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SOLIDARITY AND PATIENT MIGRATION IN THE CONTEXT OF FUNDAMENTAL RIGHTS

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National health care systems rest on boundaries, whereas EU law has been traditionally used in order to overcome boundaries. However, in relation to health care it has been argued by some that EU law impacts negatively on the composition of solidarity. The legal framework which currently regulates the cross-border movement of patients is based on the following cornerstones: according to Article 20 Regulation 883/2004 patients who wish to receive treatment in other Member States have to request permission from their state of affiliation if they want to be reimbursed. In addition, the European Court of Justice (ECJ) in Kohll developed case law that is based on the free movement of services provisions of the Treaty (Artt 56 et seq. TFEU).

By invoking the Treaty the Court created an anomaly, namely that the Treaty-based route for exit would not require from a patient to obtain authorisation in order to receive treatment in another Member State. As a consequence of linking health care with the law on free movement of services, the Court made existing boundaries more permeable. Yet the Court limited this freedom by acknowledging that restrictions by means of authorisation would be justified to the extent that ‘the maintenance of a treatment facility or medical service

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1 I gratefully acknowledge the receipt of a British Academy Mid-Career Fellowship. I would also like thank the editors of this book, Dr Esin Kucuk and Dr Egle Dagilyte, for their helpful feedback.


6 Ibid, para 54.
on national territory is essential for the public health and even the survival of the population.7

Most recently the EU adopted Directive 2011/24 which seeks to consolidate the case law of the Court in the field of cross-border movement of patients.8 Through its Article 8.2 the Directive appears to make some further inroads in limiting the scope of the above described anomaly.9

If one examines the case law on the migration of patients it is to be noted that so far this area has been exclusively determined by rights which are closely related to the internal market. In turn, human rights have not played any role. This is somewhat surprising because it is not unusual in international law to link health care with human rights.10 The difference is of significance on a (meta-) conceptual level: rights which are affiliated with the internal market follow a ‘market rationality’ and ‘neoliberalism’s depoliticizing effects’,11 whereas human rights, arguably by their very nature, are deemed to be political. It is against this background that the chapter will examine the role fundamental rights play in relation to the migration of patients across boundaries.

The chapter wants to examine in particular two issues: first, whether the EU Charter of Fundamental Rights (EU Charter) has the authority to make existing boundaries more

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7 Ibid, para 51.
9 Article 8.2. Directive 2011/24: ‘Healthcare that may be subject to prior authorisation shall be limited to healthcare which:
(a) is made subject to planning requirements relating to the object of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources and:
(i) involves overnight hospital accommodation of the patient in question for at least one night; or
(ii) requires use of highly specialised and cost-intensive medical infrastructure or medical equipment’
10 For a more detailed account on international law, human rights and health see Thérèse Murphy, Health and Human Rights (Hart Publishing 2013) Chapter 1.
11 Mark Flear, ‘The Open Method of Coordination on Health Care After the Lisbon Strategy II: Towards a Neoliberal Framing?’ (2009) 13 European Integration Online Papers 1, 4.
permeable than the current framework, which is based on free movement law;\textsuperscript{12} secondly, whether the EU Charter possesses the authority to even redraw existing boundaries altogether.\textsuperscript{13} Addressing these two questions is of particular importance in relation to solidarity: while the matter of boundary-permeability only has an impact on the degree of national solidarity, boundary-redrawing prescribes supranational solidarity.

\textbf{1. The EU Charter and the Permeability of Boundaries}

The costs of health care systems are usually a bone of contention in the national political discourse.\textsuperscript{14} Arguably, these costs are predominately determined by especially two parameters: the first controls how long patients have to wait for their scheduled treatment (‘waiting-times’) and the second regulates the range of treatment which is financially covered by public health care systems (‘scope of treatment’). In a nutshell: the more generously and faster the treatment has to be delivered to patients, the more costly the system becomes. Whatever level of decision-making holds authority over these two parameters, wields significant power when it comes to influencing the overall costs of a health care system. In the context of public health care systems, this means that the level of decision making also influences the degree of solidarity which is infused into the system.

Given the sensitivity of waiting times and the scope of treatment it is therefore of no coincidence that Article 20.2 of Regulation No 883/2004, which covers the cross-border movement of patients, targets especially these two parameters. The provision stipulates in

\textsuperscript{12} On authority see Joseph Raz, ‘Authority and Justification’ (1985) 14 Philosophy \& Public Affairs 3.
\textsuperscript{14} See on the matter of costs: R Baeten, and B Vanhercke, ‘Inside the black box: The EU’s economic surveillance of national healthcare systems’ (2016) Comparative European Politics 1
particular that authorisation only has to be granted if the treatment cannot be provided to a patient ‘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’. In addition, the treatment has to be ‘among the benefits provided for by the legislation in the Member State where the person concerned resides’. The primary aim of Article 20.2 and its predecessors was to prevent EU health care law from establishing any additional positive duties on Member States and preserve, to the maximum extent possible, their sovereignty in this field.

With regard to the discussion in this chapter the question then becomes whether in the context of cross-border movement of patients the EU Charter has the authority to weaken the composition of functional boundaries of health care systems, thereby enabling patients to gain quicker access to treatment and also increase the scope of treatment. The analysis will be divided into two sections: EU Charter rights which have corresponding rights in the European Convention; and those provisions, for the purposes of this chapter in particular Article 35 EU Charter, which do not have any such corresponding or mirroring Article in the European Convention. This division is of importance because only with regard to the former group of rights there already exists some guidance as to how the corresponding rights of the EU Charter are to be interpreted. In contrast, when it comes to Article 35 EU Charter one is dealing with an empty vessel.

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17 According to Article 52.3 EU Charter ‘[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.’
EU CHARTER RIGHTS MIRRORED

For mainly two reasons the focus in this section will be on two Articles of the European Convention, namely Article 2 (‘the right to life’) and Article 8 (‘the right to private and family life’): first, Article 2 of the Convention has a mirroring provision in Article 2 EU Charter, while Article 8 of the Convention is also matched by an identical wording of Article 7 EU Charter. Secondly, both of these provisions not only have been used in the context of health care generally but also at least some limited portion of the case law of the European Court of Human Rights (ECtHR) addressed the specific problem of permeability of boundaries. Therefore these provisions should provide a good indicator in order to determine to what extent the EU Charter has the authority to change the composition of existing boundaries.

In the case of *Scialacqua v Italy*, the applicant had received some herbal treatment for his deteriorating hepatitis B which – in the end – proved to be a success. Unfortunately, for the patient, the treatment as such was not recognised and therefore not covered by the Italian public health care system which was the patient’s system of affiliation. The abolished European Commission of Human Rights considered the submission to be ‘manifestly ill-founded’ under Article 2 ECHR. Nevertheless, the Commission also offered some general guidance regarding the interpretation of Article 2 ECHR. It held that the Convention ‘cannot

18 Article 2 ECHR: ‘Everyone’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.’
19 Article 8 ECHR: ‘Everyone has the right to respect for his private and family life, his home and his correspondence.’
21 There is identical wording of Article 7 EU Charter and Article 8 ECHR. Therefore the case law of the ECtHR is also of relevance in the context of the Charter. (Shazia Choudhry, ‘Article 7 – Family Life Aspects’ in Steve Peers et al (eds) *The EU Charter of Fundamental Rights. A Commentary* (Hart Publishing 2014) para 7.11B.
22 *Scialacqua v Italy* App. No 34151/96 (Eur Comm’n H.R., 1 July, 1998).
be interpreted as requiring States to provide financial covering for medicines which are not listed as officially recognised medicines’.  

What was at stake in this case was the question whether human rights, in particular the right to life, have the authority to alter the ‘scope of treatment’. The finding of the ECtHR seems to coincide with the current status quo in EU health care law, which also negates the existence of positive duties for Member States to expand the scope of treatment. The ECJ in *Elchinov* summarised its position in the following terms: ‘European Union law … cannot, in principle, have the effect of requiring a Member State to extend such lists of medical benefits.’  

Thus it would appear that neither the human rights law of the ECHR nor the free movement law of the TFEU obligate states to change their lists of treatment.

This finding of the European Commission of Human Rights was endorsed by the ECtHR in the case of *Wiater v Poland*. The applicant in this case was suffering from a chronic sleep disorder. Originally the only effective medical treatment was given to the applicant free of charge by his medical doctor. Yet when the drug became readily available in pharmacies it was no longer on the list of drugs which were covered. While the applicant was free to buy the drug, he obviously had to pay for it. The claim based on Article 2 ECHR was rejected by the ECtHR as ‘manifestly ill-founded.’  

The Strasbourg judges – in line with *Scialacqua v Italy* – simply noted that no case law existed which would require ‘funding for a particular type of treatment.’

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24 *Scialacqua* (n 22).


27 *Wiater* (n 26) para 43.

28 *Scialacqua* (n 22).

29 *Wiater* (n 26) para 39.
It could be argued that both types of illnesses hepatitis B and chronic sleep disorder do not regularly constitute life threatening diseases.\textsuperscript{30} This fact alone may explain why applicants unsuccessfully invoked the right to life. In the case of \textit{Hristozov and others v Bulgaria}\textsuperscript{31} applicants were diagnosed with terminal cancer. Clearly, the facts of the case suggest the presence of a life and death situation. Applicants considered it to be their only hope to get access to a ‘compassionate use’\textsuperscript{32} of drugs scheme, once the conventional drugs had failed to improve their condition. However, any such schemes were banned under Bulgarian national law, the law of their home state, in order to protect vulnerable patients. Since the pharmaceutical company provided the (test) drug free of charge to patients, obviously financial considerations were of no concern here. Nevertheless, the ECtHR held that the Convention ‘cannot be interpreted as requiring access to unauthorised medicinal products for the terminally ill to be regulated in a particular way.’\textsuperscript{33}

The other right that has been invoked in the context of health care is Article 8 ECHR.\textsuperscript{34} While so far the focus of this discussion was on the scope of treatment, the case \textit{Passannante v Italy}\textsuperscript{35} dealt with the matter of waiting times. The European Commission of Human Rights was called to examine the long waiting times of the Italian health care system in the light of Article 8 ECHR. In the end, the Commission declared the case to be inadmissible but elaborated more generally on the nature of Article 8. It acknowledged that ‘the essential object of Article 8 [was] to protect the individual against arbitrary interference

\textsuperscript{30} WHO, ‘Hepatitis B’, Factsheet No 204 (2015), available at \url{http://www.who.int/mediacentre/factsheets/fs204/en/}.


\textsuperscript{32} This means that patients can gain access to unauthorised drugs outside trials which was not possible under Bulgarian law.

\textsuperscript{33} \textit{Hristozov} (n 31) para 108.


\textsuperscript{35} \textit{Passannante v Italy}, App. No. 32647/96 (Eur Comm’n H.R. 1 July, 1998)
by the public authorities. However, in addition to this negative duty the Commission held that ‘there may be positive obligations inherent in effective respect for private life.’ And yet it did not further elaborate on this point.

It is to be noted that especially in the context of Article 8 ECHR the margin of appreciation has played a prominent role. The existence of a margin of appreciation, in turn, questions positive duties under the ECtHR because the doctrine underlines ‘the subsidiary nature of international law.’ In the already mentioned case of Hristozov, with reference to Article 8 ECHR, the judges invoked the margin of appreciation. Among the justifications given by the judges was the argument that there exists no consensus among Convention states regarding this specific matter of health-care policy, that is the compassionate use of drugs. Therefore states are granted a wide margin in order to balance the competing private and public interests. After all, so the ECtHR found ‘[t] is not for an international court to determine in place of the competent national authorities the acceptable level of risk in such circumstances.’

The main point of criticism by the dissenting judges in Hristozov was – unsurprisingly – the wide margin of appreciation. For the dissenting Judge De Gaetano, who was joined by Judge Vučinić, the majority did not adequately take into account the ‘obvious life-or-death implications’ of this case when balancing the competing private and public interests. The dissenting judges underlined that the balancing test, which was undertaken by the majority in the judgment, ‘should have given more weight to the value of life’ which – among the various

36 Ibid.
37 Ibid. (emphasis added).
39 Katherine G Young, Constituting Economic and Social Rights (Oxford University Press 2014) 117.
40 Hristozov (n 31) para 119.
41 Ibid., para 121-124.
42 Ibid., para 125.
43 Dissenting Opinion of Judge De Gaetano joined by Judge Vučinić in Hristozov, ibid., para 5.
Convention rights – is ‘chief.’ The partly dissenting Judge Kalaydjieva went as far as to argue that the doctrine in this judgment had been used by the majority ‘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.’

Conceptually it would appear that the majority and the dissent were discussing different facets of the doctrine of margin of appreciation. While the dissenting judges made reference to a ‘substantive’ margin, which seeks to actually balance ‘individual freedoms and collective goals’, the majority applied a ‘structural’ margin of appreciation which 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.’ Applying Young’s typology of judicial review it can be argued that the former amounts to ‘peremptory review’ which solves the matter at hand instantly without giving the legislator a chance to change, whereas the latter constitutes a ‘deferential review’. The interchangeable use of the concept, while unfortunate, is not unusual. Letsas notes, ‘[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.’

The point Letsas makes seems important in relation to the question as to whether the interpretation of the ECtHR can be transferred to the context of the EU Charter. While Gerards acknowledges that both of the two courts ‘operate in different contexts’, she also thinks that both nevertheless share ‘sufficient similarities between them to make a comparison

44 Ibid., para 4.
45 Partly dissenting Opinion of Judge Kalaydjieva in Hristozov (n 31).
46 Letsas (n 38) 81 (emphasis added).
47 Young (n 39) 143-147 and 162-166.
48 Letsas (n 38) 81.
worth while of the ways in which they deal with problems of pluralism.\textsuperscript{49} For Shelton, the matter of translating the margin of appreciation from the Convention-context to the EU-context causes only marginal difficulties because, according to her, the ECJ already applies the margin of appreciation in everything apart from its name.\textsuperscript{50} And yet, I submit that this claim is only persuasive in relation to the substantive version of the margin of appreciation which includes a proportionality test that may plausibly be based on similar criteria also in the EU context.

In turn, refusing to review a decision with reference to the ECtHR’s status as an international tribunal – the basis for the structural margin of appreciation – cannot necessarily apply in the same way to the ECJ. This is so because of the different constitutional roles and statuses the two courts occupy. The relationship between the margin of appreciation and the subsidiary nature of international law (and its enforcement system) has been mentioned here; the situation in the EU context is radically different.\textsuperscript{51} Most notably, however, the ECJ is called to adjudicate in cross-border circumstances. Consequently, the ECJ

must somehow balance state \textit{variables} of protection. When goods, persons or services cross national borders, they are likely to cross value borders too. This basic fact can trigger a whole range of fundamental rights conflicts that the Court must accommodate – against each other; but also, against or within the additional competing demands of the EC internal market and free movement law. Applying a margin of appreciation is therefore futile.\textsuperscript{52}

\begin{thebibliography}{99}
\bibitem{rieder} See on the interrelationship between the ECJ with national courts and its consequences: Clemens Rieder, ‘Courts and EU Health Law and Policies’ in Tamara Hervey and Calum Young (eds.) \textit{Research Handbook in EU Health Law and Policy} (Edward Elgar, forthcoming)
\end{thebibliography}
It would appear, in conclusion, that the principles developed by the ECtHR in the context of the Convention do not alter the permeability of boundaries. The ECtHR clarified that the Convention must not have any financial impact on the existing health care systems but also the judges are very careful not to impose other duties than financial ones Convention States as the example of the compassionate use of drugs shows. Leaving the question aside as to whether the ECJ is doctrinally obligated to adopt the same interpretation of the Articles of EU Charter which are mirrored in the Convention,\(^53\) certainly the ECtHR has considerable authority which cannot be ignored easily. Nevertheless there exists one possible exception to this claim: to the extent the ECtHR justified its reading of the Convention by drawing on a structural margin of appreciation relation it can be argued, due to the ECJ’s different constitutional role, that the ECtHR has not occupied this space. Consequently, the ECJ can develop its own approach of interpreting the EU Charter. The focus now shifts to Article 35 EU Charter which is different from the Articles that have been discussed so far because it has no corresponding provision in the Convention.\(^54\)

**ARTICLE 35 EU CHARTER**

According to Article 35 EU Charter, ‘[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. A high level of human health protection shall be ensured in the definition and implementation of all the Union’s policies and activities.’ The Article appears to have a considerable potential for change when it comes to making boundaries more

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permeable, but also the redrawing of boundaries; while the former will be discussed now, the latter will be at the center of the subsequent section. The difficulty in establishing the meaning of the provision are twofold: since Article 35 is not phrased in an absolute manner, it is first necessary, to accurately interpret the relevant limitations. Secondly, and this is closely related to the issue of limitation, it will be critical to discuss as to whether Article 35 constitutes a ‘right’ or a ‘principle’. Arguably, principles only allow for a ‘qualified enforcement’. 55

The first of the limitations is mentioned in Article 35 EU Charter itself and stipulates that the right to health care is enjoyed under conditions ‘established by national laws and practices.’ However, Article 35 is further limited by Article 52.6 EU Charter which demands that ‘[f]ull account shall be taken of national laws and practices as specified in this Charter.’ The wording of the provision effectively repeats the limitation already outlined in Article 35 EU Charter itself. Both of these limitations refer back to the national level without any ability for the ECJ to balance competing interests. The ECJ, so it seems, takes the role of a voiceless bystander in this process.

In contrast, the limitation clause of Article 52.1 EU Charter introduces the idea of a ‘reasonable limitation’ 56 which vests the ECJ with the authority to undertake the balancing exercise. It stipulates that

[any 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. 57

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55 Young (n 39) 116.
56 Ibid., 104.
57 Emphasis added.
Since Article 35 belongs to the provisions of the Charter which trigger Article 52.6, it is necessary also to clarify the relationship between Article 52.1 and 52.6. The Explanatory Note on Article 52.6 does not offer much in terms of guidance and substantive clarification. It only makes reference to ‘the spirit of subsidiarity’ and emphasizes that the limitation needs to be ‘national’.58 This could either mean ‘that any national limitations must always automatically be accepted as valid, no matter how much they restrict the right in question’ or, that national laws only ‘control’ the exercise of the right.59 The literal interpretation of Article 52.6 EU Charter seems to support the former conclusion because according to the wording of the provision, ‘full account shall be taken of national laws and practices.’60 Yet Peers and Prechal argue that any such extreme reading of the provision, namely that national laws can fully abolish a Charter ‘right’, would be ‘incompatible with the nature of a human rights text.’61

It would appear that they want to suggest that any limitations need to respect the ‘essence of those rights and freedoms’ in the EU Charter. This amounts to a ‘guarantee of an inalienable core as a limit to limits’ (Wesensgehaltsgarantie).62 In support of their argument, one may draw on the principle lex specialis derogat legi generali which helps to accommodate conflicts between norms.63 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,’ Article 52.1 requires limitations to ‘respect the essence of those rights and freedoms’ guaranteed in the EU Charter. Therefore, it is Article 52.1 which, arguably, specifies the reach of ‘[a]ny limitation’ in the EU Charter, and – through the principle of proportionality – gives

59 Ibid., para 52.198.
60 Emphasis added.
61 Peers and Prechal (n 58) para 52.198.
the ECJ a voice in the deliberation process. Thus one could argue that Article 52.1 in effect limits the other limitation clauses.

As suggested above, another form of limitation is ‘qualified enforcement’. When it comes to Article 35 EU Charter the way the question presents itself is whether the norm constitutes a ‘right’ or a ‘principle’. Distinguishing between rights and principles is required because Article 51.1 EU Charter stipulates that rights need to be ‘respected’, whereas principles are only to be ‘observed’. While one could consider this to be an exercise in semantics, Article 52.5 of the Charter considers only ‘rights’ to convey subjective rights to an individual. The Explanatory Note on Article 52.5 EU Charter elaborates 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.’

The Explanatory Note on Article 35 EU Charter considers the provision to be a principle. And yet if one takes the literal wording of the provision seriously, the statement in the Explanatory Note, at first, appears to be at odds with the language that is used in parts of Article 35 EU Charter. Michalowski argues that the first sentence of Article 35 is ‘formulated as an individual right, rather than as a state obligation.’ In turn, the level of protection addressed in the second sentence of Article 35 EU Charter is to be understood rather as a ‘programmatic statement.’ While it is possible that an Article constitutes both a principle and a right, the Explanatory Note on Article 52.5, which cites examples, does not make reference to Article 35.

64 Peers and Prechal (n 58), para 52.151.
65 Explanations to the Charter of Fundamental Rights 2007 OJ C303/17, Art 52.5 (emphasis added).
67 Ibid.
The categorization of ‘principles’ and ‘rights’ remains a troubling one. Advocate General Villalón considers it to be ‘striking that the Charter does not assign the fundamental rights to either of the two groups, as is usual in comparative law.’ Hilson, in an attempt to distinguish principles from rights invoked abstract criteria, in particular the autonomous nature of rights, the double-sidedness of principles or the different legal impacts and accountability that rights have in comparison to principles. His conclusion, however, was 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.’ Yet if it is difficult or maybe even impossible to meaningfully distinguish between rights and principles the question then becomes: does it matter?

The answer to this question is to be found in Article 52.2. 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.

Advocate General Villalón in his Opinion in *AMS* argued that the narrow understanding of ‘implementation’ of principles refers to acts which ‘*give specific substantive and direct expression to the content of the “principle”*’ but he also thought that the

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68 See for more details Rieder (n 16).
69 Case C-176/12 AMS, Opinion of AG Villalón, para 43 (18 July 2013 [nyr]).
71 Ibid., 215.
72 Opinion of AG Villalón in *AMS* (n 69) para 63.
‘invokability’ of the principle, addressed in the second sentence of Article 52.5, goes beyond this narrow understanding.\(^{73}\) However, it is to be noted that the Court in \textit{Glatzel} applied a narrow approach when it comes to the invokability of principles. It held that the use of principles ‘before the court is allowed for the interpretation and review of the legality of legislative acts of the European Union which implement the principle laid down in [the respective] article.’\(^{74}\) Be that as it may, the narrow reading of ‘implementation’ covers secondary law, namely Regulation 883/2004 and also Directive 24/2011. In line with the findings from above it also seems plausible to argue that national laws, which derogate from the EU health care framework, can be reviewed based on the principle contained in Article 35 EU Charter.

What can therefore be concluded: if Article 35 amounts to a principle and in the light of the discussion revolving around ‘implementation’ – to the extent the principle can be applied in the process of judicial review – it follows that the intensity of review remains limited in comparison to rights.\(^{75}\) In turn, if Article 35 constitutes a right, as argued, it is granted under limitations only. Overall it remains questionable whether provisions of the EU Charter have the authority to change the permeability of functional boundaries because the EU Charter either lacks scope, that is, certain restrictions apply when it comes to judicial review or it lacks substance, that is, Articles do not convey positive obligations on Member States.

\(^{73}\) ‘[T]he second sentence of Article 52(5) differs from and is broader than that of the legislative acts giving specific expression to a principle. Specifically, all those implementing acts which go beyond the substantive and direct expression of the “principle” will be the acts which may be relied on before the courts together with the other implementing acts.’ (ibid., para 70).

\(^{74}\) Case C-356/12, \textit{Glatzel} 22 May 2014, para 74 [nyr].

So far the focus of discussion was on the question whether human rights have the authority to make boundaries of health care systems more permeable. This, so at least I argued, would impact exclusively on the degree of national solidarity. Now the center of attention changes and it will be examined whether human rights have the power to redraw boundaries. If this is the case it would mean that human rights have the authority to prescribe supranational solidarity. The analysis in this second part of the chapter will focus in particular two provisions: first, on Article 3 ECHR (‘prohibition of torture’) which has a mirroring provision in Article 4 EU Charter. In addition, the analysis will return again to Article 35 EU Charter. The first part of the discussion will be a conventional doctrinal analysis which will then take the discussion – revolving around the concept of responsibility – to a more theoretical and normative level.

DOCTRINAL CONSIDERATIONS ON THE REDRAWING OF BOUNDARIES

In the case of D v the United Kingdom the ECtHR flirted with the idea of transnational solidarity in the context of Article 3 ECHR. In this case a person from St Kitts entered the UK in order to visit family but at one point was arrested because of drug possession. He was put in jail for a three-year sentence. During his prison sentence he was diagnosed HIV-positive and suffering from AIDS. Before he was to be released, the UK immigration authorities wanted to deport him to St Kitts. The question arose whether, given the applicant’s health

76 ‘No one shall be subjected to torture or to inhuman or degrading treatment or punishment.’ The wording is identical with Article 4 EU Charter and therefore the case law of the ECtHR is applicable in the context of the EU Charter (Manfred Nowak and Anne Charbord, ‘Article 4 – Prohibition of Torture’ in Steve Peers et al (eds) The EU Charter of Fundamental Rights. A Commentary (Hart Publishing 2014) para 4.14.

condition, deportation would violate Article 3 ECHR which according to the drafters of the ECHR constitutes an absolute right.\textsuperscript{78} It was not contentious that if $D$ were to be deported to St Kitts, this would considerably shorten his life expectancy. 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 this was a case of ‘very exceptional circumstances’.\textsuperscript{79} The judges consequently found in favour of a violation of Article 3 ECHR.

About 10 years later the ECtHR was called to decide upon $N$ v the United Kingdom a case, which on its facts, was rather similar to the case $D$ v the United Kingdom.\textsuperscript{80} The UK wished to deport a Ugandan woman who was suffering from HIV. Lord Hope, in the House of Lords, made reference to the floodgate-argument by pointing out that if she were allowed to stay and become entitled to receive treatment ‘the United Kingdom [would risk to draw] large numbers of people already suffering from HIV in the hope that they too could remain here indefinitely so that they could take the benefit of the medical resources that are available in this country’.\textsuperscript{81} The reasoning applied by the House of Lords was classical in its consequential nature and, arguably, in contrast with the ECtHR’s deontological interpretation of Article 3 ECHR in the earlier case of $D$.\textsuperscript{82}

When the case $N$ v the United Kingdom was decided, the ECtHR no longer found a violation of Article 3 ECHR. The majority of judges provided three arguments in order to support their finding: first, they made reference to the exceptional character of the earlier judgment of $D$ v the United Kingdom. In particular they made the point that this earlier case needed to be factually distinguished from the current case of $N$ v the United Kingdom. Most


\textsuperscript{79} $D$ v UK (n 77) para 54 (emphasis added).

\textsuperscript{80} $N$ v the United Kingdom, App. No 26565/05 (Eur. Ct. H.R. 27 May, 2008) para 44.

\textsuperscript{81} $N$ v Secretary of State for the Home Department, [2005] 2 W.L.R. 1124, 1142.

\textsuperscript{82} Joint dissenting Opinion of Judges Tulkens, Bonello and Spielmann in $N$ v UK (n 80) paras 6-7.
importantly the applicant in *D v the United Kingdom* was closer to death. However, the judges also made the contentious claim that the Convention did not guarantee social and economic rights. Finally in *N v the United Kingdom* the ECtHR denied the absolute nature of Article 3 ECHR and consequently balanced the interests of the community with those of the individual.\(^{83}\)

It may come with little surprise that the case of *N v the United Kingdom* was controversial among the judges themselves and triggered a joint dissenting opinion of Judges Tulkens, Boneelo and Spielmann who all considered the factual distinction between *N v the United Kingdom* from *D v the United Kingdom* to be ‘misconceived’.\(^{84}\) The judges in particular criticized the ‘high-threshold’ requirement applied by the ECtHR in the context of health care and suggested instead the application of the ‘Pretty-threshold’.\(^{85}\) According to this (lower) threshold a violation of Article 3 ECHR takes place when the suffering ‘is or risks being, exacerbated by treatment, whether flowing from conditions of the detention, expulsion or other measures, for which the authorities can be held responsible.’\(^{86}\)

The dissenting judges further criticized the majority for their statement that the Convention is exclusively about civil and political rights which, according to the minority, ignores the ‘social dimension of the integrated approach adopted by the Court’\(^{87}\) in its case law. Finally, the minority of judges also drew attention to the nature of Article 3 ECHR as an absolute right which prohibits any ‘balancing exercise.’\(^{88}\) Nevertheless, according to the majority in *N v the United Kingdom* it would appear that the Convention does not have sufficient doctrinal authority in order to change the quality of solidarity by introducing

\(^{83}\) *N v UK* (n 80) paras 42-51.
\(^{84}\) Joint dissenting Opinion of Judges Tulkens, Bonello and Spielmann in *N v UK* (n 80) para 25.
\(^{85}\) Ibid., para 5.
\(^{87}\) Joint dissenting Opinion of Judges Tulkens, Bonello and Spielmann in *N v UK* (n 80) para 6.
\(^{88}\) Ibid., para 7.
supranational solidarity. The focus will now turn again to the already mentioned *lex specialis* of health care, namely Article 35 EU Charter. The question which will be addressed is whether its application would make any difference when it comes to the redrawing of boundaries.

The only guidance with regard to the meaning of this norm in the context of cross-border movement of patients comes from Advocate General Colomer provided in the case of *Stamatelaki*.\(^89\) Mr Stamatelaki suffered from bladder cancer. He was (publicly) insured in Greece but had received treatment on two occasions in the UK in a private hospital. When Mr Stamatelaki asked to be reimbursed by the Greek public funds, his request was denied because his treatment in the UK was performed in a private hospital. While the Court solved the matter with its classical free movement approach the Advocate General made specific reference to Article 35 EU Charter.

In acknowledgment of the earlier cases, the Advocate General 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’.\(^90\) He then went on 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.’\(^91\) With this last point in particular the Advocate General clearly appears to suggest that the authority of Article 35 EU Charter goes beyond making boundaries more permeable. Instead, the Advocate General argues for the redrawing of boundaries and supranational solidarity.

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\(^90\) Ibid., para 40.
\(^91\) Ibid. (emphasis added)
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 ‘solemly proclaimed’ by the Commission, the Council, and Parliament. This argument is no longer convincing because the Lisbon Treaty has changed the legal status of the EU Charter.\(^\text{92}\) And yet, even in subsequent cases, such as *Commission v Spain*,\(^\text{93}\) *Commission v France*,\(^\text{94}\) or *Elchinov*\(^\text{95}\)—all decided after the Charter gained legal force—the Court referred neither to the EU Charter nor any other human rights law.

The problem with the Advocate General’s approach is that he makes these far-reaching claims without developing a solid doctrinal argument. He does not discuss the prominent role limitations play in the context of Article 35 EU Charter only to mention one example. In the wake of the earlier arguments made, it remains questionable whether the Advocate General would be able to build a successful doctrinal argument. In the remainder of this Chapter, I therefore want to pursue a different approach and develop a sketch of an argument that is of a different character. Lichtenberg highlights the standard philosophical claim that ‘rights entail duties, but duties do not necessarily entail rights’.\(^\text{96}\) Thus a shift in analysis will take place and there will be no longer a focus on rights. Instead, I want to draw out whether there exists a duty, based on the concept of responsibility, which requires the introduction of supranational solidarity.

\[^{92}\text{Article 6.1 TEU.}\]
\[^{93}\text{Case C-211/08, Commission v Spain [2010] E.C.R. I-05267.}\]
\[^{94}\text{Case C-512/08, Commission v France [2010] E.C.R. I-08833.}\]
\[^{95}\text{Elchinov (n 25).}\]
\[^{96}\text{Judith Lichtenberg, Distant Strangers. Ethics, Psychology, and Global Poverty (Cambridge University Press 2014) 70.}\]
NORMATIVE CONSIDERATIONS ON THE REDRAWING OF BOUNDARIES

At the beginning of this discussion about normative arguments in favour of supranational solidarity, I want to return to the case D v UK in which the ECtHR established a form of supranational solidarity. In this case the ECtHR reasoned that the UK had ‘self-assumed’ special responsibilities in relation to D.\(^{97}\) Thus the claim made by the ECtHR was not based on impartial-cosmopolitan considerations but remained firmly grounded in particularism. Conceptually, it seems that the ECtHR tried to justify the existence of special obligations based on a (social) contractual relationship: ‘[a] promissor, 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.’\(^{98}\)

However, given the facts of the case it remains rather questionable whether one can persuasively argue that the UK had in fact really ‘assumed responsibility’ for D in any meaningful way. The ECtHR somewhat failed to offer a convincing argument that the UK made that voluntary promise which, according to the ECtHR, constituted the precondition for assuming responsibility. The fact that the applicant became ‘reliant on the medical and palliative care’\(^{99}\) may be an account of his ‘vulnerability’ but cannot function as a substitute for the required promise. One way in order to overcome the shortcomings of the ECtHR’s reasoning in relation to the creating of ‘self-assumed’ supranational solidarity which is based

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\(^{97}\) D v UK (n 77) para 53.


\(^{99}\) D v UK (n 77) para 53.
on particularism is offered by Goodin. He draws on the ‘vulnerability’ of a person in order to establish special relationships without the need for a promise.\textsuperscript{100}

Incidentally, ‘vulnerability’ also features prominently in the ethics of care which runs counter the idea that people are self-sufficient and autonomous entities. Instead it is suggested that they are dependent on each other.\textsuperscript{101} Dependency however, it goes without saying, increases vulnerability. In his studies Norbert Elias already observed that ‘[h]uman beings are bound by the fact that they are constantly living in a functional dependency on each other.’\textsuperscript{102} But the situation has not much changed in our modern world. It would appear that almost the contrary is true. Richard Sennett’s book \textit{The Corrosion of Character} reads like an account of modern day hardships. In one of the episodes he portrays in his book Sennett speaks ‘about the aggravated vulnerability built into careers today.’\textsuperscript{103} What is the case on the micro-level also translates to the macro-level where similar developments can be observed. Arguably, European integration has increased dependency and in line with the argument made above also increased vulnerability. The question then becomes how these special obligations can be best discharged. The solution offered by Goodin is the ‘assigned responsibility model’.\textsuperscript{104}

The basic idea of the model is that the different responsibilities are allocated to specific entities. Nation states with their boundaries perform this purpose. However, ‘[t]he duties that states (or, more precisely, their officials) have vis-à-vis their own citizens are not in any deep sense special. At root, they are merely the general duties everyone has toward everyone else worldwide.’\textsuperscript{105} In Goodin’s ‘assigned responsibility model’ people are not

\begin{itemize}
\item \textsuperscript{100} Goodin (n 98) 779-782.
\item \textsuperscript{101} Virginia Held, \textit{The Ethics of Care. Personal, Political, and Global} (Oxford University Press, 2006) 10.
\item \textsuperscript{102} Norbert Elias, \textit{Die Gesellschaft der Individuen} (Suhrkamp, 2003) 34 (the English is my translation): ‘[der Mensch] ist dadurch gebunden, daß er ständig in funktioneller Abhängigkeit von anderen Menschen lebt.’ (emphasis added).
\item \textsuperscript{103} Richard Sennett, \textit{The Corrosion of Character} (Norton paperback 1999) 130.
\item \textsuperscript{105} Ibid., 681.
\end{itemize}
necessarily picked ‘naturalistically’ but rather selected ‘socially’;\textsuperscript{106} this is clearly in contrast to ideas of nationalism. According to Goodin’s model ‘[i]f some states prove incapable of discharging their responsibilities effectively, then they should either be reconstituted or assisted.’\textsuperscript{107} In relation to the EU it can be argued that if Member States cannot offer adequate health care to their citizens or can do so only to some extent, this means that Member States are under an obligation to help or even that responsibilities are ‘reconstituted’. Thus, this could require that boundaries need to be redrawn and this in turn opens the gate to supranational solidarity.

A different approach is offered by the ‘no-harm principle’. The gist of the principle runs as follows: ‘If you have harmed people you owe them compensation.’\textsuperscript{108} Therefore, the majority of people would probably agree that if $D$ had contracted HIV/AIDS during his stay in a UK prison, would in itself amount to a rather strong moral obligation to help. Again, the approach based on the ‘no-harm-principle’ does not need to draw on the contentious issues of promises in order to establish responsibilities. In addition, it seems plausible to argue that the closer the relationship with a person, the easier it is to do harm to that person. Again, the findings from the micro-level can be scaled up to the macro-level.\textsuperscript{109}

Arguably, European integration has increased the intensity of relationships (Member) States have with each other. At the same time the process of integration has not necessarily produced pareto-efficient solutions.\textsuperscript{110} This means that some people or Member States will gain more from the process of integration than others. Thus it may be the case that European integration or Member States participating in this process harm people or other Member

\textsuperscript{106} Ibid., 680.
\textsuperscript{107} Ibid., 685 (emphasis added).
\textsuperscript{108} Lichtenberg (n 96) 42.
\textsuperscript{110} Cf. Martin Höpner and Armin Schäfer, ‘Grundzüge einer politökonomischen Perspektive auf die europäische Integration’ in Martin Höpner and Armin Schäfer (Eds.) \textit{Die Politische Ökonomie der europäischen Integration} (Campus 2008) 11, 39.
States at least through a form of ‘structural violence’.\textsuperscript{111} In line with the argument made above, the boundaries of Member States will then no longer justify particularism based on them. Put differently, the \textit{Lumpenproletariat} across boundaries is equally affected, harmed, by European integration instead of, let’s say, the British or the Austrians representing a homogenous group.\textsuperscript{112} This amounts to a strong moral argument in favour of redrawing existing membership boundaries, that is, citizenship and exercise solidarity even beyond them.\textsuperscript{113}

In conclusion: from a purely doctrinal perspective it appears obvious that the ECtHR is rather reluctant to read positive duties into the ECHR when it comes to health care. And this in turn means that it is unlikely that the ECJ would read authority into the EU Charter so that it can be used as an instrument in order to redraw boundaries of membership. From a normative perspective two approaches were identified which allowed for partialism without the need of making promises as would be required in a social contract type situation. Especially two moral reasons were provided, namely ‘vulnerability’ and the ‘no-harm principle’, which ought to justify that the boundaries of membership are to be redrawn. However, there remains one (democratic) problem: while the duty is to be found on the national level, the principle or right is supranational. And this makes it difficult for the ECJ to establish strong principles or rights on the supranational level.

\textbf{3. Conclusion}

\textsuperscript{113} Cf Otto Bauer, \textit{Die Nationalitätenfrage und die Sozialdemokratie} (Verlag der Wiener Volksbuchhandlung Ignaz Brand 1907) 576.
The aim of this chapter was to offer an analysis regarding the question whether the EU Charter has the authority to significantly change the character of the current cross-border movement regime by deepening the level of integration and thereby not only changing the quantity but also the quality of solidarity. In relation to the quantity of solidarity, that is, the potential impact EU law has on functional boundaries, the conclusion drawn was that if the ECJ interprets the EU Charter in correspondence with the respective provisions of the ECHR – as one would assume from Dworkin’s judge Hercules – it is to be expected that no substantive change will take place in comparison to the effects the current EU cross-border framework has on national health care systems. When it comes to the quality of solidarity, that is, whether EU law would impact on membership boundaries and thereby change solidarity from national to supranational solidarity, the conclusion drawn was that – leaving moral arguments aside – a doctrinal analysis of the EU Charter seems to give little indication that it has this kind of authority.

And yet, this is not to suggest that the application of human rights would be without value. Arguably, it makes conceptually a difference whether the ECJ draws on free movement law or the EU Charter. It seems that especially in field of health care the law on free movement of services has reached its outer limits and stands on tentative ground. The saga of the (infamous) Services Directive provides ample evidence that the free movement of services has developed a notoriously bad reputation over the years.\textsuperscript{114} The situation is different for human rights, as Beitz aptly points out, when he argues that ‘the public discourse of peacetime global society can be said to have a common moral language, it is that of human rights.’\textsuperscript{115}

In this Chapter a doctrinal case has been made in favour of moderate permeability of health care boundaries but also for the redrawing of membership boundaries at least under very exceptional circumstances. Overall it is not to be expected that the application of human rights in the field of health care would revolutionise this field of law. Nevertheless, human rights could serve two useful purposes: first, they could offer a more solid grounding for EU health care law than free movement law currently does. Secondly, if the Court adopted the language of human rights, in the future they could also serve as a reference or focal point for new forms of governance.\textsuperscript{116}