

# **THE LEGAL FRAMEWORK IN RELATION TO PATIENT MOBILITY**

## **THE CHARACTERISTICS OF THE WELFARE STATE**

Each welfare state is unique. Its organisation, and particularly the allocation of function between the main institutions of capitalist society – the family, the market and the state (including the state-subsidised and -regulated semi-public organisations) – is largely the product of the economic, social and political history of each State. Aspects such as the role of the social partners or, as regards health care provision, the level of provider autonomy or patient choice, are historically-rooted and, as a general rule, enjoy broad public support<sup>1</sup> (Cantillon 1999 : 13; Mossialos and McKee 2002 : 27-28; Kuhnle 1999).

This diversity, which has rightly been called legitimate (Vandenbroucke 2002 : 834; Scharpf 2002), has led some authors to elaborate on typologies of welfare states. The best known typology is indubitably that of the Danish scholar Esping-Andersen, who classified welfare states according to their ability to decommoify. Esping-Andersen distinguished between the liberal welfare state (low degree of decommoification, the state playing a subsidiary role and with emphasis on means-tested social assistance and low levels of benefits), the conservative welfare state (medium degree of decommoification, social rights being tied to class and status and with a tendency towards social segmentation) and the social-democratic welfare state (high degree of decommoification, universality and generous benefits going hand in hand) (Esping-Andersen 1990).

### **Government Intervention and Solidarity**

Although in economic terms, health care services and products may be regarded as commodities which could be supplied by private players operating in a purely commercial market, not one Member State – not even the Anglo-Saxon ones, which lean towards the liberal model – has chosen to fully entrust the supply of medical care to the market and its principles of *laissez faire* and free competition<sup>2</sup>. All Member States, and indeed all welfare states, have intervened in the essentially private relationship between a patient – consumer of health care – and the health care provider supplying it. This government intervention can take several forms: regulation, finance and public production (van der Mei 2003 : 3).

Substantial government involvement in the provision of health care is motivated by reasons of economic efficiency and social justice. Firstly, from an economic point of view, the purely private provision of health care is not necessarily the most efficient one. Economic efficiency implies that resources are allocated in such a manner that it becomes impossible to improve the situation of at least one individual without making any other individual worse off (Pareto-

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<sup>1</sup> See for instance the level of choice of patients in Belgium, France and Luxembourg, who, contrary to their counterparts in other European countries, have access to specialist care without prior referral by a general practitioner.

<sup>2</sup> That is not to say that all sectors of health care supply are totally withdrawn from the open market. Notably for those sectors which do not entail a direct service provision to consumers, such as the allocation of manpower and pharmaceuticals, a relatively free operation of the market exists. See Kesteloot 1999 : 20-21 and Mossialos, McKee *et al.* 2002 : 882.

optimality). Markets can only function (Pareto-)optimally if several conditions are fulfilled, namely perfect information and foresight, perfect competition and the absence of externalities (van der Mei 2003 : 3). Where these conditions are met, economically speaking, no public intervention is needed. However, if this is not the case, the market cannot function perfectly and government intervention is required to repair the situation of “market failure”. The health care market is far from being devoid of market failure. For one thing, there is a strong *information asymmetry* between patients and health care providers. Medical information is technically complex and so not easily understood by patients, who in general lack the necessary background knowledge to make an informed decision about the care they need. The health care provider, on the other hand, is often approached by the patient precisely to have his undefined demand for care specified. Accordingly, the provider, who is the producer of the medical care, is able to manipulate the patient’s demand for care through the information he communicates. If the doctor passes on correct and objective information, and thus recommends an amount of the different types of treatments which the patient would have asked for if he were well-informed, he acts as the perfect agent of the patient. However, the medical care provider may also betray the patient’s (involuntarily blind) confidence and take into consideration his own objectives, such as income and spare time<sup>3</sup>. The phenomenon where a health care provider manipulates the information according to his own interests is called supplier-induced demand (De Graeve 1998 : 153; Schut 2003). *Uncertainty* regarding illness and regarding the effects of treatments constitutes yet another essential and market-distorting feature of the demand for health care. The market response to this problem is to develop an insurance market to remove the uncertainty surrounding medical care spending. However, this health insurance market itself involves features resulting in market failure. Notably, moral hazard arises when the act of insurance increases the likelihood of the occurrence of the event insured against (Mossialos and Dixon 2002 : 27). It is indeed easily conceivable that the knowledge of having extensive health insurance coverage may incite insured persons to bother less about a healthy lifestyle or to refrain from getting precautionary medical check-ups. Furthermore, health-insured patients will be more inclined to over-consume health care, that is to demand health services and goods which they would not choose if they had to pay for them directly<sup>4</sup> (De Graeve 1998 : 151-152; Kesteloot 1999 : 11). Finally, the demand for health care is characterised by the prevalence of *externalities*, producing market failure. The consumption of health care does not only concern the patient in question, but in addition can harm others<sup>5</sup>, or, what is more probable, can offer benefits to others<sup>6</sup>. Besides unalloyed self-interest, paternalistic and even altruistic motives may lead people to experience benefits when a fellow citizen receives appropriate care or when his well-being increases respectively (De Graeve 1998 : 150-151)<sup>7</sup>. These elements, and their mutual interactions, have meant that health care provision, to a large extent, is not organised according to the conventional market logic; the incapacity of the

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<sup>3</sup> See G.B. Shaw, who writes: “[t]hat any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair...”, in *Preface on doctors. The doctor’s dilemma: a tragedy*, Baltimore, Penguin, 1913, 9, cited by Rodwin 2004 : 1328.

<sup>4</sup> Moral hazard is usually associated with the consumer of care, yet it is clear that the health care provider, in a system of full coverage, may also feel less conscience-stricken to supply more care than is actually needed: see Vandenbroucke 2001 : <http://www.vandenbroucke.com/soc/T-010521.htm>

<sup>5</sup> For instance, the over-consumption of antibiotics can lead to the development of antibiotic-resistant bacteria.

<sup>6</sup> The textbook example being vaccination, protecting people in the environment of the vaccinated person against infection.

<sup>7</sup> See also X., *Health Sector Reform and Sustainable Financing: Introduction to the Concepts and Analytical Tools*, The Basics of Markets and Health Care Markets, V.I., World Bank Institute, <http://www.worldbank.org/wbi/healthflagship/module1/sec4v1.html#v1>.

free market to create a situation in which health care providers are motivated to and rewarded for acting in a socially efficient manner when making care choices, has prompted governments to intervene, as regulator, payer or often even as provider (Kesteloot 1999 : 11)<sup>8</sup>.

Besides considerations of economic efficiency, reasons of social justice have led governments to substantially interfere with the provision of health care. Health care is regarded as an essential facility, access to which should not be determined by ability-to-pay, but on the contrary is a fundamental right, enshrined in most European constitutions<sup>9</sup> (Nickless 2002 : 80). All Member States endorse the fundamental goal of access to necessary health care for the whole population, irrespective of individual health and financial status. This shared solicitude has resulted in national health care systems which, in spite of their differences, are all based on the principle of solidarity<sup>10</sup>, in accordance with which contributions are based on ability to pay (the vertical dimension) and benefits measured according to need (the horizontal dimension) (Mossialos and McKee 2002 : 33-34)<sup>11</sup>. Furthermore, compulsory membership of all citizens – including the better-off, the healthy, the active, the younger – provides these redistributive schemes with a solid institutional and financial foundation (Ferrera 2003 : 10 and 24).

### The Principle of Territoriality

Welfare states are territorially closed systems. It is evident that the social responsibility of a State does not extend to all persons, no matter where they work or live, nor to all possible situations which may arise (Cornelissen 1996 : 440). There needs to be a relationship between the territory of a State and a group of individuals, contributions, benefits and/or risks governed by the legislation of that State (Pennings 2001 : 4-5). This territoriality encompasses two aspects which deserve our attention. First, it means that welfare state benefits, such as health care benefits or social housing, can only be effectively provided and

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<sup>8</sup> See also Arrow (1963), stating that “when the market fails to achieve an optimal state, society will, to some extent at least, recognize the gap, and nonmarket social institutions will arise attempting to bridge it”.

<sup>9</sup> See e.g. the Constitutions of Belgium (Article 23), Italy (Article 32), Finland (Article 15a), Luxembourg (Article 11.4) and Portugal (Article 64). See also Article 11 of the European Social Charter and Article 35 of the Charter of Fundamental Rights of the European Union, *Official Journal* C 364 of 18 December 2000, 1-22, incorporated into the draft Treaty establishing a Constitution for Europe (Article II-35), *Official Journal* C 169 of 18 July 2003, 1-105. See more generally Toebes 1999.

<sup>10</sup> See also Koivusalo, *Health Systems, Solidarity and other European Community Policies*, <http://www.psir.org/epsuconference/documents/Koivusalo%20Paper.doc>. Some authors, having observed that European countries consider collective solidarity to be something of paramount importance, speak of a European social model. This model is founded on the idea that social protection is a means to enhance both social cohesion and economic growth (Mossialos and McKee 2002 : 27 e.s.). See however Kleinman (2002), rejecting the idea of a European social model, and stating that the concept should rather be regarded as a founding myth for the purpose of a politically integrated Europe (57-58). See also Chapon (2004), who sees the European social identity threatened by changing views on the goal of social protection. Where schemes of social protection used to be judged on their capacity to de-commodify (*cf. supra*), they are currently being appraised on their ability to “commodify”, that is the extent to which they increase people’s employability. She adds : “[d]une façon globale, la conception non contradictoire de la protection sociale et de l’économie, en vigueur durant les Trente Glorieuses, cède la place à une conception dans laquelle le progrès social et l’efficacité économique sont mis en opposition, le premier constituant une menace pour la seconde” : 253-263. “L’Europe sociale : quelle réalité aujourd’hui?”, *Revue du Marché commun et de l’Union européenne* 2004, 253-263.

<sup>11</sup> It has been contended that medical need is the only rational and just criterion for the allocation of scarce resources in health care provision. For a critical discussion of alternative theories offering criteria on the basis of which resources are to be distributed, that is the libertarian (based on desert), the utilitarian (based on the maximisation of aggregate benefit), “first come first served” and chance, see Ramsay 1995, 53-63. This author further highlights the need for objective indicators to verify (real) need empirically, so that, *idealiter*, “needs” and “wants” coincide.

consumed in the State territory. Accordingly, third-party payers (national health institutions or sickness funds) do not in principle pay foreign medical bills<sup>12</sup>. As a general rule, health care benefits are non-portable (van der Mei 2003 : 227-228). The second aspect of the territoriality principle implies that publicly funded benefits are preserved for persons residing or working within the State territory to the exclusion of those living or working outside the State borders. Welfare state benefits are essentially based on a notion of “membership”, which not only grants rights, but also entails duties, not least the duty to contribute to the financing of the system. In general, the matching between rights and duties must be accurate and stringent, if fiscal bankruptcy is to be avoided (Ferrera 2004 : 9). The link between the second facet of the territoriality principle and national solidarity should not go unnoticed. The latter principle connotes a particular set of ties, i.e. sharing ties, between a group of people committed to dividing, exchanging and sharing social goods (*ibid.* : 8). The said redistribution and solidarity cannot be achieved on a voluntary basis. It needs to be organised by governments that have the power to make affiliation to public benefits schemes compulsory and to enforce duties to pay taxes or premiums. It is precisely this regulatory tool – making affiliation mandatory, so as to “lock in” the rich and the healthy – that allows the welfare state to affirm itself as a powerful redistributive institution<sup>13</sup>. However, as a corollary of this obligatory inclusion of the members, non-members are excluded from entering those redistributive spaces; those who do not live or work in the national territory, i.e. those who do not belong to the domestic solidarity system, cannot – in principle – assert any rights stemming from that system (van der Mei 2003 : 5-6 and 462; Ferrera 2003 : 10 and 15<sup>14</sup>).

## **THE WELFARE STATE AND “NEGATIVE INTEGRATION”**

### General Comments

It has been contended that welfare states are essentially national states (Kuhnle 1999). As Davies (2002) puts it: “[t]he community of compassion, the fundamental basis for the provision of vital services, remains the nation” (: 38). As barriers fall, and many activities become international, even global, welfare remains backward in this respect, a last bastion of nationalism, and perhaps the only respectable one (: *ibid.*).

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<sup>12</sup> In Belgium, for instance, this principle is laid down in Article 136 § 1 of the Act concerning the statutory insurance for medical care and benefits, coordinated on 14 July 1994 (*Belgisch Staatsblad* of 27 August 1994). In Estonia, it is enshrined in Subsection 27 (1) of the Health Insurance Act of 19 June 2002 (*RT<sup>I</sup>* 2002, 62, 377).

<sup>13</sup> “The idea of redistributive justice presupposes a bounded world; a group of people committed to dividing, exchanging and sharing social goods, first of all among themselves”: see M. Walzer, *Spheres of Justice – A defense of Pluralism and Equality*, New York, Basic Books, 1983, 31, cited by van der Mei (2003) : 5.

<sup>14</sup> In his analysis of the influence of European integration on national welfare states, Ferrera elaborates on the work of the Norwegian scholar Rokkan, in particular on the latter’s insights into the nexus between boundary building and internal structuring. The processes of “state formation” and “nation building” imply *inter alia* a gradual foreclosure of exit options of players and resources, through the erection of territorial and membership boundaries. Membership boundaries indicate mechanisms to distinguish insiders from outsiders; they specify the criteria for “insiderhood”. These membership boundaries are very important. As Rokkan put it: “[they] tend to be much firmer than geographical boundaries: you can cross the border into a territory as a tourist, trader or casual labourer, but you will find it much more difficult to be accepted as a member of the core group claiming pre-eminent rights of control within a territory” (Ferrera 2003 : 4-5, with reference to P. Flora, S. Kuhnle and D. Urwin (eds.), *State Formation, Nation Building and Mass Politics in Europe. The Theory of Stein Rokkan*, Oxford, Oxford University Press, 1999, 422 p.).

At first glance, the European Community, focused as it is on market building, leaves national sovereignty in welfare matters untouched (*cf.* Leibfried and Pierson 2000 : 268). The dominant ideological premise of the early years, largely informed by the so-called Ohlin Report, was that social progress would be the corollary of the economic progress fostered by the benefits of the common market, suggesting that an interventionist social policy would be counterproductive. This approach resonated neatly over the years with Member States concern to preserve national welfare sovereignty (Shaw 2000 : 5-6). Notwithstanding their gradual expansion in the last decades, the powers in the field of social policy, public health and education attributed to the European Community institutions have remained relatively minor and are not such as to compromise Member States' sovereignty in those areas<sup>15</sup>.

Leibfried and Pierson (2000), however, have argued convincingly that “[t]he process of European integration has eroded both the sovereignty (by which we mean legal authority) and the autonomy (by which we mean *de facto* regulatory capacity of member states in the realm of social policy). National welfare states remain the primary institutions of European social policy, but they do so in the context of an increasingly constraining multi-tiered polity”. They add: “[t]he emergence of the multi-tiered structure is less the result of welfare-state-building ambitions of Eurocrats than a result of spill-overs from the single market initiative” (: 268).

In other words, although the European Community holds no formal powers in the field of welfare organisation, Member States' sovereignty and autonomy do suffer erosion through negative European integration, i.e. through the issuing of interventions [regulations, directives and rulings of the European Court of Justice (henceforth: ECJ or Court)] (Busse, Wismar, Berman *et al.* 2002). These interventions increase market integration by eliminating national restraints on trade and distortions of competition (Kuhnle 1999); in short, they contribute to the establishment of a common market.

### The Common Market

The establishment of a common market, although formally only one of its means (: Article 2 ECT), is undoubtedly one of the principal foundations of the European Community. Competition and free movement constitute, together with economic and monetary union and the common commercial policy, the basic layer of the economic constitutional law of the EC (Cruz 2002 : 85). The concept of a common market, which is undefined in the ECT, is very broad and can be described as “a market in which every participant within the Community is free to invest, produce, work, buy and sell, to supply or obtain services under conditions of competition which have not been artificially distorted wherever economic conditions are most favourable” (Kapteyn and VerLoren van Themaat 2003 : 104). The concept is thus broader than that of the internal market which, according to Article 14 ECT, “shall comprise an area without internal frontiers in which the free movement of goods, persons, services and capital is ensured in accordance with the provisions of this Treaty”. Unlike the common market, the internal market does not extend to the Treaty rules on competition (Gormley 2002 : 517-518), which are nevertheless essential for its functioning (Case C-453/99 *Courage* : § 20). On many occasions, the Court of Justice has stressed the cardinal importance of the Treaty

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<sup>15</sup> See in that regard Articles 137 § 4, 152 § 5 and 149 § 1 of the Treaty establishing the European Community (hereinafter referred to as ECT), dealing with social security, public health and education respectively.

provisions on free movement<sup>16</sup> and competition<sup>17</sup>, which both have a constitutional rank in the Community legal order (Cruz 2002 : 86; see more generally Oliver and Roth 2004).

## Outline

In assuring compatibility with these basic common market rules, a great deal of interventions have been issued that concern the welfare state, and health care in particular. Research has identified no fewer than 233 interventions in the period from 1958 to 1998, in the form of Community secondary legislation or ECJ rulings, that have a potential impact on the purchasing, supply and delivery of health services (Busse, Wismar, Berman *et al.* 2002). The bulk of these interventions concern the pharmaceutical market<sup>18</sup> and the free movement of health care providers<sup>19</sup>. Furthermore, directives have been adopted to facilitate cross-border activities of private health insurers<sup>20</sup>. Insofar as they can be classed as undertakings within the meaning of the relevant ECT provisions, health care providers' and health insurers' activities can be scrutinised under the competition rules<sup>21</sup>.

This report, however, will concentrate on another, highly topical issue, which is the "portability" of health care rights and the extent to which Member States have retained control over the medical consumption of their citizens. It does not take a great deal of imagination to consider the harsh confrontation between the antithetic principles of territoriality and free movement. Even so, the conflict was initially only thought of in terms of the free movement of workers. Pursuant to the Community regulations on the coordination of national social security schemes, insured persons are entitled to health care benefits-in-kind in another Member State at the expense of their national payer. However, save where these benefits become necessary on medical grounds, the beneficiaries of these regulations have to obtain prior authorisation from their national competent institution. In a series of rulings commencing with the 1998 *Kohll* and *Decker* judgements, the Court of Justice has paved the way for a second method of planned health care abroad, so carrying out what many European law scholars have already been expecting for some time: the Court applied the Treaty provisions on services and goods to the field of health care provision. The severity of the confrontation between the territorially based schemes of health care provision on the one hand

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<sup>16</sup> Case C-169/98 *Commission v. France*: "[...] the articles of the Treaty concerning the free movement of goods, persons, services and capital are fundamental Community provisions and any restriction, even minor, of that freedom is prohibited" (: § 46).

<sup>17</sup> Case C-453/99 *Courage* : § 20.

<sup>18</sup> This legislation is predominantly concerned with market access through harmonisation and centralised authorisation procedures. See Directive 2001/83/EC of the European Parliament and of the Council of 6 November 2001 on the Community code relating to medicinal products for human use, *Official Journal* L 311 of 28 November 2001, 67-128 and Regulation (EC) No 726/2004 of the European Parliament and of the Council of 31 March 2004 laying down Community procedures for the authorisation and supervision of medicinal products for human and veterinary use and establishing a European Medicines Agency, *Official Journal* L 136 of 30 April 2004, 1-33. The pricing and reimbursement of pharmaceuticals remain largely a matter for the Member States. However, measures have been taken to safeguard transparency in that regard, see the Council Directive 89/105/EEC of 21 December 1988 relating to the transparency of measures regulating the prices of medicinal products for human use and their inclusion in the scope of national health insurance systems *Official Journal* L 40 of 11 February 1989, 8-11. For an analysis of pharmaceutical regulation in Europe, see Mossialos, Walley and Mrazek (eds.) 2004.

<sup>19</sup> These interventions, most notably the legislation on the mutual recognition of professional qualifications, are dealt with at length in the subsequent part.

<sup>20</sup> See e.g. Directive 1992/49/EEC of 18 June 1992 on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance and amending Directives 73/239/EEC and 88/357/EEC, *Official Journal* L 228 of 11 August 1992, 1-23 (third non-life insurance directive).

<sup>21</sup> See e.g. Joined Cases C-180/98 to 184/98 *Pavlov*. See also *infra*, sub II.1.d.

and the free movement of goods and services on the other was predicted (Cornelissen 1996 : 465-466)... and so revealed itself (Kessler and Lhernould 2002 : 750). Whereas the Community interventions mentioned in the former paragraph were not always implemented without any resistance<sup>22</sup>, the reception they met with in the Member States was not in any sense comparable to that of the said rulings handed down by the Court of Justice<sup>23</sup>. The gist of this case law, the ambit of which was clarified in subsequent rulings<sup>24</sup>, can be briefly summarised as follows: medical treatments, both intra- and extramural and regardless of the way Member States organise and finance their social security systems, constitute services within the meaning of the Treaty. The requirement of prior authorisation for the reimbursement of medical costs incurred in another Member State is an obstacle to the free provision of services both for patients and providers of medical services. Such restrictions can only be justified in respect of the assumption of the costs of cross-border intramural care. These health care rulings, especially the *Kohll* and *Decker* judgements, have sparked a flood of protests, some of which are better-founded than others. While many Member States moved heaven and earth to demonstrate that their system, given its alleged particular nature, was not affected by the relevant case law (*cf.* Jorens 2004 : 377; Gobrecht 1999 : 16-17)<sup>25</sup>, others warned of the looming spectre of unbridled medical tourism. Likewise, the subsidiarity principle was – wrongfully – brought to the fore to denounce to Court’s judgements<sup>26</sup>. Now that, seven years later, the Court’s case law has largely crystallised and the dreaded massive flux of patients has failed to materialise<sup>27</sup>, it is time to take stock of the actual implications of the Court’s health care rulings. Before doing so, however, this report will give a description of what is called the Regulation-based method of patient mobility, with a particular emphasis on recent legislative changes, which, it has been contended, have significantly extended patients’ entitlement to cross-border care (Title I). In the second title, the health care cases of the Court of Justice will be subjected to an in-depth analysis. First of all, due attention will be paid to the way in which the ECJ brought the State-organised provision of health care within the ambit of the free provision of services. A comparison will be made with earlier case law, in which national education was held to be outside the scope of free movement provisions. Notably through a brief reference to several competition cases, we will attempt to provide an explanation for these divergent approaches, in particular by pointing to the different settings against which the applicants asserted – or had to assert – their rights. *In a subsequent chapter, an overview will be given of the justification grounds put forward by the parties to the health care cases. Elaborating on the Court’s replies, the distinction between intramural and extramural care – the summa divisio of the Treaty-based method of patient mobility – will be subjected to an in-depth analysis. Next, drawing from the observations made by the Court upon the assessment of the legitimacy of the Dutch conditions for granting prior authorisation, the chapter will comment on the implications of the health care rulings for national policies in respect of waiting lists and waiting times, and with respect to benefits*

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<sup>22</sup> *Cf.* the transposition of the third non-life insurance directive in the French *Code de la Mutualité*. See in this regard Hamilton 2002 : 43-47.

<sup>23</sup> Case C-158/96 *Kohll*. Case C-120/95 *Decker* deals with the free movement of goods and is outside our purpose.

<sup>24</sup> Case C-368/98, *Vanbraekel*; Case C-157/99 *Geraets-Smits and Peerbooms*; Case C-385/99, *Müller-Fauré and Van Riet*; Case C-56/01, *Inizan*; Case C-08/02, *Leichtle*. These cases, together with *Kohll*, will hereinafter be referred to as the ‘health care cases’.

<sup>25</sup> And still do so: see e.g. the United Kingdom’s reply to the Social Protection Committee (SPC) Questionnaire on Social Services of General Interest, 2005. See further *supra*.

<sup>26</sup> See on this matter du Pré (1998), who rightly contends that the principle of subsidiarity only has a role to play in legislative procedures and has nothing to do with directly effective Treaty provisions (: 370-371).

<sup>27</sup> See the Commission Staff Working Paper, Report on the application of internal market rules - Implementation by the Member States of the Court's jurisprudence, Brussels, 28 July 2003, SEC(2003)900.

*packages. The last chapter will look into the matter of the coverage of cross-border care, which includes both the price setting in the Member State of treatment and the reimbursement by the Member State of affiliation. Finally, in the third title, the relationship between the two methods of patient mobility will be discussed, as well as Article 23 of the Commission Proposal for a Directive on services in the internal market, which is intended to codify the Court's case law.*

## **TITLE II. THE TREATY-BASED METHOD OF PATIENT MOBILITY**

### **II.1. THE QUALIFICATION OF HEALTH CARE PROVISION AS A SERVICE**

#### **II.1.a. General Comments**

Article 49 ECT lays down the principle of freedom to provide services on a temporary basis by a Member State national established in one Member State to a recipient established in another. Services shall be considered to be “services” within the meaning of the Treaty where they are “normally provided for remuneration, in so far as they are not governed by the provisions relating to freedom of movement for goods, capitals and persons” (: Article 50 ECT). It may seem a leap to infer from these provisions, as the ECJ has been doing for more than half a decade now in its famous health care rulings<sup>28</sup>, a right for patients established in one Member State to obtain medical treatment in another Member State and have the bill paid by the health institution or sickness fund of the former Member State.

As mentioned above, the judicial classification of the provision of health care as a service nonetheless came as little surprise to many European law scholars. Ever since the judgements in *Luisi* and *Carbone* (Joined Cases C-286/82 and C-26/83) and *Grogan* (Case C-159/90) (private) health care services are deemed to fall within the ambit of the “economic” fundamental freedoms of the ECT (Hatzopoulos 2002 : 688). In the former case, the Court held that “the freedom to provide services includes the freedom, for the recipients of services, to go to another Member State in order to receive a service there, without being obstructed by restrictions [...] and that tourists, persons receiving medical treatment and persons travelling for the purpose of education or business are to be regarded as recipients of services” (: § 16). This case’s contribution to the Community legal order is twofold: firstly, it is clearly stated that Article 49 ECT, which, according to a literal reading, only covers the free *provision* of services, also encompasses, as the “necessary corollary” thereof, the freedom to *receive* services (: § 10)<sup>29</sup>. Moreover, it is implicitly indicated that the delivery of medical treatment is a service within the meaning of the ECT. This point has been made explicit in *Grogan*, in which the Court, putting aside the moral debate, qualified the termination of pregnancy as “a medical activity which is normally provided for remuneration and may be carried out as a part of a professional activity”, thus bringing it within the ambit of Article 49 e.s. ECT (: § 18)<sup>30</sup>.

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<sup>28</sup> Cases C-120/95 and C-158/96, *Kohll and Decker*; C-368/98, *Vanbraekel*; C-157/99, *Geraets-Smits and Peerbooms*; C-385/99, *Müller-Fauré and Van Riet*; C-56/01, *Inizan*; C-08/02, *Leichtle*

<sup>29</sup> It has been contended that the EJC’s ruling in this case has sown the seeds for the insertion of the chapter regarding the citizenship of the Union by the Maastricht Treaty (Fallon 2002 : 166). It is further to be noted that, long before the judgement in *Luisi* and *Carbone*, several Community instruments made mention of the rights of service recipients, such as for example Directive 73/148/EEC of the Council of 21 May 1973 on the abolition of restrictions on movement and residence within the Community for nationals of Member States with regard to establishment and the provision of services, *Official Journal* L 172 of 28 June 1973, 14-16. See Weiss and Wooldridge 2002 : 122.

<sup>30</sup> In *Grogan*, the Court was asked whether the Treaty provisions on the freedom to supply services preclude an Irish rule prohibiting the provision of information concerning abortion services legally carried out in the United Kingdom. The Court agreed that abortion performed in accordance with the law of a particular Member State did constitute a service within the meaning of the ECT. However, in the Court’s view, the prohibition could not be regarded as a restriction within the meaning of Article 49 ECT for lack of an economic link between the providers of the information (students’ associations) and the providers of the economic service being advertised (the UK doctors). The implication was that the restriction could in fact impede the free provision of services, but legally these restrictions fell outside the scope of the relevant Treaty provisions. This judgement has been criticised for its focus on the (absence of an economic) link between the information provider and the service

Incidentally, the mention of “activities of the professions” in Article 50 ECT and the reference to “medical and allied and pharmaceutical professions” in Article 47 § 3 *jo.* Article 55 ECT as well provides an indication of the qualification of health care provision as a service for the purposes of the relevant Treaty provisions.

The foregoing should not lead to the conclusion that the health care cases added nothing to the matter of the applicability of the ECT Articles on services. Unlike in the cases just discussed, in which the “private” provision of health care was at stake or the nature of the care was not specified<sup>31</sup>, the health care cases were concerned with health care provided within the framework of a system of social security<sup>32</sup>. It is precisely this embedment in solidarity-based, State-organised and State-financed systems that produces several thorny legal questions as to the applicability of the Treaty. Does the special nature of national health care systems remove them from the application of the Treaty? Can (semi-)public bodies provide the necessary remuneration? It will be demonstrated that the Court answers these questions with a great deal of pragmatism, seemingly not at all hindered by the alleged delicacy of the issues under its scrutiny.

### II.1.b. The “Special Nature” of the “Services” Concerned

In the *Kohll* case, the compatibility with Article 49 ECT was challenged of a Luxembourg rule denying reimbursement of medical expenses incurred abroad (*in casu* costs related to the delivery of orthodontic treatment in Germany) unless the insured person had sought and obtained prior authorisation. Several Member States represented in the proceedings submitted that the Luxembourg rules did not fall within the scope of the ECT provisions on freedom to provide services, in that they concerned social security. They referred to previous case law of the Court in which it had held that Community law does not detract from the powers of Member States to organise their social security systems (Case C-70/95 *Sodemare* : § 27; Case C-238/82 *Duphar* : § 16) and that it is for the legislature of each Member State to lay down the conditions creating the right or the obligation to become affiliated to a social security scheme (C-110/79 *Coonan* : § 12; Case C-349/87 *Paraschi* : § 15) and to determine the conditions for entitlement to social security benefits (Joined Cases C-4/95 and C-5/95 *Stöber and Piosa Pereira* : § 36). On the same wavelength is Fuchs (2002). This author refers to the history of the Treaty and the gradual development of the free provision of services as well as to the Court’s rulings on the compulsory affiliation to social security schemes, to conclude

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provider. It has been contended that the correct inquiry was the effect of the information on the free supply of medical services (O’Leary 1996 : 72).

<sup>31</sup> In its judgement in *Grogan*, the Court failed to refer to the Commission’s argument that abortion should only be considered a service within the meaning of Article 50 ECT if it is provided privately and entirely paid for by the recipient (O’Leary 1996 : 76).

<sup>32</sup> Health care systems in the Member States are generally divided into two categories: social insurance systems and national health services. *National health services* are funded through tax revenues. Health care is provided on a universal basis and is usually free at the point of receipt. Such services necessitate some degree of centralised administration. This ensures, in theory at least, a uniformity of benefits that matches responses to needs. *Social insurance systems* are based on a Bismarckian model of insurance in which the law determines who is compulsory insured. The categories of beneficiaries have progressively expanded so that all or virtually all of the population is now covered. In turn social insurance systems can be divided in two groups. Benefits-in-kind systems provide health care generally free of charge from providers contracted by the sickness funds, which also pay the provider directly. Reimbursement systems confer upon those insured the right to be reimbursed for medical bills that they have paid for themselves. The insured person has a free choice of health care provider, who may or may not be a party to the national agreement. There is no tiered referral procedure for obtaining care (AIM 2000: 16 e.s.; Jorens 2002 : 83-84).

that Articles 49 e.s. ECT cannot apply to social security, on pain of ‘open[ing] floodgates without knowing how much water would be set free’ (: 550).

The ECJ, supported by Advocate General Tesouro in his excellent Opinion, did not uphold these arguments. The Court, using a formula which begins to acquire the status of a catechism (Davies 2002 : 28), notes that Community law does not detract from the power of Member States to organise their social security systems. Yet, the Advocate General argues, this by no means implies that the social security sector constitutes an island beyond the reach of Community law and that, as a consequence, all national rules relating to social security fall outside its scope. In the absence of harmonisation at Community level, it is for the Member States to lay down the conditions governing affiliation to the social security system and, at least in principle, the conditions governing entitlement to social security benefits. However, when doing so, they must also comply with Community law. In other words, while it is true that the organisation of the social security system remains a matter for the Member States and that the relationship between the social security institutions and their members is governed by national law, this does not mean that Member States may contravene with impunity a fundamental principle established by the Treaty to secure the free movement of persons, namely the prohibition of discrimination on grounds of nationality (Opinion : §§ 17 e.s.; Ruling : §§ 17 e.s.).

The approach adopted by the Court and the Advocate General is consistent with earlier case law and can be agreed with. As van der Mei (2003 : 281) rightly points out, there is in fact not a single policy area or area of law in which Member States and their institutions can ignore the principles of non-discrimination and freedom of movement. Matters like criminal law and direct taxation do not as such fall within the EC’s jurisdiction, but Member States must nevertheless exercise their retained powers in those domains in compliance with Community law (see, as regards criminal law, Case C-348/96 *Calfa* : § 17 and, concerning direct taxation, Case C-9/02 *De Lasteyrie du Saillant* : § 44).

### II.1.c. The Remuneration Requirement: Considering the Relevant Relationship

#### *Geraets-Smits and Peerbooms*

The cases *Geraets-Smits and Peerbooms* and *Müller-Fauré and Van Riet* both concerned the Dutch health insurance system providing benefits-in-kind. Geraets-Smits and Peerbooms, who were both insured under this system, had obtained medical treatment outside the Netherlands, for which their sickness fund refused to pay. On the strength of Dutch law, sickness funds are under no obligation to assume the costs of medical benefits provided by non-contracted providers, such as the foreign-based hospitals where Geraets-Smits and Peerbooms had received medical care, save where prior authorisation has been granted, *quod non in casu*. The granting of such authorisation is contingent upon the fulfilment of two conditions: *primo*, the proposed treatment must be capable of being regarded as a qualifying benefit within the meaning of the relevant Dutch legislation, which implies that it can be considered as “normal in the professional circles concerned” and *secundo*, the treatment in question must be necessary, which supposes that adequate treatment is not available without undue delay in the Netherlands.

Some of the intervening governments contended that, as the services supplied by hospitals operating within the relevant sickness insurance scheme are provided in kind and free of charge, they are not provided for consideration and hence, they cannot constitute an economic

activity within the meaning of the Treaty. There is no remuneration for the purposes of Article 50 ECT, so the argument goes, where the patient receives care in a hospital infrastructure without having to pay for it himself or where all or part of the amount he pays is reimbursed to him (Case C-157/99 *Geraets-Smits and Peerbooms* : § 49). The argument was brave, since in fact both patients had paid the hospitals themselves and then sought reimbursement (Davies 2002 : 28). The Advocate General Colomer proposed a more evolved version of the argument, realising that the Court had accepted as early as 1988 that Article 50 ECT does not require the service to be paid for by those for whom it is performed (Case C-352/85 *Bond van Adverteerders* : § 16). The learned Advocate General observed that the amount paid by the Dutch sickness funds to the health care providers was calculated with reference to a number of factors not directly related to the treatment itself and according to an abstract mathematic formula, which made these payments more similar to a financing budget than to a remuneration. He further noted that some transfers were made, even in the absence of treatment effectively offered, in order to secure the financial needs of practitioners and hospitals. For these reasons, the Advocate General, evoking the *Humbel* judgement (Case C-263/86) – where the Court had held that the essential characteristic of remuneration is the fact that it constitutes consideration for the service in question, the amount of which is agreed upon between the provider and the recipient of the service – concluded that, in the light of the characteristics of the Netherlands compulsory sickness insurance scheme, the health care benefits in kind which it provides to insured persons lack the element of remuneration and are not therefore services within the meaning of Article 50 of the ECT (Opinion : §§ 27 e.s.). The argument appears to be targeted not so much at the nature of the Dutch system providing benefits-in-kind, but rather on a typical, yet not unique feature of it, namely the type of payment of health care providers. Following this reasoning, fixed payment systems (in which there is no link between payment of the provider and his activities) and prospective payment systems (in which there is no link between the payment of the provider and his costs) could not provide the necessary remuneration within the meaning of the Treaty<sup>33</sup> (see Jegers, Kesteloot, De Graeve and Gilles 2002 for a typology of provider payment systems). Kieffer (2001 : 2-10) and Makarouni (1997 : 32-35) adopt a similar line of reasoning, although the latter curiously qualifies a hospital as a service provider because the patient is to be considered a recipient of services.

One thread running through these arguments is that they all consider a national, “intrastate” scenario of health care delivery, as if *Geraets-Smits and Peerbooms* had stayed within the territorial boundaries of the Dutch health care system. In doing so, their advocates ignore the fact that these patients had actually paid the foreign health care provider and that there had not been a financial transfer from the sickness fund to a Dutch contracted health care provider.

The Court of Justice, on its part, began by reiterating that medical activities fall within the scope of Article 50 of the Treaty, and added – without further specification – that there was no need to distinguish in that regard between care provided in a hospital environment and care provided outside such an environment (: § 53). Next, the Court replied to the “intrastate” arguments raised by several intervening Member States and the Advocate General. By reference to the judgements in *Bond van Adverteerders* and *Humbel*, the Court concluded that “the payments made by the sickness insurance funds under the contractual arrangements provided for by the [Ziekenfondswet], albeit set at a flat rate, are indeed the consideration for the hospital services and unquestionably represent remuneration for the hospital which

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<sup>33</sup> It is to be noted that under the Belgian system of health care provision, which is a reimbursement scheme, hospital financing also contains significant fixed and prospective elements (Beeckmans 2003 : 139-164; see also Sermeus 2003).

receives them and which is engaged in an activity of an economic character” (: § 58). The Court’s reply has rightly been the subject of scholarly criticism, the tenor of which is that the bold statements of the Court cannot conceal the lack of legal foundations of the theses advanced. “The ECJ’s pronouncements seem at risk of being viewed as mere objects of faith, rather than reasoned arguments of legal principle” (Flear 2004 : 218)<sup>34</sup>. For one thing, some explanation would have been in order regarding the assertion, presented as obvious, that there needs to be no distinction between care provided in a hospital environment and care provided outside such a setting. In support of that, the Court refers to its rulings in *Luisi and Carbone*, *Grogan* and *Kohll*, even though none of these cases expressly concerned health care provided in a hospital, nor is it indicated in these cases that such care is to be classified as a service within the meaning of the Treaty. By the same token, the qualification of the flat rate payments as remuneration for the purposes of Article 50 ECT, although perfectly defensible<sup>35</sup>, is not as “unquestionable” as the Court would have one believe.

The Court’s affirmation is all the more unfortunate, it is contended here, since its statement is irrelevant to its ultimate reasoning and is likely to create confusion (*cf.* van der Steen 2001 : 218). Indeed, in paragraph 55 of the judgement the Court made clear that the relevant relationship is that between the patient and the foreign health care provider:

“[w]ith regard more particularly to the argument that hospital services provided in the context of a sickness insurance scheme providing benefits in kind, such as that governed by the [Ziekenfondswet], should not be classified as services within the meaning of Article [50]<sup>36</sup> of the Treaty, it should be noted that, far from falling under such a scheme, the medical treatment at issue in the main proceedings, which was provided in Member States other than those in which the persons concerned were insured, did lead to the establishments providing the treatment being paid directly by the patients. It must be accepted that a medical service provided in one Member State and paid for by the patient should not cease to fall within the scope of the freedom to provide services guaranteed by the Treaty merely because reimbursement of the costs of the treatment involved is applied for under another Member State’s sickness

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<sup>34</sup> See also Hatzopoulos (2002), who states that “the use of strong words instead of convincing arguments is an ‘unquestionable’ sign of weakness of the judgment” (: 692-693). See further Cabral 2004 : 677.

<sup>35</sup> The concept of remuneration in the field of the provision of services is intended to restrict the applicable rules to circumstances constituting “economic activities” within the meaning of Article 2 of the Treaty. Consequently, it must be given a wide interpretation (Niedobitek 1997 : 112; Case C-53/81 *Levin* : § 13). The Court has ruled that that activities performed by members of a community based on religion or another form of philosophy as part of the commercial activities of that community – supplying its material needs through the running of a discotheque, a bar and a launderette – constitute economic activities in so far as the services which the community provides to its members – board and lodging, pocket money – may be regarded as the indirect *quid pro quo* for genuine and effective work (Case C-196/87 *Steymann* : § 14). In *Schindler* (Case C-275/92), the Court held the organisation of a lottery to be a service provision, whereby the remuneration is constituted by the price of the lottery ticket (§§ 27-28). Neither the chance character nor the recreational aspect preclude the existence of an economic transaction (: §§ 33-34). In *Deliège* (Case C-191/97), the Court ruled that sporting activities and, in particular, a high-ranking athlete’s participation in an international competition, are capable of involving the provision of a number of separate, but closely related, services even if some of those services are not paid for by those for whom they are performed. For example, an organiser of such a competition may offer athletes an opportunity of engaging in their sporting activity in competition with others and, at the same time, the athletes, by participating in the competition, enable the organiser to put on a sports event which the public may attend, which television broadcasters may retransmit and which may be of interest to advertisers and sponsors. Moreover, the athletes provide their sponsors with publicity the basis for which is the sporting activity itself (: §§ 56-57). See also Fallon 2002 : 37 and 164 as well as Davies 2002 : 34.

<sup>36</sup> We have taken the liberty of replacing, in quotations of judgements, references to the pre-Amsterdam numbers of the ECT Articles with post-Amsterdam numbers, as in force as of 1 May 1999.

insurance legislation which is essentially of the type which provides for benefits in kind”.

Thus, whether or not the medical treatments paid by the sickness funds and provided by Dutch contracted care providers to their patients are services and fall within the ambit of the Treaty – they probably do in the presence of an intra-Community dimension<sup>37</sup> – this does not matter since, according to the Luxembourg Court, the relevant relationship is that between the foreign health care provider and the mobile patient. As a result, the character of the domestic system is irrelevant (Davies 2004 : 101).

### Müller-Fauré and Van Riet

The Court confirmed and exemplified this pragmatic approach in *Müller-Fauré and Van Riet*<sup>38</sup>, yet without eradicating the ambiguity ensuing from *Geraets-Smits and Peerbooms*. Indeed, the Court recalled that “the fact that the applicable rules are social security rules and, more specifically, provide, as regards sickness insurance, for benefits in kind rather than reimbursement does not mean that the medical treatment in question falls outside the scope of the freedom to provide services guaranteed by the EC Treaty” and that *in casu* “the treatment provided in a Member State other than that in which the persons concerned were insured resulted in direct payment by the patient to the doctor providing the service or the establishment in which the care was provided” (: § 39).

However, the argument raised by the United Kingdom government as to the alleged uniqueness of the National Health Service (NHS) – “which is a non-profit-making body” (: § 59) – allowed the Court to transcend the facts of the case, which dealt with a benefits-in-kind system, and to state the following:

“[...] a medical service does not cease to be a provision of services because it is paid for by a national health service or by a system providing benefits in kind. The Court has, in particular, held that a medical service provided in one Member State and paid for by the patient cannot cease to fall within the scope of the freedom to provide services guaranteed by the Treaty merely because reimbursement of the costs of the treatment involved is applied for under another Member State’s sickness insurance legislation which is essentially of the type which provides for benefits in kind (Smits and Peerbooms, paragraph 55). The requirement for prior authorisation where a person is subsequently to be reimbursed for the costs of that treatment is precisely what constitutes, as has already been stated in paragraph 44 above, the barrier to freedom to provide services, that is to say, to a patient's ability to go to the medical service provider of his choice in a Member State other than that of affiliation. There is thus no need, from the perspective of freedom to provide services, to draw a distinction by reference to whether the patient pays the costs incurred and subsequently applies for reimbursement thereof or whether the sickness fund or the national budget pays the provider directly” (: § 103).

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<sup>37</sup> cf. Case C-97/98 *Jägerskiöld*: “the provisions of the Treaty relating to the freedom to provide services [...] are not applicable to activities which are confined in all respects within a single Member State” (: § 42).

<sup>38</sup> This case concerns once again two Dutch patients who went abroad for treatment; *Müller-Fauré* went to Germany for dental work provided outside a hospital environment. *Van Riet*, whose case is more interesting, went to Belgium for an arthroscopy and some other treatment, partly provided in a hospital and partly outside. Van Riet went largely to avoid the six month waiting time in Holland. Both had requested prior authorisation, both had been rejected.

It would seem that the remark made by the British government induced the Court to what appears to be another excursion into a hypothetical “internal” situation. A coherent response would have been to dispose of the said argument by stating that it was irrelevant, as the service provision exists between the foreign health care provider and the patient, the latter remunerating the other. In so doing, the Court would have fully drawn the consequences from its focus on the relationship between those two players, rendering the nature of the health care system of the Member State of affiliation immaterial. Instead, it looks as if the Court wants to indicate that even national health services “internally” provide services to the patients, whereby one might well wonder what could constitute the interstate element necessary to trigger the application of the free movement provisions. Or does the Court approach matters from the interstate angle, hinting at the situation where a patient obtains services from a provider operating within a national health service? That is fairly improbable and in any case not the situation the United Kingdom had in mind, concerned as it was with the effects of an increased outflow of patients on the management of its waiting lists (: §§ 55-57). Another, more plausible possibility is that the Court, still reasoning from an interstate point of view, alludes to the setting aimed at by the British government. But why then does the Court in the first sentence of paragraph 103 speak of the payment of the foreign provider by a national health service or by a benefits-in-kind system, whereas in *Geraets-Smits and Peerbooms* it mentions the reimbursement of the patient – who has prepaid the foreign provider – by the national payer, a statement which is reiterated in the second sentence of paragraph 103? Should the reimbursement of the patient who has paid the foreign health care provider be considered as an indirect payment of the latter by the national third-party payer? Or can it be inferred from the last sentence of paragraph 103 that the Court, sensitive to the “social” argument in accordance with which only the better-off are capable of advancing the costs of often expensive treatments, refers to the situation where the patient, typically after being granted authorisation, does *not* pay the foreign provider, who is directly paid by national third-party payer? (*cf.* Flear 2004 : 220-221). Even in the absence of a remuneration by the patient, the care received in another Member State could still qualify as a service, if the national third-party payer has agreed to compensate the provider<sup>39</sup>. This would amount to a further step in the attuning process of the two methods of patient mobility (*cf. infra, sub* III.2.d).

Over to the Court to set things straight.

### Outlook

The fact that the Court – leaving aside some elaborations – concentrates on the relationship between the patient and the foreign health care provider, in spite of requests of Member States and Advocates General to consider the “national” dimension, should not cause much surprise. After all, the approach taken by the Court reflects the factual situation underlying the health care cases; the Court was not asked to speak out on the economic nature of the Luxembourg and Dutch schemes<sup>40</sup>; rather, it was invited to state whether the free provision of services implies a right to obtain medical treatments in another Member State at the expense of the national health insurance institution. The focus on the intra-Community nature of the health

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<sup>39</sup> Although it is to be stressed that, under the Treaty rules on services, the national health insurance institution could not be obliged to pay the foreign provider an amount which is higher than that it would have assumed if the treatment had been obtained in the national territory.

<sup>40</sup> Comp. Hatzopoulos (2002), who speaks of an “atypical situation” (: 692) and Kieffer (2001), who argues that the remuneration requirement has to be met “internally” and adds that “[e]n effet, si l’on se limitait à considérer uniquement la nature du service obtenu à l’étranger, il est évident qu’il est toujours possible d’obtenir dans toute l’Europe des soins de santé qui satisfont aux critères prévus par l’article [50 du Traité]”.

care provision allows the Court to avoid what would be politically unthinkable, namely a differential treatment of the national health care schemes as far as the application of the Treaty provisions on services is concerned (*cf.* Jorens 2004 : 377; Cabral 2004 : 678). Its approach renders irrelevant the nature of the system, both of that with which the patient is affiliated<sup>41</sup> and of that within which the foreign health care provider operates<sup>42</sup>.

Logical as the position of the Court might seem, the consequences thereof are far-reaching. Its approach hints at fundamental considerations regarding the relationship between the internal market and the national schemes of health provision. It reveals that, as far as the field of the free provision of services is concerned, the Court does not treat the public provision of health care, with its triangular structure and its involvement of a third-party payer, any differently than other service sectors (*cf.* Fuchs 2002 : 540). The third-party payer, on its part, only comes to the fore upon examination of the existence of a restriction to the free provision of services (see already *du Pré* 1998 : 371). By making the assumption of health care costs incurred abroad subject to restrictive conditions, such as a prior authorisation requirement, or by providing for a lower reimbursement of these costs than the insured person would have obtained if he had undergone the same treatment under the same conditions in the Member State of affiliation, the payer erects an obstacle to the freedom to provide services, both for the patient and the foreign provider (Case C-385/99 *Müller-Faure and Van Riet* : § 44; Case C-368/98 *Vanbraekel* : § 45). In this regard, it should be kept in mind that the mere fact that the national health insurance institution refuses to pay for medical expenses incurred in another Member State does not seem sufficient to hold it liable of restricting the free movement of services. A refusal to pay for a service received abroad only comprises a restriction on movement if there is some prior obligation, or possible obligation, to pay. Otherwise, as one author puts it, what is to stop frivolous suits insisting that the government pay for holiday villas for all? (Davies 2004 : 101). Therefore, where a certain medical treatment is covered under the national health scheme of the Member State of affiliation, be it under certain conditions (e.g. referral by a general practitioner), the rules of this Member State should allow this same medical treatment, provided in another Member State under the same

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<sup>41</sup> In that context, the fact that none of the health care cases concerned a Member State operating a national health service would seem immaterial. Nonetheless, the Court, in *Müller-Fauré and Van Riet*, deemed it necessary to expressly refer to the situation of national health services, indicating, most probably, that the provision of health care within such a framework constitutes as well a service for the purpose of the ECT. Comp. Hervey and McHale 2004 : 135. Admittedly, the issue, which will be discussed further *infra*, is contentious. A definite answer to the question as to whether the Court's health care cases affect national health systems that are funded by a greater proportion of public taxation than social insurance, is expected in the pending *Watts* Case, in which the Court is asked, *inter alia*, "on the true interpretation of Article 49 EC", whether "there [is] any distinction between a State funded national health service as the NHS and insurance funds such as the Netherlands ZFW scheme, in particular having regard to the fact that the NHS has no fund out of which payment must be made": see the reference for a preliminary ruling by the Court of Appeal (England and Wales) (Civil Division) of 12 July 2004 in the case of *The Queen on the application of Yvonne Watts*, and 1) Bedford Primary Care Trust, 2) The Secretary of State for Health, Case C-372/04, *Official Journal* C 273 of 6 November 2004, 15. The case involves Yvonne Watts, who, facing a delay in receiving a hip replacement operation, sought authorisation to receive the treatment in another Member State at the expense of the national health authority. On refusal, she travelled to France for the operation and claimed reimbursement. Her case, brought before the English High Court, failed on the facts, as she was unable to show that she was confronted with an "undue delay". What matters here is that the High Court, referring to the Court's health care judgements, held that, in principle, the application of Article 49 ECT in the context of a right to be reimbursed for the cost of medical treatment obtained abroad remains the same irrespective of whether the reimbursement comes from a national health insurance fund or from a national budget [(2003) EWHC 2228 : §§ 105 e.s.].

<sup>42</sup> It is generally accepted that, under the Treaty-based procedure, the foreign health care provider does not need to have entered into agreements with the national health insurance institution of its Member State of establishment, i.e. the Member State of treatment: see e.g. Busse, Drews and Wismar 2002 : 241.

conditions, to be covered to the same extent in default of which the rules of the former Member State will constitute a restriction of the exercise of the free provision of medical services<sup>43</sup>.

This said, the actual implications of the Court's repeated assertion that Community law does not detract from the powers of the Member States to organise their social security systems and, particularly, of its even more recurrent statement that Member States must still comply with Community law when exercising their powers, become clear. The application of the Treaty provisions on the free provision of services, consistent with the former assertion and with the Community's limited competences in the field under consideration, appears to leave intact national power to determine the three parameters of social protection as regards sickness insurance. Thus, Member States retain full powers to determine who can become affiliated to the social security scheme in question (personal scope), the conditions to be fulfilled in order to receive benefits, and what these benefits will be (material scope) (Flear 2004 : 229-230; *cf.* AIM 2000 : 121-125)<sup>44</sup>. Member States can regulate these matters as they see fit, provided they do not discriminate against services and nationals of other Member States. On the other hand, compliance with Community law seems to entail for the Member States *a loss of spatial control over the medical consumption* of their citizens (Ferrera 2003 : 19) and, accordingly, in the presence of an intra-Community situation, a *Europeanization of the range of providers* whom the patient is entitled to visit.

In the subsequent part, dealing with the legal framework in relation to the mobility of health care providers, we argue that this Europeanization should not be construed by reference to the nature of the national health care systems. Having examined the ruling in *Geraets-Smits and Peerbooms*, as confirmed and elucidated by *Müller-Fauré and Van Riet*, we conclude that Member States, even if they operate a selective contracting system domestically by virtue of which appealing to the services of domestic non-contracted providers is contingent upon prior authorisation or results for the patient in a lower level of cover, are liable of restricting the free provision of services if they fail to equate the rights of insured persons who applied to a foreign health care provider with the rights of those who visited a domestic *contracted* provider (see the subsequent part, *sub* II.5.a).

The ease with which the Court brings the intra-Community provision of health care within the ambit of application of the Treaty and with which it passes over the differences between the various national health care schemes contrasts sharply with its judgement in the *Humbel* case (Case C-263/86), in which the plaintiffs appealed to the Treaty provisions on the free movement of services to obtain equal access to the national education system of another Member State, but were rejected as early as at the stage of the applicability of these provisions. It will be contended that, rather than intrinsic differences between health care and national education, considerations relating to the integrity of the welfare scheme concerned may provide an explanation for this divergent approach; the applicants in *Humbel* were challenging the (second aspect of) the territoriality principle, in that they sought access to a foreign redistributive space, which is liable to put at risk the national solidarity implemented by the scheme at issue. The health care cases further show a radically different approach from that adopted in the competition cases<sup>45</sup>, in which the Court judged that bodies governing

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<sup>43</sup> Of course, part of the problem is transferred to the appropriate definition of the "same" medical treatment, the "same" conditions and the "same" extent. See on this *infra*.

<sup>44</sup> See also Case C-385/99 *Müller-Fauré and Van Riet* : §§ 100 and 106. These retained powers make the Treaty-based method of patient mobility altogether "relatively uncontentious" (Flear 2004 : 231; Hervey 2002 : 83).

<sup>45</sup> See Joined Cases C-159/91 and C-160/91 *Poucet and Pistre*; Case C-218/00 *Cisal*; Joined Cases C-264/01, C-306/01, C-354/01 and C-355/01 *AOK*. See further *infra*.

statutory schemes of social security could not be qualified as undertakings for the purposes of the application of the competition rules. What was at stake in these cases was the relationship between the insurer/third party payer and the insured person. This relationship, so the Court held, lacks an economic character as it is based on the principle of solidarity. To allow the managing entities, who had been granted exclusive rights, to be subjected to the competition rules would lead to their collapse.

More generally, we will defend the view that the prospect of an adverse effect on national solidarity within welfare schemes through the application of the common market rules appears to result in the complete exemption therefrom. Such an adverse effect is to be feared when the application of those rules not merely widens the *territorial* boundaries of the national welfare state, but, more fundamentally, threatens to break into the closed *membership* circle. Then the Court does not shun the most drastic of measures, i.e. to simply declare those rules non-applicable. Yet, if that is not the case, the Court shows no intention whatsoever to exempt the “sacred cow” of social security from the application of those rules, on the understanding that, where appropriate, legitimate national interests may justify restrictive measures. Accordingly, in the health care cases, the Court could be less “considerate” towards Member States’ declared interests, as, in its view, the non-economic relationship between the insured person and the insurer/third party payer was not in order there. At issue was the interstate relationship between a patient and a foreign health care provider. The challenging, under the Treaty rules on services, of the (first aspect of the) territoriality principle, that is the non-portability of health care rights, would not cause the decline of national schemes of health care provision. Patients seeking health care abroad do not leave their national redistributive “solidarity circle” (*cf.* Becker 1998 : 361; *contra*: Fuchs 2002 : 544), nor do they try to enter that of the host Member State<sup>46</sup>.

#### II.1.d. Remuneration from Public Bodies

##### *Humbel*

Underlying *Humbel* (Case C-263/86) was a dispute between the Belgian State and the parents of Frédéric Humbel, French nationals residing in Luxembourg, where Humbel senior was employed. The Belgian State claimed payment of the sum of 35.000 BEF (EUR 867,63), the amount of the *minerval* due in respect of the course of secondary legislation followed by Frédéric during the school year 1984-1985 at the State Institute for General and Technical Education in Libramont (Belgium). The *minerval* was not charged to Belgian students. As the Humbels refused to pay, the Belgian State brought the proceedings before the national court, which referred to the ECJ the question, among others, as to whether courses taught in an institute which form part of the secondary education provided under the national education system are to be regarded as services for the purposes of Article 49 ECT. The Court ruled as follows:

“The essential characteristic of remuneration thus lies in the fact that it constitutes consideration for the service in question, and is normally agreed upon between the provider and the recipient of the service.

That characteristic is, however, absent in the case of courses provided under the national education system. First of all, the State, in establishing and maintaining such a system, is not seeking to engage in gainful activity but is fulfilling its duties towards its own population in the social, cultural and educational fields. Secondly, the system

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<sup>46</sup> An important exception may be the issue of price setting in the host Member State. See on this *infra*, *sub* II.3.a.

in question is, as a general rule, funded from the public purse and not by pupils or their parents”.

The nature of the activity is not affected by the fact that pupils or their parents must sometimes pay teaching or enrolment fees in order to make a certain contribution to the operating expenses of the system. A fortiori, the mere fact that foreign pupils alone are required to pay a minerval can have no such effect.

The answer [...] should therefore be that courses taught in a technical institute which form part of the secondary education provided under the national education system cannot be regarded as services for the purposes of Article [49 ECT], properly construed” (: §§ 17-20).

The Court confirmed this case law in *Wirth* (Case C-109/92), denying the qualification of “service” to education provided in an institute of higher education financed essentially out of public funds (: §§ 14-16). On the other hand, as the Court stated in an *obiter dictum*, where courses are given in establishments which are financed essentially out of private funds, in particular by students or their parents, and which seek to make an economic profit, these courses become services within the meaning of Article 50 ECT (: § 17; see also Case C-153/02 *Neri* : § 39)<sup>47</sup>.

#### What distinguishes education from health care?

Education and health care are comparable in many respects. Education can also be regarded as a service which in principle can be supplied by private players, operating within a commercial market. Yet in all welfare states, the provision of education, like that of health care, is largely shielded from market forces. For education as well, government intervention is dictated by economic efficiency and social justice. The education market is characterised by market failure; for one thing, the consumption of educational services has significant positive externalities, such as lower unemployment and increased international competitiveness. Moreover, the market mechanism could not guarantee that all members of society, irrespective of their financial strength or place of residence, have access to education (van der Mei 2003 : 337).

Both education and health care are financed for the most part out of public resources. This is not altered by the fact that patients and students are asked to make relatively small contributions, in the form of enrolment fees for education or user charges for health care (*cf.* the Opinion of Advocate General Slynn in Case C-263/86 *Humbel*).

By the same token, access to systems of national education is governed by the principle of territoriality. As a rule, non-residents are permitted to these systems by way of favour (van der Mei : 339-340).

The European Community has only limited powers in the field of education. In its current wording, Article 149 § 1 ECT states that the Community shall “fully [respect] the responsibility of the Member States for the content of teaching and the organisation of education systems and their cultural and linguistic diversity”. The fourth paragraph expressly excludes any harmonisation of the laws and regulations of the Member States.

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<sup>47</sup> Several Member States relied on this paragraph to advance in *Geraets-Smits and Peerbooms* that the profit motive of the service provider constitutes a condition for the services to be economic. The Court laconically replied that the argument could not be accepted (*Geraets-Smits and Peerbooms* : § 50 and 52). And rightly so: the profit motive is irrelevant in competition law and it is undesirable to introduce quasi psychological elements in the law if they are not necessary (see Davies 2002 : 29-30).

Notwithstanding these important parallels, the publicly financed provision of education falls outside the ambit of the free provision of services, as opposed to the State-subsidised delivery of health care. What justifies this differential treatment?

The Court's statements in *Humbel* do little to clarify matters. In that case, the Court did not seem prepared to consider the state payments to the educational institutions as consideration, as the State was fulfilling its *duty* to its population in the social, cultural and educational fields and not acting commercially. The argument of the State duty, as antithesis to commercial behaviour, does not take us very far. It is reasonable to assume that all actions of the State are in fulfilment of the duties it bears towards its citizens, or ought to be. Besides, ensuring that the population receives adequate health care is every bit as much a State duty as providing education (Davies 2002 : 32).

The fact that the money came from the *public purse* did not matter in the health care cases, and indeed was considered irrelevant by the Court of Justice on numerous occasions in the past (see O'Leary 1996 : 76)<sup>48</sup>.

### *The separation between the payer and the provider*

Several authors have contended that, what makes public "services" services for the purposes of the Treaty, is the way they are organised. Notably, the separateness between the paying and the providing institutions would be decisive. Such a payer-provider split creates a potential market-like situation, in which services are exchanged for remuneration and to which the Treaty provisions on services apply (*cf.* the health care cases). In the absence of such a separation, the payer and the provider are essentially working together to provide a single service, rather than exchanging that service for money. They are intrinsically part of an integrated whole (*cf. Humbel*) (Davies 2002 : 34-38; see also van der Mei 2003 : 313-315 and Flear 2004 : 220-222).

In the case of a bi-partite provider-recipient relationship under which the State itself acts as the provider, the "public/private funding distinction" may indeed constitute the main, and perhaps the decisive, criterion for determining the economic character of activities performed. If the origin of the funding is public, the activity concerned cannot be qualified as a service, since the separation between the payer and the provider is lacking. Yet certain publicly organised but privately financed courses, such as post-graduate courses – notably LL.M's – mainly financed out of tuition fees, could very well be regarded as services within the meaning of the Treaty (van der Mei 2003 : 313-314)<sup>49</sup>.

In the health care cases, emphasis was laid on the relationship between the paying patient and the foreign health care provider; consequently the Court was not confronted with the problem at hand. However, even if the financial transfers from the national third party payer are held

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<sup>48</sup> In *Kempf* (Case C-139/85), the Court ruled that "a person in effective and genuine part-time employment cannot be excluded from the [the] sphere of application of [the provisions laying down the fundamental freedom of movement of workers] merely because the remuneration he derives from it is below the level of the minimum means of subsistence and he seeks to supplement it by other lawful means of subsistence [...] [such as a financial assistance drawn from the public funds of the Member State in which he resides]" (: § 14). In *Bettray* (Case C-344/87), another case involving the free movement of workers, the Court rejected as irrelevant the fact that the productivity of persons employed in a scheme for rehabilitation or reintegration is low and that their remuneration is largely provided by subsidies from public funds : "[n]either the level of productivity nor the origin of the funds from which the remuneration is paid can have any consequence in regard to whether or not the person is to be regarded as a worker" (: § 15). See also the 'museum Cases' and *Cowan*, discussed *infra*.

<sup>49</sup> This is the situation to which the Court alluded in *Wirth* (Case C-109/92) : § 17.

to be a (direct or indirect) remuneration of the foreign health care provider (*cf. supra*), the payer-provider split is still present. More than that, this split is inherent in the intra-Community situation; the payer of Member State A pays a provider, established in Member State B, who has provided health care to a citizen of Member State A. The nature of the national health care system is then irrelevant: the payment by the Spanish national health service to a Portuguese health care provider, whether or not he operates within the Portuguese national health service, can easily be qualified as remuneration for the purposes of Article 50 ECT. The circumstance that there could be a case against the “internal” qualification of national health services as service providers, that is to say vis-à-vis their own patients, precisely because the paying and providing institutions are one and the same, does not matter in this regard (van der Mei 2003 : 313-315).

It is submitted that in the separateness between the payer and the provider of the service lies an important difference between *Humbel* and the health care cases. Appealing to the Treaty rules on the free provision of services, the Humbels attempted to obtain a benefit – access to secondary education free of charge – provided by a Belgian public institution and paid for by the Belgian State (no payer-provider split). By contrast, Müller-Fauré and Van Riet, to take an example, challenged the refusal by the Dutch sickness fund<sup>50</sup> to assume the costs they incurred with a German and Belgian health care provider respectively (payer-provider split, even if the Dutch, German and Belgian health care schemes were national health services, *quod non*).

Nonetheless, the separation theory may not be infallible. Whereas it is credible that the *Humbel* case might have turned out differently if the Humbels had paid the Belgian school in Libramont a sum amounting to the cost of a school year and subsequently asked the French or Luxembourg authorities for reimbursement thereof, the same cannot be said of a situation where the Belgian educational institution was an independently operating private school likewise subsidised by the State. Still, the payer-provider split exists in both assumptions. Furthermore, the separation theory only stands up after *Müller-Fauré and Van Riet* – in which the ECJ seems to indicate that national health services also provide services as referred to in Article 49 e.s. ECT “internally” – insofar as it is accepted that the Court in these national health services detects the requisite separation between the payer and the provider (see, in this sense, Flear 2004 : 222). This is however far from imaginary, given the fact that under many national health services, most notably the NHS, reforms in recent years have to some extent separated the provision and the funding of medical care; care is increasingly being provided by hospitals and general practitioners operating on an independent and semi-commercial basis (van der Mei 2003 : 313; AIM 2000 : 113)<sup>51</sup>.

### *The absence of a compensation mechanism at Community level*

We have already pointed out that the outcome of the *Humbel* judgement might have been different if the Humbels had not applied to the host country (Belgium) to cover the expenses of the education received by their son. Here, an important difference crops up between the intra-Community provision of health care and that of education. For the latter, unlike for health care<sup>52</sup>, no Community rule or mechanism exists which imposes on the State from which students move a duty to bear the true economic cost of the education which students

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<sup>50</sup> Sickness funds may well be seen as public bodies (Davies 2002: 32-33).

<sup>51</sup> See Groves 1999 : 747-748. For an overview of the subsequent changes to the NHS, see <http://www.nhs.uk/england/aboutTheNHS/history/default.cmsx>

<sup>52</sup> See *supra*, Title I.

receive in other Member States (*cf.* the Opinion of Advocate General Slynn in Case C-263/86 *Humbel*). Therefore, the courses taught to Frédéric Humbel would not constitute services for the purposes of the Treaty, because there is no third party which can be required to pay the cost, and thus the remuneration requirement is not fulfilled (van der Mei 2003 : 315). Conversely, the fact that Member States, through the mechanism set up by Regulation 1408/71, have a longstanding familiarity with paying for the health care “their” patients obtained abroad, could offer an explanation for the ease with which health care provision was brought within the scope of the Treaty provisions on the free movement of services.

### Acces to foreign redistributive spaces

The plaintiffs in the health care cases wanted to be reimbursed by their national payer for health care costs incurred in another Member State. As such, what was challenged under the Treaty rules on services was the first facet of the territoriality principle (*cf. supra*), that is the non-portability of health care benefits. The Humbels, on the other hand, sought to shift educational costs onto the Belgian taxpayer; they essentially asked to be admitted to a foreign, *in casu* Belgian, redistributive space, yet found that the Articles 49 *e.s.* ECT did not allow them to. They saw their plans thwarted by the operation of the second aspect of the territoriality principle, which, as we have seen, is closely connected to the solidarity principle and the preservation of welfare state interests.

Indeed, the tension between the goal of guaranteeing freedom of movement and the safeguarding of these interests fully comes to the surface when one considers the cross-border rights of service recipients, i.e. those who travel to other Member States to receive a service, without relocating the centre of their economic and private interests. Territoriality entails several things, but above all it means that public benefits are in principle reserved to persons working and residing within the State borders. Only such persons can be required to contribute their equal share to the funding of public benefits schemes and, as “members”, gain access to these schemes. If Member States were forced to open up the borders of their welfare states to non-residents, an unbridled “welfare tourism” could be the pernicious consequence, not least for those Member States with generous and high-quality schemes: overcrowded waiting rooms and classrooms, soaring costs and eventually, bankruptcy. Even if it does not have to come to that<sup>53</sup>, it is clear that Member States’ ability to maintain public services partly depends on their capacity to exclude residents of other Member States (van der Mei 2003 : 462 and 469)<sup>54</sup>.

The Community legislature has acknowledged the danger of welfare tourism, even in respect of non-economic residents, namely Member State nationals who reside in the territory of another Member State without being economically active there. The three Residency

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<sup>53</sup> The various factors limiting patient mobility mentioned by the Court in *Müller-Fauré and Van Riet* apply also in this respect (: §§ 95-96).

<sup>54</sup> The extent to which national public benefits schemes could suffer from unlimited access of non-residents differs. In this regard, van der Mei (2003) makes a distinction between three categories of public benefits. The first category comprises services which can be attributed to the classical “night watch State”, such as police and fire protection, public transportation, public roads etc. These services have a minimal magnetic effect, while spill-over effects are basically absent. The second group consists of social assistance benefits, maintenance grants and other tax-funded benefits which seek to offer beneficiaries a minimum income for meeting basic costs of living. The magnetic effect of such systems is strong, as are spill-over effects; the grant of any additional benefits leads to an increase in costs. Health care and education belong to the third group of public benefits. These benefits systems are more likely to be affected by non-residents’ access than the first group, but at the same time are not as fragile as those of the second category (: 477-478).

Directives, which confer upon economically inactive nationals of a Member State and members of their family a general right to reside in the European Community, provide that their beneficiaries must not become an unreasonable burden on the public finances of the host Member State. The right of residence is granted only if they “are covered by sickness insurance in respect of all risks in the host Member State and have sufficient resources to avoid becoming a burden on the social assistance system of the host Member State during their period of residence”<sup>55</sup>.

The gist of these directives is clear: a person who is not actively involved in economic life must take care of his or her vital necessities in a manner congruent with taking his or her own responsibility, without enjoying the right to rely on public funds of the state of residence (Tomuschat 2000 : 455). Recently, the Court of Justice, applying the Treaty provisions on Union citizenship, in particular Article 18 ECT, has held that Member States, upon assessment of the fulfilment of the conditions laid down in the Residency Directives, cannot proceed mechanically, but at all times have to act in accordance with the principle of proportionality<sup>56</sup>.

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<sup>55</sup> Council Directive 90/364/EEC of 28 June 1990 on the right of residence, *Official Journal* L 180 of 13 July 1990, 26-27, Article 1 § 1. See also Council Directive 90/365/EEC of 28 June 1990 on the right of residence for employees and self-employed persons who have ceased their occupational activity, *Official Journal* L 180 of 13 July 1990, 28-29 and Council Directive 93/96/EEC of 29 October 1993 on the right of residence for students, *Official Journal* L 317 of 18 December 1990, 59-60. These conditions are maintained in Directive 2004/38/EC of the European Parliament and of the Council of 29 April 2004 on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States amending Regulation (EEC) No 1612/68 and repealing Directives 64/221/EEC, 68/360/EEC, 72/194/EEC, 73/148/EEC, 75/34/EEC, 75/35/EEC, 90/364/EEC, 90/365/EEC and 93/96/EEC, *Official Journal* L 158 of 30 April 2004, 77-123, Article 7. For a discussion of the new Directive, see Oosterom-Staples 2004 : 286-291.

<sup>56</sup> For instance, the fact that a student, who is a Member State national, has recourse to social assistance in the host Member State should not automatically result in the withdrawal of his residence permit (Case C-184/99 *Grzelczyk* : §§ 42-44). Furthermore, the Court, having observed that the “limitations and conditions [laid down by Directive 90/364] must be applied in compliance with the limits imposed by Community law and in accordance with the general principles of that law, in particular the principle of proportionality”, has ruled that the refusal to allow the person concerned to exercise the right of residence which is conferred on him by Article 18 ECT on the grounds that his sickness insurance does not cover the emergency treatment given in the host Member State would amount to a disproportionate interference with the exercise of that right (Case C-413/99 *Baumbast and R*: §§ 90-93). Without prejudice to the idea that the exercise of the right of residence of citizens of the Union can be subordinated to the legitimate national interests, these cases imply that “Member States can no longer rely on blanket rules and irrebutable presumptions to calculate when any given person has overstayed their welcome” (Dougan and Spaventa 2003 : 706). Proportionality requires them to take into account a number of additional variables, such as previous periods of lawful residency within the territory of the host Member State and the financial implications of the social advantage to which the claimant seeks access (: *ibid.*). In *Baumbast and R* for instance, the Court took account of the fact that Baumbast had sufficient resources, that he worked and therefore lawfully resided in the host Member State for several years, that during that period his family also resided in the host Member State and remained there even after his professional activities in that State came to an end, that neither Baumbast nor the members of his family have become burdens on the public finances of the host Member State and, lastly, that both Baumbast and his family have comprehensive sickness insurance in another Member State of the Union (: § 92). See also the Opinion of Advocate General Colomer in Case C-138/02 *Collins* : § 67.

Compare the judgement in *Trojani* (Case C-456/02). In that case, the claimant, a French national who had worked for a short period of time in Belgium in 1972 and who returned there in 2000 without means of subsistence, could not derive a right to reside in the Belgian territory from Article 18 ECT, for want of sufficient resources within the meaning of Directive 90/364/EEC. The Court pointed out that, unlike in *Baumbast and R*, there was no indication that the failure to recognise that right would go beyond what is necessary to achieve the objective pursued by that Directive (: §§ 36). However, as the Brussels municipal authorities had granted Trojani a residence permit – albeit a temporary one – he was lawfully residing in Belgium, and consequently within the personal scope of the Treaty and its Article 12, prohibiting discrimination on grounds of nationality (: § 40 e.s.; cf. Case C-85/96 *Martínez Sala* : § 63). Relying on that Article, Trojani was able to claim the Belgian *minimex*, which, as follows from *Grzelczyk*, falls within the scope *ratione materiae* of the ECT. For a discussion

Admittedly, there have been cases where non-resident Community nationals have obtained access to public benefits in another Member State by appealing to the Treaty provisions on services. In Case C-45/93 (*Spanish museums*), the Commission had brought proceedings against Spain for maintaining discriminatory museum admission conditions. Pursuant to Spanish legislation, only Spanish citizens, foreigners resident in Spain and nationals of other Member States under 21 years benefited from free admission to national museums, while nationals of other Member States more than 21 years of age were required to pay an entrance fee. The Commission did not attempt to challenge the definition of remuneration by arguing that publicly funded museums were to be considered as service providers for the purposes of the Treaty; rather, it argued that there was a close link between the reception of services as tourists and museum admission conditions. The Court accepted the argument and found that the Spanish admission rules to be contrary to Article 49 ECT (Spaventa 2004 : 274; see also Case C-388/01 *Italian museums*)<sup>57</sup>. In *Bickel and Franz* (Case C-274/96), an Austrian lorry driver and a German tourist challenged the legitimacy under Article 12 ECT of a Decree of the Italian Province of Bolzano for the protection of the German-speaking minority. By virtue of that Decree, German-speaking citizens resident in the Province of Bolzano are entitled to use their own language in relations with the judicial and administrative authorities based in that Province or entrusted with responsibility at regional level. *Bickel and Franz*, who were both summoned to appear before the local District Magistrates' Court, requested that the proceedings be conducted in German. The Court of Justice decided in their favour and rejected the justification ground put forward by the Italian government consisting in the protection of the ethno-cultural minority residing in the Province. The ECJ observed that *Bickel and Franz's* situation was covered by the Treaty, as they were recipients of services and Union citizens, and consequently had the right to visit and move around in the host Member State. This right, the Court added, is enhanced if Union citizens are able to use a given language to communicate with the authorities of a State on the same footing as its nationals. Hence, pursuant to Article 12 ECT, *Bickel and Franz* were entitled to treatment no less favourable than that accorded to nationals of the host Member State so far as concerns the use of languages which are spoken there (: §§ 15 e.s.).

In the earlier case *Cowan* (C-186/87), the Court had gone even further. *Cowan* was a British tourist who was mugged as he left the Paris *Métro*. French legislation provided for government compensation for the victims of criminal violence, but it applied only if the claimant was a French citizen, a foreigner in possession of a French resident's card or a citizen of a country having a reciprocal agreement with France on this matter. *Cowan* did not fall into these categories. It was beyond doubt that the benefit *Cowan* applied for could not be regarded as a service. Nevertheless, the French government's defence that the right at issue was a manifestation of the principle of national solidarity and presupposed a closer bond with the State than that of a recipient of services was of no avail. The ECJ ruled that, as a tourist, *Cowan* was a recipient of services, and consequently within the scope of the ECT. It then stated that when Community law gives someone the right of free movement, that right implies, as a necessary corollary, that he must be protected against physical violence and, if it nevertheless occurs, the prohibition of discrimination demands that he be given compensation

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of this case, see de Waele 2004, who concludes that “[w]aar het Hof toe lijkt te dwingen, wil een Lidstaat als België een toestroom van ‘welfare shoppers’ uit andere EU-landen afwenden, is ofwel het afzien van de verlening van tijdelijke verblijfsvergunningen en direct een keuze maken voor definitieve verwijdering of toelating; ofwel hervorming van de nationale sociale zekerheid” (: 325).

Note, lastly, that the Community legislature, in the new Residency Directive 2004/38/EC, has partly curtailed the consequences of *Grzelczyk* (Case C-184/99) (: Article 24 § 2).

<sup>57</sup> As critically analysed by Davies (2005).

to the same extent as a citizen. In the Court's view, this is not altered by the fact that the compensation was financed out of public funds (: §§ 15-17). The judgement in *Cowan* has been sharply criticised in doctrine. Does it suffice for a Community national to travel to the territory of another Member State, as a potential recipient of unspecified services, to be able to claim any benefit in the host Member State? (see Green, Hartley and Usher 1991 : 143-144; Chalmers and Szyszczak 1998 : 419; Spaventa 2004 : 274-275).

However, the aforementioned cases are not incompatible with the proposition advanced here, that is that the Court adopts a cautious attitude when the application of the ECT rules on the provision of services are liable to put at risk the principle of national solidarity and the survival of national welfare schemes. Indeed, in these cases, elaborating on *Luisi* and *Carbone* (Joined Cases C-286/82 and 26/83), the public benefit itself is not qualified as a service. The Court follows a functional approach: access is ensured as regards rights or benefits which may be regarded as a corollary, or which may enhance the exercise of, the right to travel to other Member States (van der Mei 2003 : 53). While this is particularly evident in the *Spanish museums* case, the link between the receipt of services and the public benefit is more severe in *Bickel and Franz* and especially in *Cowan* (Spaventa 2004 : 274)<sup>58</sup>. There, the reference to the free movement of services appears to be chiefly aimed at bringing the claimants within the personal scope of the Treaty, in the former case in conjunction with Article 18 ECT. Even so, it is difficult to see how the admittance to publicly funded education or *planned* health care in another Member State could contribute to a service recipient's right to travel to that Member State<sup>59</sup>. Moreover, the public benefits at issue in these cases are not likely to be gravely affected by the access of foreign service recipients. Whereas it is perfectly plausible that free museum admission exerts a magnetic effect, it is crystal-clear that it is not at the expense of the operation and funding of the museums. By the same token, to grant equal rights to victims of violent crime does not entail any structural burden, which would increase just through the fact of the existence of that entitlement (Tomuschat 2000 : 456). In *Bickel and Franz*, the Court pointed out that an extension of the Decree at issue to cover German-speaking nationals of other Member States would not undermine the – *in se* legitimate – aim of protecting the ethno-cultural minority resident in the Province of Bolzano, and noted, incidentally, that “the courts concerned are in a position to conduct proceedings in German without additional complications or costs” (: §§ 29-30).

Such harmless consequences are not to be expected if, as a result of the qualification as services of the provision of health care and education, Member States were to open up their national schemes regarding these public benefits; such opening up could indeed generate welfare tourism, especially towards those Member States with comprehensive social services. Member States should at least have the possibility to impose limits on the inflow of foreign service recipients and an obvious means to do so is by establishing residency requirements<sup>60</sup>. Yet the rules and principles governing the free movement of services do not seem to leave enough room for the application of residency requirements in cases where these are actually

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<sup>58</sup> Although the protection from harm, at issue in *Cowan*, might well constitute a special case, as it is not something we would expect a community to provide preferentially to its Members. The compensation could in fact be regarded as an “extra”, to “make up” for the crime, from the harm arising from the infringement of rights that was the State's duty to protect but that it was not able to guarantee (see Davies 2005 : 53 and the Opinion of Advocate General Lenz in Case C-186/87 *Cowan* : § 52).

<sup>59</sup> Manifestly, this does not hold true for emergency care. It can be argued, however, that the host country can pass the corresponding cost on to the Member State of affiliation of the patient, given the coordination mechanism in force.

<sup>60</sup> Nationality requirements are forbidden altogether in Community law, save in some exceptional and strictly defined cases (see van der Mei 2003 : 464 e.s. and Davies 2005 : 52).

needed for protecting public services (van der Mei 2003 : 469). According to a well-established case law, these requirements are the very negation of the free provision of services<sup>61</sup>.

On the other hand, Community travellers can rely on Article 12 ECT to challenge national rules denying them access to or enjoyment of public benefits on the grounds that they do not reside in the State concerned<sup>62</sup>. This provision does leave some room for maintaining residency requirements. Evidently, such requirements, if properly construed<sup>63</sup>, constitute indirect discrimination on grounds of nationality, and are thus in principle incompatible with Article 12 ECT. Yet they can be justified if the State applying the requirements can demonstrate that they are necessary for, and proportional to, the legitimate public interest of protecting the financial stability and/or maintaining public benefit schemes (van der Mei 2003 : 471; Case C-274/96 *Bickel and Franz* : § 27). An illustration can be found in the recent judgement in *Collins* (Case C-138/02). Collins, a “social tourist posing as a jobseeker” (de Waele 2004 : 325) applied in the United Kingdom for a jobseeker’s allowance which was refused on the grounds that he was not habitually resident in the United Kingdom. The Court of Justice upheld the residence requirement, stating that it was “legitimate for a Member State to grant such an allowance only after it has been possible to establish that a *genuine link* exists between the person seeking work and the employment market of that State” (: § 69, emphasis added). This important judgement, the ingredients of which were already present in *D’Hoop* (: § 38), explores the frontiers of welfare shopping (Meulman and de Waele 2004 : 287). Rights in the host Member State, notably those which are liable to generate a magnetic effect and impose a structural burden on the public purse, will not be acquired the moment one crosses the border but will accumulate gradually over time (*cf.* Davies 2005 : 55).

Regarding equal access to national education in the host Member State, Article 12 ECT has been invoked successfully. A few years before the Humbels were rejected with their appeal to Article 49 ECT, the Court had handed down a remarkable judgement in *Gravier* (Case C-293/83). Having – creatively – brought the conditions of access to vocational training within the scope of the Treaty, by perceiving a common policy based on Article 128 ECT (current Articles 149 and 150 ECT), the Court ruled that Article 12 precluded the imposition on students who are nationals of other Member States of a fee (the Belgian *minerval*) where the same fee is not imposed on students who are nationals of the host Member State (: § 26)<sup>64</sup>.

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<sup>61</sup> The ECJ has indeed consistently held that “[...] the requirement of a permanent establishment [...] makes a dead letter of Article [49] of the Treaty, a provision whose very purpose is to abolish restrictions on the freedom to provide services of persons who are not established in the State in which the service is to be provided” (Case C-439/99 *Commission vs. Italy* : § 30). See also Article 21 of the Commission Proposal for a Directive on services in the internal market, Brussels, 13 January 2004, COM(2004) 2 final.

<sup>62</sup> See cases *Bickel and Franz* and *Cowan*, discussed above. See further, as regards the equal treatments rights of the economically inactive, Case C-85/96 *Martínez Sala* and Case C-224/98 *D’Hoop*.

<sup>63</sup> A true residency condition would be one that excludes also non-resident nationals. Only such requirements are formally nationality-neutral. If, for the purpose of benefit eligibility, Member States – often in good faith – define the group as “national citizens and resident foreigners”, nationality becomes again an element making the scheme unacceptable to the Treaty. See in this regard Davies (2005), who, referring *inter alia* to the *museums* Cases, writes that Member States may be blind to the position of their non-resident nationals (“the invisible émigré”), the effect of which is that even where residence is a defensible condition for a benefit, that condition will perhaps be applied to foreigners only, rendering it (directly) discriminatory, thus undermining what could, if properly handled, be legitimate (: 50). The assumption that, even when a national is no longer resident he still has a particular bond with his government (“once a citizen, always a citizen”) might not be tenable: “[...] Europe does not just require the absorption of foreigners, but also the rejection of expatriates. A meaningful notion of equality entails that when a national emigrates, he becomes assimilated to a foreigner, and thus loses the privileges that go with residence – and formerly with nationality” (: 53).

<sup>64</sup> The ruling in *Gravier* was confirmed afterwards and extended to other types of higher education: see Cases C-24/86 *Blaizot* and C-42/87 *Commission v. Belgium*. The term “vocational training” covers “any form of

The importance of this judgement for the development of an intra-Community mobility of students cannot be overestimated. However, it is less welcomed by those Member States which, notably because of the universal nature of their national language, receive significantly more foreign students than they export national ones. *Gravier* places a heavier burden on these net-importers. The imbalance in flows of students and their financial implications have been repeatedly denounced; for the time being, the Court does not seem amenable to such objections (Case C-24/86 *Blaizot* : § 22; Green, Hartley and Usher 1991 : 191-192; O’Leary 1996 : 188-190).

### Concluding remarks

Green, Hartley and Usher (1991) rightly state that in this area, policy, rather than legal principle, is the dominant consideration (: 143). We submit that the explanation for the different approach taken by the Court in the health care cases and *Humbel* does not so much lie in the fact that those two areas are intrinsically different, but rather in the dissimilar background against which the patients and the Humbels asserted their rights. The former claimed a public benefit from their host Member State, to whose solidarity circle they belonged – and continued to belong. This is not altered by the sole fact that they applied to a provider of health care established in another Member State. This extension, of a territorial nature, does not entail significant adverse effects for the national scheme of health care provision, which in principle is not affected more than if the patient had obtained health care within the national borders.

That latter applied to a provider of public benefits, who at the same time was the payer thereof. Under these circumstances, an exchange of services for remuneration is hard to conceive. Moreover, and more fundamentally, they wanted that benefit to be paid for by the home Member State, with which they had no bond whatsoever. Neither the Humbels nor the Court were aware of being backed by the existence of a compensation mechanism at Community level, which could have relieved the host Member State financially. To allow the solidarity circle of a Member State to be broken into by people who have no appreciable link with that State – and no aim at establishing such a link – might actually seriously affect national welfare schemes. It would seem that the Court kept these considerations in mind when categorically excluding the public provision of education from the ambit of the Treaty Articles on services. The fact that the Court, a couple of years earlier, endorsed a general right to equal access to national education throughout the Community on the basis of Articles 12 *jo.* 149 and 150 ECT need not compromise our proposition. Rather than the Treaty provisions on services, Article 12 ECT offers a better framework for assessing the admittance of non-residents to public benefits in the host Member State (van der Mei 1998b : 397), a framework, paraphrasing Fuchs, that allows for a closure of the gates, if too much water were to stream in (*cf.* 2002 : 750).

### II.1.e. The Competition Cases

The Court of Justice has not only been the scene of battle for the conflict between the internal market and territoriality-based welfare schemes. Repeatedly, it has been asked to assess the

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education which prepares for a qualification for a particular profession, trade or employment or which provides the necessary skills for such a profession, trade or employment [...] whatever the age and the level of training of the pupils or students, even if the training programme includes an element of general education” (Case C-242/87 *Erasmus* : § 24). As such, it does not encompass primary and secondary education (Case C-263/86 *Humbel* : § 12). Yet it is to be assumed that, since the extension of Community powers in the field concerned through the Maastricht Treaty, Article 12 ECT can also be relied on to be granted equal access to those types of education (van der Mei 2003 : 375).

compatibility with the ECT rules on competition of activities of entities managing statutory schemes of social protection. An extensive discussion of this complex issue is outside our purpose. We will instead briefly look into the manner in which the Court leaves intact the exclusive rights awarded to these bodies to conclude that, once again, policy seems to prevail over principle.

As pointed out before, solidarity cannot be established on a voluntary basis. It presupposes, broadly, that all members of a given group are required to contribute, according to their income and irrespective of their risk profile, to the financing of a '*pot commun*', which is used to fund benefits, granted to those for whom the risk materialises (Dupeyroux 1990 : 743).

In essence, the confrontation between competition law and social security law arises from the fact that exclusive rights (monopolies) have been granted to the bodies governing social security schemes, in order for them to be able to perform their redistributive task (Kessler 1997 : 252)<sup>65</sup>. According to a well-established case law, "an undertaking vested with a legal monopoly may be regarded as occupying a dominant position within the meaning of Article [82 ECT]" (Case C-18/88 *RTT* : § 17). Pursuant to the first paragraph of that Article, "[a]ny abuse by one or more undertakings of a dominant position within the common market or in a substantial part of it shall be prohibited as incompatible with the common market in so far as it may affect trade between Member States".

For the Treaty provisions on competition to apply to institutions of social security, these institutions must be able to be qualified as 'undertakings'. The notion of undertaking, which is the key jurisdictional element for the application of the ECT, is a functional one, focusing on the subject-matter the entity in question is concerned with, as opposed to its institutional characteristics ("substance prevails over form") (Winterstein 1999 : 324-325). As the Court has consistently held, "the concept of an undertaking encompasses every entity engaged in an economic activity, regardless of the legal status of the entity and the way in which it is financed" (Case C-41/90 *Höfner* : § 21). If an activity is performed which, in the widest sense of the word, is of an economic nature, that is which could, at least in principle, be carried on by a private undertaking in order to make profits, then we are dealing with an undertaking for the purpose of the ECT competition rules (Van de Gronden 2004 : ; Joined Opinion of Advocate General Jacobs in Joined Cases C-67/96 *Albany*, C-115/97 to C-117/97 *Brentjens* and Case C-219/97 *Drijvende Bokken* : § 311). The Court has subsequently narrowed down this all-encompassing definition by incorporating the element of *imperium* to exempt these public entities whose activities flow from the state's sovereignty (C-364/92 *Eurocontrol*). This is merely the mirror image of the general principle: when exercising *imperium* (e.g. powers of coercion with regard to users of air space, the granting of licences and concessions), the State faces neither actual nor potential competition (Winterstein 1999 : 325-326; Louri 2002 : 159 e.s.)<sup>66</sup>.

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<sup>65</sup> See also Dupeyroux (1993) stating that "*tout le problème de l'application du droit de la concurrence aux régimes de Sécurité sociale [...] se ramène à une seule question : celle de savoir si l'Etat ou d'autres que l'Etat – partenaires sociaux ; représentants qualifiés des professions non salariées... - peuvent ou non être autorisés à instituer une solidarité entre les membres d'une collectivité déterminée face aux incidences de certains risques. Si c'est oui, le « pot commun », impliqué par l'idée même de la solidarité, est inéluctable et il exclut, par hypothèse, le jeu de la libre concurrence; si c'est non, il faut effectivement faire table rase de tous les régimes, légaux et conventionnels*" ( : 494).

<sup>66</sup> It has to be well understood that an activity neither loses its economic nature by the mere fact that it is exercised by the State or by a State body nor becomes economic by virtue of the fact that it is performed by a private company. The State may act either by exercising public powers or by carrying on economic activities (Winterstein 1999 : 327).

However, confronted with the question as to whether activities consisting in the administration of statutory social protection schemes are of an economic nature, the Court has departed from its functional approach. It has excluded these activities from the ambit of the ECT competition rules on the basis of the solidarity principle, thereby creating a new category of “non-undertakings” (Van de Gronden 2004 : 88; Baron 1998 : 495; Winterstein 1999 : 327). The principle of solidarity, in all its forms<sup>67</sup>, is used to determine whether the bodies concerned qualify as undertakings.

In *Poucet and Pistre* (Joined Cases C-159/91 and 160/01), the plaintiffs challenged the monopoly rights enjoyed by two French entities managing social protection schemes for self-employed persons (the one providing sickness and maternity insurance for self-employed persons in non-agricultural occupations and the other old-age pensions for craftsmen). They refused to pay their contributions, claiming that they should be free to take out equivalent private insurance. The Court did not rule in their favour; it held that the entities concerned could not be qualified as undertakings for the purposes of the Treaty rules on competition. In doing so, the Court took account of the income solidarity featured by the first scheme, as well as of the “intergenerational” solidarity ensuing from the financing of the old-age scheme as a pay-as-you-go system (: §§ 10-11). Furthermore, the Court appreciated the solidarity between the various social security schemes, according to which the schemes in surplus contribute to the financing of those with structural financial difficulties (: § 12). Yet the mandatory affiliation – underlying the dispute at hand – appeared to serve as the decisive factor in the Court’s reasoning : “[...] the social security schemes, as described, are based on a system of compulsory contribution, which is indispensable for application of the principle of solidarity and the financial equilibrium of those schemes” (: § 13).

This case law reiterated in *Cisal* (Case C-218/00), in which the compulsory affiliation with the Italian National Institute for Insurance against Accidents at Work (INAIL) was challenged. INAIL was given the task of operating, on behalf of the State and under its supervision, a system of compulsory insurance for workers against accidents at work and occupational diseases. Under that system, contributions were not systematically proportionate to the risk insured and were partly calculated on the basis of the insured person’s earnings, while the amount of benefits paid was not necessarily proportionate to these earnings (: §§ 39-40). From the absence of any direct link between the contributions paid and the benefits granted, the Court deduced a degree of solidarity between better paid workers and those who, given their low earnings, would be deprived of proper social cover if such a link existed (: § 42). This degree of solidarity, together with the fact that the amount of benefits and contributions was, in the last resort, fixed by the State and that affiliation was compulsory, made the Court conclude that INAIL’s activity was not an economic activity and that it does not therefore constitute an undertaking for the purposes of competition law (: §§ 43-45).

The approach taken by the Court is convincing because of its outcome, rather than being remarkable for any legal coherence (*cf.* Kessler 1997 : 258). Without exclusive rights, these entities would probably go down due to an overrepresentation of insured persons with an unfavourable risk profile. Indeed, the better-off, the healthy and the economically active will drop out and take out private insurance, offering them better conditions (Davies 2004 : 104).

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<sup>67</sup> Winterstein (1999) distinguishes “scope solidarity” (compulsory affiliation), risk solidarity, income solidarity, intergenerational solidarity (pay-as-you-go, as opposed to financing according to the capitalisation method) and inter-scheme solidarity (: 327-328).

On the other hand, it has been rightly pointed out that the solidarity-based exemption for entities monopolistically governing statutory social security schemes fits only awkwardly with the conceptual framework of the ECT, as generally applied by the Court of Justice (Winterstein 1999 : 330). Whereas the principle of solidarity indeed culminates in these statutory schemes, there are numerous other sectors, the economic character of which is hardly debatable, which incorporate elements of solidarity. Consider, for instance, along with other services of general economic interest, postal services, the provision of which is characterised by elements of risk solidarity and in respect of which the question as to the legitimacy of exclusive rights has been raised as well (see Case C-320/91 *Corbeau*). What is more, while the Court correctly stresses the link between compulsory affiliation and the solidarity principle<sup>68</sup> – the sacrosanct “*pot commun*” indeed presupposes a mandatory participation to the public *scheme* – such obligatory participation need not necessarily involve the awarding of exclusive rights to the managing *entities*. It is perfectly conceivable that several semi-public or even private<sup>69</sup> health insurers offer their services within a context of regulated competition. Within the limits set by the authorities (open enrolment, basic minimum cover, ban on risk selection) and through premium and package differentiation, these insurers bid for the favour of the insured person, who is liable for insurance yet has a free choice of health insurer. In order to compensate for differences in costs and risk portfolios, a risk adjustment mechanism is set up between these insurers<sup>70</sup>.

The Court’s recent judgement in *AOK* (Joined Cases C-264/01, C-306/01, C-354/01 and C-355/01), a case involving the German sickness funds operating within an environment of managed competition, serves to demonstrate the extent to which the Court has departed from its functional approach. In its view, “the latitude available to the sickness funds when setting the contribution rate and their freedom to engage in some competition with one another in order to attract members” does not detract from the fact that “the sickness funds are similar to the bodies at issue in *Poucet and Pistre* and *Cisal* and that their activity must be regarded as being non-economic in nature” (: §§ 55-56)<sup>71</sup>.

Several authors have criticised the solidarity-based creation of a novel category of non-undertakings (Winterstein 1999 : 330; Louri 2002 : 169 e.s.; cf. Houdijk 2004 : 193 and Baron 1998 : 49-500). They argue that, by totally excluding managing entities of statutory social security schemes, the Court confuses two essential matters: on the one hand, the question of the application of the competition rules (jurisdiction) and on the other hand the question of the

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<sup>68</sup> See further *FFSA* (Case C-244/94), in which the Court reached a different conclusion, based, however, on the same line of reasoning. It held that the scheme in question – a supplementary, optional retirement scheme for self-employed French farmers operating in accordance with the principles of capitalisation – notwithstanding the fact that it pursued a social objective, lacked any profit motive and had some solidarity features, was an undertaking since the degree of solidarity was insufficient to remove it from the scope of the competition rules: “[i]n any event, the principle of solidarity is extremely limited in scope, which follows from the optional nature of the scheme. In those circumstances, it cannot deprive the activity carried on by the body managing the scheme of its economic character” (: § 19). See also Case C-238/94 *García* : § 14.

<sup>69</sup> See in this regard the future Dutch care insurance scheme, described by Houdijk 2004 : 181-196.

<sup>70</sup> A risk adjustment mechanism is at the same time a guarantee for maintaining solidarity and a precondition for healthy competition, neutralising incentives for risk selection. See Van de Ven, Beck *et al.* 2003 : 75-98 and Gress, Groenewegen, *et al.* 2002 : 235-254.

<sup>71</sup> In his Opinion, Advocate General Jacobs took the view that the *Krankenkassen* were to be qualified as undertakings: “[i]t [...] appears that the sickness funds are indeed able to compete, albeit within defined margins, with one another and with private undertakings in the provision of health insurance services. Given the existence of such competition, the EC competition rules should in my view apply” (: § 42). See also Slot (2004), who found conclusive evidence that the sickness funds acted as undertakings (: 586). See further Belhaj and Van de Gronden (2004), stating that “[t]he Court would probably have respected its own jurisprudence if it had followed the approach that the Advocate General Jacobs advocated in his opinion in the *AOK* case” (: 687).

justification of aspects restrictive of competition (justification). Rather than a measure of the level of solidarity and, hence, of the non-economic character of the activity performed by the entities governing social security schemes, compulsory affiliation to these entities should be reduced to what it essentially is: a restriction of competition, which might however be justifiable on the strength of Article 86 § 2 ECT<sup>72</sup>. The (peaceful) coexistence<sup>73</sup> between competition law and social security would then take the shape, not of utter *separation*, but rather of a *compromise*, whereby the elements of solidarity displayed by the scheme concerned, including compulsory affiliation, would be left intact because (but in so far as) these are necessary for the performance of the particular, redistributive tasks with which it is entrusted (Bosco 2000 : 14). Such cases will have to be assessed on an individual, one-off basis (Hatzopoulos 2002 : 721).

### II.1.f. Conclusion

As a rule, the Court takes the “first hurdle”, that of the applicability of the rules regarding the free movement of services and competition, with ease. In so doing, it can draw from a vast array of case law, in which the core principles “remuneration” and “undertaking” are consistently given a wide interpretation. Quite often, the first hurdle – like the second one, consisting in the finding of a restriction – is merely a formality, a prelude to the more substantive question at the stage of justification, “where the law does its real work” (Davies 2004 : 102). At that third stage, Member States are given a forum to express their legitimate interests, which under certain conditions take priority over the interest of an unimpeded common market.

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<sup>72</sup> Artikel 86 § 2 ECT states that “[u]ndertakings entrusted with the operation of services of general economic interest or having the character of a revenue-producing monopoly shall be subject to the rules contained in this Treaty, in particular to the rules on competition, in so far as the application of such rules does not obstruct the performance, in law or in fact, of the particular tasks assigned to them. The development of trade must not be affected to such an extent as would be contrary to the interests of the Community”. The Court adopted this approach in the *Albany* case (Case C-67/96), in which the mandatory affiliation to a Dutch sectoral pension fund was held against the light of European law. The Court qualified the fund, which was financed on a capitalisation basis, as an undertaking. Yet the issue of solidarity re-entered the scene at the stage of justification. Having observed that the exclusive right of the sectoral pension fund to manage the pension fund restricted competition and constituted a breach of Article 86 § 1 ECT, the Court examined whether that breach was justified under § 2 of Article 86, and concluded in the affirmative. It held that the pension scheme at issue did fulfil a “service of general economic interest” and that its exclusive right was necessary for the performance of that service. In reaching this conclusion, the Court explicitly considered matters of social solidarity. The fund at issue displayed a high level of solidarity, resulting, in particular, from the fact that contributions do not reflect the risk, from the obligation to accept all workers without a prior medical examination, the continuing accrual of pension rights despite exemption from the payment of contributions in the event of incapacity for work, the discharge by the Fund of arrears of contributions due from an employer in the event of insolvency and the indexing of the amount of pensions in order to maintain their value. Moreover, the Court observed that: “[i]f the exclusive right of the fund to manage the supplementary pension scheme for all workers in a given sector were removed, undertakings with young employees in good health engaged in non-dangerous activities would seek more advantageous insurance terms from private insurers. The progressive departure of ‘good’ risks would leave the sectoral pension fund with responsibility for an increasing share of ‘bad’ risks, thereby increasing the cost of pensions for workers, particularly those in small and medium-sized undertakings with older employees engaged in dangerous activities, to which the fund could no longer offer pensions at an acceptable cost. Such a situation would arise particularly in a case where, as in the main proceedings, the supplementary pension scheme managed exclusively by the Fund displays a high level of solidarity resulting, in particular, from the fact that contributions do not reflect the risk, from the obligation to accept all workers without a prior medical examination, the continuing accrual of pension rights despite exemption from the payment of contributions in the event of incapacity for work, the discharge by the Fund of arrears of contributions due from an employer in the event of insolvency and the indexing of the amount of pensions in order to maintain their value” (: §§ 108-109).

<sup>73</sup> Cf. *Idot* 1999 : 4-8.

The – foretold – confrontation with the national welfare state shows a different, original picture. The answer to the question of the applicability of the rules on services and competition seems contingent upon considerations which usually only come to the fore in the third phase, that of justification. When an answer in the affirmative threatens to put at risk the survival of the welfare scheme concerned, the Court appears to back down and refrain from taking the first hurdle. Such cases are blocked at the stage of jurisdiction, even if, from a strictly legal perspective, this need not be so.

It would seem that the health care cases reflect the Court's conviction that the partial loss of the (first aspect of the) territoriality principle does not substantially impair the maintenance and the financial equilibrium of the national systems of health care provision, even though it might “[affect] the ways in which health-care expenditure may be controlled in the Member State of affiliation” and even if it entails for some Member States the establishment of mechanisms for *ex post facto* reimbursement in respect of care provided in another Member State (*cf. Müller-Fauré and Van Riet* : §§ 94 and 102 e.s).

The same does not hold true for *Humbel* and the competition cases. To allow service recipients, through unconditional access to publicly financed benefits, to burden the public purse of the host Member State, and with which State the affinity must not go beyond an appreciation for the quality of the national education scheme, is less innocuous and is actually liable to significantly affect the stability of the scheme in question. Likewise, the entities in the competition cases, who managed statutory schemes of social protection, could not survive without the exclusive rights awarded to them. Only by radically reorganising the entire scheme could solidarity be preserved<sup>74</sup>.

It seems no coincidence that the Court declared the common market rules inapplicable in *Humbel* and the competition cases, as they are situated along the *membership* axis (*cf. Ferrera* 2003 : 4-5 and 24 e.s.). Much more than the mere *territorial* dimension, which was at stake in the health care cases (cross-border access to public benefits without leaving one's redistributive space), the membership dimension goes to the heart of the national welfare state. Only those people who reside within the State borders and who have located the centre of their private and economic interests there, can gain, as members, access to welfare benefits. The solidarity which is instituted between those members supposes a double closeness. The members, who find themselves within the solidarity circle, cannot leave that circle, on pain of pulling down the foundations of redistribution (*cf. the competition cases*); non-members in principle cannot enter the circle, on pain of gravely jeopardising the stability and the equilibrium of the welfare scheme concerned (*cf. Humbel*).

It has been rightly pointed out that “the issue of reconciling the principle of social protection with that of free movement in a widening market has been taken more seriously by the Court than usually acknowledged” (Ferrera 2003 : 26). The over-simplified perception of the Court as a “market police” clearly needs adjustment. In some crucial cases regarding the relationship between the common market and the national welfare state, the Court has sided with the latter (*cf. ibid.*). It has resolutely defended essential prerequisites for the maintenance of national solidarity, whereby the prospect of serious adverse effects on that vital principle through the application of the common market rules appears to result in the complete exemption therefrom. This exemption has its origins not so much in the fact that welfare state

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<sup>74</sup> And even then the scheme would not be out of the firing line of the Community common market rules, in particular the third non-life insurance directive. See on this RVZ 2002 : 32 e.s. and Houdijk 2004 : 186-188.

activities do not meet the conditions broadly defined by the Court to that end, but rather in the fact that the organisation of welfare schemes, notably of social security and national education, remains a matter for the Member States. Community law does not regulate these areas directly, nor does it impinge on them, where its application would have the effect of seriously jeopardising the stability of national welfare schemes and, notably, the principle of solidarity contained in them (*cf.* the Joined Opinion of Advocate General Tesouro in Cases C-120/95 *Decker* and C-158/96 *Kohll* : § 22; Winterstein 1999 : 331; Hatzopoulos 2002 : 721 e.s.).

A closing remark: the solidarity-based exemption from the Treaty provisions on the free movement of services and on competition cannot hide the fact that the Court of Justice, in another field, is stretching the boundaries of redistribution beyond individual Member States (*cf.* Ferrera 2003 : 30). As the free movement of persons, parallel to the development of the concept of Union citizenship – which is “destined to be the fundamental status of nationals of the Member States” (Case C-184/99 *Grzelczyk* : § 31) – gradually breaks free from the economic grip of the internal market (Dougan and Spaventa 2003 : 703), elements creep in the Court’s case law that allude to an intra-Community solidarity. Through the provision of Article 12 ECT, read in conjunction with Article 18 of the Treaty, nationals of the Member States might advance at least some claims over the social welfare system of another Member State with which he has no connection based on nationality or economic status (*ibid.* : 711). The judgements in *Martínez Sala* and *Grzelczyk* are of great importance in that respect<sup>75</sup>. Yet one should guard against jumping to conclusions regarding cross-border access to foreign redistributive spaces. The said cases cannot be seen outside their factual context and, it must be remembered, concerned (economically inactive) residents. Underlying the Court’s approach, and with the *Gravier* case law as a notorious exception, there seems to be a presumption that the consequences of the request for access to public benefits in the host Member State must be weighed against the link which the applicants has with that State. When these consequences are significant, which is most likely to be the case with tax-funded “income benefits”, and to a lesser extent with education and health care, residence requirements might constitute necessary and proportionate measures. This was confirmed recently in the *Collins* judgement, endorsing what has been called a “proximity principle” (Carlier 2005 : 71 and 74).

This judicial reserve is appropriate: it is one thing to supply Union citizens with generous welfare rights throughout the Community; it is quite another to foot the consequent welfare bill. Pan-European solidarity ambitions will eventually run up against the lack of a European-wide organised collection and pooling of financial resources (Dougan and Spaventa 2003 : 704; Tomuschat 2000 : 454). The establishment thereof, which would bring the “ever closer union among the peoples of Europe” to another level, does not seem near.

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<sup>75</sup> See e.g. Cases C-85/96 *Martínez Sala* and C-184/99 *Grzelczyk*. In the latter judgement, the Court explicitly refers to “a certain degree of financial solidarity between nationals of a host Member State and nationals of other Member States” (: § 44).