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Case C-243/19, A v Veselības ministrija, Judgement of the Court (Second Chamber) of 29 October 2020, EU:C:2020:872

Keywords

Crossborder healthcare – Directive 2011/24 – Freedom of Religion – Jehovah's Witnesses – Regulation 883/2004

1 Introduction

The interplay between an individual's right to health, autonomy and freedom of religion is not an easy one to resolve when designing a public health system whose aim is to serve the needs of society. This becomes even more complex as other dimensions are added, such as the rights and interests of minor patients and parental discretion in the upbringing of their children. Even where a Member State has designed a mechanism that could, at least theoretically, be responsive to a variety of needs, it might not necessarily function in such a way in practice because of the practical solutions in place in order to realise the right to the highest attainable standard of health. When a public healthcare system that is funded by taxpayers' money and that operates under the principle of greatest good for the greatest number of people[1] is not responsive to a particular patient's needs, and that patient belongs to a particular minority group, questions emerge. In the context of EU law, the central issue tied

1 Constitutional Court of the Republic of Latvia, Case No. 2008-37-03 of 29 December 2008, para.11.3.

to these questions is how the EU rules on cross-border healthcare enable a patient to access healthcare in another Member State at the expense of the state of affiliation.

From the perspective of the right to the highest attainable standard of health, states have several obligations to observe when designing their public health systems. In addition to ensuring availability, accessibility and quality of medical care, the system should also be acceptable to the healthcare recipients.[2] At a systemic level, the public health system should be designed in a way that respects various considerations, including the culture of individuals, minorities, peoples and communities.[3] Thus far, the Court of Justice of the European Union (CJEU) has been firm on ensuring effective accessibility to the available (or equally medically effective) medical care.[4] In *Petru* the CJEU went further and established that the lack of medication and basic medical supplies to provide the necessary medical care is a reason that precludes issuing an authorisation to access healthcare in another Member State.[5] By doing so, the CJEU has effectively secured genuine accessibility of available medical care so that availability does not become illusory, as well as stepped into the domain of quality. Can EU law also serve as a means to further acceptability of medical care – "[a]ll health facilities, goods and services must be respectful of medical ethics and be culturally appropriate"[6] – and if so, how? How, if at all, can the provisions on free movement of services enshrined in the Treaty on the Functioning of the European Union (TFEU), Regulation No 883/2004 on the coordination of social security systems (Regulation No 883/2004), Directive 2011/24/EU on the application of patients' rights in cross-border healthcare (Directive 2011/24/EU), applied in conjunction with the Charter of Fundamental Rights of the European Union (CFREU) be interpreted to make it work?

2 UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12 of the Covenant), 11 August 2000, E/C.12/2000/4.

3 UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12 of the Covenant), 11 August 2000, E/C.12/2000/4, para. 12.

4 For example, Case C 56/01 Patricia Inizan v Caisse primaire d'assurance maladie des Hauts-de-Seine [2003] ECR I-12403, paras 45 and 60; Case C-372/04 The Queen, on the application of Yvonne Watts v Bedford Primary Care Trust and Secretary of State for Health [2006] ECR I-04325, para.61, and Case C-173/09 Georgi Ivanov Elchinov v Natsionalna zdravnoosiguritelna kasa [2010] Court Reports I-08889, para. 65.

5 Case C-268/13 Elena Petru v Casa Judeţeană de Asigurări de Sănătate Sibiu and Casa Naţională de Asigurări de Sănătate, published in the electronic Reports of Cases, ECLI:EU:C:2014:2271, paras 33–36.

6 UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12 of the Covenant), 11 August 2000, E/C.12/2000/4, para. 1.

The case of *A v Veselibas ministrija* that was referred to the CJEU by the Supreme Court of Latvia, Department of Administrative Cases (Supreme Court), contains these questions at its heart. It deals with a request for an authorisation to receive surgery without a blood transfusion in another Member State due to the inability to ensure medical care to a minor patient that would conform to the religious beliefs of Jehovah's Witnesses. In so doing, it tested the scope of Article 20 of Regulation 883/2004. Additionally, it deals with a right to reimbursement when the necessary care that conforms to the values of a patient's parents is received in another Member State, and consequently, the rights of patients under Article 7 and possible restrictions that are permitted under Article 8 of Directive 2011/24/EU. More generally, this preliminary reference deals with the interplay between secondary EU law in cross-border healthcare and the CFREU and general principles of EU law. It tests the capacity of EU law to serve as a means to ensure that a public healthcare system is sensitive to the values that patients could hold and that care is offered that is acceptable to different societal groups. This ruling shows the CJEU's reluctance to encroach significantly on national self-determination in healthcare and its use of EU law as a means to further the creation of inclusive national public health systems. The implications of this preliminary ruling concern all societal groups and individuals who wish to access value-conforming medical care and are ready to travel to another Member State for that purpose.

2 Facts and Legal Background: An Escalating Dispute at the National Level

The applicant's (*A*) son, a minor, (*B*) suffered from a congenital cardiovascular disease for which he needed to undergo a surgical intervention, a total correction of tetralogy of Fallot (medical procedure). The medical procedure in Latvia was carried out using a method that included a blood transfusion. In principle, *A* was in agreement about the need to carry out the medical procedure as it was in his child's interests. However, he refused to consent to the provision of the medical procedure if it included a blood transfusion due to his religious beliefs as a Jehovah's Witness. Relying on the rights stemming from Article 20 of Regulation 883/2004 on the coordination of social security systems,[7] *A* requested the National Health Service of Latvia (NHS) issue

7 Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems (Text with relevance for the EEA and for Switzerland). OJ L 166, 30.4.2004, p. 1–123. Consolidated text, available online at http://data.europa.eu/eli/reg/2004/883/2019-07-31 (accessed 7 March 2021).

an S2 form "Certificate conforming the right to receive healthcare" so that he could access healthcare in another Member State to be paid for by the NHS. In March 2016 the authority refused to grant the authorisation; while it conceded that *B* was indeed in need of the medical procedure, it argued that appropriate medical care was available in Latvia.[8] *A* appealed to the Ministry of Health, which upheld the decision of the NHS.[9]

A brought an action to the District Administrative Court against the decision of the Ministry of Health. He argued the constitutional and human rights protection of freedom of religion, the right to health and protection of integrity, identity and dignity. He also argued that the NHS had not adequately addressed the seriousness of the issue and reduced the fundamental right to freedom of religion to a mere whim of his. Furthermore, as the medical care available in Latvia was centred on the wishes of the majority; the applicant claimed there was a failure to accommodate the needs of his represented minority.[10] Finally, *A* submitted that he had not refused medical care in its entirety, only a particular method offered. This refusal, if not accommodated, meant there had been a denial of medical care, which constituted a disproportionate restriction of rights.[11]

The District Administrative Court dismissed *A*'s request finding that the principle of equality and prohibition of discrimination had not been violated because the necessary medical care was available in Latvia, and there was no established medical requirement to carry out the necessary surgery using a bloodless perfusion technique.[12] It found that acceptability of medical care needs to be assessed in the context of application of law, and respect of refusal of medical care that does not conform to the patient's values.[13] Additionally, it considered the question of reimbursement (presumably under the provisions implementing Directive 2011/24/EU). In principle, cardio surgery could be subject to cross-border care in accordance with national rules, but that would then require an authorisation issued by the NHS.[14] However, as authorisation had not been requested, the question of reimbursement had not been

8 See a summary of facts in Judgement of a District Administrative Court in case No A420281216 (Archive No A42-02812-16/16) of 9 November 2016, para. 1.

9 *Ibid.*

10 *Id.*, para. 2.

11 *Ibid.*

12 *Id.*, paras 7–10.

13 *Id.*, para. 11. Validity of the provisions (unconstitutionality) does not seem to have been disputed by the applicant. Hence the court considered it based on how the existing rules accommodate 'acceptability'.

14 *Id.*, para.12.

considered by the NHS. Therefore, it found that there was no foundation to the claim that he had been unable to access reimbursement.[15] Ultimately, as the District Administrative Court did not find any evidence to prove that the method used for the medical procedure in Latvia was not medically suitable for the patient, it rejected the appeal.[16] The applicant lodged an appeal to the Regional Administrative Court. This court shared the reasoning of the first instance court and dismissed the appeal.[17]

The applicant's final action was to lodge an appeal at the Supreme Court. The Supreme Court, having reviewed the facts of the case and the existing CJEU case law, identified a matter of EU law that needed to be clarified, namely that the assessment of the availability of equally effective care within the Member State of residence under Article 20(2) of Regulation 883/2004 previously focused on strictly medical criteria. However, at the same time, both the right to private life and freedom of religion permit choosing to receive value-conforming medical care. Moreover, a state has positive obligations to further acceptability of medical care, including in regard to religion. A national rule that does not accommodate religious beliefs is indirectly discriminatory, and its justification is subject to the proportionality assessment. It was on this that the Supreme Court believed further guidance was necessary from the CJEU. Additionally, Article 8(5) of Directive 2011/24 EU raises doubts regarding the capability to accommodate religious beliefs.[18] In this light, the Supreme Court decided to stay proceedings in order to refer two questions to the CJEU. Firstly, it sought guidance on the interpretation of Article 20(2) of Regulation No 883/2004 in conjunction with Article 21(1) of the CFREU. In particular, it wanted to know whether these provisions permit a Member State to refuse to grant authorisations where medically effective hospital care is available, but the method of treatment used is contrary to that person's religious beliefs. Secondly, it sought to clarify whether Article 56 of the TFEU and Article 8(5) of Directive 2011/24/EU, in conjunction with Article 21(1) of the CFREU, permit a Member State to refuse to grant authorisation for cross-border healthcare in the said circumstances.

15 *Ibid.*

16 *Id.*, paras 14–15.

17 Judgement of a Regional Administrative Court in case No A420281216 (Archive No AA43-0920-17/13) of 10 February 2017.

18 Decision of the Senate of the Republic of Latvia in case No A420281216, SKA-143/2019 of 8 March 2019. See also request for a preliminary ruling in Case C-243/19, available online at http://curia.europa.eu/juris/showPdf.jsf?text=&docid=219771&pageIndex=0&doclang=en&mode=req&dir=&occ=first&part=1&cid=3907412 (accessed 7 March 2021).

3 Opinion of the Advocate General

3.1 *The Point of Departure*

Having presented the factual and legal background of the case and the scope of the preliminary reference,[19] Advocate General Hogan set the scene by recalling that hospital and non-hospital care as services that are provided for remuneration fall within the scope of the TFEU provisions on free movement of services.[20] It is well-established that a requirement of prior authorisation of a planned treatment in another Member State constitutes an obstacle to the freedom to provide services.[21] However, such an obstacle could, in principle, have justifiable aims.[22] Furthermore, the measures that a Member State takes to safeguard a particular legitimate objective should not exceed what is objectively necessary for that purpose. Finally, it is important that the same result cannot be achieved by less restrictive rules. Additionally, any such system must be constructed to circumscribe the discretion of the national authorities, and thus must be based on objective, non-discriminatory criteria, which are known in advance.[23] In other words, proportionality and preclusion of discretion, and transparency of the measures, characterise justification of the legitimate restrictions under the previous case law, and they are also central features that shaped Advocate General Hogan's reasoning.

Regulation 883/2004 and Directive 2011/24 establish two essentially different mechanisms to access healthcare in another Member State, and create different obligations for the Member States. Among their central differences is the scope of choice conferred on a patient and the expenses for the Member State. Having mapped out the central features, the Advocate General moved on to examine the content of Article 20 of Regulation 883/2004 and the rights, freedoms and obligations stemming from Directive 2011/24, as well as the two central differences of the two mechanisms: the possibilities that each provides to a patient; and the financial implications for the Member State. Advocate General Hogan then applied the provisions to the case at hand and carried out the Article 51(1) CFREU test.

19 Opinion of Advocate General Hogan, in Case C-243/19, A v Veselības ministrija (30 April 2020), paras 38–41.

20 *Id*., para. 44.

21 *Id*., para. 45.

22 *Id*., para. 46.

23 *Id*., para. 47.

3.2 *Considerations on the Rules Laid Down in Regulation No 883/2004 and Directive 2011/24*

The Advocate General began the analysis on Article 20 of Regulation 883/2004 by recalling that despite the prima facie wording of the provision, the established essence of Article 20(2) is that it sets forth "two cumulative conditions which, if satisfied, render mandatory the grant by the competent institution of the prior authorisation applied for on the basis of that article."[24] The first of these is that the care must be provided by the Member State of the insurance,[25] and the second that this care "cannot be given within the time normally necessary for obtaining the treatment in question in the latter Member State, taking account of his or her current state of health and the probable course of his or her disease."[26] The authorisation cannot be denied where the care is generally provided by the Member State of affiliation, but that specific care or equally effective medical treatment cannot be given without undue delay.[27] Drawing on the previous case law where the CJEU emphasised that the latter criterion requires an individual assessment,[28] the Advocate General opined that the criterion set forth in Article 20(2) "is exclusively concerned with medical need and not, as such, with personal choice on the part of the patient in question."[29] Consequently, the Advocate General pointed out that based on this criterion alone, albeit subject to the application of the CFREU, the decisions of the national authorities cannot, in principle, be faulted.[30]

Advocate General Hogan began the analysis on Directive 2011/24 by recalling that unlike Regulation 883/2004 the Directive gives patients "a real and effective choice" over the Member State in which they wish to receive healthcare, if the respective care is provided for by the Member State of the patient's affiliation.[31] Although Article 7(1) of Directive 2011/24 introduces an open-ended mechanism of access to cross-border healthcare, Article 8 allows for restrictions. However, a grammatical interpretation of the provision leads to the preliminary conclusion that the system of prior authorisation, essentially a system that limits the free choice of patients that can be established by a Member State under Article 8, is exceptional in nature and therefore must be interpreted restrictively.[32]

24 *Id.*, para. 49.
25 *Id.*, para. 50.
26 *Id.*, para. 51.
27 *Id.*, para. 52.
28 *Ibid.*
29 *Id.*, para. 54.
30 *Id.*, para. 55.
31 *Id.*, para. 61.
32 *Id.*, para. 65.

More specifically, Article 8(2)(a) of Directive 2011/24 sets out what healthcare may be subject to prior authorisation, which includes care that involves overnight hospital accommodation for the patient in question for at least one night or requires the use of highly specialised and cost-intensive medical infrastructure or medical equipment.[33] As follows from Article 8(6)(d) of Directive 2011/24, the Member State of affiliation may refuse to grant prior authorisation where the healthcare can be provided in its territory within a time limit which is medically justifiable. However, Article 8(5) of Directive 2011/24 provides, inter alia, that the Member State of affiliation may not refuse to grant prior authorisation when the patient is entitled to the healthcare in question in accordance with Article 7 and when this healthcare cannot be provided in its territory within a time limit that is medically justifiable.[34] This led the Advocate General to conclude that "the wording of those provisions is unambiguous and that the only criteria specifically contemplated are medical in nature."[35]

3.3 *Application of Regulation No 883/2004, Directive 2011/24 and Article 10(1) and Article 20(1) of the CFREU to the Case at Hand*

Having established that both of the mechanisms deal with criteria that are medical in nature, the Advocate General went on to recall the importance of Article 51(1) CFREU; in particular, that the Member States are obliged to respect the rights, observe the principles and promote the application of the provisions of the CFREU when they are implementing the EU law, including the provisions at stake in the case at hand, Articles 10(1) and 21(1) of the CFREU.[36] This brought the Advocate General to what appeared to be an interim conclusion, namely, that the national court should verify whether the relevant national provisions, which are inter alia based on Article 20(2) of Regulation 883/2004 and Article 8(6)(d) of Directive 2011/24, "do not directly hinder the practice of religion or give rise to direct discrimination on the basis of religion."[37] In the view of the Advocate General, the case law of the CJEU provides considerable guidance. He set about reviewing it and considering how it plays out in the two questions at hand.

Advocate General Hogan opined that the previous case law on cross-border healthcare set forth several objectives that could justify the authorisation

33 *Id.*, para. 66.
34 *Id.*, para. 67.
35 *Id.*, para. 72.
36 *Id.*, para. 73.
37 *Id.*, para. 74.

system. These criteria can be divided into two groups: financial, and organisational and structural, even if they have an indirect financial impact.[38] Regarding the organisational and structural ones, the Advocate General pointed out that if there are no organisational or structural reasons to justify a limitation on the free movement of healthcare under Article 56 TFEU, in his view, it was unlikely that they could justify a limitation on the right to practise one's religion or not to suffer discrimination on the grounds of religion guaranteed under the CFREU. An exception to the latter, however, could be made if it was likely to give rise to an increase in applications for cross-border healthcare based on religious grounds and if its consequences "would be capable of undermining in an appreciable manner the orderly and balanced provision of effective healthcare in Latvia."[39] However, judging from the arguments of the Ministry of Health and the Latvian Government, which mainly focused on the limited available financial resources, the Advocate General noted that it did not seem to be the case.[40]

Thereafter, the Advocate General analysed how the issue of cost can be assessed in the context of cross-border healthcare in the given case. He drew a distinction between what could be said to relate to the negative and positive obligations of a Member State, a state's role in *forum internum* and *forum externum*. In the words of the Advocate General, a distinction needed to be drawn between freedom of religion, which "is essential in a free society where differences of religious conviction and philosophical beliefs must, if at all possible, be accommodated and protected by the Member States", and "the grant of financial support from public monies for these purposes".[41] However, in either case, the financial burden for the Member State of affiliation could potentially be more onerous if care is authorised in accordance with Regulation 883/2004 in comparison with Directive 2011/24.[42]

In regard to Regulation 883/2004, the Advocate General opined that the national court should undertake an examination of the impact of the financial factors. If they risk putting the Latvian healthcare system under strain, "thereby resulting in a potentially appreciable increase in costs to the detriment of the provision of healthcare to others, then such an accommodation of religious beliefs would neither be required nor proportionate."[43] The failure to take into account the religious beliefs of a patient would not be regarded as an

38 *Id*., paras 77–78.
39 *Id*., para. 80.
40 *Id*., para. 81.
41 *Id*., para. 82.
42 *Id*., para. 85.
43 *Id*., para. 86.

unwarranted hindrance on the right to practise religion (*forum externum*) or amount to indirect discrimination on grounds of religion.[44]

In regard to the Directive, the Advocate General recalled that Articles 7 and 8 are guided by the principle of free choice. Article 8(6)(d) permits but does not oblige a Member State to impose pre-authorisation requirements for accessing cross-border healthcare services "for organisational and structural reasons."[45] In the case at hand, that there was an "apparent absence of any financial, organisational or structural reason for refusing to grant (prior) authorisation to B to receive cross-border healthcare pursuant to Directive 2011/24," and "that (prior) authorisation could not legitimately have been refused simply because the operation was available and could be provided by the Latvian public health system." As these reasons did not exist, the refusal of permission to receive care in another Member State was neither permissible nor proportionate as mandated under Article 52.1 CFREU.[46]

4 Judgment of the CJEU

4.1 *Question 1. On Authorisation in Accordance with Article 20(2) of Regulation 883/2004, Applied in Conjunction with Article 21(1) of the CFREU*

The CJEU began to consider the question of the interpretation of Article 20(2) of Regulation 883/2004 in conjunction with Article 21(1) of the CFREU by recalling the aim of Regulation 883/2004 to coordinate the social security schemes of the Member States and ensure effective realisation of the right to free movement of persons.[47] Drawing on *Inizan*, the Court pointed out that Article 20(2) of Regulation 883/2004 gives rights that do not stem from the free movement of services provision as set out in Article 56 TFEU and codified in Directive 2011/24/EU.[48] In such a way, the CJEU made a clear distinction between the social security coordination framework and free movement rights.

The CJEU then explained the aim of Article 20(2) of Regulation 883/2004 in light of its previous case law, which was to make it impermissible for the competent authority to refuse to issue an authorisation to receive medical care

44 *Id*., para. 87.
45 *Id*., para. 91.
46 *Id*., para. 93.
47 Case C-243/19 A v Veselības ministrija, not yet published (Court Reports – general) ECLI:EU:C:2020:872, para. 22.
48 *Id*., para. 24.

in another EU Member State.[49] It is required that two cumulative conditions that are enshrined in the provision are met; firstly, that the treatment at issue is among the benefits provided for by the legislation of the Member State of affiliation, and, secondly, it cannot be given within the time normally necessary for obtaining the treatment in question in the Member State of affiliation, considering the patient's current state of health and the probable course of illness.[50] In this case, it is vital to ascertain whether or not the second criterion set out in Article 20(2) is met.[51]

With reference to *Petru*, the CJEU noted that a Member State can refuse to issue an authorisation if identical or equally effective medical care can be provided within the Member State of residence.[52] The assessment whether or not such a treatment is available is an overall assessment that is done separately in each case.[53] However, the CJEU noted, as Advocate Hogan had, that this assessment was only medical and did not accommodate the personal choices (preferences) of a patient.[54] Consequently, the CJEU stated that the regulation in itself did not require considering personal choices and preferences.[55] In essence, this means that the CJEU implicitly acknowledged that the previous case law was still good case law.

The CJEU then turned to the CFREU and addressed the principle of equal treatment and non-discrimination.[56] It recalled that the prohibition of discrimination has an imperative character in the EU legal order, and as such, it is capable of generating individual rights.[57] In accordance with this principle, comparable situations do not permit differentiated treatment and different situations do not permit the same treatment unless there are objective reasons to justify it.[58] In principle, it is the task of the referring court to assess whether the refusal under Article 20(2) of Regulation 883/2004 is a differentiated treatment based on the person's religion. If it is, the national court is instructed to examine whether this treatment is based on an objective and reasonable criterion.[59] As this assessment strongly relates to the application of EU law, the

49 *Id.*, para. 25.
50 *Ibid.*
51 *Id.*, para. 27.
52 *Id.*, para. 28.
53 *Id.*, para. 29.
54 *Id.*, para. 30.
55 *Id.*, paras 32–33.
56 *Id.*, para. 35.
57 *Id.*, para. 36.
58 *Id.*, para. 37.
59 *Id.*, para. 38.

CJEU has given guidance on how to conduct this test.[60] The CJEU noted that the national framework is neutral on its face, and therefore does not create direct discrimination.[61] However, it is an indirect differentiated treatment.[62] Therefore, it needs to be assessed whether or not it is based on an objective and reasonable criterion.[63]

It began by considering appropriateness. The CJEU accepted that planning and the financial balance of the system can be legitimate objectives that could justify differentiated treatment based on religion.[64] However, the reimbursement principles under Regulation 883/2004 open up the possibility of a Member State incurring higher expenses than if the healthcare was provided in the state of insurance. It recognised the objection by the referring court that religious beliefs fall within the *forum internum* and as such are subjective, which leads to the difficulty in foreseeing costs that a health system may incur.[65] Additionally, the CJEU noted the argument put forward by the Italian Government that "it is possible that national health systems may face a large number of requests for authorization to receive cross-border healthcare which are based on religious grounds rather than on the insured person's medical situation."[66] This obligation could risk undermining a legitimate objective that is recognised by EU law, namely, that of protecting the financial stability of the healthcare insurance system. The CJEU pointed out that "a prior authorisation system which does not take account of the insured person's religious beliefs but which is based exclusively on medical criteria may reduce such a risk and therefore appears to be appropriate for the purpose of achieving that objective."[67]

The CJEU then moved on to considering the need for such a measure. It recalled its previous case law where it had accepted that the level of protection of health could differ between the different Member States as they had the liberty to determine the level of protection which they wished to afford to public health and the way in which that level was to be achieved.[68] If other criteria than medical were to be considered, that would risk creating an additional financial burden for the Member State of affiliation. Such a burden

60 *Ibid.*
61 *Id.*, para. 39.
62 *Id.*, para. 43.
63 *Ibid.*
64 *Id.*, para. 47.
65 *Id.*, para. 50.
66 *Id.*, para. 51.
67 *Id.*, para. 52.
68 *Id.*, para. 53.

would not only be difficult to foresee but could also carry the risk of harming the financial stability of the public healthcare system.[69] The CJEU therefore concluded that a system that did not take into account the insured person's religious beliefs could be justified in light of a legitimate objective recognised by EU law, namely, an objective "to protect the financial stability of the health insurance system, which is a legitimate objective recognised by EU law", as long as it does not exceed what is objectively necessary for that purpose and satisfies the requirement of proportionality. This enabled the CJEU to arrive at the conclusion that Article 20(2) of Regulation No 883/2004, read in the light of Article 21(1) of the CFREU, does not preclude such national legislation that refuses to grant that person the authorisation provided for in Article 20(1) of that Regulation if hospital care is available in that Member State, even though the method of treatment used is contrary to that person's religious beliefs, provided that its medical effectiveness is not contested.[70]

4.2 *Question 2. On Article 8(5) and (6)(d) of Directive 2011/24, Read in the Light of Article 21(1) of the CFREU*

CJEU began addressing the substantive part of the question by recalling the place and role of Article 8 in Directive 2011/24 vis-à-vis Article 56 TFEU. Drawing on recital 8 of Directive 2011/24, it noted that the Directive codifies the CJEU case law on the freedom to provide services guaranteed by Article 56 TFEU in the field of healthcare, while also striving to ensure a more general, and also effective, application of the principles that were developed within that case law.[71] In that light, the provisions of Directive 2011/24, and in particular, the general principle set forth in Article 7(1) and restrictions outlined in Article 8, will be read.

To begin with, Article 7(1) of Directive 2011/24 places an obligation on the Member State of affiliation to ensure that the costs incurred by an insured person who receives cross-border healthcare are reimbursed if the specific healthcare is among the benefits to which the insured person is entitled in the Member State of affiliation, subject to the provision of Article 8 and 9.[72] Following the rules on reimbursement set forth in Article 7(4), the CJEU noted that the reimbursement is required up to the level of costs that would have been assumed by the Member State of affiliation had this healthcare been

69 *Id.*, para. 54.
70 *Id.*, para. 56.
71 *Id.*, para. 66.
72 *Id.*, para. 67.

provided there without exceeding the actual costs of healthcare received in another Member State.[73]

Article 8 (meaning Article 8(1)) allows a Member State to introduce a system of prior authorisation for reimbursement of costs of cross-border healthcare. However, this system is subject to a proportionality assessment as required under that very same article.[74] The CJEU found guidance in the application of this provision in recital 43 of Directive 2011/24, namely that "the criteria attached to the grant of the prior authorisation should be justified in the light of the overriding reasons of general interest capable of justifying obstacles to the free movement of healthcare, such as planning requirements relating to the aim of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources."[75] It therefore found that the aspiration "to control costs and to ensure sufficient and permanent access to a balanced range of high-quality treatment" as argued by the Latvian Government was, in principle, legitimate.[76] However, this was subject to the necessity and proportionality requirement. While the CJEU acknowledged that "it remains for the referring court to determine" whether these are satisfied, it then went on to provide a rather specific guidance on the issue.[77]

In testing the necessity criterion regarding the objective to maintain financial stability, the CJEU pointed out the central differences between Regulation 883/2004 and Directive 2011/24 regarding the financial impacts that reimbursement could create,[78] and aspired to align the interpretation to uphold the intention set forth in recital 29, namely that liberalisation of healthcare should "prevent any significant effect on the financing of the national healthcare systems."[79] It also noted the well-established fact that Directive 2011/24 introduced a twofold limit on the reimbursement. Firstly, the reimbursement is calculated on the basis of the fees for healthcare in the Member State of affiliation. Secondly, the reimbursement should not exceed the actual costs of the treatment received if the cost of the healthcare provided in the host Member State is lower than that of the healthcare provided in the Member State of

73 *Id*., para. 68.
74 *Id*., para. 69.
75 *Id*., para. 70.
76 *Id*., para. 71.
77 *Ibid*.
78 *Id*., para. 72.
79 Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare OJ L 88, 4.4.2011, p. 45–65.

affiliation.[80] Therefore, in principle, the national system will not be subjected to anything that would undermine the stability of the healthcare system.[81] The CJEU concluded that following these principles of reimbursement, "as a rule, [the Member State of affiliation will not] be exposed to any additional financial costs with respect to cross-border healthcare."[82] This allowed the CJEU to hint to the referring court that "[i]n such circumstances, such an objective cannot, as a rule, be relied on to justify the refusal to grant the authorisation provided for in Article 8(1) of Directive 2011/24 in circumstances such as those in the main proceedings."[83] In other words, the necessity criterion was not met in regard to the financial stability argument.

In the next step, the CJEU reviewed the objective of maintaining treatment capacity or medical competence. It noted that the Supreme Court would need to examine whether the national provisions that implement Article 8(1) of Directive 2011/24, in accordance with which prior authorisation was considered, were "restricted to what was necessary and proportionate to achieve that objective."[84] Should the court find that it is not the case, the Latvian authorities cannot make reimbursement of cross-border healthcare subject to obtaining prior authorisation issued in accordance with Article 8(5) and (6)(d) of Directive 2011/24.[85] However, if it is the case, the CJEU pointed out that "Article 8(5) and (6)(d) of Directive 2011/24 must be interpreted as meaning that that latter provision takes account only of the patient's medical condition."[86] Thus, the CJEU found that similar to Regulation 883/2004, Article 8(5) and (6)(d) of Directive 2011/24 are medical in their nature.[87]

In either case, when a Member State refuses to grant prior authorisation, it is implementing EU law within the meaning of Article 51(1) of the CFREU. In doing so, the Member State is required to respect the fundamental rights set forth therein, including Article 21.[88] The CJEU noted that a refusal in this context amounts to indirect discrimination based on religion. Although the differentiated treatment pursues a legitimate objective, it also needs to be proportional. Thus, the national court "must in particular examine whether the taking into account of patients' religious beliefs when implementing

80 A v Veselības ministrija (n 47) para. 74.
81 *Id*., para. 75.
82 *Id*., para. 77.
83 *Id*., para. 78.
84 *Id*., para. 79.
85 *Id*., para. 80.
86 *Id*., para. 81.
87 *Id*., para. 82.
88 *Id*., para. 83.

Article 8(5) and (6)(d) of Directive 2011/24 gives rise to a risk for the planning of hospital treatment in the Member State of affiliation."[89] It gave no further guidance on the criteria based on which that assessment should be done, and whether the same considerations that justify introduction of authorisation per se under Article 8(1) of Directive 2011/24 are acceptable under this criterion. The CJEU concluded that Article 8(5) and (6)(d) of Directive 2011/24, read in the light of Article 21(1) of the CFREU, precludes a Member State of affiliation from refusing to grant that patient the authorisation provided for in Article 8(1) of that Directive where hospital care is available in that Member State, even though the method of treatment used is contrary to that patient's religious beliefs, unless that refusal is objectively justified by a legitimate aim relating to maintaining treatment capacity or medical competence, and is an appropriate and necessary means of achieving that aim. This is conditioned on the fact that the medical effectiveness of the treatment is not contested.[90]

5 Comment

5.1 *A v Veselības ministrija and the Past*

Since Regulation 883/2004 entered into force, the CJEU has had three opportunities to adjudicate on Article 20,[91] two of which (including this case) focused on the second paragraph of this provision. While the number seems relatively small, this provision builds on the wealth of cases decided under Article 22(1)(c) of Regulation 1408/71, and consequently, the relatively well defined scope of application of the respective provision. However, of these cases, this is the first one where the CJEU was called on to consider the interplay between Article 20(2) and the provisions of the CFREU. Likewise, this seems to be the first case that dealt with acceptability of medical care from a patient's perspective when care for a particular condition, in principle, is available in the Member State of affiliation. Similarly, even though the CJEU has been called to

89 *Id*., para. 84.

90 *Id*., para. 85.

91 A v Veselības ministrija (n 47); Case C-777/18 – Vas Megyei Kormányhivatal (Cross-border healthcare); Case C-222/18 VIPA Kereskedelmi és Szolgáltató Kft. v Országos Gyógyszerészeti és Élelmezés-egészségügyi Intézet, published in the electronic Reports of Cases (Court Reports – general), ECLI:EU:C:2019:751; Case C-255/13 I v Health Service Executive, published in the electronic Reports of Cases (Court Reports – general) ECLI:EU:C:2014:1291.

adjudicate five times on Directive 2011/24/EU since it entered into force,[92] this is the first case where the CJEU considered implementation of its provisions in light of the CFREU and its capability to accommodate medical treatment conforming to the patient's values.

This case gave rise to an important issue, namely, the importance of freedom of religion within the EU legal order generally – an issue that has been on the CJEU radar for the last few years[93] – as well as how to accommodate freedom of religion, particularly *forum externum* in its other fields of law and policies, notably social security coordination and free movement. Moreover, it provided methodological guidance on the interplay between Article 7 and 8 of Directive 2011/24, which to some extent represented a move away from the previous case law on reimbursement under the TFEU provisions by excluding the previous legitimate objective of financial stability as an adequate one when applying Article 8 of Directive 2011/24. Finally, it is striking in the way it dealt with a child as a patient yet undertook no explicit consideration of the rights and interests of a minor patient.

With this case, the CJEU demonstrated that cross-border healthcare is no different from other areas of EU law and is subject to the general provisions of the CFREU applied under the Article 51(1) test.[94] Thus, even if the wording of the secondary law is constructed rather narrowly to address only medical considerations, the practical effect is that the Member States need to consider the CFREU. This, in theory, could lead to a different conclusion than that reached by simply applying the respective secondary law instrument which in itself does not consider fundamental rights.

In this case, the CJEU focused on religion and indirect discrimination.[95] It is well-established that indirect discrimination can be justified if the disputed

92 A v Veselības ministrija (n 47); Vas Megyei Kormányhivatal (n 101); Case C-132/14 European Parliament and European Commission v Council of the European Union published in the electronic Reports of Cases (Court Reports – general) ECLI:EU:C:2015:813; Case C-57/12 Fédération des maisons de repos privées de Belgique (Femarbel) ASBL v Commission communautaire commune de Brussels-Capitale published in the electronic Reports of Cases (Court Reports – general) ECLI:EU:C:2013:517.

93 *See*, in that regard, the analysis by E. Ahlm, *EU Law and Religion – A Study of How the Court of Justice has Adjudicated on Religious Matters in Union Law* (Uppsala: Uppsala University, 2020).

94 CFREU applies to the Member States when they are implementing the EU law. Charter of Fundamental Rights of the European Union OJ C 326, 26.10.2012, p. 391–407, Article 51.1.

95 It did not address Article 10 CFREU *expressis verbis* despite it being one of the essential elements of the question referred to it by the national court. However, the approach of the CJEU in addressing the matter under Article 21 and its express acknowledgment that

measure in question pursues a legitimate aim, and if it is appropriate, necessary and proportionate.

First, on the proportionality assessment under Article 20(2) of Regulation 883/2004 in correlation with Article 21 CFREU, the CJEU upheld the previous criteria that could serve as objective justifications for a restriction on free movement, notably, financial stability. The restriction needs to be appropriate for the aim it pursues as well as necessary. If it is objectively necessary to pursue the aim, it could be regarded as proportional. The CJEU, in carrying out the proportionality assessment for the national court, did not emphasise the least restrictive requirement,[96] and proportionality as a requirement was not expressly included in the answer the CJEU gave to the national court. This could signify the Court's willingness to maintain the Member States' discretion even when applying the CFREU in designing their systems and the sensitivity of using social security coordination as a means to tame the Member States' discretion under Article 168(7) TFEU.[97] This can be compared with Advocate General Hogan's indication that only an appreciable increase in costs[98] could tip the balance in favour of an indirectly discriminatory national system.

Second, on the proportionality assessment in setting up an authorisation system under Article 8(1) of Directive 2011/24, in this case, the national measure was subject to two proportionality assessments and the CJEU did not provide guidance on whether and to what extent these assessments overlap. The first proportionality assessment relates to implementation of Article 8(1) of Directive 2011/24 to what is necessary and proportionate to achieve a legitimate aim.[99] The second assessment relates to the refusal of authorisation and indirect discrimination, and whether consideration of the patients' religion could pose a risk to what the aim of the measure is intended to preclude. The CJEU focused on patients as a group, not on a particular case.[100] This could suggest that the referring court will need to do an estimation of the possible

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the issue concerns freedom of religion could, nonetheless, suggest the application of that provision.

96 See A v Veselības ministrija (n 47), paras 55, 52 and 57.

97 See in that regard A v Veselības ministrija (n 47) para. 53 and also Case C-198/14 Valev Visnapuu v Kihlakunnansyyttäjä (Helsinki) and Suomen valtio – Tullihallitus, published in the electronic Reports of Cases (Court Reports – general) EU:C:2015:751, para. 118.

98 Opinion of Advocate General Hogan (n 21) para. 89.

99 *Id*., para 81. Emphasis on the first proportionality consideration is not new in the CJEU jurisprudence. However, if the Member States had doubts about the purpose of Article 8 and the scope of restrictions, they have not had much time to adjust the systems. The first case where the CJEU defined *expressis verbis* narrow application of Article 8(1) was Vas Megyei Kormányhivatal (Cross-border healthcare) (n 92), para. 71, which was adjudicated less than two months before A v Veselības ministrija.

100 A v Veselības ministrija (n 47), para. 84.

further subsequent cases and how these could affect the legitimate objective of maintaining treatment capacity or medical competence. One could argue that in carrying out this assessment, the national courts are, again, given quite some discretion. The answer given by the CJEU to the national court noted appropriateness and necessity, and the reasoning required considering whether accommodation of religious beliefs "gives rise to a risk for the planning of hospital treatment in the Member State of affiliation."[101] While this risk would need to be genuine, a *de minimis* threshold was not set. This can be contrasted with Advocate General Hogan's approach where he suggested that the risk of undermining the orderly and balanced provision of effective healthcare in that Member State in *an appreciable manner* could tip the balance in favour of a Member State.[102]

5.2 *A v Veselības ministrija and the Future*

Although the CJEU used considerably different rhetoric in addressing matters pertaining to social security coordination, on the one hand, and free movement of services, on the other hand, one cannot fail to note the softness in dealing with indirectly discriminatory national systems. Thus, in a way, this decision could be seen as a heavy hit to different societal groups, including religious and cultural minorities, that hoped to benefit from a generous reading of Article 20(2) of Regulation 883/2004. It is also an indirect reminder of the boundary drawn by Article 168(7) TFEU which the CJEU seems to be willing to respect. At the same time, through confirming a narrow interpretation of Article 8 of Directive 2011/24 and setting out guidance on the interplay between Articles 7(1), 7(4) and 8 of Directive 2011/24, the CJEU showed that acceptability of medical care could be subject to shared responsibility between the Member State of affiliation and the patient, whereby the former contributes to the extent that of the cost in its own country, unless it wants to be more generous, and the latter covers the rest. In a way, it indirectly affirms that acceptability of medical care is subject to affordability, and that patients can practise their religion in this respect only if they have adequate means to do so.

The interplay between Regulation 883/2004 and Article 56 TFEU, as well as Directive 2011/24 and Article 56 TFEU, has been interesting to observe. This case reminds us that Article 20(2) of Regulation 883/2004 confers on the insured person possibilities that are not within the scope of free movement of

101 *Ibid.*

102 Opinion of Advocate General Hogan (n 21) para. 98.

services. This sits well with the objectives of Regulation 883/2004 and the legal basis on which it was adopted, and its previous case law.[103]

Directive 2011/24 and Article 56 TFEU have been another pair that have continued to tango despite the recent harmonisation.[104] In this case, despite the apparent relevance of free movement of services and inclusion of Article 56 TFEU in the questions referred to the CJEU, the court adjudicated solely on the basis of the provisions of the Directive, noting the recital 8. Thus, *A v Veselības ministrija* might have cut the umbilical cord between primary law and secondary law, and unless a serious deficiency emerges that requires restoration of the general rules of free movement of services, it could be that Directive 2011/24 starts to live a more independent life in cases to come. Moreover, it has now been established that, unlike under the free movement of services provisions,[105] under Directive 2011/24 financial stability of a health care system "as a rule"[106] is no longer a legitimate objective in itself. One could opine that, given the twofold reimbursement limit, the CJEU saw in that criteria protectionism and a purely economic argument that was a valid one in such early cases as *Kohll*.[107]

6 Aftertaste

It is clear that this case was a test case for a community that is struggling to secure acceptable medical care for its needs; and it is of importance EU-wide, as well as nationally. It is too early to discuss implications of the preliminary ruling for *A* and his child *B* or the national public health system in Latvia, as the national competent national court has not had a chance to give its final verdict.[108] Nonetheless, the CJEU has signaled a restrictive take on the question

103 For example, Case C-372/04 The Queen, on the application of Yvonne Watts v Bedford Primary Care Trust and Secretary of State for Health [2006] ECR I-04325, para. 47; Case C-368/98 Abdon Vanbraekel and Others v Alliance nationale des mutualités chrétiennes (ANMC) 2001 I-05363, paras 37–53.

104 Vas Megyei Kormányhivatal (Cross-border healthcare) (n 92), paras 73–86.

105 See e.g. Case C-157/99 B.S.M. Geraets-Smits v Stichting Ziekenfonds VGZ and H.T.M. Peerbooms v Stichting CZ Groep Zorgverzekeringen [2001] ECR I-05473, para. 71.

106 A v Veselības ministrija (n 47) para. 78.

107 Case C-158/96 Raymond Kohll v Union des caisses de maladie [1998] ECR I-01931, para. 41.

108 In line with the applicable national rules, Supreme Court adopted a judgement with which it referred the case back to the Regional Administrative Court (Court of Appeal) to hear the case again on its merits. See Judgement of the Senate of the Republic of Latvia in case No A420281216, SKA-18/2020 of 27 November 2020. As of 7 April 2021, the Regional Administrative Court has not pronounced its judgement.

under Regulation 883/2004 and a generous one under Directive 2011/24, and it could be expected to reflect in the national judgement along with filling out the unknown data and considerations in proportionality assessment under the Directive. Had the CJEU been more generous or creative in liberalising access to care through social security coordination, that could have opened the door to obtaining medical care in another Member State and could have put pressure on the Member States to adjust their system to the particular minority, and to face uncertainty about other indirect discrimination situations and other struggling minorities.

One can, nevertheless, question whether there is room to re-read Article 20(2) of Regulation 883/2004 to further minority protection. This requires taking a step back and looking at the national law in Latvia that regulates availability of publicly funded healthcare services. These provisions, at the time the case was referred, were neutral on their face and covered access to pediatric cardio surgery, disregarding the method used to carry it out.[109] Thus, from the perspective of national law the restriction lies not so much with the state as with the healthcare providers within the state. Now, following the judgement of the CJEU, additional considerations emerge. The CJEU put considerable emphasis on the different financial burdens imposed by Regulation 883/2004 and Directive 2011/24. While this is so under the EU law, under the Latvian laws infrastructure costs are included in the tariff and thus paid only when a healthcare provider provides a particular service to a patient. If a patient chooses to obtain healthcare in another Member State, the possibility of neutral expenses *versus* larger expenses (Directive 2011/24 *versus* Regulation 883/2004 created mechanisms) lies not only with the NHS but also with a hospital. The national hospital will be the one not receiving the income, and thus will be the one indirectly bearing the cost of cross-border healthcare services. Hospitals, even when they provide publicly funded healthcare, are commonly commercial actors, for-profit entities. The public system will risk bearing the cost only if the state needs to rescue a particular hospital, or when (in those rare cases) the state has committed to pay for services disregarding whether or not a patient has been given medical care. This might be a previously unconsidered consequence of the cross-border system.

If the national law is neutral on the face of it, one could further question whether the CJEU has located the issue under the correct limb of Article 20(2) of Regulation 883/2004. Thus far, the CJEU has not taken the opportunity to fully elaborate on the meaning of the requirement that the treatment at issue

109 Cabinet Regulation 1529 of 17 December 2013 (lapsed), Latvijas Vēstnesis, 253, 30.12.2013, annex 3, 2.1.12.

is among the benefits provided for by the legislation of the Member State of affiliation. It has, however, often been concerned with the Member State's ability to ensure treatment within the time normally necessary, considering the patient's individual situation.[110] It is well-established that the second criterion covers the same or equally effective medical care,[111] and thus allows for flexibility for Member States. The CJEU has been silent on the fact that the Member States have committed to ensure pediatric cardio surgery without specifying how it should be carried out. This approach sits well with the CJEU's take on *no choice* under Article 20(2) of Regulation 883/2004, but coupled with the generous reading of the second limb of the provision, it is not something that sits well with designing healthcare systems that are responsive to the interests and needs of minorities. Indirectly, this affirms respect for the Member States' responsibilities regarding the definition of their health policy and organisation, as well as delivery of health services and medical care as set forth in Article 168(7) TFEU and the EU's unwillingness to intervene.

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110 *See*, for example, Watts (n 103).
111 *See*, for example, Inizan (n 4) para. 46; Elchinov (n 4) para. 66.