commission of Human Rights. In *Wiater*, the applicant suffered from a chronic sleep disorder.¹⁶⁰ Originally, the applicant's doctor provided him the only successful medical treatment free of charge.¹⁶¹ Yet, when the drug became readily available in pharmacies, it was no longer on the list of covered drugs.¹⁶² The applicant invoked Article 2 of the ECHR, but given the non-life-threatening nature of his illness, the ECtHR unsurprisingly rejected the claim to be “manifestly ill-founded.”¹⁶³ In line with *Scialacqua v Italy*,¹⁶⁴ the judges simply noted that no case law existed which required “funding for a particular type of treatment.”¹⁶⁵

¹⁵⁸ WHO, ‘Hepatitis B’, available at <http://www.who.int/mediacentre/factsheets/fs204/en/> (last visited 10 February 2016).

¹⁵⁹ *Scialacqua*, *supra* note 153.

¹⁶⁰ *Wiater v Poland*, Appl. No. 42290/08 (Eur. Ct. H.R. 15 May 2012) ¶ 3.

¹⁶¹ *Id.* ¶ 4.

¹⁶² *Id.*,

¹⁶³ *Id.*, ¶ 43.

¹⁶⁴ *Scialacqua*, *supra* note 153.

¹⁶⁵ *Wiater*, *supra* note 160, ¶ 39.

The ECtHR's interpretation of Article 2 of the ECHR in relation to health care can be described as deferential to the preferences of the State Parties to the Convention.¹⁶⁶ The ECtHR appears reluctant to interfere in *Scialacqua* and *Wiater* with the management of national health care systems. The ECtHR justifies its approach because, in its words, “[it] is for the competent authorities of the Member States to consider and decide how their limited resources should be allocated. . . . Those authorities are after all better placed than the Court to evaluate the relevant demands in view of the scarce resources and to take responsibilities for the difficult choices which have to be made between worthy needs.”¹⁶⁷ The article revisits this point, which is an expression of the margin of appreciation.¹⁶⁸ The cases above, however, do not answer whether the ECtHR's interpretation of Article 2 of the ECHR would substantially change if the applicants suffered from any life threatening illnesses.

The case of *Hristozov and others v Bulgaria* gave the ECtHR an opportunity to address this variation of facts.¹⁶⁹ All of the applicants had terminal cancer and unsuccessfully received conventional treatment.¹⁷⁰ They considered their only hope to be getting access to a scheme called “compassionate use”¹⁷¹ of drugs.¹⁷² However, Bulgarian law banned the use of such drugs in order to protect vulnerable patients.¹⁷³ Since the drug was offered free of charge by the

¹⁶⁶ Cf. *LETSAS*, *supra* note 17, 81.

¹⁶⁷ *Wiater*, *supra* note 160, ¶ 39; Newdick has made a similar point in relation to the ECJ in *Newdick*, *supra* note 127, at 1652.

¹⁶⁸ “5.Repsect for Private and Family Life”.

¹⁶⁹ *Hristozov and Others v Bulgaria*, App. No. 47039/11 and 358/12 (Eur. Ct. H.R 29 April, 2013).

¹⁷⁰ *Id.*, ¶ 8.

¹⁷¹ This means that patients can gain access to unauthorised drugs outside trials which was not possible under Bulgarian law.

¹⁷² *Hristozov*, *supra* note 169, ¶ 9.

¹⁷³ *Id.*, ¶ 99.

pharmaceutical company, financial concerns of the state were not relevant here.¹⁷⁴ The applicants argued that a complete ban on the use of “compassionate drugs”—a factual submission questioned by the findings of the Court¹⁷⁵—would amount to a violation of their right to life.¹⁷⁶ The ECtHR again was deferential and found that the Convention “cannot be interpreted as *requiring* access to *unauthorised* medicinal products for the terminally ill to be regulated in a particular way.”¹⁷⁷

Invoking the ECtHR's Article 2 case law in the EU or before the ECJ—by virtue of EU Charter Article 2—is unlikely to help applicants expand the list of treatments Member States must provide. This result seems to coincide with the current *status quo* in EU law, summarized recently by the ECJ in *Elchinov*: “European Union law . . . cannot, in principle, have the effect of requiring a Member State *to extend such lists of medical benefits*.”¹⁷⁸ The analysis shifts now to another provision frequently invoked in the context of health care: the prohibition of torture and inhuman or degrading treatment or punishment.

4. Prohibition of Torture and Inhuman or Degrading Treatment or Punishment

¹⁷⁴ Dissenting Opinion of Judge De Gaetano joined by Judge Vučinič in *id.*, ¶ 3.

¹⁷⁵ *Hristozov*, *supra* note 169, ¶ 108

¹⁷⁶ *Id.*, ¶ 107.

¹⁷⁷ *Id.*, ¶ 108 (emphasis added).

¹⁷⁸ For example: *Elchinov*, Case C-173/09, [2010] E.C.R. I-08889, ¶ 58 (emphasis added).

Article 3 of the ECHR is identical in wording to Article 4 of the EU Charter and reads, “[n]o one shall be subjected to torture or to inhuman or degrading treatment or punishment.”¹⁷⁹ Nowak and Charbord argue “the rich case law of the ECtHR and the former European Commission of Human Rights shall be the primary source of interpretation of the rights contained in Article 4 EUCR.”¹⁸⁰ In the health care context, the ECtHR held that a violation of Article 3 occurs when the “suffering which flows from a naturally occurring illness . . . is, or risks being, exacerbated by treatment stemming from measures for which authorities can be held *responsible*.”¹⁸¹ Arguably, allowing a health care system to have extensive waiting times or to deny a specific health care treatment to a patient may constitute a measure for which the state “can be held responsible” according to Article 3.

At the same time, the ECtHR made clear that the Convention “does not place an obligation on the Contracting States to alleviate the disparities between the levels of health care available in various countries.”¹⁸² Analogously, the ECJ in *Geraets-Smits and Peerbooms* held that “the fact that a particular type of medical treatment is covered or not covered by the sickness insurance schemes of other Member States is irrelevant in this regard.”¹⁸³ Thus, considerable similarities exist between the ECJ's approach, which is based on the free movement of services (Article 56 of the TFEU), and the ECtHR's approach based on Article 3 of the ECHR. Neither of the two courts appear to impose a positive obligation on the state.

¹⁷⁹ ECHR, *supra* note 13, art 3.

¹⁸⁰ Manfred Nowak and Anne Charbord, *Article 4 – Prohibition of Torture*, in THE EU CHARTER OF FUNDAMENTAL RIGHTS. A COMMENTARY, ¶ 4.14 (Steve Peers *et al* eds., 2014).

¹⁸¹ *Id.*

¹⁸² Hristozov, *supra* note 169, ¶ 113.

¹⁸³ *Geraets-Smits and Peerbooms*, *supra* note 74, ¶ 87.

Yet, before reaching a final conclusion on Article 3's applicability, the case of *D v the United Kingdom*¹⁸⁴ needs mentioning because it shows Article 3's potential to change the quality of the cross-border movement of patients through the introduction of supranational solidarity. A person from St. Kitts entered the UK as a visitor, but at the airport he was arrested for drug possession.¹⁸⁵ He received a six-year jail sentence.¹⁸⁶ In prison, he was diagnosed as HIV-positive and suffering from AIDS.¹⁸⁷ Before releasing him, the UK immigration authorities wanted to deport him to St. Kitts.¹⁸⁸ The applicant challenged his deportation on the grounds that given his health condition, deporting him violates, among other provisions, Article 3.¹⁸⁹ While Article 3, according to the case law of the ECtHR, constitutes a negative right, its drafting history also suggests that it is absolute in its nature.¹⁹⁰ A prohibition which is absolute in nature “operates on a strictly binary mode: it is either respected or it is not – there is no grey area. In the context of the Convention, either the state has refrained from doing what is prohibited or it has done it – there is no proportionality test to be applied.”¹⁹¹

It was undisputed that if the UK deported *D* to St. Kitts, it would considerably shorten his life expectancy.¹⁹² In an unanimous judgment, the ECtHR ruled that the UK had “*assumed responsibility* for treating the applicant’s condition,” but the judges also hastened to add that

¹⁸⁴ *D v the United Kingdom*, Appl. No. 30240/96 (Eur. Ct. H.R. 2 May, 1997).

¹⁸⁵ *Id.*, ¶ 7.

¹⁸⁶ *Id.*

¹⁸⁷ *Id.*, ¶ 8.

¹⁸⁸ *Id.*, ¶ 10.

¹⁸⁹ *Id.*, ¶ 37.

¹⁹⁰ JEREMY WALDRON, TORTURE, TERROR AND TRADE-OFFS. PHILOSOPHY FOR THE WHITE HOUSE 214 (2010).

¹⁹¹ Dembour, *supra* note 156, at 83.

¹⁹² *D v UK*, *supra* note 184, ¶¶ 16-17.

this was a case of “very exceptional circumstances.”¹⁹³ An interpretation of the judgment is that the UK has special responsibilities in relation to *D* because it “assumed” them.¹⁹⁴ It seems that the ECtHR tried to avoid making an argument based on impartialism, which is too elusive and morally demanding.¹⁹⁵ The ECtHR—implicitly at least—suggested that special obligations exist between *D* and the UK as if they were in a social contract situation. In a contract, “[a] promisor, through a voluntary act of will, imposes upon himself an obligation that is peculiarly his own, not shared by the world at large, and his obligation is owed to a specific individual, the promisee, rather than to the world at large.”¹⁹⁶ If a special relationship exists, then the floodgate argument, to be outlined subsequently, is no longer of any concern. But it also means that there is in existence a strong duty which correlates with a strong right.¹⁹⁷ Both considerations influence the application of Article 3 ECHR.

Given the facts of the case, however, it remains questionable whether the UK really had “assumed responsibility” for *D* in any meaningful way. The ECtHR failed to offer a convincing argument in order to demonstrate how the UK made that voluntary promise, which in turn created special obligations in relation to others.¹⁹⁸ That the applicant became “reliant on the medical and palliative care”¹⁹⁹ may be an account of his “vulnerability” but cannot substitute as a promise. There may be normative arguments based on impartialism, such as parable of the

¹⁹³ *Id.*, ¶¶ 54 (emphasis added).

¹⁹⁴ *Id.*, ¶ 53.

¹⁹⁵ Cf. John Cottingham, ‘Partiality, Favouritism and Morality’ 36 *THE PHILOSOPHICAL QUARTERLY* 357 (1986).

¹⁹⁶ Robert E Goodin, *Vulnerabilities and Responsibilities: An Ethical Defense of the Welfare State*, 79 *THE AMERICAN POLITICAL SCIENCE REVIEW* 775, 777 (1985).

¹⁹⁷ Judith Lichtenberg, *Distant Stranger. Ethics, Psychology, and Global Poverty* (Cambridge University Press 2014) 50.

¹⁹⁸ H L A Hart, ‘Are There Any Natural Rights?’ (64) *THE PHILOSOPHICAL REVIEW* 175, 183-184 (1955).

¹⁹⁹ *D v UK*, *supra* note 184, ¶ 53.

Good Samaritan,²⁰⁰ as to why the UK should take care of *D*. Yet the approach chosen by the ECtHR is unconvincing. The situation would have been entirely different if *D* had contracted HIV and AIDS during his stay in a UK prison. This would have amounted to a violation of the “no-harm principle,” which constitutes the strongest moral obligation for help.²⁰¹

About ten years later, the ECtHR decided *N v the United Kingdom*,²⁰² which is factually similar to *D v the United Kingdom*.²⁰³ Once again the question was whether solidarity should be exercised with a non-citizen in a show of supranational solidarity. The UK wished to deport a Ugandan woman who entered the UK seriously ill and suffering from HIV.²⁰⁴ She applied for asylum in the UK.²⁰⁵ Receiving asylum would have allowed her to gain access to the required treatment, which would have been more difficult to obtain in Uganda.²⁰⁶ Lord Hope made the argument in the House of Lords that if the UK permitted her to stay and to receive treatment, it would open the floodgates to medical immigration.²⁰⁷ Other people suffering from HIV would come to the UK and hope to be granted indefinite leave, overburdening the available resources.²⁰⁸ The consequential reasoning applied by the House of Lords contrasts with the ECtHR’s deontological interpretation of Article 3 of the ECHR in *D*.²⁰⁹

²⁰⁰ Luke 10:25-37.

²⁰¹ THOMAS POGGE, *WORLD POVERTY AND HUMAN RIGHTS* (2d ed, 2008) 138.

²⁰² *N v the United Kingdom*, App. No 26565/05 (Eur. Ct. H.R. 27 May, 2008), ¶¶ 8-17.

²⁰³ *D v UK*, *supra* note 184, ¶¶ 6-21.

²⁰⁴ *N v UK*, *supra* note 202, ¶ 9.

²⁰⁵ *Id.*, ¶ 10.

²⁰⁶ *Id.*, ¶¶ 18-19.

²⁰⁷ *N v Secretary of State for the Home Department*, [2005] 2 W.L.R. 1124, 1141.

²⁰⁸ *Id.*

²⁰⁹ Joint dissenting Opinion of Judges Tulkens, Bonello and Spielmann in *N v UK*, *supra* note 202, ¶¶ 6-7.

When deciding *N v the United Kingdom*, the ECtHR no longer found a violation of Article 3.²¹⁰ The majority provided three grounds of reasoning in support of their finding. The first ground emphasized the exceptional character of *D v the United Kingdom*, and pointed out that *D* was factually distinguishable from *N v the United Kingdom*.²¹¹ The judges highlighted that in *D*, “the applicant was critically ill and appeared to be close to death, could not be guaranteed any nursing or medical care in his country of origin and had no family there willing or able to care for him or provide him with even a basic level of food, shelter or social support.”²¹² The judges in *N* also acknowledged that the “quality of the applicant’s life, and her life expectancy, would be affected if she were returned to Uganda.”²¹³ They argued, though, that “[t]he applicant is not, however, at the present time critically ill. The rapidity of the deterioration which she would suffer and the extent to which she would be able to obtain access to medical treatment, support and care, including help from relatives, must involve a certain degree of speculation.”²¹⁴

Second, the judges reasoned that “[a]lthough many of the rights it [the Convention] contains have implications of a social or economic nature, the Convention is essentially directed at the protection of civil and political rights.”²¹⁵ Following this distinction, the ECtHR held that “Article 3 does not place an obligation on the Contracting State to alleviate such disparities through the provision of free and unlimited health care to all aliens without a right to stay within

²¹⁰ *N v UK*, *supra* note 202, ¶ 51.

²¹¹ *Id.*, ¶¶ 46-51.

²¹² *Id.*, ¶ 42.

²¹³ *Id.*, ¶ 50.

²¹⁴ *Id.*

²¹⁵ *Id.*, ¶ 44.

its jurisdiction.”²¹⁶ Finally, the ECtHR invoked a consequential argument by highlighting the need to balance “the demands of the general interest of the community and the requirements of the protection of the individual’s fundamental rights.”²¹⁷

In the context of EU health care, Advocate General Tesouro in *Kohll* also made a consequentialist argument, stating, “The only effect I can conceive of is that one optician established in Luxembourg will have sold one less pair of spectacles and the only orthodontist established in the same State will have lost one patient.”²¹⁸ It would appear that both the ECHR as a human rights instrument and Article 56 of the TFEU, which is economic in its nature, now follow a form of consequentialism that seeks to protect the inviolacy of national health care systems. Hence the structure of the legal argument under human rights and free movement law seems rather similar in nature.

N v the United Kingdom was controversial among the judges themselves, triggering a joint dissenting opinion of Judges Tulkens, Boneelo, and Spielmann. All three judges considered the factual distinction between *N v the United Kingdom* and *D v the United Kingdom* to be “misconceived.”²¹⁹ They criticized the “high-threshold” requirement in the context of health care and suggested instead the “*Pretty* threshold.”²²⁰ A violation of Article 3 of the ECHR occurs under the *Pretty* threshold when the suffering “is or risks being, exacerbated by treatment, whether flowing from conditions of the detention, expulsion or other measures, for

²¹⁶ *Id.*

²¹⁷ *Id.*

²¹⁸ Opinion of AG Tesouro, Cases C-120/95 and C-158/96, Decker and Kohll, [1998] E.C.R. I-01831, ¶ 58 (FN 90).

²¹⁹ Joint dissenting Opinion of Judges Tulkens, Bonello and Spielmann in *N v UK*, *supra* note 202, ¶ 25.

²²⁰ *Id.*, ¶ 5.

which the authorities can be held responsible.”²²¹ The dissenting judges also criticized the majority's statement that the Convention ought to be about civil and political rights for ignoring the “social dimension of the integrated approach adopted by the Court” in its case law.²²² Finally, the minority also drew attention to the nature of Article 3 as an absolute right, which prohibits any “balancing exercise.”²²³

After *N v the United Kingdom*, it appears that Article 3 does not have the authority to change the nature of health care systems by making boundaries for outsiders more permeable and introducing a notion of supranational solidarity.²²⁴ Yet, even following the deontological interpretation of Article 3 developed by the ECtHR in *D v the United Kingdom*, which introduces supranational solidarity, cases within the EU context would most likely fail on the facts. *D v the United Kingdom* was rather exceptional and had a “high threshold,” according to *N v the United Kingdom*.²²⁵ If Article 3 of the ECHR and Article 4 of the EU Charter are closely similar, then it would appear that Article 4 of the EU Charter does not have the authority to change the current character of the framework regulating the cross-border movement of patients.

5. Respect for Private and Family Life

²²¹ *Pretty v the United Kingdom*, App. No. 2346/02 (Eur. Ct. H.R. 29 April, 2002) ¶ 52.

²²² Joint dissenting Opinion of Judges Tulkens, Bonello and Spielmann in *N v UK*, *supra* note 202, ¶ 6.

²²³ *Id.*, ¶ 7.

²²⁴ See also *infra* ‘6. Health Care’.

²²⁵ *N v UK*, *supra* note 202, ¶ 43.

Article 7 of the EU Charter²²⁶ guarantees respect for private and family life and corresponds to Article 8 of the ECHR.²²⁷ Article 8 of the Convention stipulates that “[e]veryone has the right to respect for his private and family life, his home and his correspondence.”²²⁸ Given the identical wording of Article 7 of the EU Charter and Article 8 of the ECHR, the “rich and substantive amount of case law [that] has been built up by the European Court of Human Rights regarding the scope and application of Article 8 . . . can be drawn on with regard to the interpretation of Article 7 of the Charter.”²²⁹ In the ECtHR's jurisprudence, this provision received the greatest attention in the context of health care.²³⁰ To be relevant to health care, the case law needs to cover problems which are of pivotal importance in the cross-border movement of patients, either that of reducing the wait times or that of accessing treatments not available in the patient's state of affiliation.

In *Passannante v Italy*, the issue of long wait times was reviewed under Article 8 of the ECHR.²³¹ The European Commission of Human Rights declared the case inadmissible, but it nevertheless acknowledged that “while the essential object of Article 8 is to protect the individual against arbitrary interference by the public authorities, it does not merely compel the State from such interference: in addition to this negative undertaking, there may be *positive obligations* inherent in effective respect for private life.”²³² This language on positive

²²⁶ EU Charter, *supra* note 8, art 7

²²⁷ ECHR, *supra* note 13, art 8.

²²⁸ *Id.*

²²⁹ Shazia Choudhry, *Article 7 – Family Life Aspects*, in THE EU CHARTER OF FUNDAMENTAL RIGHTS. A COMMENTARY, ¶ 7.11B (Steve Peers *et al* eds., 2014).

²³⁰ Sabine Michalowsky, *Health Care Law*, in THE EU CHARTER OF FUNDAMENTAL RIGHTS 287, 292 (Steve Peers and Angela Ward eds, 2004).

²³¹ *Passannante v Italy*, App. No. 32647/96 (Eur Comm'n H.R. 1 July, 1998).

²³² *Id.* (emphasis added).

obligations echoes the identical wording of the ECtHR in *Marckx*,²³³ which first established the link between Article 8 and positive rights.²³⁴ Yet, the substance of any positive duty in the context of health care appears to be limited, as exemplified by *Hristozov and Others v Bulgaria*.²³⁵

As mentioned above, in *Hristozov and others*, Bulgaria denied the applicants access to the compassionate use of drugs.²³⁶ When the case reached the ECtHR, the judges referred to the “margin of appreciation.”²³⁷ They argued “that matters of health-care policy are in principle within the *margin of appreciation* of the domestic authorities.”²³⁸ The margin of appreciation is narrow for a state “[w]here a particularly important facet of an individual’s existence or identity is at stake.”²³⁹ By contrast, “where the case raises sensitive moral or ethical issues, the margin will be wider” as well as “if the State is required to strike a balance between competing private and public interests or Convention rights.”²⁴⁰

The majority in *Hristozov and others* applied the above-outlined criteria and believed that the national authorities should be granted a wide margin.²⁴¹ The majority argued that not only does no consensus exist among Convention states on the compassionate use of drugs, but

²³³ *Marckx v Belgium*, App. No. 6833/74 (Eur. Ct. H.R. 13 June, 1979) ¶ 31.

²³⁴ A M Connelly, *Problems of Interpretation of Article 8 of the European Convention on Human Rights*, 35 INTERNATIONAL AND COMPARATIVE LAW QUARTERLY 567, 573 (1986).

²³⁵ *Hristozov*, *supra* note 169, ¶¶ 117-127.

²³⁶ *Id.*, ¶ 9.

²³⁷ *Id.*, ¶ 117.

²³⁸ *Hristozov*, *supra* note 169, ¶ 119 (emphasis added); specifically on the doctrine about the margin of appreciation: LETSAS, *supra* note 17, Chapter 4.

²³⁹ *SH and Others v Austria*, App. No 57813/00 (Eur. Ct. H.R. 3 November, 2011) ¶ 94.

²⁴⁰ *Id.*

²⁴¹ *Hristozov*, *supra* note 169, ¶ 124.

also public health care systems need to balance private and public interests.²⁴² The ECtHR has a long tradition of assigning considerable importance to the question of whether there exists consensus, or a common ground, on a specific matter within the European Council when it comes to determining the width of the margin of appreciation.²⁴³ At the same time, the dissenting judges mainly criticized—unsurprisingly—the broad margin of appreciation granted by the majority to Convention states in the field of health care.²⁴⁴

For dissenting Judge De Gaetano, joined by Judge Vučinić, the majority did not adequately account for the “obvious life-or-death implications”²⁴⁵ of the case when balancing the competing private and public interests.²⁴⁶ The dissenting judges underlined that the balancing test in the judgment “should have given more weight to the value of life,” which—among the various Convention rights—is “chief.”²⁴⁷ Partly dissenting, Judge Kalaydjieva went as far as arguing that the majority used the doctrine in this judgment “as an instrument to justify the national authorities’ complete failure to demonstrate any appreciation whatsoever of the applicants’ right to personal life, or to strike the requisite balance between this right and presumed counterbalancing public interests.”²⁴⁸

²⁴² Hristozov, *supra* note 169, ¶¶ 121-124.

²⁴³ Janneke Gerards, *Pluralism, Deference and the Margin of Appreciation Doctrine*, 17 EUROPEAN LAW JOURNAL 80, 108-110 (2011).

²⁴⁴ See to that effect partly dissenting Opinion of Judge Kalaydjieva in Hristozov *supra* note *supra* note 169 [**no para provided??**] and Dissenting Opinion of Judge De Gaetano joined by Judge Vučinić in Hristozov, *supra* note 169, ¶¶ 3-4. [**not sure how to reference this properly**]

²⁴⁵ Dissenting Opinion of Judge De Gaetano joined by Judge Vučinić in Hristozov, *supra* note 169, ¶ 5.

²⁴⁶ *Id.*, ¶ 9.

²⁴⁷ *Id.*, ¶ 4.

²⁴⁸ Partly dissenting Opinion of Judge Kalaydjieva in Hristozov, *supra* note 107 [**re pincite see above-no para in the opinion**]

Studying *Hristozov and others*, it appears as if the majority²⁴⁹ and the dissent²⁵⁰ were discussing different facets of the margin of appreciation. The dissenting judges referred to a “substantive” margin that addresses the relationship “between individual freedoms and collective goals.”²⁵¹ The majority applied, though, a “structural” margin of appreciation that focuses on “the limits or intensity of the review of the European Court of Human Rights in view of its status as an international tribunal.”²⁵² This interchangeable use of the concept is unsurprising since “[t]he Court uses the same term (margin of appreciation) both for saying that the applicant did not, as a matter of human rights, have the right he or she claimed, and for saying that it will not substantively review the decision of national authorities as to whether there has been a violation.”²⁵³

The criteria developed by Letsas²⁵⁴ help distinguish the substantive margin from the structural margin of appreciation. The ECtHR in the field of health care, seems to apply a structural margin of appreciation. The judges referred to public morals, highlighted the lack of consensus on how to deal with the compassionate use of drugs, and pointed out that an international court ought not to replace the competent national authority.²⁵⁵ In *Wiater* the ECtHR also seemed to apply the structural concept of the margin of appreciation to Article 2 of the ECHR. The Court argued—particularly due to the lack of European common ground on the issue—that national authorities are better positioned to decide how resources should be

²⁴⁹ *Hristozov*, *supra* note 169, ¶ 125

²⁵⁰ Partly dissenting Opinion of Judge Kalaydjieva in *Hristozov*, *supra* note 169 [NB no paras in the Opinion] and Dissenting Opinion of Judge De Gaetano joined by Judge Vučinič in *Hristozov*, *supra* note 169, ¶¶ 3-4.

²⁵¹ *LETSAS*, *supra* note 17, 80-81.

²⁵² *Id.*, 81.

²⁵³ *Id.*

²⁵⁴ *Id.*, 90-92.

²⁵⁵ *Hristozov*, *supra* note 169, ¶¶ 122-127.

spent.²⁵⁶ To the extent the ECtHR applies a structural margin of appreciation it will not even create “a (patrolled) state space.”²⁵⁷ This constitutes a problem because the ECtHR and the ECJ operate in “different context[s],”²⁵⁸ and the transferal of meaning from the Convention, in order to interpret the EU Charter, is not necessarily compelling.

So far in this Article, the EU Charter mirrored the respective provisions of the ECHR. Article 35 of the EU Charter is different because it has no “twin-norm” in the ECHR. At the same time, Article 35 is the only health care provision of the EU Charter that played a (modest) role in the cross-border context, even if only by reference in the Opinion of the Advocate General.

6. Health Care

In this article, “general” human rights provisions have been adopted in the particular context of health care. However, EU Charter Article 35 constitutes a *lex specialis* in relation to health care.²⁵⁹ According to this provision, “[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.”²⁶⁰ The question is whether Article 35 has the potential to influence the terms and conditions under which patients may exit their system of affiliation. In particular,

²⁵⁶ Wiater, *supra* note 160, ¶ 39

²⁵⁷ Niamh Nic Shuibhne, *Margins of appreciation: national values, fundamental rights and EC free movement*, 34 EUROPEAN LAW REVIEW 230, 231 (2009).

²⁵⁸ Gerards, *supra* note 243, at 104

²⁵⁹ EU Charter, *supra* note 8, art 35.

²⁶⁰ *Id.*

does Article 35 have the doctrinal authority to change the current legal framework that regulates free movement of patients in a way that allows patients to shorten their waiting times or increase the scope of treatment available to them?

Article 35's interpretation is difficult because in contrast to the Articles discussed so far, there exists no mirroring Article in the ECHR. Since there is “so little jurisprudence to go on, it is difficult to be certain of the scope of the application of Article 35.”²⁶¹ At least one EU case, *Stamatelaki*, references Article 35 of the EU Charter in relation to the cross-border movement of patients.²⁶² Mr. Stamatelaki suffered from bladder cancer.²⁶³ Though publicly insured in Greece, he received treatment on two occasions in the UK, in a private hospital.²⁶⁴ When Mr. Stamatelaki asked for a reimbursement from the Greek public funds, the funds rejected his request because his treatment in the UK was performed in a private hospital.²⁶⁵ According to Greek legislation, treatment undertaken in private hospitals abroad would only be reimbursed if an agreement existed between the private hospital and the public fund, or if the patient was under 14 years of age.²⁶⁶ For Advocate General Colomer, albeit not for the ECJ, it was beyond a doubt that the EU Charter played a role in the cross-border movement scenario.²⁶⁷

In *Stamatelaki*, the Court upheld its reasoning developed in the earlier case law, that health care is covered by the law on free movement of services in accordance with Article 56

²⁶¹ Hervey and McHale, *supra* note 9, ¶ 35.20.

²⁶² Opinion of AG Colomer, *Stamatelaki*, *supra* note 11, ¶ 40.

²⁶³ *Id.*, ¶ 15.

²⁶⁴ *Stamatelaki*, *supra* note 11, ¶ 9.

²⁶⁵ *Id.*, ¶ 11.

²⁶⁶ *Id.*, ¶¶ 7-8.

²⁶⁷ Opinion of AG Colomer, *Stamatelaki*, *supra* note 11, ¶ 40.

TFEU.²⁶⁸ One possible explanation for the Court’s refusal to follow the Opinion of the Advocate General is the doctrinal argument based on *ratione temporis*. When the ECJ decided *Stamatelaki*, the EU Charter still was a non-binding instrument that had only been “solemnly proclaimed” by the Commission, the Council, and Parliament.²⁶⁹ This argument is no longer convincing after the Lisbon Treaty changed the legal status of the EU Charter.²⁷⁰ Yet, even in subsequent cases, such as *Commission v Spain*,²⁷¹ *Commission v France*,²⁷² or *Elchinov*²⁷³—all decided after the Charter gained legal force—the Court referred neither to the EU Charter nor any other human rights law.

The Advocate General in *Stamatelaki* acknowledged the earlier cases and argued that “although the case-law takes as the main point of reference the *fundamental freedoms* established in the Treaty, there is another aspect which is becoming more and more important in the Community sphere, namely the right of citizens to health care, proclaimed in Article 35 of the Charter.”²⁷⁴ Advocate General Colomer provided a sketch of how Article 35 of the EU Charter should be interpreted.²⁷⁵ Referring to the Opinion of the European Economic and Social Committee on “Healthcare,” the Advocate General pointed out that “being a fundamental asset, health cannot be considered solely in terms of *social expenditure and latent economic*

²⁶⁸ *Stamatelaki*, *supra* note 11, ¶ 38.

²⁶⁹ EU Charter, *supra* note 8.

²⁷⁰ TEU, *supra* note 40, art 6.1.

²⁷¹ *Commission v Spain*, Case C-211/08, [2010] E.C.R. I-05267.

²⁷² *Commission v France*, Case C-512/08, [2010] E.C.R. I-08833.

²⁷³ *Elchinov*, *supra* note 178.

²⁷⁴ Opinion of AG Colomer, *Stamatelaki*, *supra* note 11, ¶ 40 (emphasis added).

²⁷⁵ *Id.*

difficulties.”²⁷⁶ In his Opinion, Advocate General Colomer pushed the envelope even further by stating that “[t]his right is perceived as a *personal entitlement, unconnected to a person’s relationship with social security*, and the Court of Justice cannot overlook that aspect.”²⁷⁷

With this last point in particular, the Advocate General suggests that Article 35 has the potential to introduce supranational solidarity. As noted earlier, the ECtHR flirted with the idea of supranational solidarity in *D v the United Kingdom*.²⁷⁸ Yet, in *N v the United Kingdom*, the ECtHR made clear that *D v the United Kingdom* only applies under the most limited circumstances, namely that there is no treatment available in the patient’s home country.²⁷⁹ The ECHR, then, obliges the State Parties to the Convention only exceptionally to supranational solidarity. In the EU context, it appears that there is no room left, *mutatis mutandis*, for the application of the notion of supranational solidarity developed in *D v the United Kingdom*.²⁸⁰

Many important aspects play a critical role in the interpretation of Article 35, but the Advocate General did not discuss them in his Opinion. Most notably among them is the role of limitations. Peers argues that “[t]he rules on limitation of rights in the EU Charter of Fundamental Rights will likely become increasingly relevant as the Charter gains a larger role as a source for the human rights.”²⁸¹ Without understanding the scope of the limitation clauses,

²⁷⁶ Opinion of the European Economic and Social Committee on ‘Healthcare’, approved by the Plenary Session on 16 and 17 July 2003, 2003 O.J. C 234/36 quoted by Opinion of AG Colomer, Stamatelaki, *supra* note 11, ¶ 40 (emphasis added).

²⁷⁷ Opinion of AG Colomer, Stamatelaki, *supra* note 11, ¶ 40 (emphasis added)

²⁷⁸ *D v UK*, *supra* note 117, ¶ 54.

²⁷⁹ *N v UK*, *supra* note 125, ¶ 42.

²⁸⁰ *D v UK*, *supra* note 117, ¶ 54.

²⁸¹ Steve Peers, *Taking Rights Away? Limitation and Derogations*, in THE EUROPEAN UNION CHARTER OF FUNDAMENTAL RIGHTS 141 (Steve Peers and Angela Ward eds., 2004).

it is impossible to identify the substance of a right.²⁸² One of these limitations is in Article 35 itself,²⁸³ and the others are in Article 52.²⁸⁴

The right to health care in Article 35 is granted “under the conditions established by national laws and practices.”²⁸⁵ Similarly worded, Article 52.6 of the EU Charter demands that “[f]ull account shall be taken of national laws and practices as specified in this Charter,”²⁸⁶ endorsing the limitation outlined in Article 35 itself. Article 52.1 of the EU Charter contains another limitation, stipulating that:

[a]ny limitation on the exercise of the rights and freedoms recognised by this Charter must be provided for by law and respect the essence of those rights and freedoms. Subject to the principle of proportionality, limitations may be made only if they are necessary and genuinely meet objectives of general interest recognised by the Union or the need to protect the rights and freedoms of others.²⁸⁷

What is the relationship between Articles 52.1 and 52.6 of the EU Charter? Addressing this question is essential because Article 35 seemingly belongs to those provisions of the Charter that trigger Article 52.6.²⁸⁸ The Explanatory Note on Article 52.6 do not provide much substantive clarification, only referencing “the spirit of subsidiarity” and emphasizing that the limitation needs to be “national.”²⁸⁹ This could, for example, mean either “that any national limitations must always automatically be accepted as valid, no matter how much they restrict

²⁸² ROBERT ALEXY, A THEORY OF CONSTITUTIONAL RIGHTS 178-181 (Julian Rivers tr, 2010).

²⁸³ EU Charter, *supra* note 8, art 35.

²⁸⁴ *Id.*, art 52.

²⁸⁵ *Id.*, art 35.

²⁸⁶ *Id.*, art 52.6.

²⁸⁷ *Id.*, art 52.1.

²⁸⁸ *Id.*, art 52.6.

²⁸⁹ *Id.*, ¶ 52.193.

the right in question,” or that national laws only “control” the exercise of the right.²⁹⁰ The literal interpretation of Article 52.6 seems to support the former conclusion because, by its wording, “*full account shall be taken of national laws and practices.*”²⁹¹ If this view is correct, the EU Charter may not be able to alter a national authorization regime, even if the regime is extremely restrictive in its nature.

Yet, Peers and Prechal argue that this extreme literal reading of the provision, which permits national laws to fully abolish a Charter right, is “incompatible with the nature of a human rights text.”²⁹² The argument they seem to make is that there exists a “guarantee of an inalienable core as a limit to limits” (*Wesensgehaltsgarantie*).²⁹³ This point may also be supported by drawing on the statutory interpretation principle *lex specialis derogate legi generali*.²⁹⁴ The aim of this principle is that it helps in solving conflicts of norms (antinomies).²⁹⁵ While Article 52.6 of the EU Charter stipulates that “[f]ull account shall be taken of national laws and practices as specified in this Charter,”²⁹⁶ Article 52.1 requires limitations to “respect the essence of those rights and freedoms” guaranteed in the EU Charter.²⁹⁷ Arguably, it is Article 52.1 which specifies the reach of “[a]ny limitation” of the EU Charter.²⁹⁸

²⁹⁰ *Id.*, ¶ 52.198.

²⁹¹ Emphasis added.

²⁹² Peers and Prechal, *supra* note 130, ¶ 52.198.

²⁹³ ALEXY, *supra* note 282, 192.

²⁹⁴ FRANZ BYDLINSKI, *JURISTISCHE METHODENLEHRE* 465 (2 ed. 2011)

²⁹⁵ *Id.*

²⁹⁶ EU Charter, *supra* note 8, art 52.6

²⁹⁷ *Id.*, art 52.1.

²⁹⁸ *Id.*

Finally, Article 52.2 of the EU Charter is also a limitation clause, which stipulates that “[r]ights recognised by this Charter for which provision is made in the Treaties shall be exercised *under the conditions and within the limits defined by those Treaties*.”²⁹⁹ This Article is particularly relevant to Article 35.³⁰⁰ The Explanatory Note on Article 35 of the EU Charter reference Article 168 of the TFEU,³⁰¹ which addresses the issue of “public health.” Article 168 may be an example of a “right . . . for which provision is made in the Treaties.”³⁰² However, applying Article 168 of the TFEU, in particular its paragraph 7, does not provide much interpretative guidance regarding possible conditions and limitations. The Article reads 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.”³⁰³ Yet, in health care, Member States' responsibilities are not only determined by national but also international law.³⁰⁴ So, the responsibilities of Member States are not only shaped but also determined by supranational obligations. The argument becomes circular because the international (or supranational) law influences the Member States' responsibilities.

Another pivotal aspect important to establishing the relevance of Article 35 is whether it constitutes a “right” or a “principle.” Distinguishing between rights and principles is necessary because Article 51.1 of the EU Charter stipulates that rights need to be “respected,” whereas principles only need to be “observed.”³⁰⁵ While criticizable as an exercise in

³⁰⁰ *Id.*, art 35.

³⁰¹ TFEU, *supra* note 40, art 168.

³⁰² EU Charter, *supra* note 8, art 52.2

³⁰³ TFEU, *supra* note 40, art 168.7.

³⁰⁴ See for an overview on international human rights law and health (care) law MURPHY, *supra* note 12, Chapter 1.

³⁰⁵ Explanatory Note, *supra* note 15, art 52.5.

semantics, Article 52.5 of the Charter considers only “rights” to be “judicially cognisable.”³⁰⁶ The Explanatory Note on Article 52.5 elaborate that principles “become significant for the Courts only when such acts [of the Member States which are implementing EU law] are interpreted or reviewed. They do not however give rise to direct claims for positive action by the Union’s institutions or Member States authorities.”³⁰⁷ The ECJ so far has not given any guidance on the distinction between rights and principles and the consequences for an Article that falls into one or the other camp.

For the time being, the only guidance comes from Advocate General Villalón's Opinion.³⁰⁸ In *AMS*, the Advocate General examined whether Article 27 of the EU Charter, which protects the workers’ right to information and consultation within the undertaking, constitutes a right or a principle.³⁰⁹ The Advocate General concluded that Article 27 amounts to a principle because its “content is so indeterminate that it can be interpreted only as an obligation to act, requiring the public authorities to take the necessary measures to guarantee a right.”³¹⁰ Given the constitutional character of the EU Charter in general, this is not surprising.³¹¹ Yet, linguistic indeterminacy is something that Article 27 shares with other

³⁰⁶ EU Charter, *supra* note 8, art 52.5 (emphasis added).

³⁰⁷ Explanatory Note, *supra* note 15, art 52.5.

³⁰⁸ Opinion of AG Villalón, *AMS*, in *Association de médiation sociale v Union locale des syndicats CGT and Others.*, Case C-176/12, 15 January 2014 [nyr], ¶¶ 28-80.

³⁰⁹ “Workers’ right to information and consultation within the undertaking:

Workers or their representatives must, at the appropriate levels, be guaranteed information and consultation in good time in the cases and under the conditions provided for by Union law and national laws and practices.”

³¹⁰ Opinion of AG Villalón, *AMS*, *supra* note 308, ¶ 54.

³¹¹ Cf. Mattias Kumm, *Constitutional Rights as Principles: One the Structure and Domain of Constitutional Justice*, 3 INTERNATIONAL JOURNAL OF CONSTITUTIONAL LAW 574 (2004).

provisions of the Charter, such as Article 35.³¹² The second similarity Article 35 shares with Article 27 is its inclusion in the chapter on “Solidarity” in the Charter.³¹³ This chapter “incorporates mainly rights regarded as *social* rights with respect to their substance, for the content of which a form of wording such as that in Article 27 is preferred.”³¹⁴ Both Articles 27 and 35 of the EU Charter share considerable similarities. Systematic consistency provides a strong argument that they should also be treated alike.

Yet categorizing “principles” and “rights” convincingly remains troubling. Advocate General Villalón finds it “striking that the Charter does not assign the fundamental rights to either of the two groups, as is usual in comparative law.”³¹⁵ Hilson attempts to distinguish principles from rights based on abstract criteria.³¹⁶ In doing so, Hilson references the autonomous nature of rights, the double-sidedness of principles, and the different legal impacts and accountability that rights have in comparison to principles.³¹⁷ But, he concludes that “one is left with the need to make *ad hoc* arguments based on each Article as to its precise justiciability. It is simply not possible – as the Charter Explanations try to do – to make generalisations based on arguments that all principles act in this or that particular way.”³¹⁸

Even if it is difficult or impossible to distinguish rights from principles in the context of the Charter, does it matter in the specific context of health care? In other words, would it still

³¹² Cf. also Michalowski, *supra* note 10, at 291.

³¹³ EU Charter, *supra* note 8, art 27.

³¹⁴ Opinion of AG Villalón, AMS, *supra* note 308, ¶ 55.

³¹⁵ *Id.*, ¶ 43.

³¹⁶ Chris Hilson, *Rights and Principles in EU Law: A Distinction without Foundation?*, 15 MAASTRICHT JOURNAL OF EUROPEAN AND COMPARATIVE LAW 193, 199-210 (2008).

³¹⁷ *Id.*

³¹⁸ *Id.*, at 215.

be possible to invoke Article 35 if it were a principle, which seems more plausible in light of the above? To address this point, it is necessary to return to Article 52.5 of the EU Charter, which stipulates that “[t]he provisions of this Charter which contain principles may be implemented by legislative and executive acts taken by institutions, bodies, offices and agencies of the Union, and by acts of Member States when they are implementing Union law, in the exercise of their respective powers. They shall be *judicially cognisable* only in the interpretation of such acts and in the ruling on their legality.”³¹⁹

The Court in *Glatzel* made clear that a principle “cannot by itself confer on individuals a subjective right which they may invoke as such.”³²⁰ The wording of Article 52.5 also makes clear that principles are either “implemented by legislative or executive acts” of the Union or when Member States “are implementing Union law.”³²¹ The former covers secondary EU law—such as Regulation 883/2004 and Directive 24/2011—that operates in the context of the cross-border movement of patients. In relation to the latter, as argued above, Member States implement Union law even when they derogate from free movement law by means of national law.³²² Thus, the current legal framework could still be read in the light of Article 35.

To conclude, among the various Articles of the EU Charter it is safe to say that Article 35 has the most potential in relation to the cross-border movement of patients. So far, the Court has not applied the provision in the context of the cross-border movement of patients, so there remains considerable uncertainty about how the Court might use Article 35. First, the provision operates with three limitations, and the Court will need to establish clearly the substance of Article 35. Whether the substance of Article 35, in the end, provides deeper integration than the

³¹⁹ EU Charter, *supra* note 8, art 52.5 (emphasis added).

³²⁰ Wolfgang Glatzel v Freistaat Bayern, Case C-356/12, 22 May 2014 [nyr], ¶ 78.

³²¹ EU Charter, *supra* note 8, art 52.5.

³²² See *supra* note ,

current free-movement law is an open question. Second, while the ECJ still needs to clarify whether Article 35 constitutes a right or a principle, it seems plausible to argue that patients will not be given a subjective right that they can invoke. Nevertheless, Article 35 of the EU Charter, even as a principle, could still be invoked in the process of judicial review. After all, principles can be taken into account when it comes to “the interpretation of secondary legislation and Member State legislation that is implementing EU law.”³²³

7. Conclusion

The aim of this article was to analyze whether the EU Charter has the authority to change the character of the current cross-border movement regime significantly by deepening the level of integration. The analysis of the relevant ECHR provisions revealed that no substantive change should be expected in the legal framework regulating the cross-border movement of patients, even if the ECJ decided to apply the EU Charter. Given the closeness of the relationship between the ECHR and the EU Charter,³²⁴ Dworkin’s judge Hercules would closely consider the findings of the ECtHR in relation to the Convention.³²⁵ Leaving theoretical and doctrinal considerations aside, given the sensitivity of the policy area, the Court will carefully and strategically depart from existing case law only when there are persuasive, doctrinal reasons for doing so.³²⁶

³²³ Thomas von Danwitz and Katherina Paraschas, *A Fresh Start for the Charter: Fundamental Questions on the Application of the European Charter of Fundamental Rights*, 35 *FORDHAM INTERNATIONAL LAW JOURNAL* 1396, 1413 (2012).

³²⁴ EU Charter, *supra* note 8, art 52.3.

³²⁵ Cf. Ronald Dworkin, ‘Law as Interpretation’, (9) *Critical Inquiry* 179, 191-196 (1982).

³²⁶ Cf. generally KAREN J ALTER, *THE EUROPEAN COURT’S POLITICAL POWER. SELECTED ESSAYS* Chapter 6 (2010).

Of particular interest is the role that Article 35 might play in the cross-border movement of patients, since the Article specifically covers health care and was cited by the Advocate General in a case on the free movement of patients. Because this provision does not have a corresponding right in the ECHR, it is difficult to judge its substance. Two areas of controversy arise regarding Article 35's interpretation. First, it is unclear how the applicable limitations in relation to Article 35 ought to be understood, which crucially impact the interpretation of the provision. Second, it is also difficult to establish whether Article 35 of the EU Charter is a right or a principle. Given sparse guidance from the Court, the tentative conclusion is that Article 35 probably amounts to a principle. This still permits examination of the current EU health care framework in light of the Charter, but an individual does not have a subjective right based on Article 35.

Though one might therefore argue that the EU Charter does not offer much added value to the health care framework, which is currently driven by the internal market and the free movement of services, it appears that the law on the free movement of services has reached its outer limits when it comes to health care. The saga of the Services Directive³²⁷ has made it very obvious that free movement of services has developed a notoriously bad reputation.³²⁸ Instead I suggest that the relationship between human rights and public health care appears to be far more tenable and offers considerably greater potential. Beitz aptly points out that “the public discourse of peacetime global society can be said to have a common moral language, it is that of human rights.”³²⁹

³²⁷ Directive 2006/123/EC of the European Parliament and of the Council of 12 December 2006 on services in the internal market, 2006 O.J. L376/36.

³²⁸ Cf. Mads Dagnis and Peter Nedergaard, *From ‘Frankenstein’ to ‘Toothless Vampire’? Explaining the Watering Down of the Services Directive*, 19 JOURNAL OF EUROPEAN PUBLIC POLICY 844 (2012).

³²⁹ BEITZ, *supra* note 28, 1.

Human rights offer a more solid grounding for health care, even if EU health care law would not change substantially. If the EU and, in particular, the Court seek to make inroads into this stronghold of Member States, the EU and ECJ will unsurprisingly meet resistance on the way because the redistribution of resources—at least for the time being—is in the hands of Member States. If the Court adopted the language of human rights, it could serve as a reference point for new forms of governance.³³⁰ The Open Method of Coordination, for example, “uploads”³³¹ only ideas but not the policy making process itself, which offers a certain amount of freedom from the legitimacy, competence, and democracy discourse. The Court could make its contribution to the further development of EU health care law beyond the application of rights.

³³⁰ Sandra Fredman, *Transformation or Dilution: Fundamental Rights in the EU Social Space*, 12 EUROPEAN LAW JOURNAL 41, 58 (2006).

³³¹ KENNETH A ARMSTRONG, GOVERNING SOCIAL INCLUSION. EUROPEANIZATION THROUGH POLICY COORDINATION (Oxford University Press 2010) 13.