Chapter 3
EU

3.1. Constitutional framework

3.1.1. The status of the unborn under EU law

A common conception of the status of the unborn does not exist in EU law. The beginning of life has not been defined in any EU legislative instrument, nor in any ruling of the Court of Justice of the European Union (CJEU). It is not, for example, decided how the term 'everyone' under Article 2(1) Charter ('Everyone has the right to life') is to be defined.[1] This matter is – so it can be concluded – left to the discretion of the Member States.

Two CJEU rulings have, nevertheless, indirectly touched upon this sensitive issue. The cases *Sabine Mayr* (2008)[2] and *Brüstle* (2011)[3] concerned the interpretation of terms and concepts in EU Directives which have a (remote) connection to the unborn. While these judgments give some clues with regard to the CJEU's approach to the unborn, it must be underlined that it remains impossible to draw any substantive conclusions as to the status of the unborn in EU law from these rulings. This has everything to do with the fact that the definitions given by the CJEU were strictly confined to the context of the relevant Directives, which concerned employment law and patent law respectively.

The case of *Sabine Mayr* (2008) concerned the question whether a female worker who was undergoing *in vitro* fertilisation treatment was protected against dismissal under EU law.[4] The Grand Chamber of the Court ruled that the prohibition of dismissal of pregnant workers in Article 10(1) of Council Directive 92/85/EEC,[5] did not extend

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1 The explanations to the Charter provide no clarification on this point. Guiding is therefore the case law of the ECtHR on this point. As set out in Ch.2, the ECtHR left this matter to the States to decide upon. It is, furthermore, noted that the European Parliament held in a Resolution of 1989 that there was a need ' to protect human life from the moment of fertilization'. Resolution of the European Parliament on artificial insemination *in vivo* and in vitro of 16 March 1989, Preamble under C, [1989] OJ C96/127, p. 172.

2 Case C-506/06 *Sabine Mayr* [2008] ECR I-1017, ECLI:EU:C:2008:119.

3 Case C-34/10 *Oliver Brüstle* v. *Greenpeace eV* [2011] ECR I-9821, ECLI:EU:C:2011:669.

4 The preliminary reference, *inter alia*, concerned the interpretation of Council Directive 92/85/EEC of 19 October 1992 on the introduction of measures to encourage improvements in the safety and health of pregnant workers, workers who have recently given birth and women who are breastfeeding [1992] OJ L348/1.

5 Council Directive 92/85/EEC of 19 October 1992 on the introduction of measures to encourage improvements in the safety and health of pregnant workers, workers who have recently given birth and women who are breastfeeding [1992] OJ L348/1.

to a female worker who was undergoing *in vitro* fertilisation treatment where, on the date she was given notice of her dismissal, her ova had already been fertilised by her partner's sperm, so that *in vitro* fertilised ova existed, but they had not yet been transferred into her uterus.[6] Such dismissal was, however, precluded by EU law if the woman was in 'an advanced stage' of IVF treatment and inasmuch as it was established that the dismissal was essentially based on the fact that the woman had undergone such treatment.[7] The Court defined an 'advanced stage' of IVF treatment as '[…] between the follicular puncture and the immediate transfer of the *in vitro* fertilised ova into [the woman's] uterus'.[8]

Hence, apparently the CJEU considered an advanced stage of IVF treatment to come so close to pregnancy that the protection against dismissal as afforded by the Directive to pregnant women had to be extended to this situation. To infer from this ruling any finding in respect of the beginning of life or the status of the unborn under EU law, would not, however, be possible without resorting to speculation.

In *Brüstle* (2011)[9] the German Federal Court of Justice had made a preliminary reference to the CJEU concerning the patentability of biotechnological inventions in which human embryos were used. The CJEU gave an autonomous interpretation of the term 'human embryo' within the meaning of Directive 98/44/EC on the legal protection of biotechnological inventions ('the Biotechnology Directive').[10] The Court underlined that such a uniform definition was desired, to avoid the '[…] risk of the authors of certain biotechnological inventions being tempted to seek their patentability in the Member States which [had] the narrowest concept of human embryo and [were] accordingly the most liberal as regards possible patentability, because those inventions would not be patentable in the other Member States.' According to the Court such a situation would have adversely affected the smooth functioning of the internal market which was the aim of the Directive.[11] The Court also underlined the following:

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6 Case C-506/06 *Sabine Mayr* [2008] ECR I-1017, ECLI:EU:C:2008:119, para. 53.

7 *Idem*, para. 54. The Court based its finding on Arts. 2(1) and 5(1) of Council Directive 76/207/EEC of 9 February 1976 on the implementation of the principle of equal treatment for men and women as regards access to employment, vocational training and promotion, and working conditions.

8 *Idem*, para. 54.

9 Case C-34/10 *Oliver Brüstle* v. *Greenpeace eV* [2011] ECR I-9821, ECLI:EU:C:2011:669; see also S. Henette-Vauchez, 'L'embryon de l'Union', 48 *RTD eur.* (2012) pp. 355–368.

10 Directive 98/44/EC of the European Parliament and of the Council of 6 July 1998 on the legal protection of biotechnological inventions [1998] OJ L213/13.

11 Case C-34/10 *Oliver Brüstle* v. *Greenpeace eV* [2011] ECR I-9821, ECLI:EU:C:2011:669, para. 28. For critique in this respect, see H. Somsen, 'Brüstle: embryonale fout met grote gevolgen' ['Brüstle: embroynic mistake with major consequences'], *Nederlands Tijdschrift voor Europees Recht* (2012) p. 33 at p. 37 and F.M. Fleurke, 'Case note to Case C-34/10 (*Brüstle*)', 13 *European Human Rights Cases* 2012/54 (in Dutch). Spranger held it to be 'hardly comprehensible' how the Court could arrive at this 'unambiguous evaluation'. The author held that the existing divergences in patent law 'in no way' needed necessarily to be aligned in the direction of a wide embryo-concept. T.M. Spranger, 'Case C-34/10, Oliver Brüstle v. Greenpeace e.V., Judgment of the Court (Grand Chamber) of 18 October 2011', 49 *CLMRev.* (2012) p. 1197 at 1202.

> '[…] although, the definition of human embryo is a very sensitive social issue in many Member States, marked by their multiple traditions and value systems, the Court is not called upon, by the present order for reference, to broach questions of a medical or ethical nature, but must restrict itself to a legal interpretation of the relevant provisions of the Directive.'[12]

Hence, the Court confined itself to the legal interpretation of the concept of 'human embryo' within the meaning of the Biotechnology Directive, i.e., within the context of patent law.[13] According to the Court this concept was to be understood in a wide sense however, as the 'context and aim'[14] of the Directive showed that the European Union legislature intended to exclude any possibility of patentability where respect for human dignity could be affected.[15] The Court held that any human ovum after fertilisation, any non-fertilised human ovum into which the cell nucleus from a mature human cell had been transplanted, and any non-fertilised human ovum whose division and further development had been stimulated by parthenogenesis constituted a 'human embryo' within the meaning of the Directive.[16] The CJEU left it for the referring court to ascertain, in the light of scientific developments, whether this also held for a stem cell obtained from a human embryo at the so-called blastocyst stage (i.e., approximately five days after fertilisation).[17]

Precisely because the Court stressed that it only gave a 'legal interpretation' of the term 'human embryo' and only within the context of the Biotechnology Directive, one has to be very careful in making any inferences from this judgment in respect of the status of the unborn in EU law in a broader sense,[18] such as the question as

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12 Case C-34/10 *Oliver Brüstle* v. *Greenpeace eV* [2011] ECR I-9821, ECLI:EU:C:2011:669, para. 30. The Court referred to Case C-506/06 *Sabine Mayr* [2008] ECR I-1017, ECLI:EU:C:2008:119, para. 38.

13 Art. 6(2)(c) of Directive 98/44/EC.

14 Remarkably, the Court did not refer to the EU Charter of Fundamental Rights, nor to the European Convention on Human Rights. See also Fleurke 2012, *supra* n. 11.

15 Case C-34/10 *Oliver Brüstle* v. *Greenpeace eV* [2011] ECR I-9821, ECLI:EU:C:2011:669, para. 34.

16 *Idem*, para. 38. Spranger observed that this definitely was '[…] not only extremely broad, but also open towards further extension, with further developments of modern life sciences.' Spranger 2012, *supra* n. 11, at p. 1203. AG Cruz Villalón has held in a case of a later date that an ovum whose development has been stimulated without fertilisation and which was not capable of becoming a human being could not be considered a human embryo. However, if this ovum was genetically manipulated in such a way that it could develop into a human being, it had to be regarded as a human embryo and as such excluded from patentability, the AG held. Case C-364/13 *International Stem Cell Corporation* v. *Comptroller General of Patents*, *nyr,* ECLI:EU:C:2014:2104, Opinion of AG Cruz Villalón.

17 Case C-34/10 *Oliver Brüstle* v. *Greenpeace eV* [2011] ECR I-9821, ECLI:EU:C:2011:669, para. 38. At the blastocyst stage, embryonic stem cells are pluripotent, which means that there are able to develop into various organs and tissues, but not into a complete individual.

18 Advocate General Bot had also warned that from the 'legal definition' as chosen by him, no inferences could be drawn 'for other areas which relate to human life, but which are on an entirely different level and fall outside the scope of Union law.' For that reason, Bot considered that the reference made at the hearing to judgments delivered by the European Court of Human Rights on the subject of abortion was, 'by definition', outside the scope of the *Brüstle* case. He held it not to be possible to compare the question of the possible use of human embryos for industrial or commercial purposes 'with national laws which seek to provide solutions to individual difficult situations.' Case C-34/10 *Oliver Brüstle* v. *Greenpeace eV* [2011] ECR I-9821, ECLI:EU:C:2011:138, Opinion of AG Bot, para. 49.

from which developmental stage an embryo is an independent bearer of rights.[19] In the words of Spranger '[…] all attempts to ascribe a general legal significance to the decision of the Court of Justice going beyond the realm of patent law must be emphatically opposed.'[20] The author underlined 'the limited relevance of patent law', which understood itself '[…] basically as a value-neutral subject matter and [was], also for systematic reasons, not the right place for the establishment of all-purpose new standards for the entire European legal order.'[21] Nevertheless, some have argued that the approach taken by the Court presupposed a certain bio-ethic vision, that was however not made explicit.[22]

For one thing, the cases of *Sabine Mayr* and *Brüstle* confirmed the observation that the CJEU shows considerable judicial restraint in cases which touch upon such sensitive and ethical issues such as the status of the unborn. Furthermore, the interpretation of Union law that the CJEU gave was in both these cases confined to the very specific subject matter at stake.

3.1.2. (Potentially) relevant Charter rights

Several Articles of the Charter of Fundamental Rights of the European Union (CFR)[23] relate in one way or another to reproductive rights.[24] The CJEU's case law on these provisions is, however, still fairly limited and therefore provides little guidance in respect of application of these Articles in the context of the present case study. It is recalled in this regard, that the CFR also has a limited scope of application; its provisions '[…] are addressed to the institutions, bodies, offices and agencies of the

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19 T. Groh, 'Anmerkung zu C-34/10 (*Brüstle*)' ['Case note to Case C-34/10 (*Brüstle*)'], 23 *Europäische Zeitschrift für Wirtschaftsrecht* (2011) p. 910 at p. 910.

20 Spranger 2012, *supra* n. 11, at p. 1205.

21 *Idem*.

22 B. van Beers, 'Het Europese Hof van Justitie over de vermarkting van menselijke embryo's. Van economische naar ook bio-ethische integratie binnen de EU?' ['The European Court of Justice on the commercialisation of human embryos. From economic to also bio-ethical integration in the EU?'], 37 *NTM/NJCM-Bull.* (2012) p. 242 at pp. 255–256. Without substantiating this with references, Spranger held that '[a]lready shortly after the publication of the decision, the opinion that the Court of Justice has delivered a complete embryo definition for all areas of European Law or that this complete, or all-purpose, definition should at least be indirectly derived from the decision in the interest of a consistent legal order, has actually been expressed by various stakeholders. The author held '[t]hese attempts at interpretation', to be 'falsified by the remarks of the Court of Justice itself". He furthermore held that they misjudged the 'scope' which the CJEU and the ECtHR had so far, 'and with good reasons' attributed to the Member States, ' in view of the concretization of ethically problematic or socially controversial concepts of the modern life sciences'. Spranger 2012, *supra* n. 11, at p. 1205. See also at pp. 1208–1209.

23 Charter of fundamental rights of the European Union [2000] OJ C364/1.

24 Yet in 1989 – hence much before the Charter of Fundamental Rights even existed – the European Parliament had held in a Resolution that the main criteria governing the area were '[…] the mother's right to self-determination and the respect of the rights and interests of the child, i.e. the right to life and physical, psychological and existential integrity, the right to a family, the right to be looked after by its parents and to grow up in a suitable family environment and the right to its own genetic identity. Resolution of the European Parliament on artificial insemination in vivo and in vitro of 16 March 1989, Preamble under D [1989] OJ C96/127, p. 172.

Union with due regard for the principle of subsidiarity and to the Member States only when they are implementing Union law'.[25]

Article 1 CFR, to start with, contains a fundamental right to human dignity.[26] While there is little case law on this specific Charter Article, the right to human dignity was already recognised by the CJEU as part of Union law in 2001.[27] Also, it has been upheld as a justification for restrictive measures in free movement cases.[28] The CJEU, furthermore, considered it 'not indispensable' in that regard for the restrictive measure issued by the authorities of a Member State to correspond to a conception shared by all Member States as regards the precise way in which the fundamental right or legitimate interest in question was to be protected.[29]

The right to life and the right to integrity of the person are codified in Articles 2 and 3 CFR, respectively. The latter Article provides that in the fields of medicine and biology the free and informed consent of the person concerned; the prohibition of eugenic practices; the prohibition on making the human body and its parts, as such, a source of financial gain;[30] as well as the prohibition of the reproductive cloning of human beings, must be respected in particular.[31]

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25 Art. 51 TFEU. See also, *inter alia*, Case C-617/10 *Åkerberg Fransson* [2013] ECR 0000, ECLI:EU:C:2013:105; K. Lenaerts, 'The EU Charter of Fundamental Rights: Scope of Application and Methods of Interpretation', in: V. Kronenberger et al. (eds.), *De Rome à Lisbonne: les juridictions de l'Union européenne à la croisée des chemins: mélanges en l'honneur de Paolo Mengozzi* (Bruxelles, Bruylant 2013) p. 107 and W.B. van Bockel and P.J. Wattel, 'New Wine into Old Wineskins: the Scope of the Charter of Fundamental Rights of the EU after Åkerberg Fransson', 38 *European law review* (2013) p. 866.

26 Art. 1 CFR reads: 'Human dignity is inviolable. It must be respected and protected.'

27 Case C-377/98 *Netherlands* v. *European Parliament and Council* [2001] ECR I-7079, ECLI:EU:C:2001:523, paras. 70–77.

28 In *Omega* (2004), the Court held that there was no doubt that the objective of protecting human dignity was compatible with EU law. Case C-36/02 *Omega* [2004] ECR I-9609, ECLI:EU:C:2004:614.

29 *Idem*, para. 37.

30 As McHale has pointed out, the prohibition on making (parts of) the human body a source of financial gain is also recognised in the Tissue and Cells Directive (see also section 3.3.2 below). J. McHale, 'Fundamental rights and health care', in: E. Mossialos et al. (eds.), *Health Systems Governance in Europe: The Role of European Union Law and Policy* (Cambridge, Cambridge University Press 2010) p. 282 at p. 300, online available at www.euro.who.int/en/who-we-are/partners/observatory/studies/health-systems-governance-in-europe-the-role-of-eu-law-and-policy, visited June 2014.

31 The official explanation to this Article reads:

'1. In its judgment of 9 October 2001 in Case C-377/98 *Netherlands* v *European Parliament and Council* [2001] ECR-I 7079, at grounds 70, 78 to 80, the Court of Justice confirmed that a fundamental right to human integrity is part of Union law and encompasses, in the context of medicine and biology, the free and informed consent of the donor and recipient.

2. The principles of Article 3 of the Charter are already included in the Convention on Human Rights and Biomedicine, adopted by the Council of Europe (ETS 164 and additional protocol ETS 168). The Charter does not set out to depart from those principles, and therefore prohibits only reproductive cloning. It neither authorises nor prohibits other forms of cloning. Thus it does not in any way prevent the legislature from prohibiting other forms of cloning.

3. The reference to eugenic practices, in particular those aiming at the selection of persons, relates to possible situations in which selection programmes are organised and implemented, involving campaigns for sterilisation, forced pregnancy, compulsory ethnic marriage among others, all acts

A related Charter provision that may potentially prove of relevance for the status and development of reproductive rights within EU law is Article 35 CFR. Following this Article '[e]veryone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices.'[32] This provision thus '[…] does not recognize *per se* a right to health assured by EU law, but rather a principle of access to health based on national legislation'.[33] The Article has been categorised amongst the Charter rights which in fact merely constitute 'pure objectives' of the Union[34] and it has been questioned whether it will make a practical difference in terms of litigation.[35]

Article 7 of the Charter contains a right to respect for private and family life which corresponds to Article 8 ECHR.[36] Article 9 CFR lays down the right to found a family, a right that is disconnected from the right to marry, that is also provided for in Article 9.[37] The Commentary to the Charter by the EU Network of Independent Experts on Fundamental Rights of 2006 noted – without specifying this further – that the right to found a family provided '[…] for some aspects of reproductive choice including the use of new procreative technologies'.[38] At the same time, it was noted that there was 'a diversity of domestic legislation on this subject'.[39] This diversity is implied in the fact that this right – like under Article 12 ECHR on which it is

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deemed to be international crimes in the Statute of the International Criminal Court adopted in Rome on 17 July 1998 (see its Article 7(1)(g)).'
Explanations relating to the Charter of Fundamental Rights [2007] OJ C303/17, p.18.

32 Art. 35 CFR further provides that '[a] high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.'

33 S. De la Rosa, 'The directive on cross-border healthcare or the art of codifying complex case law', 49 *CML Rev.* (2012) p. 15 at p. 35, footnote 75. The Explanations to this Article also speak of 'principles' that are set out in this Article, which are based on Art. 168 TFEU and Arts. 11 and 13 of the European Social Charter.

34 T. K. Hervey, 'We don't see a Connection: the "Right to Health" in the EU Charter and European Social Charter', in: G. De Búrca et al. (eds.), *Social rights in Europe* (Oxford, Oxford University Press) p. 305 at p. 318.

35 J. McHale, 'Fundamental rights and health care', in: E. Mossialos et al. (eds.), *Health Systems Governance in Europe: The Role of European Union Law and Policy* (Cambridge, Cambridge University Press 2010) p. 282 at pp. 304 and 306–307, online available at www.euro.who.int/en/who-we-are/partners/observatory/studies/health-systems-governance-in-europe-the-role-of-eu-law-and-policy, visited June 2014. McHale refers (in footnote 98), to T. Hervey, 'The right to health in European Union law', in: T. Hervey and J. Kenner (eds.), *Economic and social rights under the EU Charter of Fundamental Rights: a legal perspective* (Oxford, Hart 2003) p. 193 at p. 210.

36 Explanations relating to the Charter of Fundamental Rights [2007] OJ C303/17, p. 20.

37 EU Network of Independent Experts on Fundamental Rights, *Commentary of the Charter of Fundamental Rights of the European Union*, June 2006, online available at www.ec.europa.eu/justice/fundamental-rights/files/networkcommentaryfinal_en.pdf, visited June 2014. In this Commentary it was observed (at p. 103): 'Article 9 of the Charter approaches the rights at stake, i.e. the right to found a family and the right to marry as two different and separate rights, suggesting that the former is not necessarily connected with the latter. Apparently, it seems from the wording, i.e., the usage of the plural form 'these rights', that a disconnection between the right to marry and to found a family has been envisaged. In other words, a marriage does not necessarily imply procreation.'

38 EU Network of Independent Experts on Fundamental Rights, *Commentary of the Charter of Fundamental Rights of the European Union*, June 2006, p. 104, online available at www.ec.europa.eu/justice/fundamental-rights/files/networkcommentaryfinal_en.pdf, visited June 2014.

39 *Idem*.

based[40] – is guaranteed in accordance with the national laws governing the exercise of this right. The right to found a family under Article 9 CFR has never been referred to in a CJEU judgment, let alone interpreted by the Court.

Article 33(1) CFR is also related to the family and provides that the family shall enjoy 'legal, economic and social protection'.[41] Further, other than the ECHR, the Charter provides expressly for the rights of the child, which is based on the UN Convention on the Rights of the Child.[42] Its Article 24(2) provides that '[…] in all actions relating to children, whether taken by public authorities or private institutions, the child's best interests must be a primary consideration.' Following the third paragraph of Article 24, every child has the right '[…] to maintain on a regular basis a personal relationship and direct contact with both his or her parents, unless that is contrary to his or her interests.'[43]

Article 21 CFR lays down a prohibition on discrimination. Contrary to Article 14 ECHR this is a self-standing right that can be invoked independently from other Charter rights. The provision is not intended to introduce 'a sweeping ban of discrimination' that covers any Member States' action and private action, but, like all Charter rights, addresses the institutions and the Member States when they are implementing Union law.[44] According to the Explanations to the Charter, this Article draws, *inter alia*, on Article 11 of the Convention on Human Rights and Biomedicine which contains a prohibition on discrimination on the basis of genetic heritage.

Lastly, Article 45 EU Charter grants every EU citizen the right to move and reside freely within the territory of the Member States.[45] While this right is thus granted to those with EU citizenship only, it is provided that such freedom of movement and residence may be granted to third-country nationals who are legally resident in the territory of a Member State.[46]

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40 See Explanations relating to the Charter of Fundamental Rights [2007] OJ C303/17.

41 This Article has not been applied in CJEU case law. It has only been briefly mentioned in Case C-147/08 *Jürgen Römer* v. *Freie und Hansestadt Hamburg* [2011] ECR I-3591, ECLI:EU:C:2010:425, Opinion of AG Jääskinen, para. 174.

42 Explanations relating to the Charter of Fundamental Rights [2007] OJ C303/17, p. 25.

43 The explanations to the Charter explain that this paragraph of Art. 24 '[…] takes account of the fact that, as part of the establishment of an area of freedom, security and justice, the legislation of the Union on civil matters having cross-border implications, for which Article 81 of the Treaty on the Functioning of the European Union confers power, may include notably visiting rights ensuring that children can maintain on a regular basis a personal and direct contact with both of their parents.' Explanations relating to the Charter of Fundamental Rights [2007] OJ C303/17, p. 25.

44 Explanations relating to the Charter of Fundamental Rights [2007] OJ C303/17, p. 24.

45 The Explanations to the Charter clarify that this right is guaranteed by Arts. 20(2)(a) and 21 TFEU as well as Case C-413/99 *Baumbast* [2002] ECR I-7091, ECLI:EU:C:2002:493.

46 Art. 45(2) CFR. According to the Explanations to the Charter this second paragraph refers to the power granted to the Union by Arts. 77, 78 and 79 TFEU. Explanations relating to the Charter of Fundamental Rights [2007] OJ C303/17, p. 29.

Whether the Charter supports the 'right to reproduce discourse'[47] is as yet an open question. The explanations to the Charter and the CJEU case law as they currently stand do not provide sufficient ground for such a conclusion. McHale has pointed out that in developing health policies or in litigation, use of the Charter may prove problematic because it has a limited scope, because it does not make clear how to balance conflicting rights and because it contains concepts, such as dignity, which are very broad and therefore difficult to enforce. The author has also warned that there are '[…] differing religious, cultural and ethical perspectives regarding certain fundamental rights questions' within the EU and that '[r]espect for equality and diversity of cultural and religious viewpoints does not sit easily with a single "EU" approach to fundamental human rights in health care.'[48]

3.1.3. Relevant EU competences

The EU Treaties provide for various Union competences that apply or may apply in the context of the present case study. The most general one for cross-border situations is of course the EU's competence in respect of the internal market.[49] The application of the EU's free movement rules to cross-border health care cases, and cross-border abortions and AHR treatment in particular, is discussed in more detail in sections 3.5 and 3.6.2 below. Another general competence that may be of relevance for the present case study concerns the EU's competence to adopt (harmonising) legislation to combat certain forms of discrimination.[50] The coming into being of this competence and its general application are discussed more extensively in Chapter 9,[51] while its (potential) application in respect of reproductive matters in particular is discussed in sections 3.3.3 and 3.3.4 below.

The present section briefly sets out four more specific EU competences. Most of these concern primarily the present case study, namely public health, social security and criminal law. The EU's competence in respect of civil matters (including family law) having cross-border implications, as discussed in section 3.1.3.3 below, is also relevant for Case Study II.

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47 T.K. Hervey and J.V. McHale, *Health Law and the European Union* (Cambridge: Cambridge University Press 2004) p. 145, referring (in footnote 219) to S. Millns, 'Reproducing inequalities; assisted conception and the challenge of legal pluralism', 24 *Journal of Social Welfare and Family Law* (2002) p. 19 at p. 32.

48 J. McHale, 'Fundamental rights and health care', in: E. Mossialos et al. (eds.), *Health Systems Governance in Europe: The Role of European Union Law and Policy* (Cambridge, Cambridge University Press 2010) p. 282 at pp. 312–313, online available at www.euro.who.int/en/who-we-are/partners/observatory/studies/health-systems-governance-in-europe-the-role-of-eu-law-and-policy, visited June 2014.

49 Art. 114 TFEU.

50 Art. 19 TFEU.

51 In particular in section 9.3.

3.1.3.1. Public health

Public health is generally considered a '[…] particularly sensitive area of national competence involving complex, costly, and important political and social choices'.[52] The Union's competences in respect to public health have therefore always been, and still are, rather limited. Under the Treaty of Rome (the EEC Treaty) of 1957 there was no Community competence in this field. Public health was only referred to as a ground for derogation from the free movement rules.[53] The Maastricht Treaty (1992)[54] was the first to provide for a limited Union competence regarding public health. Article 129 EC Treaty provided that the (then) European Community was to '[…] contribute towards ensuring a high level of human health protection by encouraging Member States, and if necessary, by lending support to their action'. The Lisbon Treaty (2009), as presently still in force, changed little in this regard. On the basis of Article 168 TFEU the European Union has a coordinating competence in respect of the 'protection and improvement of human health'.[55] This means that the Union may support, coordinate or supplement the actions of the Member States in this field. Following Article 168(7) TFEU Union action in the field of public health must respect the responsibilities of the Member States '[…] for the definition of their health policy and for the organisation and delivery of health services and medical care'. The responsibilities of the Member States include the '[…] management of health services and medical care and the allocation of the resources assigned to them'. The Union has the task of encouraging cooperation between the Member States, especially to improve the complementarity of the Member States' health services in cross-border areas.[56] New is that Article 9 TFEU expressly provides that the EU has the duty to protect human health in all its policies and activities.[57] Even though this 'multi-sector social clause'[58] is no basis for any EU competence, some have argued that it shows the 'social commitment' of the Union.[59]

3.1.3.2. Social security

The picture in respect of the regulation of social security is fairly similar. By way of Article 118 Maastricht Treaty (1992) the Commission was given the task of promoting close cooperation between Member states in respect of social security. Following the present Article 153 TFEU the Union supports and complements the activities of the Member States in the field of social security. It is emphasised that

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52 S. O'Leary, 'Free movement of persons and services', in: P. Craig and G. de Búrca, *The Evolution of EU law* (Oxford: Oxford University Press 2011) p. 499 at p. 522.

53 Art. 36 EEC Treaty.

54 Treaty of the European Union, together with the complete text of the Treaty establishing the European Community [1992] OJ C224/1.

55 Art. 6(a) TFEU. Shared competence between the Union and the Member States are confined only to 'common safety concerns in public health matters, for the aspects defined in this Treaty'. Art. 4(2)(k) TFEU.

56 Art. 168(2) TFEU.

57 Art. 9 TFEU however reads that 'in defining and implementing its policies and activities, the Union takes into account requirements linked to the […] protection of human health'.

58 De la Rosa 2012, *supra* n. 33 at p. 35.

59 *Idem*.

Member States retain the right '[…] to define the fundamental principles of their social security systems'.[60] The CJEU has repeatedly affirmed that EU law '[…] does not detract from the powers of the Member States to organise their social security systems'.[61] It is well-established case law that in the absence of harmonisation at EU level, it is for the legislature of each Member State to determine the conditions concerning the right or duty to be insured with a social security scheme[62] and the conditions for entitlement to benefits.[63]

3.1.3.3. Civil matters (including family law) having cross-border implications

In principle, the EU has no competences in respect of family law, however, Article 81(3) TFEU, confers on the Council the power to adopt 'measures concerning family law having cross-border implications'. This forms part of the Union's competence to develop '[…] judicial cooperation in civil matters having cross-border implications, based on the principle of mutual recognition of judgments and of decisions in extrajudicial cases.'[64] Article 81 TFEU explicitly provides that '[s]uch cooperation may include the adoption of measures for the approximation of the laws and regulations of the Member States', such as measures aimed at ensuring '[…] the compatibility of the rules applicable in the Member States concerning conflict of laws'.[65]

This legal basis for judicial cooperation in cross-border civil matters was first introduced by the Treaty of Amsterdam (1999).[66] The Presidency Conclusions of the Tampere European Council of 1999 had held that mutual recognition had to become '[…] the cornerstone of judicial co-operation in both civil and criminal matters within the Union.'[67] At the time, it was provided under the then Article 65 EC Treaty that measures could only be adopted 'insofar as necessary for the proper functioning of the internal market'. The Lisbon Treaty (2009) changed this into 'particularly when necessary for the proper functioning of the internal market', thus making Article 81

60 Art. 153(4) TFEU.

61 Case 238/82 *Duphar and Others* v. *Netherlands* [1984] ECR 523, ECLI:EU:C:1984:45, para.16 and Case C-70/95 *Sodemare and Others* v. *Regione Lombardia* [1997] ECR I-3395, ECLI:EU:C:1997:301, para. 27.

62 Case 110/79 *Una Coonan* v. *Insurance Officer* [1980] ECR 1445, ECLI:EU:C:1980:112, para. 12, and Case C-349/87 *Paraschi* v. *Landesversicherungsanstalt Württemberg* [1991] ECR I-4501, ECLI:EU:C:1991:372, para. 15.

63 Joined Cases C-4/95 and C-5/95 *Stöber and Piosa Pereira* v. *Bundesanstalt für Arbeit* [1997] ECR I-511, ECLI:EU:C:1997:44, para. 36 and Case C-158/96 *Kohll* [1998] ECR I-1931, ECLI:EU:C:1998:171, para. 18.

64 Art. 81(1) TFEU. Storskrubb has questioned whether this cross-border limitation '[…] is still able to stem the dynamism of the policy area'. The author furthermore posed questions as to the exact implications of the inclusion of the principle of mutual recognition in this Article. E. Storskrubb, 'Civil Jusitice – A newcomer and an unstoppable wave?', in: P. Craig and G. De Búrca, *The evolution of EU Law*, 2nd edn. (Oxford, Oxford University Press 2011) p. 307.

65 Art. 81(2)(c) TFEU.

66 Art. 65 EC (old).

67 Tampere European Council 15 and 16 October 1999 Presidency Conclusions, para. VI, online available at www.europarl.europa.eu/summits/tam_en.htm, visited June 2014.

TFEU a more independent legal basis.[68] In the subsequent Stockholm Programme (2010–2014)[69] it was held that mutual recognition had to be extended '[…] to fields that [had] not yet [been] covered but [were] essential to everyday life […] while taking into consideration Member States' legal systems, including public policy, and national traditions in this area.'[70]

If 'measures concerning family law with cross-border implications' are concerned, the Council can only act in accordance with a special legislative procedure; it has to consult the European Parliament first and can only adopt measures with a unanimous vote. Exceptionally, acts concerning family law with cross-border implications may be adopted by the ordinary legislative procedure. That requires a proposal from the Commission, after which the Council has to act unanimously after consulting the European Parliament.[71] Unique to this 'PIL passerelle' clause is that national parliaments must be notified of a Commission proposal and any national parliament can in principle block the adoption of the proposal by the Council.[72] This has been held to demonstrate '[…] the balance between the political desire to move forward in the area of family law and the politically sensitive nature of the area.'[73] Further, since the Treaty of Lisbon national courts may request preliminary rulings in respect of this provision.[74]

3.1.3.4. Criminal law

The Union has little competences with respect to criminal law. Possible approximation of substantive criminal laws is limited to narrowly defined '[…] areas of particularly serious crime with a cross-border dimension resulting from the nature or impact of such offences or from a special need to combat them on a common

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68 It has therefore been concluded that '[t]he position that Article 81 TFEU is but merely a lex specialis of Article 114 TFEU can no longer be maintained.' G.-R. de Groot and J.-J. Kuipers, 'The New provisions on Private international law in the Treaty of Lisbon', 15 *Maastricht Journal of European and Comparative Law* (2008) p. 109 at p. 112. But see in respect of the old Art. 65 EC Treaty: R. Baratta, 'Problematic elements of an implicit rule providing for mutual recognition of personal and family status in the EC', *IPRax* (2007) p. 4 at p. 5 and J. Meeusen et al., 'General Report', in J. Meeusen et al. (eds.), *International family law for the European Union* (Antwerpen, Intersentia 2007) p. 1 at p. 13.

69 The Stockholm Programme – An open and secure Europe serving and protecting citizens [2010] OJ C115/1.

70 *Idem*, para. 3.1.2.

71 Art. 81(3) TFEU reads: 'Notwithstanding paragraph 2, measures concerning family law with cross-border implications shall be established by the Council, acting in accordance with a special legislative procedure. The Council shall act unanimously after consulting the European Parliament.
The Council, on a proposal from the Commission, may adopt a decision determining those aspects of family law with cross-border implications which may be the subject of acts adopted by the ordinary legislative procedure. The Council shall act unanimously after consulting the European Parliament.
The proposal referred to in the second subparagraph shall be notified to the national Parliaments. If a national Parliament makes known its opposition within six months of the date of such notification, the decision shall not be adopted. In the absence of opposition, the Council may adopt the decision.'

72 See also Groot, de and Kuipers 2008, *supra* n. 68, at pp. 112–114, who sketch three scenarios in which they consider the passerelle clause likely to be used.

73 Storskrubb 2011, *supra* n. 64, at p. 307.

74 Art. 267 TFEU.

basis', none of which appears relevant for the present case study.[75] The Union may, however, take measures for coordination and cooperation between police and judicial authorities and other competent authorities.[76] There is, furthermore, foreseen in mutual recognition of judgments in criminal matters.[77] It has been in this context that the European Arrest Warrant (EAW) was drafted. The (potential) application of that instrument in the context of the present case study is discussed in section 3.6.4 below.

3.2. Absence of EU standards on abortion

As the Council has acknowledged '[t]he Treaties do not provide a basis for the Union to adopt measures with respect to questions related to abortion.'[78] As explained in section 3.1.3 above, the Union's competences in the field of health care, social security law and criminal law are generally limited. The only case that came before the CJEU which had to do with abortion was the *Grogan* case (see section 3.5.2.1 below). While – as explained below – the CJEU took a much debated approach in deciding this free movement case, no substantive conclusion in respect of abortion can be drawn from this judgment. The substantive legal regulation of abortion has always been, is, and is anticipated to remain in the near future, a matter for the Member States.

The issue of abortion has nonetheless incidentally been debated at EU level. As explained in section 3.5.1 below, particularly cross-border movement that has taken place for this purpose has caught the attention of the EU institutions. EU institutions have, however, been very hesitant to take any position in respect of substantive regulation of abortion. By way of exception, in 2013 the European Parliament's Committee on Women's Rights and Gender Equality invited the European Parliament to take a strong stance in favour of abortion, when it tabled a motion for a resolution on Sexual and Reproductive Health and Rights.[79] The Resolution held that women

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75 Art. 83(1) TFEU limits these areas of crime to the following: terrorism, trafficking in human beings and sexual exploitation of women and children, illicit drug trafficking, illicit arms trafficking, money laundering, corruption, counterfeiting of means of payment, computer crime and organised crime. On the basis of developments in crime, the Council may – unanimously and after obtaining the consent of the European Parliament – adopt a decision identifying other areas of crime that meet the criteria specified in this paragraph.

76 Art. 67(3) TFEU.

77 Arts. 67(3) and 82 TFEU.

78 Answer of the Council of 15 March 2010 to written question by Magdi Cristiano Allam (PPE) to the Council: Member States' autonomy and the right to life, P-6267/09 of 9 December 2009, www.europarl.europa.eu/sides/getAllAnswers.do?reference=P-2009-6267&language=HU, visited July 2014. In a similar vein the Commission held back in 1989 that it '[…] did not consider the approximation of national rules concerning the prevention and termination of pregnancy to be necessary for the completion of the internal market.' A. Sherlock, 'The Right to life of the unborn and the Irish Constitution', 24 *Irish Jurist* (1989) p. 13, referring (in footnote 29) to European Parliament – Written Questions with Answer [1989] OJ C111/1, p. 16.

79 Motion for a European Parliament Resolution on Sexual and Reproductive Health and Rights (2013/2040(INI)), online available at www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//NONSGML+REPORT+A7-2013-0306+0+DOC+PDF+V0//EN, visited 24 July 2014.

had '[…] the right to decide freely and responsibly the number, timing and spacing of their children' and recommended that high-quality abortion services were made legal and accessible to all women, including non-resident women.[80] The motion was rejected and the very brief Resolution that was adopted instead in Parliament merely noted that the formulation and implementation of policies on sexual and reproductive health and rights was a competence of the Member States.[81]

3.3. (Limited) EU standards related to assisted human reproduction and surrogacy

There are very few EU law standards relating to assisted human reproduction (AHR). Various of the existing standards in this regard, are, moreover, non-binding. For example, in a Resolution of 1989 the European Parliament (EP) took a clearly directive stance on assisted human reproduction.[82] The EP, *inter alia*, called on Member States to limit the number of egg cells fertilised by *in vitro* fertilisation to the number that could actually be implanted. The Parliament also called for a prohibition on 'any form of genetic experiments on embryos outside the womb' and considered that the storage of frozen embryos was only to be permitted if the woman's state of health temporarily prevented her from having the embryo implanted and she had stated that she was willing to have it implanted at a later date. Heterologous insemination was, moreover, considered 'not desirable'. The Resolution set out a number of conditions that States had to meet if they did not accept the latter principles, including, *inter alia*, that only altruistic donation of gametes would be allowed.

Other examples of non-binding EU instruments and documents relating to AHR are the Opinion of the European Group on Ethics in Science and New Technologies (EGE)[83] on ethical aspects of prenatal diagnosis (PND) of the year 1996[84] and a 2008

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80 *Idem*, paras. 28, 30 and 38.

81 European Parliament Resolution of 10 December 2013 on Sexual and Reproductive Health and Rights (2013/2040(INI)), online available at www.europarl.europa.eu/sides/getDoc.do?type=TA&reference=P7-TA-2013-0548&language=EN&ring=A7-2013-0426, visited 24 July 2014.

82 Resolution of the European Parliament on artificial insemination in vivo and in vitro of 16 March 1989, [1989] OJ C96/127, p.171.

83 The European Group on Ethics in Science and New Technologies (EGE) advises the European Commission on ethical questions relating to sciences and new technologies, either at the request of the Commission or on its own initiative. Commission Decision 2010/1/EU of 23 December 2009 on the renewal of the mandate of the European Group on Ethics in Science and New Technologies [2010] OJ L1/8. The Group of advisers to the European Commission on the ethical implications of biotechnology (GAEIB) as established in 1991 (see Commission, 'Promoting the competitive environment for industrial activities based on biotechnology within the Community' (Communication), SEC(91) 629 final), was followed-up by the present EGE in 1998. See also H. Bubsby et al., 'Ethical EU law? The influence of the European Group on Ethics in Science and New Technologies', 33 *European Law Review* (2008) p. 803.

84 Opinion of the group of advisers on the ethical implications of biotechnology to the European Commission, *Ethical aspects of prenatal diagnosing*, Opinion no. 6, 20 February 1996, online available at www.ec.europa.eu/archives/european_group_ethics/docs/opinion6_en.pdf, visited 5 June 2012. The Opinion only dealt with PND which was defined as allowing '[…] the examination of pregnancies at high risk of fetal anomaly or genetic disease to rule out or confirm the presence of such an anomaly or

Resolution on the demographic future of Europe, in which the European Parliament called on Member States '[…] to ensure the right of couples to universal access to infertility treatment'.[85] Furthermore, the European Institutions have commissioned and financed various research studies in the field. An example concerns a 2008 Comparative Analysis of Medically Assisted Reproduction in the EU by the European Society of Human Reproduction and Embryology (ESHRE), which was commissioned and financed by the Directorate-General for Health and Consumers of the European Commission.[86] This and other studies are referred to throughout this chapter, particularly in section 3.4, concerning statistics on CBRC.[87]

Only few binding EU standards on AHR exist. The EU has very limited competences in this field, which has everything to do with the sensitivity of the matter. This sensitivity was underlined by the CJEU in its judgment in the *Sabine Mayr* case (2008), which, as noted above (see section 3.1.1), revolved around the question of whether women who are in an advanced stage of IVF treatment are also protected against dismissal under EU law.[88] Using a wording comparable to the equally yet discussed *Brüstle* case (also section 3.1.1), the Court held that it was not called upon to broach medical or ethical questions:

> '[…], although, […], artificial fertilisation and viable cells treatment is a very sensitive social issue in many Member States, marked by their multiple traditions and value systems, the Court is not called upon, by the present order for reference, to broach questions of a medical or ethical nature, but must restrict itself to a legal interpretation of the relevant provisions of Directive 92/85 taking account of the wording, the broad logic and the objectives of that directive.'[89]

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disease using invasive techniques: amniocentesis, chorionic villus sampling or fetal blood sampling.' It did not deal with prenatal screening, neither preconceptional testing or screening, nor preimplantation diagnosis. It was held that these techniques introduced 'additional ethical issues which would require separate consideration.' The EGE advised that the use of PND relied on the free and informed consent of the woman or couple concerned. It stressed the importance of careful non-directive genetic counselling. In this respect, the EGE held that '[*i*]n accordance with the subsidiarity principle, the European Union [had] strive to achieve a high and comparable level of quality of the training of the professionals, namely concerning the genetic counselling, and of the services provided in different Member States.' The EGE furthermore held that PND had to always be offered on the basis of specific medical indications. It considered the choice of sex or other characteristics for nonmedical reasons an ethically unacceptable indication for PND and held that it therefore had to be prohibited. The present author is not aware of any follow-up to this EGE-Opinion.

85 European Parliament Resolution of 21 February 2008 on the demographic future of Europe, Resolution 2007/2156 INI9, P6_TA(2008)0066, www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P6-TA-2008-0066+0+DOC+XML+V0//EN, visited July 2014.

86 ESHRE, *Comparative Analysis of Medically Assisted Reproduction in the EU: Regulation and Technologies*, SANCO/2008/C6/051, online available at www.ec.europa.eu/health/blood.../study_eshre_en.pdf, visited July 2014.

87 Another example concerns A. Coverleyn et al., *Pre-implantation Genetic Diagnosis in Europe* (Joint Research Centre of the European Commission, January 2007), online available at www.ftp.jrc.es/EURdoc/eur22764en.pdf, visited 24 July 2014.

88 Case C-506/06 *Sabine Mayr* [2008] ECR I-01017, ECLI:EU:C:2008:119, para. 53–54.

89 *Idem*, para. 38.

Hence, from this judgment, no normative position on the issue of (access to) AHR treatment can be inferred. The judgment nonetheless had some impact on national policies in this field, as States from then on had to protect women who were in an advanced stage of IVF treatment against dismissal.

No normative stance was taken either in the *In vitro* diagnostic medical devices Directive (1998) and the EU Tissues and Cells Directive (2004) which set safety and quality requirements for *in vitro* diagnostic medical devices and AHR treatments for those Member States in which such devices are legally on the market, or in which such treatment is provided. The following subsections discuss these Directives. As yet no case law exists in which any of these Directives has been applied in a manner that has direct (substantive) relevance to the present case study.

3.3.1. The EU In vitro diagnostic medical devices Directive (1998)

Following a Commission Proposal of 1995,[90] Directive 98/79/EC on *in vitro* diagnostic medical devices was adopted in 1998.[91] It provides for harmonisation of national provisions governing the placing on the market of *in vitro* diagnostic medical devices,[92] including *in vitro* fertilisation and assisted reproduction technologies products.[93] Such harmonisation was considered desired as disparities as regards '[…] the content and scope of the laws, regulations and administrative provisions in force in the Member States with regard to the safety, health protection and performance, characteristics and authorisation procedures for *in vitro* diagnostic medical devices' were considered to create barriers to trade.[94] Such harmonisation was, however, not to affect the ability of the Member States to manage the funding of public health and sickness insurance schemes relating directly or indirectly to *in vitro* diagnostic medical devices.[95] On the basis of the Directive, Member States

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90 Proposal for a European Parliament and Council Directive on in vitro diagnostic medical devices [1995] OJ C172/21.

91 Directive 98/79/EC of the European Parliament and of the Council of 27 October 1998 on in vitro diagnostic medical devices [1998] OJ L331/1 amended by Regulation (EC) No 1882/2003 of the European Parliament and of the Council of 29 September 2003.

92 Art. 1(2)(b) of the Directive defines the term '*in vitro* diagnostic medical device' as: '[…] any medical device which is a reagent, reagent product, calibrator, control material, kit, instrument, apparatus, equipment, or system, whether used alone or in combination, intended by the manufacturer to be used *in vitro* for the examination of specimens, including blood and tissue donations, derived from the human body, solely or principally for the purpose of providing information: concerning a physiological or pathological state, or concerning a congenital abnormality, or to determine the safety and compatibility with potential recipients, or to monitor therapeutic measures.'

93 European Commission, DG Health and Consumer Protection*, Guidelines for conformity assessment of including In Vitro Fertilisation (IVF) and Assisted Reproduction Technologies (ART) products*, Guidance Document Meddev 2.2/4, January 2012, p. 2, www.ec.europa.eu/health/.../meddev/2_2_4_ol_en.pdf, visited July 2014.

94 Recital No. 2 Directive 98/79/EC. Accordingly, the legal basis of the Directive was Art. 95 EC Treaty (old), concerning the approximation of laws in respect of the internal market. The harmonisation of national legislation was considered 'the only means of removing such barriers to free trade and of preventing new barriers from arising' (Recital No. 3 Directive 98/79/EC).

95 Recital 4 Directive 98/79/EC.

must monitor the security and quality of *in vitro* diagnostic medical devices, which may be placed on the market and/or put into service only if they comply with certain (design and manufacturing) requirements, when duly supplied and properly installed, maintained and used in accordance with their intended purpose.[96] Member States may not create any obstacle to the placing on the market or the putting into service within their territory of devices which meet these requirements.[97] Hence, the objective of this Directive was, and is, primarily the optimisation of trade in *in vitro* diagnostic medical devices, and not to regulate AHR treatment substantively. This purely economic objective fits in with the broader internal market objectives of the EU.

While Member States may thus not create any obstacle to the placing on the market or the putting into service within their territory of *in vitro* diagnostic medical devices which meet the above-described requirements, they may, nevertheless, regulate – or even prohibit – the *use* of such devices within their territory, probably including on moral grounds. Such a regulation or prohibition would hinder market access,[98] but could possibly be justified on grounds of protection of public morals or protection fundamental rights such as human dignity, or on grounds of public order, public health or consumer protection. This only holds, of course, as long as the national measure would also be appropriate for securing the attainment of the objective pursued and would not go beyond what would be necessary in order to attain it.[99]

3.3.2. The EU Tissues and Cells Directive (2004)

The EU Tissues and Cells Directive (2004)[100] provides for a unified framework in order to ensure high standards of safety and quality with respect to the procurement,

96 Art. 3 Directive 98/79/EC.

97 Art. 5(1) Directive 98/79/EC.

98 Compare Case C-110/05 *Commission* v. *Italy* [2009] ECR I-519, ECLI:EU:C:2009:66, para. 56, where the Court held that '[…] a prohibition on the use of a product in the territory of a Member State has a considerable influence on the behaviour of consumers, which, in its turn, affects the access of that product to the market of that Member State.'

99 E.g. Case C-110/05 *Commission* v. *Italy* [2009] ECR I-519, ECLI:EU:C:2009:66, para. 59.

100 The Tissues and Cells Directive is made up of three Directives: the parent Directive 2004/23/EC of the European Parliament and of the Council of 31 March 2004 on setting standards of quality and safety for the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells [2004] OJ L102/48, which provides the framework, and two technical directives: Directive 2006/17/EC of 8 February 2006 implementing Directive 2004/23/EC of the European Parliament and of the Council as regards certain technical requirements for the donation, procurement and testing of human tissues and cells [2006] OJ L38/40 and Directive 2006/86/EC of 24 October 2006 implementing Directive 2004/23/EC of the European Parliament and of the Council as regards traceability requirements, notification of serious adverse reactions and events and certain technical requirements for the coding, processing, preservation, storage and distribution of human tissues and cells [2006] OJ L294/32. Directive 2006/17/EC was amended by Commission Directive 2012/39/EC (Commission Directive 2012/39/EU of 26 November 2012 amending Directive 2006/17/EC as regards certain technical requirements for the testing of human tissues and cells [2012] OJ L327/24), which, *inter alia*, amended one of the selection criteria and laboratory tests required for donors of reproductive cells, as set out in Annex III to Directive 2006/17/EC. As a complement to the Tissues and Cells Directive the European Society of Human Reproduction and Embryology (ESHRE) issued a revised

testing, processing, storage and distribution of tissues and cells across the EU and to facilitate exchanges thereof.[101] Such EU standards are supposed to reassure the public that tissues and cells procured in other Member States carry the same guarantees as those in their own Member States.[102] The Directive explicitly covers gametes, foetal tissue and embryonic stem cells.[103] Hence, as observed in a report of 2008:

> '[…] implementation of this Directive requires clinics in all […] EU Member States, specialized in Medically Assisted Reproductive (MAR) technologies, including fertility treatment and pre-implantation genetic diagnosis, to adapt to stringent measures and to implement systems and operating procedures concerning accreditation, designation, authorization, licensing, inspection and registration of MAR-treatments.'[104]

Both third party gametes donors and individuals or couples from whom gametes are taken in the course of an IVF cycle are considered 'donors' within the meaning of this Directive.[105] The Directive provides that Member States must 'endeavour to ensure' voluntary and unpaid donations.[106] Donors may receive compensation, but this is '[…] strictly limited to making good the expenses and inconveniences related to the donation procedure.' Member States define the conditions under which the compensation may be granted.[107] Furthermore, as a matter of principle, donation must be anonymous.[108] In respect of donation of gametes in particular, Article 14(3) provides that

> 'Member States shall take all necessary measures to ensure that the identity of the recipient(s) is not disclosed to the donor or his family and vice versa, without prejudice to legislation in force in Member States on the conditions for disclosure, notably in the case of gametes donation.'

Following Article 9 of the Directive, Member States '[…] shall take all necessary measures to ensure that all imports of tissues and cells from third countries are undertaken by tissue establishments accredited, designated, authorised or licensed for the purpose of those activities, and that imported tissues and cells can be traced

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version of its guidelines for good Practices in IVF clinics. These guidelines were published in 23 *Human Reproduction* (2008) p. 1253.

101 Recital 4 Directive 2004/23/EC.

102 *Idem*.

103 Recital 7 Directive 2004/23/EC.

104 ESHRE 2008, *supra* n. 86, at p. 1.

105 Following Art. 3(c) a 'donor' means 'every human source, whether living or deceased, of human tissues and cells'. 'Donation' is defined as donating human tissues or cells intended for human application (Art. 3(d)). ESHRE explained in its position paper on the Directive that in a couple, man and woman are considered donors to each other (see Annex 9 to the study).

106 Art. 12(1) and Preamble under 18 Directive 2004/23/EC.

107 Art. 12(1) Directive 2004/23/EC. The Commission considered the paying of substantial fees to obtain human egg cells to be against the principles expressed in Directive 2004/23/EC. See European Commission, Health & Consumer Protection Directorate-General, *Report on the Regulation of Reproductive Cell Donation in the European Union*, February 2006, p. 2, online available at www.ec.europa.eu/health/archive/ph_threats/human_substance/documents/tissues_frep_en.pdf, visited 23 June 2014.

108 Art. 15(1) and Preamble under 18 Directive 2004/23/EC.

from the donor to the recipient and vice versa […]'.[109] States are free to introduce more stringent protective measures.[110] For example, they may prohibit the donation, processing or procurement of gametes, they may prohibit or restrict the import of gametes and they are free to introduce requirements for voluntary unpaid donation.[111] Lastly, the Directive is not to interfere '[…] with provisions of the Member States defining the legal term 'person' or 'individual'.'[112]

The European Society of Human Reproduction and Embryology (ESHRE) considered execution of some of the areas in the Directive problematic, due to its wide coverage in comparison to the 'very specific nature' of AHR, '[…] including numerous repeated procedures on the same patient and the usually long duration of treatments at the clinics/units.'[113] To complement the Directive, the *ESHRE Guidelines for good practice in IVF laboratories* were drafted, '[…] to promote assurance of good laboratory practice and to define the concept of qualified embryologists.'[114]

While anonymous donation is thus clearly the point of departure of the Directive,[115] it nevertheless seems to leave some room for States to give prevalence to protection of the future child's interest in knowing his or her genetic parents, by prohibiting anonymous donation within their territory.[116] Whether this also holds in the case of IVF clinics importing gametes from other States, is less clear.[117] Another open question in this regard is if it would be an 'import' within the meaning of the Directive if a woman receives a donated gametes in the course of treatment in a third country and then travels back to her home Member State. It was observed in 2006

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109 Following Art. 8(4) Directive 2004/23/EC data required for full traceability shall be kept for a minimum of 30 years after clinical use.

110 Art. 4(2) Directive 2004/23/EC.

111 Art. 4(2) and (3) Directive 2004/23/EC.

112 Recital No. 12 Directive 2004/23/EC. This sentence was yet included in Recital No. 7 of the original Commission proposal for the Directive. The explanatory Memorandum to this Proposal does not give any further clarification on this point, rendering it difficult to draw any conclusions in respect of the interpretation of this consideration. Commission, 'Proposal for a Directive of the European Parliament and of the Council on setting standards of quality and safety for the donation, procurement, testing, processing, storage, and distribution of human tissues and cells', COM (2002) 319 final.

113 ESHRE position paper on the EU Tissues and Cells Directive EC/ 2004/23, November 2007, Annex 9 to ESHRE 2008, *supra* n. 86.

114 M.C. Magli et al., 'Revised guidelines for good practice in IVF laboratories', 23 *Human Reproduction* (2008) at p. 1253.

115 Art. 15(1) and Recital No. 18 of the Preamble to Directive 2004/23/EC.

116 See also Health & Consumer Protection Directorate-General of the European Commission*, Report on the Regulation of Reproductive Cell Donation in the European Union – Results of Survey -, Directorate C – Public Health and Risk Assessment C6 – Health measures*, February 2006, p. 3, online available at www.ec.europa.eu/health/archive/ph_threats/human_substance/documents/tissues_frep_en.pdf, visited June 2014.

117 While Art. 9 holds that States 'shall take all necessary measures to ensure' that the donor can be traced back, Art. 4(3) holds that the Directive 'does not affect the decisions of the Member States prohibiting the donation, procurement, testing, processing, preservation, storage, distribution or use of any specific type of human […] cells or cells from any specified source, *including where those decisions also concern imports of the same type of human [...] cells* (emphasis added).'

that in any case not many Member States appeared to have regulated the import and export of gametes.[118]

All in all, the Directive leaves considerable room to Member States to regulate gamete donation. In a Resolution of 2005, the European Parliament called on the Commission to assess national legislations governing gamete donation.[119] The resulting Report of 2006 showed that national approaches in respect of '[…] confidentiality, anonymity and non-remuneration in the donation of reproductive cells, as well as donor compensation, consent for egg cell donations and the importation and exportation of reproductive cells' varied greatly.[120] This supports the conclusion that in respect of reproductive treatment the Tissues and Cells Directive has – in any case until that time – had little to no harmonising effect. At the same time, this is a particularly dynamic field of law and as a consequence the situation may have changed since 2006.

3.3.3. EU non-discrimination law and access to AHR treatment

Various EU Member States – including the three EU Member States included in this research[121] – restrict access to AHR treatment on grounds of age, civil status or combined gender of the couple that wishes to have access to it. Even though this may be perceived as discrimination, EU non-discrimination law as it stands provides no ground for challenging such national regulations and it seems unlikely that this will change in the near future. Under the present EU legal framework, discrimination based on age and sexual orientation is prohibited in employment, occupation and vocational training only.[122] While in 2008 a broader Equal Treatment Directive was proposed,[123] which was intended to expand the reach of EU non-discrimination law to matters like social protection, health care and access to goods and services which are available to the public,[124] reproductive rights were explicitly excluded from the

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118 European Commission, Health & Consumer Protection Directorate-General, *Report on the Regulation of Reproductive Cell Donation in the European Union*, February 2006, p. 5, online available at www.ec.europa.eu/health/archive/ph_threats/human_substance/documents/tissues_frep_en.pdf, visited 23 June 2014. At p. 6 of this report it was held that '[f]or reproductive cells in general, no serious report or suspicion of unauthorised, illegal or otherwise suspect import/export of these human cells [had] been detected in any of the Member States.'

119 European Parliament Resolution on the trade in human egg cells (P6_TA(2005)0074).

120 European Commission, Health & Consumer Protection Directorate-General, *Report on the Regulation of Reproductive Cell Donation in the European Union*, February 2006, p. 2, online available at www.ec.europa.eu/health/archive/ph_threats/human_substance/documents/tissues_frep_en.pdf, visited 23 June 2014.

121 See Ch. 4, section 4.3.3, Ch. 5, section 5.3.3 and Ch. 6, section 6.3.2.

122 Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin [2000] OJ L180/22 and Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation [2000] OJ L303/16.

123 Commission, 'Proposal for a Council Directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation', COM (2008) 426 final. For further discussion of this proposal for a Directive, see Ch. 9, section 9.3.4.1.

124 Proposed Recital No. 17 and Art. 3(2) of COM (2008) 426 final.

scope of the Directive as proposed by the Commission. The European Economic and Social Committee (EESC) was very critical on this point, holding that access to reproductive services was an integral part of health services, in respect of which under both EU law and national law there was to be no discrimination on any grounds.[125] The EESC accordingly proposed that the Directive should apply to national laws relating to reproductive rights.[126] The European Parliament, for its part, amended the relevant proposed Article 3(2) from '[t]his Directive is without prejudice to national laws on marital or family status and reproductive rights', to the more neutral '[t]his Directive does not alter the division of competences between the European Union and its Member States.'[127] The legislative process stagnated in 2011 and it is therefore yet to be seen to what extent the Directive – if ever adopted[128] – will have a bearing on Member States' legislative choices in respect of access to reproductive care.

3.3.4. EU law and surrogacy

As matters stand today, no EU standards on surrogacy exist.[129] This, again, has everything to do with a lack of EU competences in this field. In 2011, the Commission, in answering a question by a Member of Parliament who claimed that the sensitive issue of surrogacy warranted a coordinated stance within the EU, put it as follows:

> 'The Treaty on European Union and the Treaty on the Functioning of the European Union do not give the European Union powers to adopt legislation on harmonisation of national laws on methods of reproduction with the help of surrogate mothers. It is therefore incumbent on individual Member States to regulate this matter in the light of their social and cultural traditions.'[130]

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125 The EESC held there to be evidence of discrimination in relation to reproductive services on grounds of sexual orientation, disability and age. Opinion of the European Economic and Social Committee on the 'Proposal for a Council directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation', para. 3.2.2.4 [2009] OJ C182/19, p. 21.

126 Opinion of the European Economic and Social Committee on the 'Proposal for a Council directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation', para. 3.2.2.5 [2009] OJ C182/19, p. 21.

127 Accordingly, Recital No. 17 was proposed to be amended from 'This Directive is without prejudice to national laws on marital or family status, including on reproductive rights' to 'This Directive does not alter the division of competences between the European Union and its Member States, including in the area of marital and family law and health law.' European Parliament legislative resolution of 2 April 2009 on the proposal for a Council directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation (COM (2008) 0426 – C6-0291/2008 – 2008/0140(CNS)) [2010] OJ C137E/68, pp. 75 and 81.

128 See Ch. 9, section 9.3.4.1.

129 It is reminded that this study was concluded on 31 July 2014.

130 Answer by the Commission of 10 March 2011, to written question no. 42 to the Commission by Ivo Belet (PPE) of 21 February 2011, H-000096/2011, online available at www.europarl.europa.eu/sides/getDoc.do?type=CRE&reference=20110310&secondRef=ANN-01&language=EN&detail=H-2011-000096&query=QUESTION, visited June 2014.

The Commission at the time made clear that it had no plans to explore coordination of the issue of surrogate motherhood within the EU. Instead, it referred to the work of the Hague Conference on Private International Law, of which the EU is a full member. It is in this context that the Commission follows developments on surrogate motherhood at international level (see also section 3.6.1 below).[131]

Surrogacy has incidentally been debated in European Parliament. In a Resolution of 1989, the European Parliament considered that in in general, any form of surrogate motherhood had to be rejected and that the procuring of surrogate mothers for gain had to be punishable by law.[132] While the matter was subsequently not on the table for decades, more recently the European Parliament Committee on Legal Affairs took on the issue again, thereby focussing mainly on its cross-border aspects (see 3.6.3 below). In 2013 a study came out that had been ordered by this Committee,[133] which gave a comparative overview of the Member States' legal situations in respect of surrogacy. The question was also addressed if this matter called for regulation at EU level. In this regard the conclusion was drawn that prohibiting the conception of a child through surrogacy under EU law was impossible, because no consensus on this issue consisted among the EU Member States. The report concluded that 'a global response' to surrogacy was most desirable, as 'a purely intra-EU regime' had territorial limitations.[134] In respect of possible EU action in the field, the report observed that this would have to respect the different (moral) attitudes towards surrogacy across the Member States:

> '[…] what seems clear in thinking about the future competency of the EU in this area is that Member States will retain the competency to decide on what moral grounds to act and what policy decisions to make on the permissibility of surrogacy. If an action or a legislative act was adopted, the instrument in which any harmonised response would be delivered would be required to recognise the wide spectrum of domestic law attitudes to surrogacy across states: if, as a matter of policy, a given legal system does not admit surrogacy in its domestic law, it would be inappropriate to impose on it a (European) structure of cross-border surrogacy regulation.'[135]

The report made a number of recommendations in respect of cross-border surrogacy that are discussed in section 3.6.3.2 below.

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131 *Idem* and Answer given by Mrs Reding on behalf of the Commission on 5 May 2011, to question for written answer by Ivo Belet (PPE) to the Commission of 21 March 2011, E-002642/2011, online available at www.europarl.europa.eu/sides/getAllAnswers.do?reference=E-2011-002642&language=EN, visited June 2014.

132 Resolution of the European Parliament on artificial insemination in vivo and in vitro of 16 March 1989 [1989] OJ C96/127, p. 173.

133 For the relevant terms of reference, see www.europarl.europa.eu/tenders/2012/20120423/ANNEX%20I%20Global%20terms%20of%20reference.pdf, visited June 2014.

134 L. Brunet et al., *A Comparative Study on the Regime of Surrogacy in EU Member States*, 2013, PE 474.403, pp. 157 and 194, online available at www.europarl.europa.eu/RegData/etudes/etudes/join/2013/474403/IPOL-JURI_ET(2013)474403_EN.pdf, visited 31 March 2014.

135 *Idem*, at p. 195.

The only existing CJEU case law that relates to surrogacy concerned two joined employment cases decided by the Grand Chamber of the CJEU in 2014. In both *C.D.* and *Z.* the question was raised whether EU law provided for entitlements for female employees who, as an intended mother[136] had a child through a surrogacy agreement to paid leave equivalent to maternity leave or adoption leave.[137]

In *C.D.* the woman concerned, Ms. D., was a UK national who had concluded a surrogacy agreement in accordance with UK law. Ms D.'s partner (the intended father) provided the sperm, but the egg cell was not Ms. D.'s. Right after the child was born, Ms. D. began to mother and breastfeed the child and some months later a UK court granted her and her partner full and permanent parental responsibility for the child. Yet before the baby was born Ms. D., had made an application to her employer for paid leave under its adoption policy, but was informed that there was 'no legal right to paid time off for surrogacy'. Ms. D. subsequently brought an action before the Employment Tribunal claiming that she had been the subject of discrimination on the grounds of sex and/or pregnancy and maternity. This Tribunal made a preliminary reference to the CJEU, asking the Court whether the Pregnant Workers' Directive (Directive 92/85)[138] provided a right to receive maternity leave to an intended mother who had a baby through a surrogacy arrangement, and who was breastfeeding the child. The Tribunal also wondered whether a refusal to grant such leave constituted discrimination in breach of the Equal Treatment Directive (Directive 2006/54).[139] The CJEU joined this case with another case raising similar questions, namely the *Z.* case.

The *Z.* case concerned Irish school teacher, Ms. Z., who, together with her husband, had entered into a surrogacy agreement in California. Ms. Z. had a rare condition which had the effect that, although she had healthy ovaries and was fertile, she had no uterus and could not support a pregnancy. The child born with the surrogate mother was genetically related to both Ms. Z. and her husband, and in accordance with Californian law the child's birth certificate provided that they were the child's parents. Ms. Z. applied to the government department for leave equivalent to adoptive leave, but the department refused that application on the ground that she did not satisfy the requirements laid down by the relevant maternity or adoptive leave schemes. Ms. Z. subsequently brought an action against the government department before the Equality Tribunal, claiming that she was discriminated against on the grounds of gender, family status and disability. The Equality Tribunal stayed the proceedings and referred preliminary questions to the CJEU. It, *inter alia*, asked the

136 The CJEU employed the term 'commissioning mother' instead of 'intended mother' in these cases.

137 Case C-167/12 *C.D.* v. *S.T.*, *nyr,* ECLI:EU:C:2014:169 and Case C-363/12*, Z., nyr*, ECLI:EU:C:2014:159.

138 Council Directive 92/85/EEC of 19 October 1992 on the introduction of measures to encourage improvements in the safety and health at work of pregnant workers and workers who have recently given birth or are breastfeeding (tenth individual Directive within the meaning of Article 16(1) of Directive 89/391/EEC) [1992] OJ L348/1.

139 Directive 2006/54/EC of the European Parliament and of the Council of 5 July 2006 on the implementation of the principle of equal opportunities and equal treatment of men and women in matters of employment and occupation (recast) [2006] OJ L204/23.

Court whether such a refusal to grant leave constituted discrimination on the ground of sex within the meaning of Directive 2006/54 and/or discrimination on grounds of disability within the meaning of the Employment Equality Framework Directive (Directive 2000/78).[140]

In both cases an Opinion was delivered by an Advocate General (AG). In *C.D.* AG Kokott held that an intended mother who had a baby through a surrogacy arrangement and who took the child into her care following birth – irrespective of whether she was also breastfeeding her child – had a right to receive maternity leave under the Pregnant Workers' Directive, as this leave was not intended solely to protect the health of workers, but also '[…] to protect the special relationship between a woman and her child over the period which follows pregnancy and childbirth'.[141] In practical terms the AG suggested that the leave of the intended mother was to amount to at least two weeks and that any other maternity leave taken by the surrogate mother had to be deducted. Kokott found no discrimination or unfavourable treatment in breach of the Equal Treatment Directive (Directive 2006/54) in the *C.D.* case. AG Wahl, who gave an Opinion in the *Z.* case,[142] even held that this Directive did not apply at all, as the differential treatment of which Ms. Z complained was not based on sex, so he held, '[…] but on the refusal of national authorities to equate the situation of a commissioning mother with that of either a woman who [had] given birth or an adoptive mother.'[143] Wahl, furthermore, found that the inability to have a child by conventional means was not linked to the capacity of the person concerned to work, and thus did not constitute 'disability' within the meaning of Directive 2000/78. The AG concluded his opinion with the following remark:

> '[…] I have considerable sympathy with the difficulties that [intended] parents undoubtedly face because of the legal uncertainty surrounding surrogacy arrangements in a number of Member States. However, I do not believe that it is for the Court to substitute itself for the legislature by engaging in constructive interpretation that would involve reading into Directives 2006/54 and 2000/78 (or, indeed Directive 92/85) something that is simply not there.'[144]

These words must have found an audience at CJEU, as the Court subsequently ruled in both cases that there was no breach of EU law. In respect of the Pregnant Workers' Directive the Court held that its objective was to encourage improvements in the health and safety at work of pregnant workers and workers who had recently given birth or who were breastfeeding. Maternity leave aimed to protect the health of the mother of the child in the particularly vulnerable situation arising from her pregnancy.[145] The

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140 Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation [2000] OJ L303/16.

141 Case C-167/12 *C.D.* v. *S.T.*, *nyr,* ECLI:EU:C:2013:600, Opinion of AG Kokott of 26 September 2013, para. 45.

142 Case C-363/12 *Z.*, *nyr*, ECLI:EU:C:2013:604, Opinion of AG Wahl of 26 September 2013.

143 AG Wahl used the term 'commissioning mother' instead of 'intended mother' as the CJEU would later also do. For the sake of consistency, this chapter only employs the term 'intended' in this context.

144 Case C-363/12 *Z.*, *nyr*, ECLI:EU:C:2013:604, Opinion of AG Wahl of 26 September 2013, para. 120.

145 Case C-167/12 *C.D.* v. *S.T.*, *nyr,* ECLI:EU:C:2014:169, paras. 29 and 35.

CJEU acknowledged, as AG Kokott had called to mind, that maternity leave was also intended '[…] to ensure that the special relationship between a woman and her child is protected', but held that this objective concerned only the period after pregnancy and childbirth.[146] This implied that the grant of maternity leave pursuant to the Directive presupposed that the worker concerned had been pregnant and had given birth to a child. The Court therefore concluded that Directive 92/85 did not apply to a female worker who as an intended mother had had a baby through a surrogacy arrangement, even in circumstances where she was (to be) breastfeeding the baby following the birth. The Court noted that States were not, of course, precluded by the Directive from allowing intended mothers to take maternity leave.

The CJEU further ruled that there was no discrimination on grounds of sex in breach of Directive 2006/54. There was no direct discrimination because under the applicable national legislation intended fathers were treated in the same way as intended mothers, in that they were not entitled to paid leave equivalent to maternity leave either.[147] The Court held that there was, furthermore, nothing that established that the refusal of leave at issue put female workers at a particular disadvantage compared with male workers.[148] Lastly, because an intended mother who had a baby through a surrogacy arrangement had not been pregnant, she could not, by definition, be subject to less favourable treatment related to her pregnancy. The Court thus did not equate any unfavourable treatment that is related to pregnancy with sex discrimination.[149] It furthermore did not at all refer to the general principle of equal treatment.

The question of whether the refusal to grant Ms. Z. leave constituted discrimination on grounds of disability in breach of Directive 2000/78 was also answered in the negative. In line with AG Wahl's Opinion, the Court found that the inability to have a child by conventional means did not constitute 'disability' within the meaning of the Directive, as this concept presupposed that the limitation from which the person suffered, in interaction with various barriers, could hinder that person's full and effective participation in professional life on an equal basis with other workers. This did not hold for Ms. Z., and the fact that she had been responsible for the care of the child from birth, was not such as to call that finding into question. The Court 'consequently' held it unnecessary to examine the validity of Directive 2000/78 in the light of Article 10 TFEU[150] and the Charter,[151] as the referring Tribunal had asked. It held such an examination in the light of the UN Convention on the Rights of Persons with Disabilities (the CRPD) not even possible, as the provisions of that

146 *Idem*, para. 36.

147 *Idem,* para. 47 and Case C-363/12 *Z.*, *nyr*, ECLI:EU:C:2014:159, para. 52.

148 Case C-167/12 C.D. v. S.T., nyr, ECLI:EU:C:2014:169, para. 49 and Case C-363/12 *Z.*, *nyr*, ECLI:EU:C:2014:159, para. 54.

149 Compare and contrast Case C-177/88 *Dekker* [1990] ECR I-3941, ECLI:EU:C:1990:383.

150 Art. 10 TFEU reads: 'In defining and implementing its policies and activities, the Union shall aim to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation.'

151 In particular Arts. 21, 26 and 34 CFR.

Convention had a programmatic character and were therefore not unconditional and sufficiently precise to have direct effect in EU law.

3.4. Cross-border movement for reproductive matters in the EU: some statistics

3.4.1. Statistics on cross-border abortions within the EU

On the basis of the existing studies, it is impossible to give a (complete) overview of the scale on which cross-border abortions take place within the EU. Not all Member States keep statistics of the number of abortions carried out within their territories on an annual basis, let alone the number of non-national or non-resident women involved in these abortions. An EU-wide study of 2011 has held that '[a] more consistent and coherent reporting of terminations of pregnancy is needed in the EU.'[152] The authors of this study explicitly underlined that data had to be collected '[…] to ascertain how often women [had] to cross country borders to access a termination of pregnancy.'[153]

It would go outside the scope of this legal study to examine whether statistics on cross-border abortions are kept for all 28 EU Member States and to analyse these statistics (if they exist at all). Such an exercise has been carried out, however, for the three jurisdictions selected for this research. Therefore, reference is made to Chapters 4, 5 and 6 where relevant statistics are discussed for Ireland, Germany and the Netherlands respectively. These three Member States have, or at least have had in the past, diverging abortion regimes, which can, to a certain extent, be considered representative of the entire EU. The statistics indicate that it is quite probable that cross-border abortions take place throughout the entire European Union. It is highly likely that all EU Member States function either as a country of origin, or a country of destination, or even both, in this respect. The existence of cross-border movement for abortions within the entire EU, can, it is submitted, therefore be presumed. The actual scale of this phenomenon can, however, only be estimated.

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152 M. Gissler et al., 'Terminations of pregnancy in the European Union', 119 *BJOG An International Journal of Obstetrics and Gynaecology* (2012) p. 324 at p. 324.

153 *Idem*, at p. 330. The report furthermore held that '[*t*]he data for countries with restricted access to termination of pregnancy (Ireland, Malta, and Poland) did not cover terminations performed in other countries or illegal terminations, for example in private clinics. The true rates for these countries are likely to be much higher than those presented here. […] National statistics on terminations of pregnancy in Romania, Ireland, Spain, and Greece have been reported to be too low according to national and international sources. The European statistical system should expand its quality reporting to data on terminations of pregnancy to get more detailed information on the coverage of the current reporting. […] There are no clear guidelines for including temporary migrants and visitors in the national health information systems. For most countries, this did not affect the national figures on terminations of pregnancy. In Portugal, however, the termination rate decreased by more than one-sixth after taking out the terminations of pregnancy performed for non-resident women. The rate for the Netherlands, on the other hand, increases by one-sixth if non-residents are included in the national statistics.'

3.4.2. Statistics on CBRC within the EU

Although increasingly more comparative and international research is conducted in respect of cross-border reproductive care (CBRC),[154] no exhaustive statistics are available for the entire European Union in respect of such cross-border movement. This is so because for many States it holds that '[…] data are incomplete or not collected at all'.[155] It has been submitted that '[i]n practice, it is almost impossible to obtain an estimate of the proportion of patients exiting their own country, as no data are kept in countries of origin.'[156] The European Society of Human Reproduction and Embryology (ESHRE) nevertheless estimated in 2008 in its comparative analysis of medically assisted reproduction (MAR) in the EU that a minimum number of 11,000–14,000 services recipients were involved in CBRC within the EU every year.[157] As the ESHRE acknowledged, these numbers may be even higher in reality. Further, they may have increased since 2008 and may continue to increase in the future.

The relevant studies on CBRC in various EU Member States provide information in respect of origin, age and civil status of CBRC services recipients. They also show that reasons for crossing borders for AHR treatment vary between countries of origin and concern (predominantly) legal reasons as well as accessibility and quality of AHR treatment.[158]

3.4.3. Statistics on cross-border surrogacy within the EU

As is the case for cross-border abortions and CBRC, there are no complete or exhaustive EU-wide statistics in respect of cross-border surrogacy. As pointed out in a 2012 study commissioned by the European Parliament:

> 'Precise statistics relating to surrogacy are […] hard to estimate. This is for a number of key reasons. First, traditional surrogacy does not necessarily require medical intervention and can thus be arranged on an informal basis between the parties concerned. Second, although gestational surrogacy does require medical intervention, officially reported statistics do not necessarily record the surrogacy arrangement but often only the IVF procedure. Third, in many countries there is simply no legal provision, regulation or licensing regime for either fertility treatment and/or surrogacy, to include commercial surrogacy in countries where such is not otherwise legally prohibited. This means that there are no formal reporting mechanisms, which can lead to a rather ad hoc collection of statistics by individual organisations, if indeed they are available at all. Finally, in

154 See for example F. Shenfield et al., 'Cross border reproductive care in six European countries', 25 *Human Reproduction* (2010) p. 1361 and G. Pennings et al., 'Cross-border reproductive care', 23 *Human Reproduction* (2008) p. 2182. See also Coverleyn et al. 2007*, supra* n. 87, at p. 80.

155 ESHRE 2008, *supra* n. 86, at p. 77.

156 *Idem*, Annex 6a, at p. 138.

157 *Idem*, at. p. 78.

158 *Idem*, Annex 6a, at pp. 136–137.

> countries where surrogacy is legally prohibited, those involved could potentially face criminal prosecution, thus exacerbating the difficulties of collecting relevant and accurate data.'[159]

Incidentally statistics as discussed in the previous section include reports of cases of surrogacy. Further incidental evidence proving the existence of this phenomenon can be found in case law from various (inter)national courts.[160] It must be noted, however, that such cross-border movement seems to take place primarily to States outside the EU, such as Ukraine and certain States of the United States of America, where (commercial) surrogacy is legalised.[161] Still, there is also cross-border movement taking place within Europe, for example to the UK and Greece, where surrogacy is legalised and regulated.

3.5. EU STANDARDS ON CROSS-BORDER HEALTH CARE

Even though the Treaties firmly hold that health care and social security are primarily Member State competences (see 3.2.3 above), national health care systems have not escaped considerable influence of EU law. This is mainly the result of the CJEU's internal market case law, which was triggered by the movement of workers and – later – patients throughout the Union.[162] In its case law, the CJEU has developed the '[…] basic components of a regulatory framework on cross-border healthcare services'.[163] In this exercise, the Court has always been aware of the Member States' discretion in this field:

> '[EU law] does not detract from the power of the Member States to organise their social security systems and to adopt, in particular, provisions intended to govern the organisation of health services […]. In exercising that power, however, the Member States must comply with [EU law], in particular the provisions of the Treaty on the freedoms of movement, including freedom of establishment. Those provisions prohibit the Member States from introducing or maintaining unjustified restrictions on the exercise of those freedoms in the healthcare sector […]. When assessing whether that obligation has been complied with, account must be taken of the fact that the health and life of humans rank foremost among the assets and interests protected by the Treaty and that it is for the Member States to determine the level of protection which they wish to afford to public health and the way in which that level is to be achieved. Since the level may vary from one Member State to another, Member States must be allowed discretion […].'[164]

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159 Brunet et al. 2013, *supra* n. 134, at p. 21.

160 See for example Ch.2, Ch. 4, Ch. 5 and Ch. 6.

161 Brunet et al. 2013, *supra* n. 134, at p. 2.

162 See J.W. van de Gronden, 'Richtlijn rechten van patiënten bij grensoverschrijdende gezondheidszorg: veel huiswerk voor de Nederlandse zorgwetgever?' ['Directive on rights of patients in cross-border health care: too much homework for the Dutch legislature on health?'], 59 *Tijdschrift voor Europees en economisch recht, SEW* (2001), p. 373.

163 O'Leary 2011, *supra* n. 52, at p. 522.

164 Joined Cases C-171/07 and C-172/07 *Apothekerkammer des Saarlandes a.o. and Helga Neumann-Seiwert* [2009] ECR I-4171, ECLI:EU:C:2009:316, paras. 18–19, referring to Case C-372/04

Primarily two EU law regimes, with different rationales,[165] apply to matters concerning access to, and reimbursement for, cross-border health care, of which cross-border abortions and cross-border reproductive care (CBRC) form a part. These are the Social Security Regulation[166] and the free movement rules.[167] The case law of the CJEU on the basis of the free movement rules has contributed considerably to the development of rights (and not merely privileges)[168] for patients who are crossing borders. Several of the principles as developed in the CJEU's case law on cross-border health care were subsequently codified in the Patient Mobility Directive of 2011,[169] which, in fact, now constitutes the third applicable regime. The Social Security Regulation has a primarily coordinating character: it contains no individual entitlements, but provides for equal access for services recipients from other EU Member States to entitlements provided at the national level. The Patient Mobility Directive, on the contrary, provides for (minimum) harmonisation. All in all, some have concluded that a process of 'EU competence creep' into the national health care systems is taking place.[170]

Watts [2006] ECR I-4325, ECLI:EU:C:2006:325, paras. 92 and 146; Case C-169/07 *Hartlauer* [2009] ECR I-1721, ECLI:EU:C:2009:141, paras. 29–30; Case C-322/01 *Deutscher Apothekerverband* [2003] ECR I-14887, ECLI:EU:C:2003:664, para. 103 and Case C-141/07 *Commission* v. *Germany* [2008] ECR I-6935, ECLI:EU:C:2008:492, para. 51.

165 As De la Rosa explains, the Regulation 'seeks to mitigate the negative consequences that may result from the coexistences of national systems of social protection that are rigidly different. By contrast, the system based on the freedom to provide services under the Treaty is based on a functional and finalist logic that […] involves eliminating all obstacles "to intra-Community trade with a view to the merging of national markets into a single market".' De la Rosa 2012, *supra* n. 33, at p. 22, referring (in footnote 33) to Case 15/81 *Gaston Schul Douane Epediteur BV v. Inspecteur der Invoerrechten en Accijnzen, Roosendaal* [1982] ECR 1409, ECLI:EU:C:1982:135, para. 33.

166 Council Regulation (EEC) 1408/71 of 14 June 1971 on the application of social security schemes to employed persons and their families moving within the Community [1971] OJ L149/2, consolidated version OJ L28/1, accompanied by implementing Regulation (EEC) No 574/72. The 1971 Regulation was (partly) repealed by Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems [2004] OJ L166/1, which in turn was accompanied by a 2009 implementation Regulation.

167 Arts. 28–39 and 45–66 TFEU. Palm and Glinos spoke of '[…] a dual system of access to cross-border care'. The authors discerned a third '[…] arrangement through which patient mobility takes place', namely 'the contractual route initiated bilaterally between actors in the field.' This matter will not be discussed here, as the present research focusses on State regulation in the area (see ch. 1, section 1.3.1). W. Palm and I.A. Glinos, 'Enabling patient mobility in the EU: between free movement and coordination', in: E. Mossialos et al. (eds.), *Health Systems Governance in Europe: The Role of European Union Law and Policy* (Cambridge, Cambridge University Press 2010) p. 509 at pp. 521 and 529, online available at www.euro.who.int/en/who-we-are/partners/observatory/studies/health-systems-governance-in-europe-the-role-of-eu-law-and-policy, visited June 2014.

168 Van der Mei observed that under the Regulation regime reimbursement for cross-border treatment was 'a privilege, not a right'. A.P. van der Mei, 'Zorg over de grens' ['Care across the border'], in: M. Faure and M. Peeters (eds.), *Grensoverschrijdend recht* [Cross-border law] (Antwerpen, Intersentia 2006) p. 49 at p. 49.

169 Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare [2011] OJ L88/45, p. 46.

170 J. van de Gronden and E. Szyszczak, 'Conclusions: Constructing a 'Solid' Multi-Layered Health Care Edifice', in: J.W. van de Gronden et al. (eds.), *Health care and EU law* (The Hague, T.M.C. Asser Press 2011) p. 481 at p. 484.

This section sets out this general framework on cross-border health care. The relevant aspects of the EU Social Security Regulation are described in section 3.5.1. Subsequently, the case law in which the Court applied EU free movement rules to cases of cross-border health care is examined (section 3.5.2). The more recent important development in respect of cross-border health care, the Patient Mobility Directive, is discussed in section 3.5.3. As yet open questions as to the application of these regimes in cases of cross-border abortions and CBRC are raised – and to the extent possible – (tentatively) answered, in section 3.6.2.

3.5.1. The Social Security Regulation and cross-border health care

Since the early 1970s an EU regulation on the application of social security schemes to workers and their families who are moving within the European Union, has been in force.[171] Over the years it has been amended several times, most profoundly in 2004.[172] The present Regulation 883/2004 provides that EU citizens and residents, as well as their families, and, in certain cases, their survivors, may seek health care in other Member States, with the costs covered under the insurance of the State of affiliation, provided they have obtained authorisation from the competent institution.[173] The basic principle is that benefits in kind provided by the institution of one Member State on behalf of the institution of another Member State have to be fully refunded.[174]

Initially the Regulation provided that the required authorisation could not be refused where the treatment in question could not be provided for the person concerned within the territory of the Member State in which he or she resided. The CJEU interpreted this extensively by holding in *Pierik* (1978) that the duty to grant authorisation covered both cases where the treatment provided in another Member State was more effective than that which the person concerned could receive in the Member State where he or she resided and those situations in which the treatment in question could not be provided on the territory of the State of residence.[175] Out of dissatisfaction with this broad interpretation which opened the door widely to patient mobility, the EU Member States subsequently set limits to the duty to grant

171 Regulation 1408/71 [1971] OJ L149/1, consolidated version OJ L28/1, accompanied by implementing Regulation (EEC) No 574/72. Self-employed were included in the Regulation as of 1981. See H. Vollaard, 'Patiëntenmobiliteit in een Europese zorgruimte' ['Patient mobility in the European area of care'], in: A.C. Hendriks and H.-M. Th. D. ten Napel, *Volksgezondheid in een veellalige rechtsorde. Eenheid en verscheidenheid van norm en praktijk* [Public health in a multilevel jurisdiction. Unity and diversity in standards and practice] (Alphen aan de Rijn, Kluwer 2007) p. 291 at p. 296.

172 The 1971 Regulation was (partly) repealed by Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems [2004] OJ L166/1, which in turn was accompanied by a 2009 implementation Regulation.

173 Arts. 2 and 22 Regulation (EC) No 883/2004. Hervey and McHale define the term 'benefits in kind' as 'health care services given free at the point of access'. Hervey and McHale 2004, *supra* n. 47, at p. 114.

174 Art. 36 Regulation (EC) No 883/2004.

175 Case 117/77 *Pierik (No.1)* [1978] ECR 825, ECLI:EU:C:1978:72, para. 22.

authorisation by amending the Regulation.[176] The present Article 22(2) of the present Regulation 883/2004 accordingly provides:

> 'An insured person who is authorised by the competent institution to go to another Member State with the purpose of receiving the treatment appropriate to his condition shall receive the benefits in kind provided, on behalf of the competent institution, by the institution of the place of stay, in accordance with the provisions of the legislation it applies, as though he were insured under the said legislation. The authorisation shall be accorded where the treatment in question is among the benefits provided for by the legislation in the Member State where the person concerned resides and where he cannot be given such treatment within a time-limit which is medically justifiable, taking into account his current state of health and the probable course of his illness.'[177]

As explained in section 3.5.2.3 below, the compatibility of this Regulation provision with the free movement rules has been questioned by some, but upheld by the CJEU.[178] Particularly important for the present case study is the rule that authorisation is to be accorded '[…] where the treatment in question is among the benefits provided for by the legislation in the Member State where the person concerned resides'.[179] Hence, if the national law has constrained or prohibited a certain treatment on ethical grounds and therefore does not provide for reimbursement under its national social security regime, no authorisation has to be accorded to an insured person who wishes to obtain such treatment abroad.[180] Accordingly, no costs have to be reimbursed either.

3.5.2. EU free movement law and cross-border health care

In the mid-1980s, the CJEU ruled that the freedom to provide services (presently Articles 56 and 57 TFEU) includes the freedom to receive medical treatment. In *Luisi and Carbone* (1984) the CJEU held:

176 Mei, van der 2006, *supra* n. 168, at. p. 53.

177 Art. 22(2) of Regulation (EC) No 883/2004.

178 Case C-56/01 *Inizan* [2003] ECR I-12403, ECLI:EU:C:2003:578. Critical in this respect was P. Cabral, 'The internal market and the right to cross border medical care', 29 *European Law Review* (2004) p. 673.

179 Art. 20(2) of Regulation (EC) No 883/2004.

180 In line herewith, already in *Pierik No. 2* (1979), the Commission emphasised in its submissions to the Court, that '[…] Member States retain certain powers in areas concerning morality. These powers could possibly be based on the reservations of sovereignty made by the Treaty in areas concerning public policy. Thus it can be accepted, on the basis of this principle that a competent institution can refuse the authorization where it concerns a treatment which is seriously contrary to the ethical rules prevailing in the Member State in question. However, since it is an exception to the Treaty, this principle must be very strictly construed, as meaning that the treatment in question must also be prohibited in the Member State in question. Thus a competent institution can refuse the authorization to undergo an abortion in another Member State only if abortion is prohibited in the competent institutions' own country.' Case 182/78 *Pierik (No.2)* [1979] ECR 1977, ECLI:EU:C:1979:142. See also Hervey and McHale 2004, *supra* n. 47, at p. 118.

> '[…] the freedom to provide services includes the freedom, for the recipients of services, to go to another Member State in order to receive a service there, without being obstructed by restrictions, even in relation to payments and that […] persons receiving medical treatment […] are to be regarded as recipients of services.'[181]

In this regard the Court does not distinguish between care provided in a hospital environment and care provided outside such an environment: all medical activities normally provided for remuneration constitute 'services' within the meaning of the Treaty.[182] This also holds for morally controversial, and in some Member States, even prohibited, medical activities such as AHR treatment[183] and abortion services, as follows from *Grogan* (1991).[184]

In *Grogan*, the Court did not accept that the termination of pregnancy could not be regarded as being a service, on the grounds that it was 'grossly immoral' and involved 'the destruction of the life of a human being, namely the unborn child'.[185] The CJEU considered:

> 'Whatever the merits of those arguments on the moral plane, they cannot influence the answer to the national court's first question. It is not for the Court to substitute its assessment for that of the legislature in those Member States where the activities in question are practised legally. Consequently, the answer to the national court's first question must be that medical termination of pregnancy, performed in accordance with the law of the State in which it is carried out, constitutes a service within the meaning of Article 60 [presently Article 56 TFEU] of the Treaty.'[186]

Hence, the fact that abortion was (and is) prohibited in Ireland in almost all situations, did (and does) not remove it from the scope of the free movement rules, because there were (and are) other Member States where abortion was (and is) legal.[187] Decisive

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181 Joined Cases 286/82 and 26/83 *Luisi and Carbone* v. *Ministero del Tesoro* [1984] ECR 377, ECLI:EU:C:1984:35, para. 16.

182 Case C-368/98 *Vanbraekel* [2001] ECR I-5363, ECLI:EU:C:2001:400, para. 41; Case C-157/99 *Geraets-Smits and Peerbooms* [2001] ECR I-5473, ECLI:EU:C:2001:404, para. 53, referring to Joined Cases 286/82 and 26/83 *Luisi and Carbone* v. *Ministero del Tesoro* [1984] ECR 377, ECLI:EU:C:1984:35, para. 16, Case C-159/90 *Grogan* [1991] ECR I-4685, ECLI:EU:C:1991:378, para. 18, and Case C-158/96 *Kohll* [1998] ECR I-1931, ECLI:EU:C:1998:171, paras. 29 and 51.

183 See also Hervey and McHale 2004, *supra* n. 47, at p. 150, who conclude that all forms of assisted conception and the service of surrogate motherhood, if remunerated, fall within the scope of EU law. However, goods and services that are prohibited in *all* EU Member States are excluded from the scope of the free movement rules. Compare Case C-137/09 *Josemans* [2010] ECR I-13019, ECLI:EU:C:2010:774.

184 Case C-159/90 *Grogan* [1991] ECR I-4685, ECLI:EU:C:1991:378, paras. 20 and 21.

185 This argument was put forward by *the Society for the Protection of Unborn Children Ireland Ltd*, the plaintiff in the main proceedings. See subsection 3.6.2.1 below.

186 Case C-159/90 *Grogan* [1991] ECR I-4685, ECLI:EU:C:1991:378, paras. 20 and 21. Advocate General Van Gerven had come to the same conclusion, which he formulated as follows: 'The medical operation, normally performed for remuneration, by which the pregnancy of a woman coming from another Member State is terminated in compliance with the law of the Member State in which the operation is carried out is a (cross-border) service within the meaning of Article 60 of the EEC Treaty.' Case C-159/90 *Grogan* [1991] ECR I-4685, ECLI:EU:C:1991:378, Opinion of AG Van Gerven, para. 10.

187 *Idem*.

is, further, whether the activity is 'normally provided for remuneration'.[188] For the fulfilment of this requirement, the financing basis of the national health system does not matter.[189] From the perspective of the freedom to provide services, the Court has seen no reason to draw a distinction '[…] by reference to whether the patient pays the costs incurred and subsequently applies for reimbursement thereof or whether the sickness fund or the national budget pays the provider directly.'[190] As phrased by the CJEU in *Geraets-Smits and Peerbooms* (2001):

> 'It must be accepted that a medical service provided in one Member State and paid for by the patient should not cease to fall within the scope of the freedom to provide services guaranteed by the Treaty merely because reimbursement of the costs of the treatment involved is applied for under another Member State's sickness insurance legislation which is essentially of the type which provides for benefits in kind. Furthermore, the fact that hospital medical treatment is financed directly by the sickness insurance funds on the basis of agreements and pre-set scales of fees is not in any event such as to remove such treatment from the sphere of services within the meaning of Article 60 of the Treaty [now Article 57 TFEU].'[191]

While some criticised that this ruling was '[…] hard to reconcile with the traditional case law on the notion of remuneration within the meaning of the Treaty',[192] the Court pursued the approach taken in this case in later case law and has brought all sorts of national health systems within the scope of the free movement rules, such as a national social security framework,[193] a benefits-in-kind system,[194] and a reimbursement system. In *Watts* (2006) the Court also brought medical services provided under a national health service system, within the scope of EU law.[195]

Given that medical activities are 'services' within the meaning of the Treaty – and hence the free movement rules apply – the next question to be answered is to what extent States may restrict the freedom to receive and provide cross-border health services, for instance by subjecting access to, and reimbursement for, such treatment to certain conditions. The first question that needs to be answered in this regard is

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188 More generally the Court has held that the '[…] special nature of certain services does not remove them from the ambit of the fundamental principle of freedom of movement'. Case C-158/96 *Kohll* [1998] ECR I-1931, ECLI:EU:C:1998:171, para. 20. See also Palm and Glinos 2010, *supra* n. 167, at p. 517.

189 *Inter alia* Case C-372/04 *Watts* [2006] ECR I-4325, ECLI:EU:C:2006:325. As Hervey and McHale explained '[…] remuneration need not come directly from the recipient of the services.' Hervey and McHale 2004, *supra* n. 47, at p. 120, referring (in footnote 64) to Case 352/85 *Bond van Adverteerders* [1988] ECR 2085, ECLI:EU:C:1988:196.

190 Case C-385/99 *Müller-Fauré and van Riet* [2003] ECR I-4509, ECLI:EU:C:2003:270, para. 103. See also Cabral 2004, *supra* n. 178, at p. 676.

191 Case C-157/99 *Geraets-Smits and Peerbooms* [2001] ECR I-5473, ECLI:EU:C:2001:404, paras. 55–56.

192 Cabral 2004, *supra* n. 178, at p. 677. The author alleged that 'treatment provided in the framework of a benefits-in kind system does not include the element of remuneration necessary to come within the scope of the Treaty's free movement of services provisions'. See also V. Hatzopoulos, 'Killing National Health and Insurance Systems but Healing Patients? The European Market for Health Care after the Judgments of the ECJ in Vanbraekel and Peerbooms', 39 *CMLRev.* (2002) p. 683 at pp. 705–720.

193 Case C-158/96 *Kohll* [1998] ECR I-1931, ECLI:EU:C:1998:171.

194 Case C-157/99 *Geraets-Smits and Peerbooms* [2001] ECR I-5473, ECLI:EU:C:2001:404, para. 55.

195 Case C-372/04 *Watts* [2006] ECR I-4325, ECLI:EU:C:2006:325.

whether there is indeed a restriction. While this test is generally a very generous one,[196] in the quoted *Grogan* case,[197] the Court answered this question in the negative. It concluded that the Irish prohibition on the distribution of information about foreign abortion services, constituted no restriction within the meaning of the Treaty, as it considered the link between the activity of the defendant student associations and medical terminations of pregnancies carried out in clinics in another Member State to be 'too tenuous'.[198] Because of its direct relevance for the present case study this judgment will be discussed more elaborately in the following sub-section.

3.5.2.1. A restriction of free movement? – The Grogan case

The *Grogan* case concerned a suit by *the Society for the Protection of Unborn Children Ireland Ltd* ('SPUC') against Stephen Grogan and 14 other officers of student associations who distributed free handbooks containing information about abortion services available in England.[199] The Irish High Court made a reference to the CJEU[200] for a preliminary ruling on three questions: (1) whether abortion was a 'service' within the meaning of the (then) EEC Treaty; (2) if so, whether the prohibition on distribution of information regarding those services constituted a restriction within the meaning of Article 59 of the Treaty; and (3) if so, whether such a restriction could be justified under Community law.

After having established that the termination of pregnancy was a service within the meaning of the Treaty (see above), the CJEU answered the second question in the negative. It concluded that the link between the activity of the defendant student associations and medical terminations of pregnancies carried out in clinics in another Member State was 'too tenuous' for the prohibition on the distribution of information to be capable of being regarded as a restriction within the meaning of (then) Article 59 of the Treaty.[201] The Court noted that the information concerning foreign abortion providers was '[…] not distributed on behalf of an economic operator established in another Member State.' The Court concluded that, on the contrary, the information constituted a manifestation of freedom of expression and of the freedom to impart and receive information which was independent of the economic activity carried on by clinics established in another Member State.[202] Despite this finding, the Court did not assess the claim of the student associations that the prohibition interfered with their freedom of expression (Article 10 ECHR), as the Court considered itself not to

196 T.K. Hervey, 'The Current Legal Framework on the Right to Seek Health Care Abroad in the European Union', 9 *The Cambridge Yearbook of European Legal Studies* (2007) p. 261 at p. 270. As Hervey explained, '[t]he essence of the Court's approach is to consider the potential for the restriction to inhibit inter-Member State provision of services.'

197 Case C-159/90 *Grogan* [1991] ECR I-4685, ECLI:EU:C:1991:378.

198 *Idem*, para. 24.

199 See also Ch. 5.

200 At the time, the Court of Justice of the European Communities.

201 Presently Art. 56 TFEU.

202 Case C-159/90 *Grogan* [1991] ECR I-04685, ECLI:EU:C:1991:378, para. 26.

have jurisdiction '[…] with regard to national legislation lying outside the scope of Community law'.[203] In conclusion the Court ruled:

> '[…] it is not contrary to Community law for a Member State in which medical termination of pregnancy is forbidden to prohibit students associations from distributing information about the identity and location of clinics in another Member State where voluntary termination of pregnancy is lawfully carried out and the means of communicating with those clinics, where the clinics in question have no involvement in the distribution of the said information.'[204]

Advocate General Van Gerven had earlier taken another approach in his Opinion in this case. He had argued that the right to receive services in another Member State encompassed the right to receive, unimpeded, information in one's own Member State about providers of services in another Member State and about how to communicate with them. Van Gerven had considered that the Irish prohibition on distribution of abortion information constituted a restriction of this freedom.[205] Accordingly he had examined if this restriction could be justified. Firstly he had held it to be 'undeniable' that the prohibition had been promoted by an objective which had been regarded in Ireland as an imperative requirement of public interest:

> 'The protection of the unborn enshrined in the national Constitution (and the prohibition of abortion inherent therein) and likewise the resultant need to prevent abortions – naturally only within the jurisdiction of the Member State concerned – by prohibiting the distribution of information thereon in its territory are regarded in that Member State as forming part of the basic principles of society.'[206]

Van Gerven had accepted such an objective to be justified under Community law, since it related '[…] to a policy choice of a moral and philosophical nature the assessment of which [was] a matter for the Member States' and in respect of which they were entitled to invoke the ground of public policy referred to in the Treaty. He had continued:

> 'Although the scope of the concept of public policy "cannot be determined unilaterally by each Member State without being subject to control by the institutions of the Community", nevertheless, as "the particular circumstances justifying recourse to the concept of public policy may vary from one country to another", it is necessary "to allow the competent national authorities an area of discretion within the limits imposed by the Treaty and the provisions adopted for its implementation". There can, in my estimation, be no doubt that values which, in view of their incorporation in the Constitution, number among "the fundamental values to which a nation solemnly declares that it adheres" fall within the

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203 *Idem*, para. 31.

204 *Idem*, para. 32.

205 Van Gerven considered that although the national measure was not discriminatory, it could overtly or covertly, actually or potentially, impede intra-Community trade in services. Case C-159/90 *Grogan* [1991] ECR I-4685, ECLI:EU:C:1991:249, Opinion of AG Van Gerven, para. 21.

206 *Idem*, para. 26.

> sphere in which each Member State possesses an area of discretion "in accordance with its own scale of values and in the form selected by it".'[207]

Having accepted that there was a public interest pursued with the measure, Van Gerven next had assessed if the Irish prohibition had been proportionate. He had found that the Irish prohibition had not banned all information but only information which assisted pregnant women to terminate unborn life. Therefore, Van Gerven had considered the restriction not disproportionate.[208] He had noted that his conclusion would have been different however, in respect of, for example, a ban on pregnant women going abroad or a rule under which they would be subjected to unsolicited examinations upon their return from abroad.

The Court's ruling in the *Grogan* case met with both considerable critique and comprehension in legal scholarship. It has been held that the judgment led to '[…] a great deal of speculation with respect to the extent to which the (essentially economic) principles of EU law [had to] be permitted to undermine ethical principles, especially those enshrined in national constitutions.'[209] By some, it was argued that the CJEU had unjustifiably made market freedoms triumph over human rights,[210] but others disagreed.[211] It was often argued that the judgment was at variance with the at the time existing line of case law.[212] Possibly the Court's restrained approach was influenced by the sensitivity of the subject concerned.[213] At the same time, as pointed out by many, and as feared by the Irish government, it followed from the judgment that if a direct link with the abortion providers could be established in a different case, Community law (now EU law) could potentially override the relevant Article 40.3.3° of the Irish Constitution.[214] Hence, it was argued that '[…] the message

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207 *Idem*, para. 26, referring (in footnote 41) to Case 30–77 *Regina* v. *Bouchereau* [1977] ECR 1999, ECLI:EU:C:1977:172, paras. 33 and 34; Case 41/74 *Van Duyn* v. *Home Office* [1974] ECR 1337, ECLI:EU:C:1974:133; Case C-379/87 *Groener* v. *Minister of Education* [1989] ECR 3967, ECLI:EU:C:1989:197, Opinion of AG Darmon, para. 21, and Case 121/85 *Conegate Limited* v. *HM Customs & Excise* [1986], ECR 1007, ECLI:EU:C:1986:114, para. 14.

208 *Idem*, para. 35. According to De Búrca this conclusion could well have represented 'his […] substantive reconciliation within Community law of competing moral choices and human rights'. G. de Búrca, 'Fundamental Human Rights and the Reach of EC law', 13 *Oxford Journal of Legal Studies* (1993) p. 283 at p. 300.

209 Hervey and McHale 2004, *supra* n. 47, at p. 152. The authors held that this debate went 'to the heart of matters central to the EU's "constitutional" law […].'

210 A.L. Young, 'The Charter, Constitution and Human Rights: is this the Beginning or the End for Human Rights Protections by Community Law?', 11 *European Public Law* (2005) p. 219 at p. 227, referring (in footnote 51) to, *inter alia*, D.R. Phelan, 'Right to life of the Unborn v Promotion of Trade in Services: The European Court of Justice and the Normative Shaping of the European Union', 55 *Modern Law Review* (1992), pp. 670–689.

211 E.g. De Búrca 1993, *supra* n. 208, at pp. 299–300.

212 E.g. S. O'Leary, 'The Court of Justice as reluctant constitutional adjudicator: an examination of the abortion information case', 17 *European Law Review* (1992) p. 138, particularly at p. 146.

213 Lawson pointed out that 'virtually all commentators of the judgment' noted that the CJEU had 'evaded giving a substantive ruling on a sensitive issue'. R.A. Lawson, 'The Irish Abortion Cases: European Limits to National Sovereignty?', 1 *European Journal of Health Law* (1994) p. 167 at p. 173.

214 See A.-M.E.W. Sterling, 'The European Union and Abortion Tourism: Liberalizing Ireland's Abortion Law', 20 *Boston College International & Comparative Law Review* (1997) p. 385 at p. 392; B. Mercurio, 'Abortion in Ireland: An Analysis of the Legal Transformation Resulting from Membership in the

left to Ireland as to the future acceptability of restrictions on abortion-related mobility was nevertheless clear'.[215] By some *Grogan* was even perceived as a triumph for the woman to choose.[216]

As elucidated in Chapter 5 after the *Grogan* case, the Irish government successfully lobbied for the adoption of Protocol 17 to the Maastricht Treaty. This Protocol provided:

> 'Nothing in the Treaty on the European Union or in the Treaties establishing the European Communities or in the Treaties or Acts modifying or supplementing those Treaties shall affect the application in Ireland of Article 40.3.3º of the Constitution of Ireland.'[217]

Because of consternation following the so-called *X Case* (see Chapter 5, section 5.2.2),[218] the Irish government, soon after the adoption of the Protocol, settled for a Solemn Declaration to the effect that Protocol 17 would not '[…] limit freedom either to travel between Member States or […] to obtain or make available in Ireland information relating to services lawfully available in Member States'.[219] Some argued that consequentially, it seemed that the status of EU law *vis-à-vis* Irish abortion law had not changed very much at all.[220] The same text as in Protocol 17

European Union', 11 *Tulsa Journal of International and Comparative Law* (2003) p. 141 at p. 160; B. Moriarty and A.-M. Mooney Cotter (eds.), *Human rights law* (Oxford, Oxford University Press 2004) p. 18 and F. Fabbrini, *Fundamental rights in Europe, Challenges and Transformations of a Multilevel System in Comparative Perspective* (F. Fabrinni © 2012) p. 213. See also Ch. 5, section 5.2.1.1.

215 C. Hilson, 'The Unpatriotism of the Economic Constitution? Rights to Free Movement and their Impact on National and European Identity', 14 *European Law Journal* (2008) p. 186 at p. 189.

216 Young 2005, *supra* n. 210, at p. 230.

217 Protocol Annexed to the Treaty On European Union, signed at Maastricht on 7 February 1992 [1992] OJ C191/1, p. 94.

218 See, *inter alia*, F. Murphy, 'Maastricht: implementation in Ireland', 19 *European Law Review* (1994) p. 94 at pp. 94–95.

219 Declaration of the High Contracting Parties to the Treaty on European Union Treaty on European Union, signed at Maastricht on 7 February 1992 [1992] OJ C191/1, p. 109. The relevant part of the Declaration reads: 'That it was and is their intention that the Protocol shall not limit freedom to travel between Member States or, in accordance with conditions which may be laid down, in conformity with Community law, by Irish legislation, to obtain or make available in Ireland information relating to services lawfully available to Member States.' Some uncertainty as to the legal status of this declaration existed. Sterling held that it neither appeared to be legally binding on the CJEU, nor to serve as anything more than an interpretive guide for the courts (Sterling 1997, *supra* n. 214, at p. 396, referring to A. Eggert and B. Rolston, 'Ireland', in B. Rolston and A. Eggert (eds.), *Abortion in the new Europe, A comparative handbook* (Westport, Greenwood Press 1994) p. 168 and D. Curtin, 'Case note to ECJ C-159/90', 29 *CML Rev* (1992) p. 585 at pp. 602–03). Buckley called it 'nothing more than a statement of political intent' (A.M. Buckley, 'The primacy of democracy over natural law in Irish abortion law: an examination of the C case' 9 *Duke Journal of Comparative & International law* (1998) p. 275 at p. 289). Lawson observed that to the extent that the Protocol had legal effect, it only related to the application *in Ireland* of Art. 40.3.3° (Lawson 1994, *supra* n. 213, at p. 181). See D.A. MacLean, 'Can the EC kill the Irish unborn?; An investigation of the European Community's ability to impinge on the moral sovereignty of Member States', 28 *Hofstra Law Review* (1999) p. 527 at p. 560; G. Hogan and G. Whyte, *J.M. Kelly, The Irish Constitution* (Dublin, LexisNexis Butterworths 2003) p. 1506 and Mercurio 2003, *supra* n. 214, at pp. 164–165.

220 Fabbrini 2012, *supra* n. 214, at p. 214 referring to C. Forder, 'Abortion: A Constitutional Problem in European Perspective', 1 *Maastricht Journal of European and Comparative Law* (1994) p. 56 at p. 64.

was annexed to the defeated Treaty establishing a Constitution for Europe[221] and is now annexed as Protocol 35 to the Lisbon Treaty.[222] By virtue of Article 51 TEU the Protocols and Annexes to the Treaties form an integral part thereof and consequently the CJEU has jurisdiction to interpret them. As yet, the Irish Protocol has not been invoked in any proceedings before the CJEU and it remains to be seen whether it ever will be invoked.[223]

In cross-border health care cases of a later date and of a morally less controversial nature than the *Grogan* case, the Court had less difficulty in finding a restriction of free movement. In the ground-breaking cases of *Kohll* and *Decker* (both 1998) the CJEU ruled that refusal to reimburse treatment obtained abroad and a requirement of prior authorisation for such treatment, constituted a restriction of the freedom to receive services.[224] The Court held that:

> '[…] such rules deter insured persons from approaching providers of medical services established in another Member State and constitute, for them and their patients, a barrier to freedom to provide services.'[225]

Hence, any refusal to reimburse treatment obtained abroad and any requirement of prior authorisation for such treatment constitutes a restriction of the freedom to receive services. The fact that the treatment is not legal in the state of affiliation, or not among the benefits provided for by the legislation of that State, has no bearing on this finding.

3.5.2.2. Justification of restrictions of free movement

It is recalled that restrictions of the freedom to receive services can be justified if they fulfil the four so-called *Gebhard* conditions: (1) they must be applied in a non-discriminatory manner; (2) they must be justified by imperative requirements in the general interest; (3) they must be suitable for securing the attainment of the objective which they pursue; and (4) they must not go beyond what is necessary in order to attain it.[226]

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221 Protocol 31 on Art. 40.3.3 of the Constitution of Ireland, to the (never adopted) Treaty establishing a Constitution for Europe and to the Treaty establishing the European Atomic Energy Community [2004] OJ C310/1, p. 377.

222 Protocol 35 on Art. 40.3.3 of the Constitution of Ireland to the Treaty on European Union and to the Treaty on the Functioning of the European Union and to the Treaty establishing the European Atomic Energy Community. Protocols [2008] OJ C115/201, p. 321.

223 By contrast, Joined Cases C-411/10 and C-493/10 *N.S.* v. *Secretary of State for the Home Department* [2011] ECR I-13905, ECLI:EU:C:2011:865, on Protocol (No 30) on the application of the Charter to Poland and to the United Kingdom (Protocols [2010] OJ C83/201, p. 313).

224 Case C-158/96 *Kohll* [1998] ECR I-1931, ECLI:EU:C:1998:171 and Case C-120/95 *Decker* [1990] ECR I-3941, ECLI:EU:C:1990:383. The German Minister of Health, for example, reportedly declared not to follow-up *Decker* and *Kohll*. Vollaard 2007, *supra* n. 171, at p. 298.

225 Case C-158/96 *Kohll* [1998] ECR I-1931, ECLI:EU:C:1998:171, para. 35.

226 Case C-55/94 *Gebhard* [1995] ECR I-4165, ECLI:EU:C:1995:411, para. 37.

The first *Gebhard* criterion is often fulfilled.[227] Further, in free movement cases, it is a matter of EU law, not national law, whether a justifiable public interest worthy of protection is present.[228] In cross-border health care cases, the CJEU has accepted various overriding (imperative or mandatory) reasons in the general interest capable of justifying a barrier to the principle of freedom to provide services. This goes, for example, for the possible risk of seriously undermining a social security system's financial balance.[229] The objective of maintaining a balanced medical and hospital service open to all – even if it is intrinsically linked to the method of financing the social security system – may also fall under grounds of public health under the present Article 52 TFEU,[230] in so far as it contributes to the attainment of a high level of health protection.[231] The Court has further held that Article 52 TFEU permits Member States to restrict the freedom to provide medical and hospital services, in so far as the maintenance of treatment capacity or medical competence on national territory is essential for the public health, and even the survival of the population.[232]

Until today, there has not been a case before the CJEU in which a Member State refused patients from other Member States access to treatment for reasons of overburdening of its national health services. Therefore it cannot be conclusively answered (yet) if the Court would accept such a ground for restriction of free movement rights.[233]

The following subsections discuss the conditions under which the Court has accepted prior authorisation requirements and reimbursement refusals as justified restrictions of free movement rules. Except for the above-discussed *Grogan* case – in which the CJEU concluded that the freedom to receive and provide services was not restricted – there is to date no case law in which the free movement rules have been applied to cases concerning abortion services or AHR treatment, in particular.

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227 Measures which are discriminatory on grounds of nationality can be justified only under the grounds set out in the Treaty (e.g. in Art. 52 TFEU). In the case of non-discriminatory measures, public grounds may be based on the Treaty provisions, or on other objective public interests, as accepted by the CJEU under its *rule of reason* doctrine.

228 Hervey 2007, *supra* n. 196, at p. 273.

229 Case C-158/96 *Kohll* [1998] ECR I-1931, ECLI:EU:C:1998:171, para. 41; Case C-157/99 *Geraets-Smits and Peerbooms* [2001] ECR I-5473, ECLI:EU:C:2001:404, para. 72; and Case C-385/99 *Müller-Fauré and Van Riet* [2003] ECR I-4509, ECLI:EU:C:2003:270, para. 73.

230 Art. 56 EC Treaty (*old*).

231 Case C-158/96 *Kohll* [1998] ECR I-1931, ECLI:EU:C:1998:171, para. 50; Case C-157/99 *Geraets-Smits and Peerbooms* [2001] ECR I-5473, ECLI:EU:C:2001:404, para. 73; and Case C-385/99 *Müller-Fauré and Van Riet* [2003] ECR I-4509, ECLI:EU:C:2003:270, para. 67.

232 Case C-158/96 *Kohll* [1998] ECR I-1931, ECLI:EU:C:1998:171, para. 51; Case C-157/99 *Geraets-Smits and Peerbooms* [2001] ECR I-5473, ECLI:EU:C:2001:404, para. 74; and Case C-385/99 *Müller-Fauré and Van Riet* [2003] ECR I-4509, ECLI:EU:C:2003:270, para. 67.

233 Here, an argument in the affirmative could be made by applying with analogy the *Bressol* judgment. In this case the CJEU ruled that a limitation on enrolment by non-resident students in certain university courses in the public health field is, in principle, precluded by EU law. It held such a limitation to be compatible with EU law, however, if proved justified with regard to the protection of public health. Case C-73/08 *Bressol and Others* [2010] ECR I-2735, ECLI:EU:C:2010:181.

3.5.2.3. Conditions for authorisation requirements in respect of scheduled care

Initially the finding of a restriction in *Kohll* (1998) appeared difficult to reconcile with the Social Security Regulation under which prior authorisation is a basic principle (see above). The Court tried to alleviate this tension, by interpreting the relevant Regulation provisions in line with the free movement rules.[234] Put differently, the Court has '[…] cleverly facilitated the coexistence of the two systems by emphasizing their complementary nature as much as possible'.[235] It held the relevant Article 22 of the Regulation in itself to be compatible with the free movement rules. National authorisation systems based on Article 22 of the Regulation were, however, subject to certain conditions.[236]

Firstly, the Court has made a distinction between hospital and non-hospital care.[237] Restrictions of the freedom to provide and receive services in the form of prior authorisation requirements cannot be justified for non-hospital care.[238] This is, however, different in respect of hospital care, which, by nature, requires planning:

> '[…] by comparison with medical services provided by practitioners in their surgeries or at the patient's home, medical services provided in a hospital take place within an infrastructure with, undoubtedly, certain very distinct characteristics. It is thus well known that the number of hospitals, their geographical distribution, the mode of their organisation and the equipment with which they are provided, and even the nature of the medical services which they are able to offer, are all matters for which planning must be possible.'[239]

The nucleus of this ruling is thus the 'planning' aspect and not so much the exact place where the treatment takes place.[240] What is crucial is whether the objects of ensuring sufficient and permanent access to a balanced range of high-quality and up-to-date treatment, while controlling costs and avoiding, so far as possible, any waste of

234 Case C-56/01 *Inizan* [2003] ECR I-12403, ECLI:EU:C:2003:578.

235 De la Rosa 2012, *supra* n. 33, at p. 22.

236 Cabral 2004, *supra* n. 178, at pp. 679–680.

237 Hospital care may include private hospitals. In *Stamatelaki* (2007) the Court held an absolute exclusion of reimbursement by a national social security institution of the costs occasioned by treatment of persons insured with it in private hospitals in another Member State, to be incompatible with the freedom to provide and receive services. According to the CJEU less restrictive measures could be adopted, such as a prior authorisation scheme which complies with the requirements imposed by Union law and, if appropriate, the determination of scales for reimbursement of the costs of treatment. Case C-444/05 *Stamatelaki* [2007] ECR I-3185, ECLI:EU:C:2007:231.

238 Both *Kohll* and *Decker* concerned so-called extramural care. *Kohll* concerned dental care, while *Decker* concerned the purchase of a pair of spectacles with corrective lenses.

239 Case C-157/99 *Geraets-Smits and Peerbooms* [2001] ECR I-5473, ECLI:EU:C:2001:404, para. 76.

240 In *Müller-Fauré and van Riet* the Court emphasised how difficult it is to distinguish 'hospital services' from 'non-hospital services' and pointed out that services provided in a hospital environment that could also be provided by a practitioner in his surgery or in a health centre could, for that reason, be placed on the same footing as non-hospital services. Case C-385/99 *Müller-Fauré and van Riet* [2003] ECR I-4509, ECLI:EU:C:2003:270, para. 75. In *Commission* v. *France*, the Court confirmed that planning considerations may also prove relevant for medical treatment provided outside a hospital setting. Case C-512/08 *Commission* v. *France* [2010] ECR I-8833, ECLI:EU:C:2010:579, para. 34.

financial, technical and human resources can be guaranteed.[241] Therefore, it is more appropriate to speak of 'scheduled' (generally hospital) care and 'unscheduled' care. For scheduled care a prior authorisation requirement may, in principle, be justified. However, it is nevertheless necessary that the conditions attached to the grant of such authorisation are justified in light of the relevant public imperatives, that they do not exceed what is objectively necessary for that purpose and that the same result cannot be achieved by less restrictive rules.[242]

In the *Geraets-Smits en Peerbooms* (2001)[243] and *Müller-Fauré* (2003)[244] cases the Court subjected national systems which set a prior authorisation requirement for hospital care to certain conditions.[245] Authorisation can be refused on the ground of lack of medical necessity only if the same or equally effective treatment can be obtained without undue delay within the insured person's own health care system. Hence, foreign treatment options may alleviate the burden of long waiting lists. Further, if national legislation subjects reimbursement for medical treatment obtained abroad to the condition that the treatment is regarded as 'normal in the professional circles concerned', authorisation cannot be refused on that ground where it appears that the treatment concerned is sufficiently tried and tested by international medical science.[246] Prior administrative authorisation schemes must, furthermore, provide for certain procedural guarantees. For example, the national authorities' discretion must be based on 'objective, non-discriminatory criteria which are known in advance'.[247] Further, a procedural system must be in place, '[…] which is easily accessible and capable of ensuring that a request for authorisation will be dealt with objectively and impartially within a reasonable time'. Refusals to grant authorisation must be capable of being challenged in judicial or quasi-judicial proceedings.[248]

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241 Case C-512/08 *Commission* v. *France* [2010] ECR I-8833, ECLI:EU:C:2010:579, para. 33, referring to Case C-157/99 *Geraets-Smits and Peerbooms* [2001] ECR I-5473, ECLI:EU:C:2001:404, paras. 76–81; Case C-385/99 *Müller-Fauré and van Riet* [2003] ECR I-4509, ECLI:EU:C:2003:270, paras. 76–81, and Case C-372/04 *Watts* [2006] ECR I-4325, ECLI:EU:C:2006:325, paras. 108–110.

242 E.g. Case C-173/09 *Elchinov* [2010] ECR I-8889, ECLI:EU:C:2010:581, para. 44.

243 Case C-157/99 *Geraets-Smits and Peerbooms* [2001] ECR I-5473, ECLI:EU:C:2001:404, para. 54. See Hatzopoulos 2002, *supra* n. 192, at pp. 705–720.

244 Case C-385/99 *Müller-Fauré and Van Riet* [2003] ECR I-4509, ECLI:EU:C:2003:270.

245 As Cabral explained: 'While prior authorisation systems for hospital care are thus in principle compatible with Community law, Member States must, however, comply with a certain number of conditions with regard to the way these systems are organised and operated in practice.' Cabral 2004, *supra* n. 178, at p. 683.

246 Hervey and McHale argued that '[p]articularly with relatively new treatments', there was 'likely to be considerable room for difference among professional opinion'. The authors warned that patients were likely to exploit this. Hervey and McHale 2004, *supra* n. 47, at pp. 136–137.

247 Case C-173/09 *Elchinov* [2010] ECR I-8889, ECLI:EU:C:2010:581, para. 44.

248 *Inter alia*, Case C-157/99 *Geraets-Smits and Peerbooms* [2001] ECR I-5473, ECLI:EU:C:2001:404, para. 90; Case C-385/99, *Müller-Fauré and van Riet* [2003] ECR I-4509, ECLI:EU:C:2003:270, para. 85 and Case C-372/04 *Watts* [2006] ECR I-4325, ECLI:EU:C:2006:325, para. 116.

3.5.2.4. The amount and the kind of costs to be reimbursed

Under the Social Security Regulation the amount to be reimbursed is determined on the basis of the legislation of the Member State in which the treatment is provided.[249] Even if the country of affiliation provides for a higher amount to be reimbursed, no more than the actual costs of treatment is reimbursed. On the basis of the free movement rules, the CJEU has ruled, however, that if the reimbursement of costs incurred for hospital services provided in a Member State of stay, calculated under the rules in force in that State, is less than the amount which application of the legislation in force in the Member State of affiliation would afford to a person receiving hospital treatment in that State, additional reimbursement covering that difference must be granted to the insured person by the competent institution.[250] An exception is made for so-called 'unscheduled' hospital treatment, obtained by an insured person '[…] whose travel to another Member State is for reasons relating to tourism or education, for example, and not to any inadequacy in the health service to which he is affiliated'.[251] In that situation, so the CJEU has ruled, the rules of the Treaty on freedom of movement offer '[…] no guarantee that all hospital treatment services which may have to be provided to him unexpectedly in the Member State of stay will be neutral in terms of cost'.[252]

Apart from the actual care costs, additional costs involved in foreign medical treatment, such as costs for board, lodging, travel, visitors' tax and the production of a final medical report, may also be claimed for reimbursement, to the extent that such costs would also be reimbursed had the treatment taken place in the country of affiliation.[253] Although such costs are not medical in character, and are not as a rule paid to health care providers, the CJEU nonetheless considers them to be inextricably

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249 Art. 22(1)(c) Regulation 1408/71, as interpreted in Case C-368/98 *Vanbraekel* [2001] ECR I-5363, ECLI:EU:C:2001:400, para. 33. On the basis of Art. 36 Regulation 1408/71 the competent institution remains responsible for subsequently reimbursing the institution of the place of stay.

250 Case C-368/98 *Vanbraekel* [2001] ECR I-5363, ECLI:EU:C:2001:400. Under certain circumstances also treatment obtained in a non-EU-Member State must be reimbursed. Case C-145/03 *Keller* v. *Instituto Nacional de Gestion Sanitaria (Ingesa)* [2005] ECR I-2529, ECLI:EU:C:2005:211.

251 Case C-211/08 *Commission* v. *Spain* [2010] ECR I-5267, ECLI:EU:C:2010:340, para. 61. In para. 58, the Court held that '[…] with regard at least to hospital care, […] cases of 'unscheduled treatment', as referred to in Art. 22(1)(a) of Regulation 1408/71 […] must be distinguished […] from cases of 'scheduled treatment', as referred to in Art. 22(1)(c) of that Regulation.

252 Case C-211/08 *Commission* v. *Spain* [2010] ECR I-5267, ECLI:EU:C:2010:340, para. 61. The CJEU held (in para. 79) that to impose on Member States the obligation to guarantee to persons insured under the national system that the competent institution will provide complementary reimbursement whenever the level of cover applicable in the Member State of stay in respect of the unscheduled hospital treatment in question proves to be lower that that applicable under its own legislation 'would ultimately undermine the very fabric of the system which Regulation No 1408/71 sought to establish'. Critical in this respect: A.P. van der Mei, 'Cross-border access to healthcare and entitlement to complementary "Vanbraekel reimbursement"', 36 *European Law Review* (2011) p. 431.

253 Case C-8/02 *Ludwig Leichtle* v. *Bundesanstalt für Arbeit* [2004] ECR I-2641, ECLI:EU:C:2004:161. See Mei, van der 2006, *supra* n. 168, at pp. 68–69.

linked to the cure itself.[254] Any conditions set for the reimbursement of such costs have to be justified on imperative grounds and have to meet the proportionality test.[255]

3.5.3. The EU Patient Mobility Directive (2011)

As a result of the increased number of CJEU judgments in respect of access to and reimbursement for cross-border health care, the Commission and the Member States felt the need to codify – and to a certain extent to clarify[256] – the relevant principles resulting from this case law in a new legislative instrument.[257] In 2011, this finally resulted in the adoption of a separate Directive on the application of patients' rights in cross-border health care.[258] The adoption of this instrument was, however, preceded by intense debates.

In June 2002 the Council considered that there was '[…] a need to strengthen cooperation in order to promote the greatest opportunities for access to health care of high quality while maintaining the financial sustainability of healthcare systems in the European Union'.[259] Subsequently the Commission convened a 'High-Level Process of Reflection on Patient Mobility and Healthcare Developments in the EU'. This resulted, in April 2004, in a Commission Communication on patient mobility.[260] The Commission considered a European strategy needed to ensure that citizens could exercise their rights to seek care in other Member States if they wished, and to ensure that European cooperation could help systems to work together to better meet the challenges they faced.[261] The Commission held that for citizens, the first step was '[…] to provide them with a clearer overview of the existing EU legal framework regarding access to healthcare and the reimbursement of the costs incurred in another Member State.'[262] The Services Directive draft of 2004 had included health care services.[263] However, because of its sensitivity and public finance implications,

254 *Idem*, para. 35.

255 See A. den Exter, 'Access to Health Care in the Netherlands: The Influence of (European) Treaty Law', 33 *Journal of Law, Medicine & Ethics* (2005) p. 698 at p. 703.

256 Following Art. 1(1) Directive 2011/24/EU, the Directive aims at clarifying its relationship with the existing framework on the coordination of social security systems, i.e. Regulation (EC) No 883/2004. Further, following Recital 8 of the Preamble, the Directive is intended to achieve a more general, and also effective, application of principles developed by the Court of Justice on a case-by-case basis.

257 De la Rosa call this codification exercise unique for the fact that it intervenes in a particularly sensitive area. De la Rosa 2012, *supra* n. 33, at p. 17.

258 Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare[2011] OJ L88/45, p. 46.

259 2440th Council meeting, Health, Luxembourg, 26 June 2002, 10090/02 (Presse 182) of 26 June 2002, p. 11, online available at www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/en/lsa/71383.pdf, visited June 2014.

260 Commission, 'Follow-up to the high level reflection process on patient mobility and healthcare developments in the European Union', COM (2004) 301 final.

261 *Idem*, at p. 2.

262 *Idem*.

263 Commission, 'Proposal for a Directive on services in the Internal Market', COM (2004) 2 final. Proposed Art. 23 provided for the assumption of health care costs.

this sector was excluded from the final Services Directive of 2006.[264] The Council and the European Parliament proffered a sector-specific instrument. In 2006 a public consultation on the issue was run,[265] after which a Commission proposal followed in 2008.[266] On first reading this was rejected by the Council, the prior authorisation requirement for hospital care and the legal basis of the Directive, being just some of the issues in respect of which no agreement could be reached.[267] Extensive debates and various amendments followed, resulting, at a certain point in time, in a 'political and legislative limbo'.[268] Nevertheless, in 2011 all negotiations resulted in the adoption of Directive 2011/24/EU on the application of patients' rights in cross-border healthcare ('the Patient Mobility Directive').[269] The Directive has a dual legal basis: Article 114 TFEU (internal market) and Article 168 TFEU (health).[270] The latter was allegedly chosen to secure the Member States' competences in respect of public health.[271] The deadline for implementation of the Directive by the Member States was set at October 25th 2013.

The Patient Mobility Directive '[…] provides rules for facilitating the access to safe and high-quality cross-border healthcare and promotes cooperation on healthcare between Member States, in full respect of national competencies in organising and delivering healthcare.'[272] The term 'health care' is broadly defined as '[…] health services provided by health professionals to patients to assess, maintain or restore their state of health, including the prescription, dispensation and provision of medicinal products and medical devices'.[273]

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264 Directive 2006/123/EC of the European Parliament and of the Council of 12 December 2006 on services in the internal market [2006] OJ L376/36. See also O'Leary 2011, *supra* n. 52, at p. 522.

265 Commission, 'Consultation regarding Community action on health services' (Communication), SEC (2006) 1195/4. See also Commission, 'Summary report of the responses to the consultation regarding "Community action on health services"', SEC (2006) 1195/4.

266 Commission, '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.

267 De la Rosa 2012, *supra* n. 33, at p. 26. See also T. Hervey, 'Cooperation between health care authorities in the proposed Directive', in: J.W. van de Gronden et al. (eds.), *Health care and EU law* (The Hague, T.M.C. Asser Press 2011) p. 161 at pp. 163–164.

268 G. Davies, 'Legislating for Patient's Rights', in: J.W. van de Gronden et al. (eds.), *Health care and EU law* (The Hague, T.M.C. Asser Press 2011) p. 191 at p. 191.

269 Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare [2011] OJ L88/45. The Patient mobility Directive was approved by the European Parliament on 19 January 2011 and entered into force on 24 April 2011 (Art. 22 Directive 2011/24/EU).

270 Recital No. 2 of the Preamble to the Directive explains: 'Article 114 TFEU is the appropriate legal basis since the majority of the provisions of this Directive aim to improve the functioning of the internal market and the free movement of goods, persons and services. Given that the conditions for recourse to Article 114 TFEU as a legal basis are fulfilled, Union legislation has to rely on this legal basis even when public health protection is a decisive factor in the choices made. In this respect, Article 114(3) TFEU explicitly requires that, in achieving harmonisation, a high level of protection of human health is to be guaranteed taking account in particular of any new development based on scientific facts.'

271 De la Rosa 2012, *supra* n. 33, at p. 27.

272 Art. 1(1) Directive 2011/24/EU.

273 Art. 3(a) Directive 2011/24/EU. Recital 6 to the Preamble furthermore holds that '[a]s confirmed by the [CJEU] on several occasions, while recognising their specific nature, all types of medical care fall within the scope of the TFEU.'

The Directive explicitly claims not to affect '[…] laws and regulations in Member States relating to the organisation and financing of healthcare in situations not related to cross-border healthcare.'[274] Further, following Recital No. 4 of the Preamble, the transposition of the Directive into national legislation and its application was not intended to result in '[…] patients being encouraged to receive treatment outside their Member State of affiliation.'[275] Recital No. 7 adds to this:

> 'This Directive respects and is without prejudice to the freedom of each Member State to decide what type of healthcare it considers appropriate. No provision of this Directive should be interpreted in such a way as to undermine the fundamental ethical choices of Member States.'[276]

By many, the Patient Mobility Directive has been perceived as a 'Citizenship Directive'[277] and as a reflection of the Union's 'rebalancing of its action in a more social direction'.[278] Before its adoption in amended form, Davies called mobile patients the 'winners' under the Directive.[279] Van de Gronden and Szyszczak later pointed out, however, that those provisions of the Patient Mobility Directive giving patients generous entitlements to cross-border hospital care were heavily amended before the Directive was finally adopted.[280] They concluded that respect for Member States' competences was still '[…] one of the underpinning principles of how EU law deals with health care'. Critique has been issued that the Directive is '[…] primarily aimed at individuals or groups of individuals who have the cognitive and social resources to engage in a process of mobility'.[281] De la Rosa described the Directive in the following words:

> '[The Patient Mobility Directive] displays an original combination of the codifying solutions derived from the free provision of services; the facilitation of the exercise of

274 Art. 2(4) Directive 2011/24/EU.

275 The 'Member State of affiliation' is the Member State that is competent to grant to the insured person a prior authorisation to receive appropriate treatment outside the Member State of residence. Art. 3(c) Directive 2011/24/EU.

276 Recital No. 7 of the Preamble to Directive 2011/24/EU. Recital No. 5 adds to this that '[…] decisions about the basket of healthcare to which citizens are entitled and the mechanisms used to finance and deliver that healthcare […] must be taken in the national context.'

277 Davies 2011, *supra* n. 268, at p. 207.

278 De la Rosa 2012, *supra* n. 33, at p. 16.

279 According to Davies mobile patients were the 'winners', 'provided they get what they expect and treatment abroad does not turn out to be more different and less satisfactory than they had hoped.' According to the author, the facilitation measures are at the heart of whether the Directive will be a success or not. Davies, furthermore, observes that the EU is also potentially a winner, as mobility of patients will tend to lead to a greater health care integration, which, he thinks, will ultimately strengthen the EU's position in the global health industry. The author furthermore held that: 'The rights in the Directive […], like other free movement rights, are a form of substantive constitution building, harnessing the needs and wishes of individuals to re-constitute the European space.' Davies 2011, *supra* n. 268, at pp. 207–208.

280 Gronden, van de and Szyszczak 2011, *supra* n. 170, at p. 488, referring to Davies 2011, *supra* n. 268.

281 De la Rosa 2012, *supra* n. 33, at pp. 38–39. On the other hand, the national information points for which the Directive provides (see section 3.5.3.2 below) may assist in making cross-border health care accessible for a wider public.

patient mobility by highlighting information in relation to such mobility; the promotion of cooperation between States in connection with Article 168 TFEU; and, to head the entire undertaking, the incessant reminder of the essentially national character of health policy.'[282]

3.5.3.1. Authorisation and reimbursement for cross-border health care

By way of codification of the CJEU's case law, Article 7 of the Patient Mobility Directive provides that the Member State of affiliation shall ensure that the costs incurred by an insured person who receives cross-border healthcare are reimbursed, if the healthcare in question is among the benefits to which the insured person is entitled in the Member State of affiliation. It is for the Member State of affiliation to determine, whether at a local, regional or national level, the healthcare for which an insured person is entitled to assumption of costs and the level of assumption of those costs, regardless of where the healthcare is provided.[283] Hence – as is the case under Article 22 of the Social Security Regulation – a State does not have to reimburse treatment obtained abroad, if such treatment is prohibited under the domestic law, or if the relevant national scheme does not provide for reimbursement for that kind of treatment.

The costs of cross-border healthcare are reimbursed or paid directly by the Member State of affiliation up to the level of costs that would have been assumed by the Member State of affiliation, had this healthcare been provided in its territory without exceeding the actual costs of healthcare received.[284]

Prior authorisation may be required under certain conditions. It is allowed if health care is concerned that is made subject to planning requirements relating to the object of ensuring sufficient and permanent access to a balanced range of high-quality treatment, but only if it 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.[285] Prior authorisation may also be required if the care is provided by a health care provider that, on a case-by-case basis, could give rise to serious and specific concerns relating to the quality or safety of the care, with the exception of healthcare which is subject to Union legislation ensuring a minimum level of safety and quality throughout the Union.[286] This provision is difficult to reconcile with the weight attached to mutual recognition by the CJEU in its case law.[287] Following Article 8(6) the Member

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282 *Idem,* at p. 18.

283 Art. 7(4) Directive 2011/24/EU.

284 Art. 7(4) Directive 2011/24/EU. It is furthermore stressed in Art. 1(4) that nothing in the Directive obliges a Member State to reimburse costs of healthcare provided by healthcare providers established on its own territory if those providers are not part of its social security system or public health system.

285 Art. 8(2)(a) Directive 2011/24/EU.

286 Art. 8(2)(c) Directive 2011/24/EU.

287 E.g. Case C-444/05 *Stamatelaki* [2007] ECR I-3185, ECLI:EU:C:2007:231, para. 37, where the Court held that the Greek authorities had to recognise that private hospitals located in other Member States were also subject, in those Member States, to quality controls and that doctors established in those

State of affiliation may refuse to grant prior authorisation if, according to a clinical evaluation, the patient will be exposed, with reasonable certainty, to a patient-safety risk that cannot be regarded as acceptable, taking into account the potential benefit to the patient of the sought after cross-border healthcare.[288] Prior authorisation may also be refused if the healthcare concerned can be provided on the territory of the Member State of affiliation within a time limit which is medically justifiable, taking into account the current state of health and the probable course of the illness of each patient concerned.[289]

Where medical follow-up proves necessary after a patient has received cross-border health care, the State of affiliation must ensure that the same medical follow-up is available '[…] as would have been if that healthcare had been provided on its territory.'[290]

3.5.3.2. Information rights

The Patient Mobility Directive has introduced considerable rights to information for patients involved in cross-border care.[291] Appropriate information 'on all essential aspects of cross-border healthcare' was considered '[…] necessary in order to enable patients to exercise their rights on cross-border healthcare in practice.'[292] The Directive, *inter alia*, provides for the establishment of national contact points in each Member State.[293] These are to deliver information to patients involved in cross-border care concerning healthcare providers; information on the relevant standards and guidelines; information on patients' rights, complaints procedures and mechanisms for seeking remedies, as well as the legal and administrative options available to settle disputes, including in the event of harm arising from cross-border healthcare.[294] Furthermore, in the Member State of affiliation, mechanisms have to be put in place to provide patients, on request, with information on their rights and entitlements relating to receiving cross-border healthcare, '[…] in particular as regards the terms and conditions for reimbursement of costs […] and procedures for accessing and determining those entitlements and for appeal and redress if patients consider that

States who operate in those establishments provided professional guarantees equivalent to those of doctors established in Greece. See also Case C-255/09 *Commission* v. *Portugal* [2011] ECR I-10547, ECLI:EU:C:2011:695, para. 83, where the Court ruled that a requirement of prior authorisation for reimbursement of the medical expenses in question could not be justified on public health grounds relating to the need to control the quality of healthcare services provided abroad.

288 Art. 8(6)(a) Directive 2011/24/EU.

289 Art. 8(6)(d) Directive 2011/24/EU.

290 Art. 5(c) Directive 2011/24/EU.

291 Palm and Baeten considered that the revolutionary nature of the Directive lied in the inclusion of these '"new" patient rights'. W. Palm and R. Baeten, 'The quality and safety paradox in the patients' rights Directive', 21 *Eur J Public Health* (2011) p. 272 at p. 272.

292 Recital No. 48 of the Preamble to Directive 2011/24/EU.

293 The Directive makes a distinction between responsibilities of the Member State of treatment (Art. 4) and responsibilities of the Member State of affiliation (Art. 5). It is, however, inescapable that all Member States have to meet all requirements, as they may function both as States of treatment and States of affiliation.

294 Arts. 4(2)(a) and 6(3) Directive 2011/24/EU.

their rights have not been respected […].'[295] Healthcare providers in the State where the treatment takes place, for their part, have to '[…] provide relevant information to help individual patients to make an informed choice, including on treatment options, on the availability, quality and safety of the healthcare they provide in the Member State of treatment and that they also provide clear invoices and clear information on prices, as well as on their authorisation or registration status, their insurance cover or other means of personal or collective protection with regard to professional liability.'[296] The Directive does not oblige Member States to deliver information in other languages than their official languages.[297]

3.6. Cross-border movement in reproductive matters under EU law

3.6.1. Political attention for cross-border movement in reproductive matters

Cross-border movement for reproductive matters has occasionally been discussed at the EU level. Particularly cross-border abortions have caught the attention of the EU institutions.[298] For instance, in the early 1980s when abortion was much debated in most (then) EC Member States, the European Parliament adopted a non-binding Resolution on the position of women in the European Community in which cross-border abortions were also addressed.[299] The Resolution noted '[…] the problems caused by the fact that women seeking abortions frequently [had] to seek the termination in another country and requested the Commission to press the Council for decisions at national level to obviate the need for such journeys and ensure that every woman who [found] herself in difficulty could obtain the necessary assistance in her own state.'[300] It has been noted that this was particularly controversial in a Member State like Ireland, as it '[…] gave rise to concern in certain quarters that this was the beginning of Community pressure to liberalise Ireland's abortion legislation.'[301]

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295 Art. 5(b) Directive 2011/24/EU.

296 Art. 4(2)(b) Directive 2011/24/EU.

297 Art. 4(5) Directive 2011/24/EU. See also Palm and Baeten 2011, *supra* n. 291, at p. 273, who furthermore point out that '[t]he level of information provided and the way in which the contact points will work in the different Member States is likely to reflect cultural and organizational differences […].'

298 See also the Resolution of the European Parliament of 12 March 1990 on reports of gynaecological examinations by the German Federal Frontier Police [1991] OJ C106/102, pp. 103, 113 and 135, as discussed in Ch. 4, section 4.4.1.1.

299 European Parliament resolution of 11 February 1981 on the situation of women in the European Community, [1981] OJ C50/24, p. 34. The Resolution followed a Report of the Ad Hoc Committee on Women's Rights on the position of women in the European Community, A1-0829/80. See also Sherlock 1989, *supra* n. 78.

300 As paraphrased by Sherlock 1989, *supra* n. 78, referring (in footnote 29) to [1989] OJ C111/1, p. 16.

301 *Idem*. The author stressed that the Resolution was not legally binding and that the Parliament lacks the power to initiate legislation.

In 2004, when the Portuguese authorities refused to allow the ship of the Dutch organisation *Women on Waves* to enter Portuguese territorial waters (see Ch. 6, section 6.4.1.3; and Ch. 2, section 2.4.1), this also caught the attention of the European institutions. It caused a 'lively, controversial and important debate' in the European Parliament[302] and made the Commission get involved in the matter. Upon receiving a complaint by *Women on Waves* about the refusal, the Commission inquired with the Portuguese authorities. It thereby made clear that Member States could restrict the fundamental right of free movement '[…] solely where it [was] justified on grounds of public policy, public security and public health and that where a Member State adopt[ed] a measure refusing entry to its territory based on one of these grounds, it [had to] respect the general principles of Community law and in particular the proportionality principle, and fundamental rights, including the right to freedom of information and expression.'[303] The present author is not aware of any subsequent action from the side of the Commission in this case;[304] there has not been a case before the CJEU resulting from any infringements proceedings initiated by the Commission in this matter.[305]

On another occasion, in 2006, the Council declined to give its opinion on a report that citizens of other EU Member States went to a Spanish clinic for late abortions (i.e., after 30 weeks of pregnancy).[306] The Council answered that this matter did not fall within the Union's competences.[307]

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302 Contribution of Commissioner Wallström to the debate in European Parliament of 16 September 2004, www.europarl.europa.eu/sides/getDoc.do?pubRef=-%2f%2fEP%2f%2fTEXT%2bCRE%2b20040916%2bITEM-001%2bDOC%2bXML%2bV0%2f%2fEN&language=EN, visited June 2014.

303 Letter of the Commission to the Portuguese authorities on 14 October 2004 to request further information, as referred to in Answer of the Commission to oral Parliamentary Question No. 69 by Anne Van Lancker to the Commission, of 26 November 2004 (H-0450/04), online available at www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+CRE+20041216+ANN-01+DOC+XML+V0//LV&query=QUESTION&detail=H-2004-0450, visited June 2014.

304 On 23 November 2004, the Commission received a reply from the Portuguese authorities who justified their decision on the United Nations Convention on the Law of the Sea and on the need to protect public health, safeguard the legal order and prevent abuse of rights. Three days later the Commission informed Parliament that it planned to decide on the follow-up to this official complaint in its next meeting on infringements. Answer of the Commission to oral Parliamentary Question No. 69 by Anne Van Lancker to the Commission, of 26 November 2004 (H-0450/04), online available at www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+CRE+20041216+ANN-01+DOC+XML+V0//LV&query=QUESTION&detail=H-2004-0450, visited June 2014.

305 The matter has, however, been decided by the ECtHR on the basis of Art. 10 ECHR. See Ch. 2, section 2.4.1.

306 See also Ch.6, section 6.4.1.2.

307 The Representative of the Council held that the European Union Treaties had not bestowed on the Community or the Union the competence whereby the Union could regulate on abortions. The Member States thus had the competence to regulate on this and ensure compliance in their territory with the laws that they passed. The EU could not interfere '[…] in unsatisfactory states of affairs due to differences in the legislation of Member States when it [came] to areas that [were] not within its competence.' When a Member of Parliament submitted that this concerned a European problem of a cross-border nature, the representative of the Council answered that the free mobility of people was 'one of the European Union's basic concerns'. It was held that if there were 'illegal goings-on in Member States', it was their responsibility and duty to monitor them and intervene. In this case it was incontrovertibly clear that big differences between the laws in Member States led to very different practices around Europe. Answer of the Council to oral Parliamentary Question No. 69 by B. Belder to the Council, of 7 November 2006

The motion for a resolution on Sexual and Reproductive Health and Rights,[308] as tabled by the European Parliament's Committee on Women's Rights and Gender Equality in 2013 (see 3.2 above), deplored the fact that the restrictive abortion laws of certain countries resulted in a divide between those who could afford to travel, and those who could not and were forced to seek clandestine abortions. It called on Member States to '[…] refrain from preventing pregnant women seeking abortion to travel to other Member States or jurisdictions where the procedure is legal'.[309] As explained above, the motion was not, however, adopted.[310]

Cross-border surrogacy has also received attention at the EU level. For instance, as noted in section 3.3.4 above, in 2012 the European Parliament issued a call for tender for a comparative study on the regime of surrogacy in the EU Member States, whereby the question to be addressed was also whether solutions to existing problems could be better achieved on the EU level. The findings of the ensuing study in respect of cross-border cases are discussed in section 3.6.3 below.

In international surrogacy cases, often third countries (non-EU Member States), such as Ukraine, Russia, India or the United States of America, are involved. The EU has not adopted specific foreign policies in respect of international surrogacy. For instance, the issue is not addressed in specific country strategy papers. In relation to India, the Commission stressed, in 2013, in response to Parliamentary questions, that the EU had '[…] engaged with the Government of India and Indian civil society organisations since the early 1990s, on improvement of maternal health, reducing child mortality and protecting women's rights', but that there was '[…] no funding available for the creation of information, monitoring systems or to produce and publish data with regard to the phenomenon of business of surrogate motherhood in India.'[311] The EU follows the developments on surrogate motherhood at international level through the Hague Conference on Private International Law, of which it has been a member since 2007.[312]

(H-0983/06), online available at www.europarl.europa.eu/sides/getDoc.do?type=CRE&reference=20061213&secondRef=ITEM-021&language=EN#3-429, visited June 2014.

308 Motion for a European Parliament Resolution on Sexual and Reproductive Health and Rights (2013/2040(INI)), online available at www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//NONSGML+REPORT+A7-2013-0306+0+DOC+PDF+V0//EN, visited June 2014.

309 *Idem*, paras. 28, 30 and 38.

310 See section 3.2 above.

311 Answer given by Mr. Piebalgs on behalf of the Commission (22 March 2013) to Question No E-001081/13, no. P7_QE(2013)001081.

312 See 3.3.4 above. The Hague Conference decided in 2011 that issues surrounding cross-border surrogacy arrangements required further examination, and in 2013 a study on the matter came out. The study concluded that further international work was desired with a view to ensuring legal certainty and security of legal status for children and families in international surrogacy situations and to protecting the '[…] rights and welfare of children, parents and other parties involved with the conception of children in international situations, in line with established global human rights standards.' Following this study, the General Council of the Hague Conference invited the Permanent Bureau to continue information gathering and postponed any decision on the establishment of an Experts' Group on the matter to its meeting in 2015. Permanent Bureau Hague Conference on Private international law, *The desirability and feasibility of further work on the parentage / surrogacy project*, Preliminary Document No 3 B of April 2014 for the attention of the Council of April 2014 on General Affairs and Policy of

3.6.2. Open questions regarding the application of cross-border health care standards

There are various open questions concerning the application the EU law standards on cross-border health care, as described in section 3.5 above, to cross-border abortions, cross-border reproductive care and cross-border surrogacy. With the exception of the *Grogan* case, none of CJEU judgments and legislative instruments as discussed in section 3.5 dealt explicitly with these matters. Consequently, application of these standards to situations of cross-border abortions, CBRC and cross-border surrogacy raises questions, which as yet, have not been explicitly addressed by the EU legislature, nor by the CJEU. This section identifies these open questions and endeavours to formulate tentative answers where possible.

For one thing, abortion and AHR treatment fall within the definition of 'services' within the meaning of the TFEU, and 'health care' within the meaning of the Patient Mobility Directive,[313] as long as they are not outlawed by all Member States and as long and normally provided for remuneration. Only if a certain type of AHR treatment or abortion would be outlawed by *all* Member States, could this specific treatment be excluded from the scope of the EU free movement rules.[314] While for abortion such a situation is in any case not anticipated in the near future, it is conceivable that all EU Member States could explicitly prohibit practices like gender selection in the course of AHR treatment for reasons other than medical ones. In that scenario, the EU free movement rules could not provide a basis for any claim as regards access to, or reimbursement for, such treatment.

Surrogacy is in itself not a medical activity, and the Patient Mobility Directive and specific cross-border health care case law do not, therefore, apply. In high-technological surrogacy AHR treatment is, however, involved and that type of medical treatment evidently comes within the scope of the EU standards on cross-border health-care. Surrogacy itself could possibly be considered a service within the meaning of the Treaties,[315] as a result of which the general Treaty rules (Articles 56 and 57 TFEU) apply. This certainly holds for the services that surrogacy intermediaries offer.

Even though abortion, (common types of) AHR treatment and possibly also surrogacy thus qualify as (health care) services within the meaning of the Treaty, the freedom to receive such services may be restricted. A full restriction on cross-border

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the Conference; Permanent Bureau Hague Conference on Private international law, *A study of legal parentage and the issues arising from international surrogacy arrangements,* Preliminary Document No 3 C of March 2014 for the attention of the Council of April 2014 on General Affairs and Policy of the Conference and Conclusions and Recommendations adopted by the Council on General Affairs and Policy of the Conference (8–10 April 2014). All three documents are online available at www.hcch.net/index_en.php?act=text.display&tid=183, visited June 2014.

313 See Case C-159/90 *Grogan* [1991] ECR I-4685, ECLI:EU:C:1991:378, as discussed in section 3.5.2.1 above.

314 Case C-137/09 *Josemans* [2010] ECR I-13019, ECLI:EU:C:2010:774.

315 Brunet et al. 2013, *supra* n. 134, at pp. 142–143.

movement for reproductive matters by means of a ban on travelling may be very hard to justify under EU law, however. A restriction by means of criminal prosecution after return to the home state may also not be easily justified. In most cases the double criminality rule under the European Arrest Warrant will prevent such prosecution anyhow (see section 3.6.4 below). Such measures are not, furthermore, very likely to be imposed, as the chapters on Ireland, Germany and the Netherlands for this case study have shown.[316] It is more likely that restrictions on free movement consist of refusals of reimbursement;[317] prior authorisation requirements; bans or limitations on information about foreign treatment options or refusals to provide follow-up care after treatment has been obtained abroad. Restrictive regimes concerning abortion, AHR treatment and/or surrogacy may also in themselves constitute an obstacle to free movement. All these possible restrictions are addressed in the various subsections below.

3.6.2.1. Reimbursement for treatment obtained abroad

The basic and most relevant rule for the present case study in respect of reimbursement is that States do not have to reimburse treatment obtained abroad, if such treatment is prohibited under the domestic law, or if its national scheme does not provide for reimbursement for that kind of treatment.[318] Additional costs, such as costs for board, lodging, travel, visitors' tax and the production of a final medical report, can also not be claimed in this situation.[319]

While this, at first sight, seems to be a clear-cut rule, to determine if the treatment in question is '[…] among the benefits provided for by the legislation in the Member State where the person concerned resides' may sometimes prove problematic, because entitlements to medical benefits may be phrased in rather broad terms in national (private) social security regulations.[320] For example, it may be provided under the social security scheme of Member State *A* that a couple is entitled to reimbursement for 'three IVF cycles'. Suppose that, in that State IVF treatment with the use of donated gametes is lawfully available only if such donation is altruistic and if the donor is known to the woman or couple involved in the IVF treatment. Could reimbursement be claimed for IVF treatment obtained in Member State *B*, where

316 An exception forms the (withdrawn) prosecution in the Netherlands for abortion in Spain. See Ch. 6, section 6.4.1.2.

317 It has also been pointed out, however, that most of cross-border AHR treatment takes place in the context of private treatment, '[…] and so public interest justifications with respect to the burdens on the public purse, the organisation of national health (insurance) schemes and the need for planning, management and capacity building, that are at issue in the general litigation on free movement of patients do not apply with the same force.' Hervey and McHale 2004, *supra* n. 47, at p. 152.

318 Art. 22 Regulation 883/2004 and Art. 7 Directive 2011/24/EU.

319 Case C-8/02 *Ludwig Leichtle* v. *Bundesanstalt für Arbeit* [2004] ECR I-2641, ECLI:EU:C:2004:161. Mei, van der 2006, *supra* n. 168, at pp. 68–69.

320 See Case C-173/09 *Elchinov* [2010] ECR I-8889, ECLI:EU:C:2010:581, para. 59, where the Court considered that '[…] it is for each Member State to decide which medical benefits are reimbursed by its own social security system. To that end, the Member State concerned is entitled to list precisely treatments or treatment methods or to state more generally the categories or types of treatments or treatment methods.'

commercial and anonymous donation of gametes is legal and common practice? The answer is most likely in the negative, as such treatment would not have been reimbursed if obtained in Member State *A*, the State of affiliation. In other words, it is not among the benefits provided for by the legislation in Member State *A*. Whether this is indeed the correct reading of the law has not been confirmed at EU level.[321]

Another question is, where a new type of AHR treatment has become available that is not (yet) available in Member State *A*, and therefore also not (yet) explicitly provided for or prohibited in the State of affiliation, whether it should be reimbursed by the latter state. On the basis of the existing case law there is no definite answer to this question (yet). Some guidance may be found in the case of *Elchinov* (2010) where the CJEU ruled that:

> '[…] where the list of medical benefits reimbursed does not expressly and precisely specify the treatment method applied but defines types of treatment […] it is for the competent institution of the Member State of residence of the insured person to assess, applying the usual principles of interpretation and on the basis of objective and non-discriminatory criteria, taking into consideration all the relevant medical factors and the available scientific data, whether that treatment method corresponds to benefits provided for by the legislation of that Member State.'[322]

It must be noted that the *Elchinov* case did not concern morally controversial treatment. It seems very likely that in cases concerning such controversial treatment, the national authorities would rule that foreign treatment options do not correspond to treatment available in the state of affiliation. If the authorities nevertheless come to the conclusion that the treatment methods do correspond, prior authorisation – so the Court has ruled – may not be refused on the ground that such a treatment method is not available in the Member State of affiliation.[323] That brings us to the question of whether States may restrict access to, and reimbursement for, abortions and AHR treatment that has been provided in another EU Member State, for example, by setting prior authorisation requirements.

3.6.2.2. Prior authorisation requirements and refusal of authorisation

Two issues warrant particular attention when the EU rules in respect of prior authorisation are applied in the present case study. These are the questions of whether abortions and AHR treatment qualify as 'scheduled treatment',[324] and whether safety and quality concerns may be accepted as a ground for the refusal of authorisation for such treatment.

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321 Dutch courts have in any case taken different views in this regard. See Ch. 6, section 6.5.2.

322 Case C-173/09 *Elchinov* [2010] ECR I-8889, ECLI:EU:C:2010:581.

323 *Idem*, para. 62, where the Court ruled that '[…] such a ground, if it were accepted, would imply a restriction on the scope of the second subparagraph of Article 22(2) of Regulation No 1408/71.'

324 From the CJEU's case law it follows that in this regard, not so much the hospital environment, but the planning element is decisive (see 3.5.2.3 above).

Under the Patient Mobility Directive a prior authorisation requirement for scheduled treatment can only be set if the treatment involves overnight hospital accommodation for the patient in question for at least one night, or if it requires use of highly specialised and cost-intensive medical infrastructure or medical equipment.[325] As a rule, no hospital accommodation is required for abortion and AHR treatment.[326] Whether any of these types of treatment involve 'highly specialised and cost-intensive medical infrastructure or medical equipment', within the meaning of the Directive, is less obvious.[327] The CJEU has so far given only limited guidance on the interpretation of this condition for authorisation. In *Commission* v. *France* (2010)[328] the Court accepted a prior authorisation requirement for treatment requiring the use of 'major medical equipment'[329] available outside hospital infrastructures, because the conditions for the installation, operation and use of this equipment were 'especially onerous', while both its purchase and its installation and use represented high costs of 'hundreds of thousands, even millions, of euro'.[330] The Court held that the planning endeavours of the national authorities and the financial balance of the supply of up-to-date treatment would be jeopardised, if persons insured in one Member State could, freely and in any circumstances, obtain at the expense of the competent institution, from service providers established in other Member States, treatment involving the use of major medical equipment.[331] It is submitted that generally medical equipment for abortion does not qualify as 'major medical equipment'. Presumably this also holds for equipment for most – if not all – (common) types of AHR treatment. New medical and technological developments may, nevertheless, lead to different conclusions in this regard. Hence, it cannot be ruled out that (certain types of) AHR treatment qualify as scheduled treatment, on the grounds of which a prior authorisation requirement in principle may be set. Generally, however, it is concluded that abortion and AHR treatment are not made subject to planning requirements, and that therefore no prior authorisation requirements may be set on that ground.

325 Art. 8(2)(a) Directive 2011/24/EU.

326 Within the EU practices vary as to the place where abortions and AHR treatment take place; this may be in (special clinics within) hospitals or in private clinics. In Ireland, for example, only private AHR clinics exists, whereas in the Netherlands all AHR-clinics are accommodated in public hospitals. In Germany both private and public clinics provide AHR treatment. Generally, also in situations where the treatment is carried out in a hospital, no accommodation for the night is required.

327 Art. 8(2)(a) Directive 2011/24/EU.

328 Case C-512/08 *Commission* v. *France* [2010] ECR I-8833, ECLI:EU:C:2010:579.

329 In the relevant case, under national (French) law the term 'major medical equipment' was held to include: a 'PET scanner'; a nuclear magnetic resonance imaging or spectrometry apparatus for clinical use; a medical scanner; a hyperbaric chamber and a cyclotron for medical use. See Case C-512/08 *Commission* v. *France* [2010] ECR I-8833, ECLI:EU:C:2010:579, para. 9.

330 *Idem*, para. 39. Advocate General Sharpston had proposed that 'highly specialised and cost-intensive medical infrastructure or medical equipment' could concern 'major medical equipment' that is very expensive to acquire, that may need to be installed in a specific setting and may need to be used and maintained by suitably qualified and trained personnel. Opinion of Advocate General Sharpston delivered on 15 July 2010, Case C-512/08 *Commission* v. *France* [2010] ECR I-8833, ECLI:EU:C:2010:579, para. 73.

331 Case C-512/08 *Commission* v. *France* [2010] ECR I-8833, ECLI:EU:C:2010:579, para. 40.

The rule that safety and quality issues can provide grounds for setting a prior authorisation requirement[332] may prove particularly relevant in the present case study.[333] For example, Dutch genealogists have expressed their concerns about the safety and quality of AHR treatment in Spanish clinics, where various fertilised egg cells are implanted in one cycle.[334] Could such concerns constitute ground for Dutch insurers to refuse to authorise women to have AHR treatment in Spain?[335] The answer is most likely in the negative, as the Patient Mobility Directive provides that an authorisation requirement is not allowed for types of healthcare that are subject to Union legislation ensuring a minimum level of safety and quality throughout the Union.[336] As explained in section 3.3.2 above, this is indeed the case in respect of IVF treatment, by means of the EU Tissues and Cells Directive. This minimum harmonisation therefore seems to bar the setting of prior authorisation requirements for AHR treatment such as IVF treatment. In respect of abortion there is, on the other hand, no such harmonisation in place.[337]

The foregoing conclusions render it less imperative to apply the CJEU's case law and the rules under the Patient Mobility Directive in respect of refusal of authorisation to the present case study. After all, there seems to be little ground for the setting of such authorisation requirements in the first place. Still, it may be worth examining the rule that authorisation can be refused if the same or equally effective treatment can be provided on the territory of the Member State of affiliation within a time limit which is medically justifiable, taking into account the current state of health and the probable course of the illness of each patient concerned.[338] This rule – which concerns remedying the disadvantageous consequences of waiting lists – is relevant only in situations where the treatment concerned is, in principle, legally available in the State of affiliation.

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332 Art. 8(2)(c) Directive 2011/24/EU, as discussed in section 3.5.3.1 above.

333 A further question is if the conditions concerning quality and safety could also be interpreted in a moral sense. Could the (moral or psychological) effects of certain types of treatment – such as abortion – be considered to be an unacceptable patient-safety risk, justifying a prior authorisation requirement? While, again, no final answer to this question can be given as no CJEU ruling has been made on this particular question, it is submitted that this would stretch the interpretation of these rules – which concern integrity, quality and safety of the health care provider – too far.

334 *Nieuwsuur* 9 September 2010, www.nieuwsuur.nl/onderwerp/183384-spanje-is-hoop-voor-onvruchtbare-vrouwen.html, visited January 2011.

335 Under the Patient Mobility Directive, prior authorisation may also be required (1) if the care is provided by a health care provider that could give rise to serious and specific concerns relating to the quality or safety of the care, or (2) if the patient will be exposed with reasonable certainty to a patient safety risk. Art. 8(2)(c) Directive 2011/24/EU.

336 Art. 8(2)(c) Directive 2011/24/EU.

337 As Palm and Baeten explained in respect of the Patient Mobility Directive: 'The idea that the Directive would impose Member States to define clear quality and safety standards and to establish mechanisms to ensure that providers would have to meet these standards and could be sanctioned if they did not, was considered by the Member States a bridge too far, as it would touch upon their freedom and competence to organize and deliver health care according to national principles and priorities.' Palm and Baeten 2011, *supra* n. 291, at p. 273.

338 Case C-157/99 *Geraets-Smits and Peerbooms* [2001] ECR I-5473, ECLI:EU:C:2001:404 and Art. 8(6)(d) Directive 2011/24/EU.

In various EU countries, waiting lists exist for donated gametes, which reportedly are reason for couples to go abroad.[339] This raises the question of whether the time limits involved in such waiting lists can be considered 'medically justifiable'. The answer may depend on the question if infertility – which often constitutes ground for people to wish to resort to (certain types of) AHR treatment – is considered an illness. This concerns a sensitive question, which has not (yet) been conclusively answered at EU level and may not be easily done so either. It may also depend on the age of the couple involved in the AHR treatment and the age limits that national law has set for access to AHR treatment.

Another as yet undecided issue concerns the question of whether certain types of AHR treatment or abortion can be held to be 'sufficiently tried and tested by international medical science', in which case authorisation for reimbursement cannot be refused.[340]

3.6.2.3. Medical follow-up after cross-border treatment

There are some open issues in respect of the obligation on the State of affiliation to provide the necessary medical follow-up in the context of the present case study. In principle, the State of affiliation must ensure that the same medical follow-up is available 'as would have been if that healthcare had been provided on its territory.'[341] It is insufficiently clear how this provision must be interpreted in situations where the respective treatment is prohibited in the country of affiliation. Can an Irish medical practitioner or psychologist thus refuse to treat an Irish woman who had an abortion on therapeutic or social grounds in England? Are those Dutch genealogists who refuse to treat women who underwent AHR treatment in Spain acting in breach of EU law?[342] The literal text of the Directive does not give a conclusive answer and the primary free movement rules do not give much guidance either. It may be assumed that any refusal to give a medical follow-up to a medical service received abroad constitutes a barrier to the freedom to receive services. After all, the prospect of such a refusal may withhold certain services recipients from even making use of their free movement rights. Whether such a restriction could be justified is, however, an open question. The protection of the reputation (and credibility) of the medical profession may possibly constitute an overriding public interest in such situations. Next the proportionality of the restriction must be assessed. A refusal of life-saving treatment in case of a bleeding after an abortion appears evidently disproportional, but in respect of psychological treatment after an abortion on social grounds, this disproportionality may be less evident. There are thus many open questions here.

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339 E.g. Shenfield et al. 2010, *supra* n. 154.

340 Hervey and McHale argued that '[p]articularly with relatively new treatments', there was 'likely to be considerable room for difference among professional opinion'. The authors warned that patients were likely to exploit this. Hervey and McHale 2004, *supra* n. 47, at pp. 136–137.

341 Art. 5(c) Directive 2011/24/EU.

342 See Ch. 6, section 6.5.3.

3.6.2.4. Information about foreign abortion and AHR services and surrogacy

There is nothing to indicate that the provisions of the Patient Mobility Directive in respect of information rights, as set out in section 3.5.3.2 above, would not apply in respect of cross-border abortions or reproductive care. Hence, national information points should also provide information about these types of treatment. As noted above, surrogacy does not in itself come within the scope of the Patient Mobility Directive, however. There is consequently no obligation on Member States to actively provide information about such services in other Member States. Whether they may, on the other hand, restrict access to such information, is another question that must be assessed on the basis of the Treaty free movement rules. As yet, this issue has not been addressed by the CJEU.

3.6.2.5. Different regimes as an obstacle to free movement?

EU citizens may be deterred from making use of their free movement rights under Article 21 TFEU, if the host State prohibits abortion (on certain grounds), surrogacy or (certain types of) AHR treatment. This may even be the case if the conditions for access to such treatment are stricter under the law of the host state, than under the law of the state of origin. For example, a same-sex couple may be deterred from moving to a State where access to IVF treatment is limited to (married) different-sex couples. While this matter has never been decided by the CJEU, it cannot be ruled out that the CJEU would accept that such (more) restrictive regimes constitute a restriction on free movement rights. The next question is then whether such a restriction could be justified. Various possible justification grounds are conceivable, such as the protection of public health, the protection of morals, public order grounds, protection of the unborn child, and the interests of the (future) child. The assessment of the proportionality depends on the justification ground and on the particular circumstances of the case and in this regard there are, again, various open questions.[343]

3.6.3. Recognition of parental links established abroad

There is, as matters stand, no provision of EU law that requires expressly that Member States must recognise parental links that have been established in another country in a cross-border surrogacy situation. As explained in section 3.1.3.3 above, the EU has a competence to develop judicial cooperation within the EU in civil matters with cross-border implications. None of the instruments that have been adopted on this legal basis are applicable to cross-border surrogacy cases and it is consequently the Private International Law regimes of States that are primordially decisive. For example, (non-)contractual obligations arising out of family relationships are excluded from the scope of the so-called Rome Regulations that provide for uniform rules for

[343] One factor which may be of relevance is the internal consistency of the national law. For example, in case a Member State prohibits surrogacy, it may be taken into account whether surrogacy intermediaries that collaborate with foreign surrogacy agencies are also prohibited.

determining the law applicable to contractual and non-contractual obligations in the European Union.[344] Further, the so-called *Brussels I* Regulation of 2000[345] provides for rules governing the jurisdiction of courts and the recognition and enforcement of judgments in civil and commercial matters in EU Member States, but it does not apply to 'the status or legal capacity of natural persons'.[346] The *Brussels II bis* Regulation (2003)[347] provides for automatic recognition of all judgments issued by courts of other Member States relating to parental responsibility without any intermediary procedure being required.[348] However, it is made very clear that the Regulation '[…] does not apply to the establishment of parenthood, since this is a different matter from the attribution of parental responsibility, nor to other questions linked to the status of persons.'[349] Apart from 'the establishment or contesting of a parent-child relationship' also 'judgments on adoption and the related preparatory measures, and annulment or revocation of adoption' are excluded from the scope of the Regulation.[350]

There is, moreover, as yet no EU instrument that provides for mutual recognition of birth certificates within the EU, although the first explorative steps in this regard have been taken by the European Commission, as explained hereafter.[351] A study of 2013 commissioned by the European Parliament also made suggestions for possible EU approaches to the issue (see section 3.6.3.2 below).

Whether a refusal by one Member State to recognise parental links as established in another EU Member State would constitute a violation of the free movement rules is a question that has never been conclusively answered by the CJEU. Intended parents who are EU citizens may rely on their free movement rights and if the child has EU-citizenship, they may also invoke the EU-citizenship rights of the child (Article 21 TFEU). A refusal by an EU Member State to give recognition to a birth certificate issued in another Member State may consequently well be considered a restriction of the latter right, but whether such a restriction could be upheld on public

344 See Art. 1(2)(b) Regulation (EC) No 593/2008 ('Rome I') and Art. 1(2)(a) Regulation (EC) No 864/2007 ('Rome II'). See Brunet et al. 2013, *supra* n. 134, at p. 148.

345 Council Regulation (EC) No 44/2001 of 22 December 2000 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters. The Regulation superseded the Brussels Convention of 1968, which was applicable between the EU countries before the Regulation entered into force.

346 Art. 1(2)(a). This is not different in the new version of the Regulation, European Parliament and Council Regulation 1215/2012/EU of 12 December 2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters [2012] OJ L351/1.

347 Council Regulation 2201/2003/EC of 27 November 2003 concerning jurisdiction and the recognition and enforcement of judgments in matrimonial matters and the matters of parental responsibility, repealing Regulation 1347/2000/EC [2003] OJ L338/1.

348 Recognition may be refused if such recognition is manifestly contrary to public policy, but only if it is in the best interests of the child. Art. 23 Regulation 2201/2003.

349 Recital 10 Regulation 2201/2003.

350 Art. 3(a) and (b) Regulation 2201/2003.

351 Commission, 'Green Paper 'Less bureaucracy for citizens: promoting free movement of public documents and recognition of the effects of civil status records', COM (2010) 747 final.

order grounds is as yet another open question.[352] Some guidance may be found in the *Dafeki* case (1997), where the Court held that:

> '[…] the exercise of the rights arising from freedom of movement for workers [was] not possible without production of documents relative to personal status, which [were] generally issued by the worker's State of origin.'[353]

Therefore, Member States were obliged to accept such documents, unless their accuracy was seriously undermined in an individual case. Cross-border surrogacy cases generally do not concern the free movement of workers, and it is therefore to be awaited if a similar reasoning would be applied in this context.[354]

3.6.3.1. Green Paper on recognition of civil status records (2010)

In the year 2010 the Commission published a Green Paper on the free movement of public documents and recognition of the effects of civil status records.[355] For the present research – both for this case study as well as for Case Study II – particularly the issue of recognition of the effects of civil status records is relevant. Civil status records were defined in the Green Paper as:

> '[…] records executed by an authority in order to record the life events of each citizen such as birth, filiation, adoption, marriage, recognition of paternity, death and also a surname change following marriage, divorce, a registered partnership, recognition, change of sex or adoption.'[356]

The fact that this definition thus includes records concerning birth, filiation and adoption, renders the Green Paper also relevant for cross-border surrogacy situations.

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352 States will presumably invoke public policy grounds and possibly also national identity. The CJEU has proven respectful for national identity arguments in cases concerning the spelling of names, which case-law may be relevant for the present case. However, it is uncertain if such a case would pass the proportionality test. Forceful counter-arguments would be the rights of the child and the right to respect for family life, which States have to protect when they act within the scope of EU law. Thereby note must be taken of the ECtHR judgments in the *Mennesson* and *Labassee* cases (ch. 2). See also Ch. 9, section 9.6.3.

353 Case C-336/94 *Dafeki* [1997] ECR I-6761, ECLI:EU:C:1997:579, para. 19.

354 Possibly another avenue could be via the right to receive services (Art. 56 TFEU), if surrogacy can indeed be qualified as a service. The non-recognition of parental links with a child born through surrogacy in another Member State could then possibly be seen as discouraging and thus restricting the right to receive services.

355 COM (2010) 747 final. In the so-called Stockholm programme (OJ C115/1, p. 13), the European Council had yet invited the Commission to: '[…] follow up on the recent study on the possible problems encountered with regard to civil status documents and access to registers of such documents.' It was held that '[i]n the long term, it might be considered whether mutual recognition of the effects of civil status documents could be appropriate, at least in certain areas. Work developed by the International Commission on Civil Status should be taken into account in this particular field.'

356 According to the Green paper, civil status records are '[…] records executed by an authority in order to record the life events of each citizen such as birth, filiation, adoption, marriage, recognition of paternity, death and also a surname change following marriage, divorce, a registered partnership, recognition, change of sex or adoption.' See COM (2010) 747 final, para. 4.1.

The Commission's main policy objectives were: (1) to reduce obstacles to the free movement of citizens; (2) to guarantee the continuity and permanence of the civil status situation to European citizens exercising their right to free movement and (3) to increase legal certainty in relation to civil status matters.[357] It was held that it had to be possible to guarantee the continuity and permanence of a civil status situation to all European citizens exercising their right of freedom of movement:

> '[…] the legal status acquired by the citizen in the first Member State […] should not be questioned by the authorities of the second Member State since this would constitute a hindrance and source of objective problems hampering the exercise of citizens' rights.'[358]

The Commission saw three policy options in regard of recognition of the effects of civil status records: (1) assisting national authorities to cooperate more effectively 'until there is greater convergence of MS' substantive family law'; (2) automatic recognition 'of civil status situations established in other Member States' or (3) harmonisation of conflict-of-laws rules.[359]

The second option was the most far-reaching, as it implied that once parental links had been established in one Member States, all other Member States had to accept these – even if surrogacy had been involved. The various contributions by national authorities in the public consultation process showed that such automatic recognition, if indeed proposed by the Commission, is not very likely to meet with unanimity in the Council. The German Federal Government, for example, put forward that in cases concerning issues like 'the filiation of a child in the case of a "surrogate mother"' and 'the introduction of presumptions of filiation in favour of the mother's registered female partner', the EU could not require a Member State's legislature '[…] to place its family law at the disposal of the […] other Member States without restriction, allowing the persons concerned to have a family law relationship that exist[ed] under the law of another Member State to be registered in that State even though they [had] no close ties with that state's legal order.'[360] According to the German government,

> '[i]n such a case there would be no justification for this legal order, which is purely fortuitous or chosen comparatively freely by the persons concerned, to take precedence over the assessments of legal orders which – on the basis, say, of the nationality of the persons concerned or where they actually live – have an objectively closer connection with the facts and hence a greater claim to be applied.'[361]

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357 COM (2010) 747 final.

358 *Idem*, para. 4.1.

359 The Green Paper made clear that the Commission had 'neither the power nor the intention […] to modify the national definition of marriage.' *Idem*, para. 4.3.

360 Federal Government observations on COM (2010) 747 final, pp. 12–13, online available at w w w . ec.europa.eu/justice/newsroom/civil/opinion/files/110510/public_authorities/germany_minjust_en.pdf, visited June 2014.

361 *Idem*.

The option of harmonisation of conflict-of-laws rules received more support during the public consultation, but met with critique as well. It therefore seems more realistic to anticipate that only the first policy option – i.e., closer cooperation between Member States – could receive the required unanimity in the Council. Such cooperation, by nature, does not affect the Member States' possibilities to uphold and apply their own national standards in cross-border situations, for instance by means of public policy exceptions.

The public consultation was closed in May 2011. Both the EESC[362] and the Committee of the Regions have published an Opinion on the matter.[363] In a Resolution of 2012, the European Parliament called on the Commission to propose measures to mutually recognise the effects of civil status documents on the basis of the principle of mutual recognition.[364] In the subsequent year the Commission published a proposal for a regulation on the free movement of public documents, which aimed to abolish requirements of proof of the genuineness of public documents, or the signatures of national officials on such documents, as issued by public authorities in other Member States.[365] The question of the recognition of the effects of civil status records was not, however, addressed in this proposal.[366] On that point so far no further legislative initiative has been taken.[367]

3.6.3.2. EP study on surrogacy in the EU (2013)

The European Parliament Committee on Legal Affairs has in recent years expressed a particular interest in surrogacy in the European Union. In 2010 at the request of this Committee a note was published on mutual recognition of surrogacy agreements. The note proposed

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362 European Economic and Social Committee, 'Opinion on the Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on Reinforcing sanctioning regimes in the financial services sector', COM (2010) 716 final. The EESC considered that, in connection with civil status records, the Commission had to: (1) establish a *supra*national optional system for the European civil status record; (2) start the work needed to harmonise rules concerning conflicts of law, and (3) '[…] establish mutual recognition by identifying the minimum requirements to be met by civil status records and consensus on the presumption of their general validity within the EU, once it has been verified that the relevant authority has issued them lawfully.'

363 Committee of the Regions, 'Opinion on Green Paper 'Less bureaucracy for citizens: Promoting free movement of public documents and recognition of the effects of civil status records', [2012] OJ C54/23.

364 European Parliament Resolution of 24 May 2012 on the fight against homophobia in Europe (2012/2657(RSP)) P7_TA(2012)0222). In a Resolution of November 2010 the European Parliament had yet welcomed the Commission's efforts to empower citizens to exercise their free movement rights and 'strongly' supported plans to enable the mutual recognition of the effects of civil status documents. European Parliament Resolution on civil law, commercial law, family law and Private international law aspects of the Action plan implementing the Stockholm Programme, 23 November 2010, P7_TA(2010)0426.

365 Commission, 'Proposal for a Regulation of the European Parliament and of the Council on promoting the free movement of citizens and businesses by simplifying the acceptance of certain public documents in the European Union and amending Regulation (EU) No 1024/2012', COM (2013) 228 final.

366 It was stressed in the proposal (at p. 7) that the draft Regulation did '[…] not deal with the recognition of the content of public documents issued by the authorities of the Member States.'

367 It is noted that this research was concluded on 31 July 2014.

> '[…] concerted efforts at the level of the EU and the Hague Conference for Private International Law in two directions: (i) to study cross-border surrogacy (its nature, magnitude and personal experiences) and (ii) to produce an international Convention on private international aspects of surrogacy arrangements following the model of the Hague Intercountry Adoption Convention.'[368]

Subsequently, in 2013 a comparative study on surrogacy regimes of the EU Member States came out, which also addressed the question of whether there was a need for a common EU approach to the issue (see also 3.4.4 above). The authors of the report alleged that leaving the free movement rules to operate as they did amounted to 'an implicit authorisation of surrogacy'. They also observed that '[…] mutual recognition within the EU (mostly via national laws and not EU law) allow[ed] the desired civil and parental status of children born though surrogacy to be recognised in their State of residence.'[369] Because '[…] a fragile consensus […] in relation to the acknowledgment of the child's civil status and legal parenthood' could perhaps be identified, the authors of the report held it imaginable that EU law 'authorised' what they called 'ex-post mechanisms of recognition'.[370] The report made no specific proposals for possible EU law instruments to enable such recognition, but merely held '[…] a harmonisation of conflict-of-law rules or a mutual recognition' on the basis of Articles 67(4) and 81 TFEU imaginable and '[t]he deepening of civil status mutual recognition […] a good solution'.[371] When no unanimity could be found for such an EU response to surrogacy, the enhanced cooperation procedure was considered 'an interesting one'.[372] Another possible approach suggested in the report was that the EU could join a (to be drafted) international instrument on surrogacy.[373] The report concluded that further research was needed in respect of, *inter alia*, 'the EU legal basis and their potential to frame surrogacy'.[374] The report was presented by the Committee on Legal Affairs in July 2013, but has not resulted in any legislative action at EU level in this field.

3.6.4. The European Arrest Warrant and reproductive matters

Following the adoption of the Council Framework Decision on the European Arrest Warrant (EAW) in 2002, the then existing complex and time-consuming formal European extradition system, was replaced by a system of surrender between judicial

368 European Parliament, Policy Department C, Citizen's rights and constitutional affairs, *Recognition of parental responsibility: biological parenthood v. legal parenthood, i.e. mutual recognition of surrogacy agreements: What is the current situation in the MS? Need for EU action?* Note PE 432–738, 2010, p. 9.
369 Brunet et al. 2013, *supra* n. 134, at p. 197.
370 *Idem*, at p. 197.
371 *Idem*, at p. 198–199.
372 *Idem*, at p. 198.
373 *Idem*, at p. 199.
374 *Idem*, at p. 199.

authorities.[375] This was seen as '[…] the first concrete measure in the field of criminal law implementing the principle of mutual recognition which the European Council referred to as the "cornerstone" of judicial cooperation.'[376]

On the basis of Article 2 of the Framework Decision a European Arrest Warrant may be issued for acts punishable by the law of the issuing Member State by a custodial sentence or a detention order for a maximum period of at least 12 months or, where a sentence has been passed or a detention order has been made, for sentences of at least four months.

Under the old extradition system every extradition request was tested on the basis of the principle of double-criminality following which the acts for which extradition was requested constituted an offence under the law of both the extraditing and the executing Member State. Because this was a time-consuming assessment, the Commission proposed to abolish this principle. This was not, however, acceptable to many Member States, including the Netherlands and Germany. *Inter alia*, concerns were expressed that in some States abortion was perceived as murder or grievous bodily injury and that consequently States with a more liberal regime would risk needing to surrender citizens to States where abortion was criminalised.[377] The Netherlands pled for the drafting of a 'negative' list of offences that would be excluded from the scope of application of the EAW.[378] Such list was to include issues like euthanasia, abortion and certain drugs offences.[379]

A compromise was found by the drawing-up of a list of certain offences in respect of which States have to surrender pursuant to a European Arrest Warrant, without verification of the double criminality of the act. This is the case only if the offences are punishable in the issuing Member State by a custodial sentence or a detention order for a maximum period of at least three years. The list includes, *inter alia*, murder,

375 Council Framework Decision 2002/584/JHA of 13 June 2002 on the European Arrest Warrant and the surrender procedures between Member States, amended by Council Framework Decision 2009/299/JHA of 26 February 2009 amending Framework Decisions 2002/584/JHA, 2005/214/JHA, 2006/783/JHA, 2008/909/JHA and 2008/947/JHA, thereby enhancing the procedural rights of persons and fostering the application of the principle of mutual recognition to decisions rendered in the absence of the person concerned at the trial [2009] OJ L81/24.

376 Recital 6 in the Preamble to Council Framework Decision 2002/584/JHA.

377 Sections 58 and 59 of the Irish Offences Against the Person Act 1861.

378 The implementation of the EAW Framework Decision in the Netherlands involved extensive parliamentary debates, in which concerns were expressed this endangered the Dutch legislation concerning abortion, drugs and – in particular – euthanasia. Other than is the case concerning euthanasia (Art. 13 Overleveringswet [Act on the surrender of persons]) the Dutch implementation Act does not provide for a special regulation in respect of abortion.

379 The Irish Minister of Justice supported the inclusion of list with offences to which the double criminality principles would not apply, but he was against the Dutch proposal. D. Staunton, 'Disagreements slow plans for anti-terrorism laws in EU; A proposed European arrest warrant has caused clashes among states, writes Denis Staunton', *The Irish Times* 17 October 2001, p. 13. Ireland, furthermore, protested as it had to amend its Constitution in order to provide for surrender of its nationals to other EU Member States. 'Euthanasie ongewild hoger op EU-agenda', *NRC Handelsblad* 17 October 2001, pp. 1–2. Compare F. Kools, 'Gedoogbeleid onder vuur EU; Europees strafrecht', *Trouw* 18 October 2001, p. 4.

grievous bodily injury and illicit trade in human organs and tissue.[380] For all other offences, not listed in the relevant Article 2(2), the principle of double criminality applies; surrender may be subject to the condition that the acts for which the EAW has been issued constitute an offence under the law of the executing Member State, whatever the constituent elements or however it is described.[381] Following Article 4(7)(a), the executing judicial authority may refuse to execute the EAW where it relates to offences which are regarded by the law of the executing Member State as having been committed in whole or in part in the territory of the executing Member State.[382]

Article 2(3) provides for a possibility for the Council to extend or amend the list of categories of offence as contained in Article 2(2). It may do so in the light of reports submitted by the Commission on the operation of the Framework Decision.[383] In its 2006 review of the application of the EAW, the Commission observed that some Member States had indeed expressed the intention to review the list of crimes in respect of which the double criminality requirement was lifted '[…] in particular due to concerns in relation to abortion, euthanasia and possession of drugs.'[384] The present author is not, however, aware of any follow-up in this respect.[385] In an annex to its 2011 report, the Commission noted that the Netherlands had stated that it would not surrender a national for the prosecution '[…] for an offence that [was] not an offence under Dutch law, because it [was] impossible under the relevant treaties and the national law to transfer a person where the requirement of double criminality

380 Art. 2(2) Framework Decision 2002/584/JHA.

381 Arts. 2(4) and 5(1) Framework Decision 2002/584/JHA. On the basis of Art. 2 of the Framework Decision a European Arrest Warrant may be issued for acts punishable by the law of the issuing Member State by a custodial sentence or a detention order for a maximum period of at least 12 months or, where a sentence has been passed or a detention order has been made, for sentences of at least four months.

382 As Blekxtoon and Van Ballegooij explain, this provision respects the interests of the requested state might have '[…] in the case *not* being prosecuted, at least in not being obliged to arrest and surrender the requested person, because the act is not punishable under its law and is in that state perhaps even valued positively instead of being condemned.' The authors give 'the obvious example' of ''murder' committed by a physician who has ended the life of an incurable patient (at his/her sincere request) whose severe suffering could no be relieved (euthanasia)'. R. Blekxtoon and W. van Ballegooij, *Handbook on the European Arrest Warrant* (The Hague, T.M.C. Asser Press 2005) p. 161. Under Art. 4(7)(b) such refusal is also permitted if the EAW relates to offences which have been committed outside the territory of the issuing Member State and the law of the executing Member State does not allow prosecution for the same offences when committed outside its territory.

383 Arts. 2(2) and 34(3) Framework Decision 2002/584/JHA.

384 Commission, 'Staff Working Document annexed to the Report from the Commission based on Art. 34 of the Council Framework Decision of 13 June 2002 on the European Arrest Warrant and the surrender procedures between Member States (revised version)', COM (2006) 8 final, p. 6. The Commission held the fact that Belgian legislation provided that abortion and euthanasia were not covered by 'murder or grievous bodily harm', to be contrary to the Framework Decision, since it is the law of the issuing state and not the executing state which determines whether an offence is within the list.

385 The 2009 amendment (*supra* n. 375), did not provide for any such change. A 2011 Commission working documents notes in respect of Belgium: 'The limitation of the list of offences with regard to euthanasia and abortion was made at the time of the legislative adoption of the Belgian implementing legislation. There is no political will to change it.' Commission, 'Staff working document to the 2011 report of the Commission Report from the Commission to the European Parliament and the Council on the implementation since 2007 of the Council Framework Decision of 13 June 2002 on the European arrest warrant and the surrender procedures between Member States', COM (2011) 175 final.

ha[d] not been met.' The Netherlands reportedly did not see a contradiction with the Framework Decision, since the Framework Decision did not regulate return but left that to the Member State. The Commission held it nevertheless to be '[…] clear that one of the principal advantages of this Framework Decision compared with previous extradition arrangements [was] the removal of the double criminality requirement in relation to the Article 2(2) list of categories of offences.' It held that the Dutch position 'obviously' ran counter to this.'[386]

Under the EAW Framework as currently in force, it is, in theory, possible that Member States with restrictive abortion laws, such as Ireland, can issue an EAW in a case where a national had an abortion in a Member State with more permissive abortion regimes. For such an EAW to escape the double criminality requirement, the issuing Member State would have to qualify the offences as any of the offences enlisted in Article 2(2) of the Framework Decision, for example 'murder' or 'grievous bodily injury'.[387] While the minimum requirement of three years of Article 2(2) may have been met in some cases,[388] it is not, from a language perspective a foregone conclusion that the aforementioned qualifications would indeed be employed by the issuing State. The requested State can, furthermore, refuse to execute the EAW if the abortion has taken place on its territory (Article 4(7)(a) of the Framework Decision). Moreover, it may not be very likely that States would indeed proceed to issue such an EAW, not only from a diplomatic viewpoint, considering the sensitivity of the matter in Europe, but also considering the low prosecution practice of most States.[389] Hence, the practical relevance of the EAW for abortion cases may after all prove to be limited.

In respect of AHR treatment or surrogacy no specific concerns were expressed in the process towards adoption of the EAW and the present author is not aware of any such discussions since. It is therefore equally uncertain whether the EAW regime could possibly and would ever be applied to matters related to AHR or surrogacy. As yet open questions are, for example, if trade in gametes could be qualified as 'illegal trade in human cells and tissue', in some circumstances,[390] and whether certain types of AHR treatment could be considered as 'grievous bodily injury' within the meaning of Article 2(2). So far, the CJEU has not given any ruling on these matters.

386 COM (2011) 175 final, pp. 131–132.

387 Douglas-Scott considered abortion to be indeed 'capable of falling within Art. 2(2). S. Douglas-Scott, 'The rule of law in the European Union – putting the security into the area of freedom, security and justice', 29 *European Law Review* (2004) p. 219 at p.225.

388 See for example Ch. 5, section 5.2.8.

389 See for example Ch. 5, section 5.2.9 and ch. 6, section 6.2.4.

390 Blekxtoon and Van Ballegooij have put forward that even if the conduct described in the arrest warrant is not illicit under the law of the state where the arrest warrant is meant to be executed, surrender is not barred 'as the illicit trafficking as such falls within the category and consequently double criminality is not to be verified.' Blekxtoon and Ballegooij, van 2005, *supra* n. 382, at p. 161.

3.7. Conclusions

EU law contains little to no substantial standard-setting in respect of abortion, AHR treatment or surrogacy. These matters have not gone unnoticed at the EU political level, but the EU legislature has been quite firm in stressing that there is no EU competence to regulate for these sensitive issues substantively. EU law only sets certain quality and safety standards for AHR services and for the placing in the market of *in vitro* diagnostic medical devices. While these contain certain rules on the donation of gametes, States are given much discretion in this regard (section 3.3.2 above). The EU's non-discrimination law, furthermore, has only limited implications for Member States' regulation of this area. States must provide for protection of women who are in an advanced stage of IVF treatment against dismissal, but there is no obligation under EU law to grant paid leave to intended mothers who had a child through a surrogacy agreement and restrictions on access to AHR treatment cannot be challenged on the basis of EU non-discrimination law (sections 3.3.3 and 3.3.4).

If one thing, the present chapter shows that as a result of EU (free movement) law EU citizens and residents of EU Member States have a broader range of choice when it comes to medical treatment.[391] Although exhaustive statistics are lacking, it is obvious that such cross-border movement in reproductive matters indeed takes place within the EU (section 3.4). Once treatment can be qualified as a 'medical service' – which is the case when it is lawful in at least one Member State and normally provided for remuneration – the EU regime on cross-border health care as set out in section 3.5 applies. This means that people have access to medical services, including abortion and AHR treatment, that may not be available or even prohibited in their home country. States remain free, however, to decide what treatment they wish to regulate or to prohibit within their own jurisdictions.[392]

While EU law has thus increased access to medical treatment, free movement can, nevertheless, be restrained. For instance, States are under no obligation to reimburse treatment obtained abroad, if that treatment is not among the benefits provided for by their national legislation (section 3.6.2.1). Whether they can set prior authorisation requirements in cases concerning abortion and AHR treatment, can not be said with absolute certainty (section 3.6.2.2). There are equally questions as to the obligations of States under EU law to provide medical follow-up care after a patient has had an abortion or has obtained AHR treatment in another Member State (section 3.6.2.3). It furthermore remains to be seen if the CJEU will some day rule that different regimes

391 Compare Van de Gronden and Szyszczak who held that '[…] the freedom of choice (of medical treatment) of individuals is a value that is protected in the case law of the EU Courts.' Gronden, van de and Szyszczak 2011, *supra* n. 170, at p. 487. De la Rosa observed that '[t]hrough [the] facilitation of access to care, citizens can access forms of care that, in the State in which they are insured, are either non-existent or rare, and thereby benefit from the various structures and health facilities found in different States.' De la Rosa 2012, *supra* n. 33, at p. 23.

392 Presumably, it is for that reason that Hervey and McHale observed in 2004 that until that time, 'little concrete success' could be reported in cases where parties had, by relying on EU law, sought to undermine national legal standards on human reproduction, including those enshrined in national constitutions. Hervey and McHale 2004, *supra* n. 47, at p. 153.

in respect of abortion, AHR treatment and/or surrogacy may in themselves constitute an obstacle to free movement (section 3.6.2.5). What seems established, however, is that States must actively provide information about foreign abortion services and AHR treatment options through national contact points (section 3.6.2.4). This does not hold for surrogacy, however, as that does not qualify as health care under the Patient Mobility Directive.

In respect of surrogacy there is certainly nothing provided at EU level. Intended mothers are not protected under EU employment law (section 3.3.4) and none of the existing EU PIL instruments provides for the recognition of parental links established in another Member State (section 3.6.3). The latter issue has, however, caught the attention of EU institutions and the first careful initiatives have been taken that could lead to the adoption of EU instruments in the future. Whether this indeed materialises, yet remains to be seen, particularly now that unanimity in the Council is required. In any case, any possible EU instrument could only regulate for cross-border surrogacy cases within the EU, while in many international surrogacy cases third countries are involved.

All in all, while EU law may potentially have even more impact on the reproductive matters that are central to this case study, it may well be that this potential will not be exploited, exactly because of the sensitivity of the matter at stake.