

THE EUROPEAN COURT OF JUSTICE, TRANS-NATIONAL HEALTH CARE, AND SOCIAL CITIZENSHIP – ACCIDENTAL DEATH OF A CONCEPT?

CHRISTOPHER NEWDICK*

I. INTRODUCTION

How do the concepts of social citizenship and solidarity affect the way we organize health care? They are common to any system based on finite resources, whether organized through a single national authority, such as the Beveridgean systems found in Sweden and the United Kingdom (UK), or private social insurers working within statutory constraints, as in the Bismarkian systems of France and Germany.¹ The sense of solidarity is reflected in the popular understanding that these systems are based on a complex of redistributive cross-subsidies “from rich to poor, from well to ill, from young to old, from single people to families and from workers to the non-active.”² It implies a commitment to universality, in which a whole community is included in the system; that the funding of contributions is assessed without reference to an individual’s state of health, and entitlement to benefits is based on the principle of equal access for equal need.³ Solidarity “animates the European idea of health care to this day. It encompasses the mutual responsibility of citizens for the health care of each other, equitable access to care, and

* Professor of Health Law, The University of Reading, UK. (With acknowledgement to Dario Fo, *Accidental Death of an Anarchist*.)

¹ Although blurred in practice, the paradigm distinction is that *Beveridgean* systems use central funding to support health care through *national taxation*. In contrast, *Bismarkian* systems use regulated social *insurance* schemes to fund health care, in which health care insurers must provide patients with standard benefits at standard prices, irrespective of their individual risk. In both systems the resources available are finite. See generally RICHARD FREEMAN, *THE POLITICS OF HEALTH IN EUROPE* (2000).

² European Integration and National Health Care Systems: A Challenge for Social Policy, Ghent, Belgium, Dec. 7-8, 2001, *The Influence of EU Law on the Social Character of Health Care Systems in the EU*, 2 (Nov. 19, 2001) (prepared by Elias Mossialos, Martin McKee, Willy Palm, Beatrix Karl & Franz Marhold), available at www.ose.be/health/files/summary.pdf.

³ See generally Vassilis Hatzopoulos, Financing National Health Care in a Transnational Environment: the Impact of the European Community Internal Market, 26 WIS. INT’L L.J. (forthcoming 2008).

it assumes that, in the face of illness and the threat of death, we are bound together by common needs that require a community response.”⁴

These sentiments are sometimes juxtaposed against the greater cultural commitment to individualism in the United States (U.S.).⁵ As a result, perhaps, social cohesion may be less obvious to members of Health Maintenance Organizations based on private contractual entitlements to care, but it cannot be irrelevant.⁶ As pharmaceutical technology advances, life expectancy increases, and we discover how to treat chronic conditions with expensive care over many years, the problem of hard choices becomes a challenge for us all. Only those with means to pay directly for their care without insurance can have wholly unrestricted access to care. Otherwise, systems of health insurance serving a broad community of interests require us to grapple with concepts of social cohesion and equality and to understand how individual claims to finite health care resources should be resolved if they compete with the similar interests of others.

However this emphasis on community sits uncomfortably with a modern rights based approach. For example, Ronald Dworkin is concerned about the way in which utilitarianism may undermine the status of the individual. Modern individual-focused approaches to rights resist pressure to “deny me that which is properly mine,” even if the public would benefit as a result.⁷ The tension between these “social” and “individual” rights based approaches has been illuminated in European Union (EU) law in connection with trans-national access to health care. The European Court of Justice (ECJ) has developed a notion of health care rights in which individuals within social health care systems may be free to enforce their personal claims to health care without regard to their impact on other people. This article examines the forces involved in ba-

⁴ DANIEL CALLAHAN & ANGELA A. WASUNNA, *MEDICINE AND THE MARKET: EQUITY V. CHOICE* 90 (2006).

⁵ *See id.* at ch. 3.

⁶ *See generally* TIMOTHY STOLTZFUS JOST, *DISSENTLEMENT? THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE* (2003) and Timothy Stoltzfus Jost, *Health Care Access in the United States: Conflicting Concepts of Justice and Little Solidarity*, in *INTERNATIONAL HEALTH CARE LAW—SOLIDARITY AND JUSTICE IN HEALTH CARE* (A.P. den Exter, 2008). *See also* ROBERT J. BLENDON, ET AL, *THE MASSACHUSETTS HEALTH REFORM LAW: PUBLIC OPINION AND PERCEPTION* (2006), available at http://www.bcbsmafoundation.org/foundationroot/en_US/documents/2006HealthReformPollingreport.pdf. Ronald Dworkin describes the absence of comprehensive health care coverage in the US as “our national disgrace.” RONALD DWORKIN, *SOVEREIGN VIRTUE, THE THEORY AND PRACTICE OF EQUALITY* 318 (2000).

⁷ RONALD DWORKIN, *TAKING RIGHTS SERIOUSLY* 269 (1977).

lancing the rights of individuals to health care with those of others and the relevance of social rights to the question. I argue that social citizenship is crucial to our sense of justice in social welfare. If the balance puts undue emphasis on the *individual*, we undermine cohesive forces that hold citizens together. Although the ECJ seems to have promoted this latter policy, I suggest that it has not fully grasped the implications of its decisions.

Part II of this article considers the nature of rights of access to health care. It highlights the differences between *civil* and *social* rights by using an explanatory model developed by T.H. Marshall. This illuminates a crucial distinction that is sometimes lost in the “rights debate.” Part III of this paper discusses the ECJ’s influence on health care solidarity. It observes how the Court has encouraged the development of an individualistic conception of rights to health care without properly recognizing its potential to undermine the rights of access of other people, in other words that it has not given proper recognition to social rights. Part IV examines whether the European Court of Justice’s impact can fairly be described as deliberate policy making, or rather, an unintended accident and suggests that it has not fully understood the way in which its decisions may dilute commitments to “community” which we take for granted. Finally, Part V concludes by defending the distributive ethics practiced in English health authorities, in which individual rights are balanced with the rights and needs of other people. It suggests that courts should not promote policies which happen to benefit some, without understanding whether, in doing so, they have diluted the rights of others.

II. SOCIAL RIGHTS TO HEALTH CARE

A helpful analytical framework in which to consider these issues is provided by T.H. Marshall’s celebrated theory of the rights arising from citizenship. Marshall conceived of citizenship as having evolved in three stages between the eighteenth and twentieth centuries: from civil, through political, to social citizenship. He explained the distinctions, which he thought were more the product of history than logic, as follows:

The civil element is composed of the rights necessary for individual freedom—liberty of the person, freedom of speech, thought and faith, the right to own property and to conclude valid contracts, and the right to justice . . . By the political element I mean the right to participate in the exercise of political power, as a member of a body invested with political authority or as an elector of the members of such a body . . . By the social element I mean the whole range from the

right to a modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilized being according to the standards prevailing in the society. The institutions most closely connected with it are the educational system and the social services.⁸

The contrast between the largely negative rights implied by civil rights and the positive rights contained in welfare services is marked. The civil rights which protect us from unwarranted interference are more easily understood as being derived from fundamental principles. They arise naturally from our commitment to autonomy, democracy, freedom of speech, religion, and assembly. They are to a greater extent “absolute,” in the sense that they should be respected unless there are compelling reasons for not doing so; and they are more easily enforced by the courts as substantive rights.

By contrast, it is difficult to defend Marshall’s conception of social rights with the same logical force. Perhaps the difficulty is that social rights or social citizenship is more difficult to describe in terms of “fundamentals.” First, social rights are not remotely “absolute.” They are relative, or aspirational, in the sense that the rights they create are dependent upon the will of the legislator or the discretion of a public authority. In common with many health care systems (be they public or private), the right of access to treatment is dependent upon a variety of factors including the promise made by the framework of rights conferred, the patient’s condition, and whether treatment is likely to be effective and affordable. Second, the rights involved are often procedural rather than substantive. They give rise to rights of judicial scrutiny, but not of access to the treatment itself. This also implies that the nature and extent of the welfare rights conferred by social citizenship are determined, not solely by reference to fundamental principles, but also to economics and government policy, affected as it often is with politics and the squalls of electoral anxiety. The result of these differences is that one side of the citizenship equation appears to have developed without proper attention being given to the other. Civil rights enjoy recognition not given to social rights. Frank Michelman, speaking about the failure of legal theory to accommodate the tensions that arise between civil and social rights, said that “the mainstream of our legal tradition has largely bypassed the outcome-appraising sort of distributional concern.”⁹ While the legal tra-

⁸ T.H. MARSHALL & TOM BOTTOMORE, *CITIZENSHIP AND SOCIAL CLASS* 8 (1992).

⁹ Frank I. Michelman, *In Pursuit of Constitutional Welfare Rights: One View of Rawls’ Theory of Justice*, 121 U. PA. L. REV. 962, 963 (1973).

dition has focused on the enforcement of abstract principles of rights, it is “noticeably lacking in norms, principles, and categories of analysis directly applicable to the evaluation of distributional outcomes.”¹⁰

How do social rights compare to the more concrete and substantive civil rights and what role do they play in articulating and strengthening notions of citizenship? If we agree with the communitarians that we are inherently social, interdependent creatures whose lives are enriched by, for example, cohesion, culture, and cooperation, social citizenship captures the duty to have regard for others and the responsibility to devise systems capable of doing so. It is true that giving effect to such a state of society is difficult to describe in terms of fundamental principles; for this reason, the extent to which the United States, the United Kingdom, or the Nordic countries invest in social welfare by redistributing individual wealth is very different.¹¹ But if we imagine a laissez-faire world devoid of any such commitment, where the rights of one could be enforced irrespective of their impact on others, a world of acquisitive individualists with limited sentiment for others, then we understand the fundamental impact of the concept.

Of course, this notion of social citizenship assumes the existence of cross subsidization. Consequently, decision making in this area can never be politically neutral because it promotes public interests and involves issues of health care priorities and welfare redistribution.¹² In a public health care system, this involves much more than a simple aggregation of individual interests.¹³ For example, in creating and organizing such a system of health care, thought might be given to its basic “corporate” objectives; is it to promote utilitarian values and the best health of the largest number of patients? Or are egalitarian concerns also pertinent, for instance, to reduce health care inequalities between different groups of people? Or should we broadly leave matters to the clinicians to treat those in most clinical need? Of course, there is no “right” answer to these questions. Rudolf Klein has observed that: “As medical tech-

¹⁰ *Id.* Emphasis added.

¹¹ See GØSTA ESPING-ANDERSEN, *THE THREE WORLDS OF WELFARE CAPITALISM* (1990).

¹² Dan E. Beauchamp, *Community: The Neglected Tradition of Public Health*, HASTINGS CENTER REPORT 15[6], Dec. 1985, at 28, *reprinted in* PUBLIC HEALTH ETHICS: THEORY POLICY AND PRACTICE 45, 51 (Ronald Bayer et al. eds., 2007).

¹³ For such an approach, asking whether prudent individuals would insure themselves against particular risks, see RONALD DWORKIN, *SOVEREIGN VIRTUE: THE THEORY AND PRACTICE OF EQUALITY* 307-319 (2000).

nology, the economic and demographic environments, and social attitudes change, so almost certainly will our priorities.”¹⁴

To demonstrate the normative nature of this exercise, let us consider three levels of health care decision making and the extent to which hard choices may be required between competing interests and objectives. First, at the level of clinical practice, decisions may be required whether to invest more treatment (or less) in patients who are desperately ill and for whom further care is unlikely to restore their health. When all other treatment has failed, should the “rule of rescue” require investment in treatments whose beneficial effects are unproven or marginal, especially if it means “disinvesting” from other patients on well established care? (Patients with rare diseases who need expensive “orphan” drugs¹⁵ are especially interested in this question).¹⁶ More generally, should doctors ever consider whether further “investment” in one patient in terms of treatment, will compromise the “return” available from others in respect of their recovery?

Second, in respect of health care policy, should those sections of the community with poor standards of health attract comparatively more funding per capita in order to promote equality of health outcomes in the community (e.g., through additional investment to tackle diet, smoking, and drug abuse)?¹⁷ How should we judge whether different patient groups are being treated equally, for instance, as between neonatal, pediatric, orthopedic, maternity, cancer, or mental health care? Have some groups been systematically under-funded, such as elderly patients, or should their care be reduced on the basis that they have had their “fair

¹⁴ Rudolf Klein, *Dimensions of Rationing: Who Should do What?* in RATIONING IN ACTION 103 (1993).

¹⁵ Orphan drugs are so called because they treat diseases from which very few patients suffer. Because demand is low, they may be expensive to develop and sell. They receive certain dispensations in the licensing process to make development less expensive if they treat life-threatening conditions affecting not more than 5 in 10,000 people. See The Orphan Drugs Act, Pub. L. No. 97-414, 96 Stat. 2049 (1983) (codified as amended in scattered sections of 21 U.S.C. and 42 U.S.C.). See also European Council Regulation on Orphan Medicinal Products, EC Reg. 141/2000, 2000 O.J. (L 18/1).

¹⁶ The rule of rescue presumes that, if required, vast sums of money should be spent saving individuals, without regard to its impact depleting the resources available to others. We tend to accept the presumption in connection with emergency services as a statement of our humanity and commitment to each another. However, it is difficult to sustain as a general principle in health care systems constrained by finite resources. See DWORKIN, SOVEREIGN VIRTUE, *supra* note 6 at 309-13.

¹⁷ Norman Daniels et al., *Why Justice is Good for Our Health: The Social Determinants of Health Inequalities*, 128 DAEDALUS 215 (1999), reprinted in PUBLIC HEALTH ETHICS, *supra* note 12, at 205, 221.

innings” of life?¹⁸ Should spending on the needy be diverted and directed towards those who are currently well in the interests of preventive care (e.g., to reduce levels of coronary heart disease, obesity, and diabetes in future years)?

Third, on the larger scale of organizational, or institutional policy, should the monies invested in health care be increased relative to those devoted to, say, education, the environment, defense, or housing? Should markets and micro-pressures drive health care institutions, or should central guidance and policy-making also have a role? Should patients be encouraged to perceive themselves as “consumers” of services with individual rights or does this increase the danger of inequality between competing groups (especially the inarticulate and poorly represented). Should, for example, the United Kingdom’s National Health Service (NHS) encourage private health care providers to compete for services with public hospitals as a lever to force quality up and price down or does this fragment or “commodify” the system and dilute its sense of public commitment? Who should make these decisions: doctors, health care managers, politicians, expert committees, patients, or the public? All these issues involve sensitive trade-offs between competing objectives. They are the stuff of policy and politics and involve difficult choices between competing objectives. As noted above, this enterprise cannot be undertaken by simply attempting to aggregate individual rights.

Recognizing the normative nature of this activity, UK courts have largely deferred to the reasonable decisions of statutory health authorities appointed to the task.¹⁹ Courts are unsuited to engage in substantive judgments about health care resource allocation, especially when decisions may affect patients who are not before the courts.²⁰ In claims for judicial review, the statutory authority is subjected to close scrutiny to determine whether it has considered relevant factors and given them proper weight. Thus, the UK courts insist that, amongst the relevant factors, there must be a genuine attempt to balance public and private interests. If individuals are to be denied access to treatment, they are entitled

¹⁸ Norman Daniels, *A Lifespan Approach to Health Care*, in *AGING AND ETHICS* 227, 233-39 (Nancy S. Jecker ed., 1991).

¹⁹ Statutory health authorities in the National Health Service are called “Primary Care Trusts” in England, “Health Boards” in Scotland, and “Local Health Boards” in Wales. See National Health Service Act, 2006, c. 41, § 7 (Eng.); National Health Service (Scotland) Act, 1978, c. 29, § 2; National Health Service (Wales) Act, 2006, c. 42, § 11.

²⁰ See *Re J* [1992] 4 All E.R. 614, 625 (Eng.).

to know that the merits of their individual circumstances were properly weighed and balanced.²¹ But even in the case of successful review, the remedy is normally procedural only. The matter will normally be referred back to the decision maker to be taken again because the court has neither the competence, nor the authority to deal with these matters on its own.²² While it is true that the intensity of judicial scrutiny has increased significantly over the past ten years, the principle of deference remains intact.²³ For this reason, the public, positive, procedural, and relative social rights created by policy commitments to social welfare may be distinguished from the private, negative, substantive, and civil rights about which so much more tidiness of analysis is possible.

There is a further component to social citizenship; citizenship requires that those who represent the public should be publicly accountable. At the parliamentary and local government levels, the matter is determined by periodic elections, but what equivalent reassurance can be given by health authorities making difficult choices in the public interest? In the UK, for example, health authorities are under a duty to consult on matters concerning the development and operation of NHS services.²⁴ But who is “the public” for these purposes? Obtaining the views of pressure groups is easy, but partisan affiliations do not represent “the public.” On the other hand, if “neutral” public representatives are recruited with insufficient expertise to engage in proper debate, they may be considered to be “tokens” with no independent function. Also, is it reasonable to expect the public to become actively engaged in making distinctions between deserving cases? The evidence suggests that they will not do so willingly.²⁵ Equally important, should potentially volatile public opinion dictate health care policy? Surely, if hard decisions are called for, we should also depend upon the expert bodies appointed to

²¹ See, e.g., *R v. N. Derbyshire Health Auth. ex parte Kenneth Graeme Fisher*, [1997] EWHC Admin 675 (Eng.); *R v. N. Derbyshire Health Auth. ex parte Kenneth Graeme Fisher*, [1998] 38 BMLR 76; *N.W. Lancashire Health Auth. v. A, D & G*, [2000] 53 BMLR 148 (Eng.); *Otley v. Barking and Dagenham NHS Primary Care Trust*, [2007] EWHC 1927 (Admin) (Eng.).

²² *Otley*, [2007] EWHC 1927 at para. 25

²³ When health authorities are unsuccessful in defending their actions in judicial review, although they are free in legal theory to reaffirm the decisions for which they have been criticized, they tend not to do so and to fund the care about which complaint has been made.

²⁴ The present duty to consult in England is contained in the National Health Service Act, 2006, c. 41, §§ 242-44 (Eng.).

²⁵ Jonathan Lomas, *Reluctant Rationers: Public Input to Health Care Priorities*, 2 J. HEALTH SERVICES RES. POL'Y 103, 105 (1997).

make them.²⁶ In the UK, the NHS has not entirely understood how best to engage the public in this difficult and sensitive area and this does not assist arguments for solidarity and social cohesion in the health care debate.

III. EUROPEAN INFLUENCES ON HEALTH CARE SOLIDARITY

EU law now affects these somewhat recondite aspirations based on social citizenship.²⁷ Given its post-war genesis, the EU has always respected the concepts of solidarity and social cohesion. As the European Social and Economic Committee has said, the European Union “is founded on certain common values: freedom, democracy, respect for human rights and dignity, equality, solidarity, dialogue, and social justice . . . The achievements of the European Social Model, which has evolved over [a] long time, are substantial in economic, social, and environmental terms. The emergence of a European Welfare Area is the most tangible result.”²⁸ In truth, however, although the EU has achieved much in respect of political and economic harmony, its jurisdiction in respect of social policy is limited. It holds very limited budgets of its own and the EU Treaty expressly reserves to the Member States the right to determine matters of health policy.²⁹ In addition, notions of “dignity, equality, solidarity, and social justice” are difficult to define and the Committee makes no attempt to describe what they mean in these documents. In fact, there are a whole range of meanings of these notions, each of which

²⁶ One solution has been to give committees appointed by local government authority to inspect NHS institutions and make recommendations. See the discussion of Overview and Scrutiny Committees (OSCs) in CHRISTOPHER NEWDICK, *WHO SHOULD WE TREAT?* 217-20 (2d ed. 2005). The statutory powers of OSCs are described in the National Health Service Act, 2006, c. 41, §§ 244-47 (Eng.).

²⁷ For a more sanguine analysis, see EU LAW AND THE WELFARE STATE: IN SEARCH OF SOLIDARITY (Gráinne de Búrca ed., 2005). See also Mark L. Flear, *Developing Euro-Biocitizens through Migration for Healthcare Services*, 14 MAASTRICHT J. EUR. & COMP. L. 239, 259 (2007), arguing that a pan-European approach may lead to “patients becoming obligated to migrate for healthcare services responsibly.”

²⁸ Opinion of the European Economic and Social Committee on Social Cohesion: Fleshing Out a European Model, 2006 O.J. (C 309) 25, §§ 1.6, 2.1.2.1.

²⁹ Article 152(5) EC provides that “Community action in the field of public health shall fully respect the responsibilities of the Member States for the organization and delivery of health services and medical care.” TAMARA K. HERVEY & JEAN V. MCHALE, *HEALTH LAW AND THE EUROPEAN UNION* 80 (2004). However, the duty to offer employment without reference to EU nationality is not affected. See SCOTT L. GREER, *THE NEW EU HEALTH POLICY AND THE NHS SYSTEMS* 11 (2005).

may have different policy implications. They may be understood to mean, for example:

Europe as a framework for peace, with integration marking the final end of nationalistic conflict; Europe as a liberal market economy with free competition as the source of prosperity, and a functioning single market open to world trade as a goal in itself; Europe as an economic and social arena with the harmonization of living conditions as a form of inner-European redistribution and development policy, as well as with frontiers erected against the outside world to preserve the relative homogeneity of the Western European industrial nations; Europe as a powerful player in the global competition for technological and economic leadership, requiring a targeted industrial policy and concentration of forces in competition with the outside world; Europe as a great power based on its unified economic right, serving as a platform for action to exert its political will.³⁰

These differing perceptions help explain, perhaps, why EU law took a sympathetic and deferential view of the challenges faced by national welfare systems. The “four freedoms” guaranteeing freedom of movement of labor, capital, goods, and services were used to promote private commerce within a free trade community, but they were not thought to impinge on the provision of public services.³¹ To this extent, the EU respected the politics of welfare provision, the difficult choices it provoked, and the jurisdiction of Member States to resolve how best to respond. For example in *Belgium v. Rene Humbel and Marie-Therese Edel*,³² a French family whose child was educated in Belgium claimed a right to cross border education and exemption from fees charged in Belgium to parents of non-Belgian school children. The claim was rejected because state funded education was not a “service” within the meaning of the EU Treaty on the ground that it was not “of an industrial or commercial character [or] the services of craftsmen and the professions.”³³ Public education did not engage the State in a commercial activity. Rather, the State was fulfilling broader public duties promoting culture and education. Thus, while the principle of free movement of services ap-

³⁰ Ernst-Wolfgang Böckenförde, *Conditions for European Solidarity*, in WHAT HOLDS EUROPE TOGETHER? 30, 31 (Krzysztof Michalski ed., 2006). See also STEINAR STJERNO, SOLIDARITY IN EUROPE: THE HISTORY OF AN IDEA (2004).

³¹ See generally CATHERINE BARNARD, THE SUBSTANTIVE LAW OF THE EU-THE FOUR FREEDOMS (2004).

³² Case 263/86, *Belgian State v. Rene Humbel and Marie-Therese Edel*, 1988 [EUECJ] R-263/86, paras. 2-5.

³³ *Id.* at para. 16.

plied to private enterprise, EU law did not create a right to obtain public education services without charge in another Member State.

A further explanation for this restriction on the right of access to cross border public services was given in the case of an application to obtain health care in a “host” Member State at the expense of the “home” health insurer. In *Smits and Peerbooms*, the Advocate General advised the European Court of Justice that cross-border responsibility for health care should not normally be permitted because it could lead to an unplanned influx or exodus of patients and make management and financial planning difficult.³⁴ This would not serve patient interests more generally. Therefore, he advised that prior authorization was a necessary and proportionate requirement to preserve stability and equilibrium in the health care systems of the Member States. This approach tends to create relative and procedural rights and is consistent with an approach which balances the range of interests, both public and private, that compete for priority in this area.

A change of direction has been introduced, however, by the ECJ. There has been a dilution of this deference to Member States in respect of health care and a commitment to introducing individualistic, EU transnational health care rights. Thus, rejecting the Advocate General’s concern for public interests, in *Smits and Peerbooms*, the ECJ said that the right to obtain treatment abroad arises provided (a) the treatment is “normal” in the sense that it “is sufficiently tried and tested by international medical science,” and (b) the same or equally effective treatment cannot be obtained “without undue delay” within the patient’s own Member State.³⁵ Although the ECJ recognizes the need for priority setting in public health care systems, individual rights have been given such a status that they are always likely to trump broader community interests. Thus, the Court refers to the risk of unplanned demand undermining financial balance in social security systems and that this might “constitute an overriding reason in the general interest capable of justifying an obstacle to the freedom to provide services.”³⁶ However, such a limitation is put under severe strain because its salient concern is not for the community as a whole, but the substantive interests of individual patients.

³⁴ Case C-157/99, *Smits and Peerbooms*, 2001 E.C.R. I-5473, para. 72.

³⁵ *Id.* at para. 108.

³⁶ Case C-372/04, *R (Watts) v. Bedford Primary Care Trust*, 2006 E.C.R. I-4325, para. 103 [hereinafter *Watts* (ECJ)]. See also Jean V. McHale, *Framing a Right to Treatment in English Law? Watts in Retrospective*, 14 MAASTRICHT J. EUR. & COMP. L. 263 (2007).

The difficulty is explained in *R (Watts) v. the Secretary of State for Health* in which the English Court of Appeal, faced with precisely this tension, raised the question of fairness and equality of access between patients in these circumstances.³⁷ The Court of Appeal observed that a right to obtain treatment elsewhere in the EU “would disrupt NHS budgets and planning and undermine any system of orderly waiting lists.”³⁸ The Court of Appeal continued:

... if the NHS were required to pay the cost of some of its patients having treatment abroad at a time *earlier* than they would receive it in the United Kingdom, this would require additional resources. In theory, these could only be avoided if those who did not have treatment abroad received their treatment at a *later* time than they otherwise would or if the NHS ceased to provide some treatments that it currently does provide.³⁹

Concerned that EU law could permit patients with less urgent medical needs to gain priority over patients with more urgent medical need, the Court of Appeal asked the ECJ to rule whether these considerations were relevant to the principle of freedom of movement. This goes to the heart of a system’s fairness and its commitment to social citizenship. Yet, Advocate General Geelhoed responded in the negative. He said:

Where conditions on granting authorization to receive hospital treatment in another Member State are designed to guarantee the financial stability of the national health system, considerations of a purely budgetary or economic character cannot justify a refusal to grant such authorization.⁴⁰

This framework of analysis appears blind to community interests and suggests that concerns for social justice cannot stand in the way of individual, market based rights.

Confirming this individual rights approach, the ECJ said that the words “undue delay” require the competent institution to assess the needs of the individual patient and to ensure that the waiting time “does not exceed the period which is acceptable in the light of an objective medical assessment of the clinical needs of the person concerned in the light of his medical condition and the history and probable course of his illness,

³⁷ *R (Watts) v. Sec’y of State for Health*, [2004] EWCA Civ 166, (2004) 77 BMLR 26 [hereinafter *Watts* (Eng. Ct. App.)].

³⁸ *Id.* at para. 105.

³⁹ *Id.* Emphasis added.

⁴⁰ *Watts* (ECJ), 2006 E.C.R. I-4325, at para. 92.

the degree of pain he is in and/or the nature of his disability at the time when the authorization is sought.”⁴¹ Thus, the existence of reasonable waiting times intended to ensure the fair allocation of finite resources between competing needs cannot obstruct the right of the individual. The reference point is not public interests, but the needs of individual patients:

Where the delay arising from such waiting lists appears to exceed *in the individual case concerned* an acceptable period having regard to an objective medical assessment of all the circumstances of the situation and the clinical needs of the person concerned, *the competent institution may not refuse the authorization sought on the grounds of the existence of those waiting lists [or] an alleged distortion of the normal order of priorities linked to the relative urgency of the cases to be treated.*⁴²

Therefore, normal waiting times and priority systems used to optimize efficiency and fairness cannot interfere with the EU rights of patients to travel elsewhere for treatment in these circumstances.⁴³ The European Court of Justice favors substantive/individual, rather than procedural/community solutions to the problem so that those facing undue delay may enforce their individual rights irrespective of their impact on other people. In place of the deference to politics characterized by *Humbel*, this creates enforceable substantive rights from the economic freedom to obtain services under Article 49 of the EU Treaty.⁴⁴

The ECJ has never explained why this change of social policy was necessary, or indeed, why the promise in the EU Treaty that Member States should retain jurisdiction over their own health care systems was not considered.⁴⁵ The ECJ has consistently stated its findings in terms of

⁴¹ *Id.* at para. 68.

⁴² *Id.* at para. 120 (emphasis added).

⁴³ See Gareth Davies, *Health and Efficiency: Community Law and National Health System in the Light of Muller-Faure*, 67 MOD. L. REV. 94 (2004).

⁴⁴ See Christopher Newdick, *Citizenship, Free Movement and Health Care: Cementing Individual Rights by Corroding Social Solidarity*, 43 COMMON MKT. L. REV. 1645 (2006). See also Vassilis Hatzopoulos, *Killing National Health Insurance Systems but Healing Patients? The European Market for Health Care Services after the Judgments of the ECJ in Vanbraekel and Peerbooms*, 39 COMMON MKT. L. REV. 683 (2002).

⁴⁵ The matter is now subject to a draft Directive of the European Parliament and of the Council on the Application of Patients' Rights in Cross-border Healthcare, COM (2008) 414 final (Feb. 7, 2008), [available at http://ec.europa.eu/health/ph_overview/co_operation/healthcare/docs/COM_en.pdf](http://ec.europa.eu/health/ph_overview/co_operation/healthcare/docs/COM_en.pdf). The broad principle of freedom of movement of services is proposed in the draft article 6(1): “the Member State of affiliation shall ensure that insured persons travelling to another Member State with the purpose of receiving healthcare there or seeking to receive healthcare provided in another Mem-

legal conclusions without articulating the reasons, or policies underlying them. Advocate General Ruiz-Jarabo Colomer, speaking about the right of citizens to health care, said recently:

Being a fundamental asset, health cannot be considered solely in terms of social expenditure and latent economic difficulties. This right is perceived as a personal entitlement, unconnected to a person's relationship with social security, and the Court of Justice cannot overlook that aspect.⁴⁶

This Dworkinian conception of a substantive, individual “right of access to cross border health care” is not based on fairness or consistency between patients. Rather, it is the individual’s fundamental liberty to secure their rights, irrespective of the impact they may have on the access available to others. The ECJ has “successfully fundamentalized citizenship, in the sense of transforming it into the most fundamental of all fundamental freedoms.”⁴⁷ Whereas the English courts have adopted a model that regards rights of access to health care as positive, social, and procedural, the ECJ has responded as if the rights are negative, civil, and substantive of the sort described by Dworkin and Marshall.⁴⁸

ber State, will not be prevented from receiving *healthcare provided in another Member State where the treatment in question is among the benefits provided for by the legislation of the Member State of affiliation to which the insured person is entitled*” (emphasis added). This mistakenly assumes that Member States have a distinct list of “benefits provided by legislation.” It fails to recognise that (a) many States do not attempt to maintain such lists; instead they use generic expressions to describe rights of access to health care (e.g., by reference to “necessary care,” or a “comprehensive” system) and (b) national jurisdictions recognise that health care “need” differs from one locality to another; thus they permit *local* health authorities discretion as to how they prioritise resources.

⁴⁶ Case C-444/05, *Stamatelaki v. NPDD Organismos Asfaliseos Eleftheron Epangelmaton*, 2007 E.C.R. I-03185, para. 40.

⁴⁷ Alexander Somek, *Solidarity Decomposed: Being and Time in European Citizenship*, 32 EUR. L. REV. 787, 794 (2007).

⁴⁸ Similar arguments arise in connection with transnational access to publicly-funded higher education where it is suggested large numbers of middle-class EU visitors could displace poorer “home” students which the government is trying to encourage into university. See Michael Dougan, *Fees, Grants, Loans, and Dole Queues: Who Covers the Costs of Migrant Education Within the EU?* 42 COMMON MKT. L. REV. 943, 953-54 (2005). Again, the ECJ has rejected these concerns. See Case C-147/03, *Comm’n of the Eur. Communities v. Austria*, 2005 E.C.R. I-05969, paras. 46-48 (rejecting the concern that EU visiting students could displace poorer home state students).

IV. ACCIDENTAL DEATH OF A CONCEPT?

What will be the impact of an “economic,” or market approach to healthcare rights within the EU? How will it affect the political commitment to solidarity and social cohesion discussed above?⁴⁹ There is a danger that the economic approach may create a policy vacuum between the authority of Member States and the broader EU. This is because “Member States have lost more control over national welfare policies in the face of pressures from integrated markets than the EU has *de facto* gained in transferred authority . . . there is a growing gap in our steering capacity with regard to welfare policy.”⁵⁰ This “gap” will frustrate the development of social welfare policies in the EU for a number of reasons. First, national diversity will prevent the harmony required to introduce measures at European level.⁵¹ Indeed, diversity is more likely to generate “community deficit,” than a sense of solidarity between citizens.⁵² Second, with increasing social and political heterogeneity among EU Member States, it will encourage a more individualistic approach to welfare in which the “market citizen” has no particular commitment to a community. If individuals simply play the market for their own self-interest, this seems unlikely to foster a sense of social cohesion. Self-interested “citizens” are unlikely to feel any special sense of identity with the EU.⁵³ Third, it may disincline governments to invest funds in public health objectives if there is a significant risk of the resources necessary to do so being diverted to institutions outside their own jurisdictions.

Some may argue to the contrary. Giving people choice is a reasonable way to force up standards and encourage greater allegiance to the “European” enterprise. But, as Albert Hirschman demonstrates in his book *Exit, Voice and Loyalty*, the impact of “exit” from private and public goods is very different. Hirschman argues that exit from wholly private, commercial institutions may force the provider to consider improv-

⁴⁹ See generally SOCIAL WELFARE AND EU LAW (Eleanor Spaventa & Michael Dougan eds., 2005).

⁵⁰ Frank Vandenbroucke, *The EU and Social Protection: What Should the European Convention Propose?* (Max Planck Inst. for the Study of Societies, Working Paper No. 02/6, 2002), available at <http://www.mpifg.de/pu/workpap/wp02-6/wp02-6.html>.

⁵¹ F. Scharpf, “Legitimate Diversity: The New Challenge of European Integration,” in T. Borzel and R. Cichowski, *The State of the European Union*, vol 6 (Oxford University Press, 2003), 99.

⁵² Amitai Etzioni, *The Community Deficit*, 45 J. COMMON MKT. STUD. 23, 23 (2007).

⁵³ Michelle Everson, *The Legacy of the Market Citizen*, in NEW LEGAL DYNAMICS OF EUROPEAN UNION 73, 89 (Jo Shaw & Gillian More eds., 1995).

ing his or her goods or services, or risk going out of business.⁵⁴ Hirschman says:

In the case of exit from organizations producing private goods, exit terminates the relationship between customer-member and the product organization he is leaving . . . he couldn't care less. In the case of public goods, on the other hand, one continues to "care" as it is impossible to get away from them entirely. In spite of exit one remains a consumer of the output, or at least its external effects, from which there is no escape.⁵⁵

Social welfare systems are the clearest illustration of this constraint on "exit" from public goods and services.

The constraint on "exit" from public goods and services in social welfare systems can be illustrated by comparing per capita expenditure on health care in countries in Western and Eastern Europe. In 2004, for example, in the UK and Poland, per capita expenditure in the UK was \$2,506 (at 8.0 percent of gross domestic product [GDP]).⁵⁶ In Poland, it was \$808 (at 6.2 percent of GDP).⁵⁷ Therefore, if one takes into consideration that (a) some treatments provided in the UK may not normally be available in Poland due to cost reasons, (b) some medical treatments would be considered "normal" treatments in Western Europe, (c) some treatments are not positively excluded from the health care menu in Poland, and (d) Polish patients express their EU rights to obtain such treatment elsewhere in Europe and require Polish authorities to reimburse their costs of doing so. The financial impact on other Polish patients is obvious, especially those too ill or frail to travel abroad for care. The financial impact will tend to reduce the sums available for others and destabilize systems intended to ensure a fair and equitable allocation of health care resources to the community as a whole.⁵⁸

Arguably, the viability of entire systems of the new accession states could be put at risk. For example, Gareth Davies has suggested that "Lithuania could find itself paying German [hospitals] for treatments

⁵⁴ ALBERT O. HIRSCHMAN, EXIT, VOICE, AND LOYALTY 104 (1970).

⁵⁵ *Id.* See also the concerns in James A. Morone, *Citizens or Shoppers? Solidarity Under Siege*, 25 J. HEALTH POL. POL'Y & L. 959 (2000).

⁵⁶ Nat'l Health Accounts Series, World Health Org., *United Kingdom – National Expenditure on Health* (2008), available at <http://www.who.int/nha/country/gbr.pdf>.

⁵⁷ Nat'l Health Accounts Series, World Health Org., *Poland – National Expenditure on Health* (2008), available at <http://www.who.int/nha/country/pol.pdf>.

⁵⁸ At present, the aggregate numbers seeking treatment elsewhere in the EU are small. However, the impact will be greater on communities with easy access to "host" EU countries. Transnational activity will increase over time, encouraged by "host" hospitals with spare capacity.

Lithuanian patients get when they tire of waiting for treatment at home (and that the waiting in Lithuania might be because so many of the doctors were recruited in the UK).”⁵⁹ Thus, to the extent that we all intend to benefit from our health care systems, while exit is available in a geographical sense, it is neither possible, nor even intended, in a legal and community sense. As Davies says, the ECJ’s “vaguely Marxist Community approach to its competence, in which the end justifies the means” dilutes the sense of social citizenship in national health care systems.⁶⁰

If all are subject to the NHS, then all have an interest in its maintenance. However, the individual who has learned to exit [sic] that system and receive treatment elsewhere may come to see national authorities as merely a source of funds, and will have a reduced personal interest in the quality of availability of national services . . . motivation to support solidarity is reduced once an exit-option is introduced into healthcare provision. Creating consumers out of patients is therefore not just about creating autonomous choice capable individuals, but about reducing social bonds.⁶¹

This “commodification” of medicine into units of economic value, rather than an ethical sense of community, has been discussed in the United States.⁶² Given the European Court of Justice’s previous opinion in *Humbel*, which held that matters of community and social welfare were normally beyond the Court’s jurisdiction, what has prompted this “overall pattern of decreasing control over the welfare state by individual EU Member States”?⁶³ The English Court of Appeals, commenting on the activism of the ECJ, said that it has built on Article 49 “a substantial edifice not immediately clear from its literal terms . . . There has been much judicial policy making, and the policy goes well beyond the words of the Article.”⁶⁴ This judicial policy making has also taken place with-

⁵⁹ SCOTT L. GREER, THE NEW EU HEALTH POLICY AND THE NHS SYSTEMS 26 (2005), available at <http://nuffieldtrust.org.uk/ecomm/files/090205EUhealthsystem.pdf>.

⁶⁰ Gareth Davies, *The Community’s Internal Market-Based Competence to Regulate Healthcare: Scope, Strategies and Consequences*, 14 MAASTRICHT J. EUR. & COMP. L. 215, 228 (2007). See also Catherine Barnard, *EU Citizenship and the Principle of Solidarity*, in SOCIAL WELFARE AND EU LAW (Eleanor Spaventa & Michael Dougan eds., 2005).

⁶¹ Davies, *supra* note 60, at 235.

⁶² Edmund D. Pellegrino, *The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic*, 24 J. MED. & PHIL. 243, 258 (1999).

⁶³ Tamara K. Hervey, *The European Union’s Governance of Health Care and the Welfare Modernization Agenda*, 2 REG. & GOVERNANCE 103, 106 (2008).

⁶⁴ Watts (Eng. Ct. App.), [2004] EWCA Civ 166, at para. 31.

out any discussion of the competing arguments for doing so, or an assessment of its costs or benefits.

Is this the result of deliberate change of policy, or are these consequences unintended?⁶⁵ Arguably, the ECJ has simply misunderstood how national health systems operate. For example, the ECJ concedes the rights of Member States to restrict the ambit of the health care packages they provide and to set any fees for treatment in their own discretion.⁶⁶ This, it might be said, acknowledges that the capacity of Member States to invest in health services varies throughout the EU. Economic logic suggests that the new accession states, which generate smaller gross domestic product by comparison to Western European states, could not be expected to provide the same levels of investment in, for example: hospital infrastructure, access to pharmaceutical technology, long-term nursing, and emergency care. Thus, the ECJ suggests, Member States may de-limit the “care package,” or levy charges for providing it (provided they do so in an objective and non-discriminatory manner).⁶⁷ If this was effective, it would enable Member States to retain some control over their health care priorities and to direct care to those they considered most in need.

But this mechanism is unlikely to be effective because health care systems rarely use restrictive lists in this way. Rather than specifying precisely the treatments that will or will not be available, access to care is governed by means of generic terms, such as “necessary” or “comprehensive” care or by excluding treatment which is “experimental.” The application of these generalized phrases to individuals is a matter for national discretion (and eventually, litigation).⁶⁸ The ECJ has no jurisdiction to change this system and has not suggested any desire to do so. The obstacles blocking such an endeavor are, in any event, significant. A “positive” or “white” list of approved treatments would need to be very responsive to advances in clinical and pharmaceutical developments.⁶⁹ If the system is too slow or bureaucratic, it could deprive pa-

⁶⁵ See generally CAROLYN HUGHES TUOHY, ACCIDENTAL LOGICS: THE DYNAMICS OF CHANGE IN THE HEALTH CARE ARENA IN THE UNITED STATES, BRITAIN AND CANADA 6 (1999) (emphasizing the extent to which chance and circumstance influence the direction of health policy).

⁶⁶ Case C-385/99, V.G. Müller-Fauré v. Onderlinge Waarborgmaatschappij OZ Zorgverzekeringen UA, 2003 E.C.R. I-04509, para. 98.

⁶⁷ Watts (ECJ), 2006 E.C.R. I-4325, at paras. 103-06.

⁶⁸ See generally REASONABLE RATIONING: INTERNATIONAL EXPERIENCE OF PRIORITY SETTING IN HEALTH CARE (Christopher Ham & Glenn Robert eds., 2003).

⁶⁹ “White lists” identify a specific number of treatments for which the health system will pay and need constant adjustment to keep pace with clinical developments. For such a system, described

tients of beneficial new treatments available elsewhere. Presumably a central body with a considerable breadth of clinical expertise would be required. Additionally, it would need to meet at regular intervals (monthly, weekly, or daily) to consider new and emerging evidence. Additionally, the white list of approved treatments would need to be long. Could it really accommodate all the medicines, surgical interventions, and devices available to patients, and be sufficiently sensitive to accommodate the differing ways in which patients present themselves with undiagnosed and sometimes multiple conditions? Surely, an effective system of this nature is impracticable and health care systems should be advised to continue using generic words to describe the system of care available to patients. For the same reason, a “negative” or “black” list of disapproved treatments runs the risk of excluding useful responses to exceptional patients. For example, cosmetic surgery may be excluded from treatment within the NHS as a general rule, but there are many exceptional cases treated in this manner which arise, for example, as a result of disfiguring surgery. Thus, if the ECJ believes that it is sensible to seek to limit health care coverage by explicit lists of treatments, it is surely wrong.

Furthermore, the use, by the ECJ, of the words “normal treatment” to explain treatment which may not be denied within a health care system, suggests that the ECJ has not fully understood the sociological component of medical decision-making. The ECJ assumes the existence of some objective standard in which treatments “sufficiently tried and tested by international medical science” should be available to individuals.⁷⁰ But this is a mistake. “There is no purely scientific or value neutral way to tackle [resource allocation]; ethical and value questions will impinge upon these decisions every step of the way.”⁷¹ Lynn Payer illuminates how, in the U.S., England, France, and Germany, sociology, philosophy, and politics help to explain differing concepts of “illness” and

as a health care “basket,” see Roy Gilbar & Hadara Bar-Mor, *Justice, Equality and Solidarity: The Limits of the Right to Health Care in Israel*, 16 MED. L. REV. 225 (2008). By contrast, “black lists” exclude certain treatments from health care coverage. For such an example in the UK’s NHS, see the National Health Service (General Medical Services Contracts)(Prescription of Drugs etc.) Regulations 2004, SI 2004 No. 629 (excluding some over-the-counter products and foodstuffs, including shampoos and “wines”).

⁷⁰ Watts (ECJ), 2006 E.C.R. I-4325, at para. 108. See also Case C-8/02, *Leichtle v. Bundesantalt für Arbeit*, 2004 E.C.R. I-264 (regarding the normality of treating illness with spa therapy).

⁷¹ Bruce Jennings, *Health Policy in a New Key: Setting Democratic Priorities*, 49 J. SOC. ISSUES 169 (1993), reproduced in PUBLIC HEALTH ETHICS, *supra* note 12, at 231, 233.

our differing responses to it.⁷² There will always be questions about the relative priorities of treatments which cannot be resolved by asking whether they are “normal.”

Consider, for example, to what extent the concept of “normality” assists an analysis of the following matters. Should a health care system spend more on neonatal care by comparison with mental health care, or cancer? Should it always prescribe the most effective, most expensive medicines or should it also consider “second-best,” cheaper, but marginally less effective drugs, if it can treat larger numbers of patients by doing so? Recent reforms in Italy have limited access to in vitro fertilization (IVF) for religious reasons.⁷³ Should Italian patients be encouraged to seek IVF elsewhere in Europe and return to Italy and require their local health insurer to pay the bill? Absurdly, the ECJ appears to consider the question to be governed by a concept of “normality” in EU law, capable of contradicting Italian law. Similarly, English courts have considered the lawfulness of restrictions on access to treatment for erectile dysfunction.⁷⁴ Is Viagra “normal treatment”? Medicine is about social policy, norms, and economics as well as science.

Gareth Davies suggests that: “The Court wants to get away from the question of what [health authorities think] is acceptable and move towards the question of what modern medical science thinks is acceptable.”⁷⁵ But this will give doctors disproportionate influence over value based questions of policy, politics, and health economics in which they have no particular expertise. Many of these issues are not solely amenable to notions of clinical “normality” and “international medical science” and should be subject to the broader deliberations of public authorities. This highlights a final problem of democracy. We have discussed above the concern to engage the public in the difficult decisions thrown up in

⁷² See LYNN PAYER, *MEDICINE AND CULTURE* (1996). The literature on this subject is vast. See, e.g., ROY PORTER, *THE GREATEST BENEFIT TO MANKIND: A MEDICAL HISTORY OF HUMANITY* (W.W. Norton & Co. 1998) (1997); CAROL GRONEMAN, *NYMPHOMANIA: A HISTORY* (2001); Bert Hansen, *American Physicians' "Discovery" of Homosexuals, 1880-1900: A New Diagnosis in a Changing Society*, in *FRAMING DISEASE: STUDIES IN CULTURAL HISTORY* (Charles E. Rosenberg et al., 1992); THOMAS S. SZASZ, *THE MANUFACTURE OF MADNESS* (Harper Colophon 1977) (1970); John F. Burnum, *Medical Practice A La Mode*, 317 *NEW ENG. J. MED.* 1220 (1987); M. Ennis, A. Clark & J. G. Grudzinskas, *Change in Obstetric Practice in Response to Fear of Litigation in the British Isles*, 338 *LANCET* 616 (1991).

⁷³ See Rachel Anne Fenton, *Catholic Doctrine Versus Women's Rights: The New Italian Law on Assisted Reproduction*, 14 *MED. L. REV.* 73, 73 (2006). See also McHale, *supra* note 36, at 274.

⁷⁴ See *R v. Secretary of State for Health*, (2003) 1 C.M.L.R. 19, para.17 (where the court said that the issue of affordability “must be regarded as a political decision to be taken by government”).

⁷⁵ Gareth Davies, *The Effect of Mrs. Watts' Trip to France on the National Health Service*, 18 *KING'S L. J.* 158, 162 (2007).

this area. In the past, decision making was often covert and excluded patients and the public. Today, however, as the dilemmas involved become more transparent and patients are encouraged to assert their rights as “consumers,” government is turning to public opinion to resolve the difficulty. Let us look to a future in which elected members of the public are involved in making hard, health care resourcing decisions which prioritize certain treatments over others. In such a contested and sensitive area of social policy, it is implausible for international judges to come into conflict with elected representatives in such a way.⁷⁶

V. CONCLUSION

These developments in EU law, favoring a more individualistic and less communitarian conception of rights reflect an institutional “asymmetry” within the EU, in which the ECJ favors private “economic” interests over the public “welfare” policies identified by national governments.⁷⁷ As a matter of judicial policy, the European Court of Justice is concerned with promoting free trade within the EU in a way that promotes the aspirations of civil citizenship, tolerant of the inequalities it tends to create. This “market citizenship” is consistent with inequality because individual choice, rather than government policy, is the dominant influence. But the ECJ has misunderstood the need to respect ideas of social citizenship and the non-trade priorities that the notion promotes. The ECJ has failed to articulate what value it attaches to non-economic interests, or concepts such as social cohesion and solidarity (about which, recall, the European Commission has been so supportive). The present approach makes economic freedom the central consideration, but it fundamentally undermines the moral choices which are an unavoidable component of resource allocation decisions. In doing so, it weakens the moral connection we have to the system as a whole.⁷⁸ For such a situation to have arisen without discussion of its risks and benefits, its impact on health economics, or the rights of other patients, demeans the authority of the Court.

My interest in this area is not only academic. I advise a group of primary care trusts (PCTs) in England and am a member of a committee

⁷⁶ Jennings, *supra* note 71.

⁷⁷ Fritz W. Scharpf, *The European Social Model: Coping with the Challenges of Diversity*, 40 J. COMMON MKT. STUD. 645, 665 (2002).

⁷⁸ See generally Jonathan Montgomery, *Law and the Demoralization of Medicine*, 26 LEGAL STUD. 185 (2006).

called the Berkshire Priorities Committee. The Committee makes recommendations as to the way in which finite NHS resources should be allocated. It works within the parameters of the South Central Ethical Framework, to which the neighboring PCTs in the counties of Oxfordshire, Buckinghamshire, and Hampshire also subscribe.⁷⁹ This is necessary because PCTs are responsible for the allocation of health care resources to the community. They have two salient duties (1) to “promote a comprehensive health service”⁸⁰ and (2) to ensure that their expenditure in each year does not exceed their income.⁸¹ Given that difficult choices in health care are unavoidable, which treatments should be regarded as low priority? Recognizing the opportunity costs of diverting finite resources from one use in favor of another, which principles should drive the process?⁸² Part of the aim of this paper has been to give the practical work of the Priorities Committee a theoretical context. This article has noted how citizenship articulates the concept of “rights” most clearly in connection with civil and political rights. By contrast, the more recondite notions of social citizenship find it more difficult to explain where the boundary lies between personal autonomy and “public space,” yet this is at the heart of the work of the Berkshire Priorities Committee. For the ECJ to fail to recognize a concept of public rights and the moral and ethical dimensions they contain, fails to appreciate the balance Western European society seeks to achieve between man and society. Whereas negative rights promote liberty, positive rights seek to reduce inequality; and whereas the former are more easily recognized as substantive rights, the latter need to accommodate the rights and interests of others and, therefore, tend to be relative (and procedural), rather than absolute.

⁷⁹ See THAMES VALLEY ETHICAL FRAMEWORK (2005), http://www.berkshire.nhs.uk/priorities/_policies/ab_ethical_framework.pdf. See also Christopher Newdick, *Accountability for Rationing—Theory into Practice*, 33 J.L. MED. & ETHICS 660, 662 (2005).

⁸⁰ National Health Service Act, 2006, c. 41, § 1 (Eng.). See generally CHRISTOPHER NEWDICK, WHO SHOULD WE TREAT? RIGHTS, RATIONING, AND RESOURCES IN THE NHS (2nd ed. 2005).

⁸¹ National Health Service Act, 2006, c. 41, § 224 (Eng.).

⁸² See generally MADISON POWERS & RUTH FADEN, SOCIAL JUSTICE: THE MORAL FOUNDATIONS OF PUBLIC HEALTH AND HEALTH POLICY (2006). EU cross-border rights to health care will become subject to EU regulation. See Proposal for a Directive of the European Parliament and of the Council on the Application of Patients’ Rights in Cross Border Healthcare, COM(2008) 414 final, 2008/0142 (COD).

If part of the ECJ's agenda is to bring about an "EU rights revolution,"⁸³ it has surely under-estimated the difficult distinctions between "negative" civil and political rights on the one hand, and "positive" social and economic rights on the other. Contrast this to the more deferential, public-centered view of the European Court of Human Rights (ECHR) in *Sentges v. Netherlands*.⁸⁴ The Court in *Sentges* said, in respect to an application for an expensive medical device to assist a patient suffering the debilitating effects of Duchenne Muscular Dystrophy: "regard must be had to the fair balance that has to be struck between the competing interests of the individual and of the community as a whole and to the wide margin of appreciation enjoyed by States in this respect in determining the steps to be taken to ensure compliance with the Convention." Given their familiarity with the demands made on local services, the ECHR considered that national authorities, not an international court, were best placed to determine the relative priorities given to competing demands for treatment.⁸⁵ The ECJ's clear (if unexplained) departure from a comparable approach to domestic health care planning, toward a more interventionist, individualist agenda, imposes a form of "liberalism" on Member States whose legislatures, since the Second World War, have adopted policies intended to accommodate other social values.⁸⁶ The ECJ has profoundly disturbed this understanding without, it seems, grasping the implications of its actions.

Is this an "accident" caused by the ECJ's failure to understand the crucial role of social citizenship rights? Or, as Scott Greer suggests in this volume, is it symptomatic of a distinct power struggle between national and European institutions in which the latter seek to promote the regulatory policies that "fit" their own institutional preferences and to dilute the competence of national authorities.⁸⁷ It is surely unacceptable,

⁸³ R. Daniel Kelemen, *The EU Rights Revolution: Adversarial Legalism and European Integration*, in 6 *THE STATE OF THE EUROPEAN UNION: LAW, POLITICS, AND SOCIETY* 221 (Tanja A. Börzel & Rachel A. Cichowski eds., 2003).

⁸⁴ *Sentges v. The Netherlands*, App. No. 27677/02 (2003).

⁸⁵ *Id.* See also *Pentiacova v. Moldova*, App. No. 14462/03, 40 Eur. H.R. Rep. 209, 219 (2005), a case dealing with chronic renal failure and availability of hemodialysis: "[T]he applicants' claim amounts to a call on public funds which, in view of the scarce resources, would have to be diverted from other worthy needs funded by the taxpayer . . . it cannot be said that the respondent State failed to strike a fair balance between the competing interests of the applicants and the community as a whole."

⁸⁶ See generally ANDREW MASON, *COMMUNITY, SOLIDARITY AND BELONGING* (2000). Part Three discusses the limits of a global community.

⁸⁷ Scott L. Greer, *Migration of Patients and Migration of Power: Politics and Policy Consequences of Patient Mobility in Europe*, 26 *WIS. INT'L L.J.* 3 (forthcoming 2008).

for an unelected body of judges to promote such controversial policies without democratic support, and to be wholly unaccountable to anyone for doing so. Unlike responsible parliaments at national level, European institutions have little incentive to cost their policies, or to conduct cost-benefit analyses comparing, say, the compliance costs of patient mobility in Europe with the costs of better cancer care or preventive medicine in individual Member States.

Increasing the costs of health services is not a problem because the EU does not pay for them. Equity concerns are not very important—it takes a creative mind to argue that patient mobility is anything other than a boon to the wealthy and articulate. Solidarity is not a problem because EU law on the subject is softly spoken compared to the talkative jurisprudence of the four freedoms.⁸⁸

If this analysis is correct, the debate about social citizenship illuminates a deeper tension within the EU, involving the proper authority of national democratic institutions on the one hand and the legitimate role of an international court on the other. The argument suggests that the ECJ is not a neutral arbiter in matters of this nature because it promotes a distinct agenda with its own special interests. Thus, for many years, rights arising within social welfare policy were considered to be within the competence of Member States and outside the jurisdiction of the ECJ. “Free movement” was confined to private enterprise, leaving Member States to manage social welfare systems in their own national discretion. However, by expanding the free movement principle to absorb public health care services, the power to regulate is shifted toward European institutions and national authority is undermined. Is it right for an unelected international court to dilute national commitments to social citizenship endorsed by democratic institutions over many decades? Seen in this context, the ECJ’s decisions on cross border health care rights are a serious cause for concern.

⁸⁸ *Id.*