

Power Puzzle -
The European Court of Justice as
Super-Agent in Healthcare Policy
Bachelor Thesis

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List of Abbreviations

AGs	Advocates General
EC	European Communities
ECJ	European Court of Justice
ECSC	European Coal and Steel Society
EEC	European Economic Community
EHC	EuroHealthConnect
ES	European Studies
EU	European Union
MLG	Multi-Level Governance
MS	Member States
NHS	National Health System
P-A	Principal-Agent
QMV	Qualified Majority Voting
SEA	Single European Act
TEU	Treaty on the European Union
TFEU	Treaty on the Functioning of the European Union

Preface

Throughout my Bachelor program “European Studies” (ES), integration has always been a central topic which caught my eye. Whether it was economic, legal, and political or social based – I have always had an interest in the dynamics European integration brings. I learned to understand the historical beginning of integrating Europe but also became aware of the difficulties that arise when all sort of actors are involved. When unfolding the story of European integration in order to comprehend why some EU policies develop and some do not, and to understand the limits of Europeanization, two fundamental theories come into play. These are neofunctionalism and intergovernmentalism. Throughout the ES literature they seem to be the most popular and students of European Studies will probably notice them as two constants in their program, whether they like it or not. I was one of these students and even though neofunctionalism and intergovernmentalism were my enemies at times, when writing this Bachelor thesis we became close friends. In my view, they still serve as the central theoretical perspectives of European integration.

Next to my study I worked as a student assistant at EuroHealthConnect (EHC) which is a Dutch-German competence centre located in Enschede, the Netherlands. It connects healthcare sectors in the entire border area through a large network of experts and aims to open the healthcare sector along the border. As a student of European Studies this was, and still is, highly interesting as healthcare is something that concerns every EU citizen. Annette Dwars and Antje Wunderlich, who lead EHC, gave me the opportunity to get a closer insight into the world of (cross-border) healthcare especially in the Dutch-German border area and provided me with knowledge additional to my expertise in European Studies. I learned a lot about the administrative and legal background of healthcare in both countries and was particularly attracted to the EU Directive on patients’ rights in cross-border healthcare. Being an EU instrument, I started asking myself about the development of it, as I knew from my Bachelor program that the welfare state, hence also healthcare, is a Member States’ only competence. A Directive however would address Community legislation into each Member State which would be binding and had to be transposed into national law (Hix, 2005). I gathered a lot of experience and my interest in healthcare policy was sparked, leading to this Bachelor thesis. Therefore, I want to thank Annette and Antje from EHC.

Personally, I feel that healthcare is the least favourite topic in the political arena. Also in my Bachelor program, healthcare has never been addressed. The European welfare state was discussed around the topic of social policy, but only to the extent of unemployment, poverty and workers’ rights. Moreover, I sense that EU citizen are not really aware of the EU’s impact on their daily life especially when it comes to their rights in their neighbouring countries. With this Bachelor thesis I want to awaken the reader’s interest and awareness of healthcare policy and to enrich their knowledge about their rights in healthcare.

The completion of this Bachelor thesis would not have been possible without Minna van Gerven and Veronica Junjan, who served as my supervisors. Their constant motivation, constructive critique and encouraging comments on my draft have helped me a lot in accomplishing this thesis. Thank you!

Abstract

The free movement principle is one of the cornerstones of the European Union. It therefore also applies to the mobility of patients and medical services. Every EU citizen is allowed to seek medical treatment in another Member State while its health insurance is obliged to reimburse the costs. The existing rules on cross-border healthcare in the EU have a long history of the ECJ pushing healthcare integration forward versus Member State opposition. Next to analyzing the general role of the ECJ in the EU, this research examines the Court's role in healthcare policy. Furthermore, it analyzes the role of the Member States in healthcare in order to determine the relationship between the ECJ and national governments. Intergovernmentalism, Neofunctionalism and the Principal-Agent framework is being used to explain how the ECJ was able to boost healthcare integration despite Member State opposition. The key in answering this puzzle lies in the relationship between Principal and Agent. Although the Member States had a serious chance in resuming their authority, they were not able to achieve this and remained an ordinary Principal. Having received delegated authority by the Member States but without a serious questioning of their powers, the ECJ was enabled to stimulate spillovers by pushing economic integration forward and applied internal market principles into healthcare. Slowly, the Court evolved into an extraordinary Agent, a Trustee.

CHAPTER 1

Introduction

The Development of Social Policy
 The Role of the European Court of Justice
 The ECJ and EU Health Policy
 Problem Statement and Research Questions
 Theories to Support the Research
 Structure

1.1 The Development of Social Policy

National social policy systems are formally reserved for the Member States and constitute a core element of national competences. Therefore, until the late 1990s, social Europe was hardly visible compared to the internal market and the monetary union and social aspects of the original EEC Treaty in 1957 were guided mainly towards guaranteeing the economic goals of the Economic Community (Kleinman, 2002; Schelkle, 2003). In the Treaty of Rome, the section on social policy identifies several social fields: employment; labour law and working conditions; vocational training; social security; occupational health and safety; collective bargaining and right of association. In these fields Member States were supposed to cooperate closely. One of the most significant social policy provisions in the Treaty of Rome was the social security regime for migrant workers which is to be found in the section on the free movement and mirrors a restriction of social aspects to removing barriers to labour mobility (Kleinman, 2002; G. Majone, 1993).

Nonetheless, the issues defined as social policy in the Treaty and the limited role of the Community laid down in Title III – promoting close co-operation by making studies, delivering opinions and arranging consultations - illustrate that the social policy domain was originally regarded to be outside the supranational competence of the Union and limited to economic aims of integration. Therefore, social policy belonged to the Member States' competence with the Community's ability limited to further cooperation between the Member governments. Hence, any Directives in the field of social policy needed unanimity in the Council of Ministers.

With the Single European Act (SEA) in 1986 the original EEC Treaties faced a first revision by the Member States. As in the previous years, economic aspects, hence the single European market and the free movement of goods, services, labour and capital were on the main agenda. Therefore, social policy did not play a considerable part of the SEA (Kleinman, 2002). Nugent (2010) on the other hand argues, that the SEA gave a major boost to Community social policy by extending Qualified Majority Voting (QMV) in the Council of Ministers to several policy fields which gave the Community more power to regulate in particular in the field of occupational health and safety under Article 118. By believing that the Single European market should have a social dimension, the Commission introduced the *Community Charter of Fundamental Social Rights for Workers*. One of the main principles were the free movement of workers on the basis of equal treatment in access to employment

and social protection (Nugent, 2010). Eventually however, despite the insertion of “social cohesion” into the SEA (Nugent, 2010), the social dimension can be viewed as minimal. Basically, as Falkner (1998) puts it, the social features of the Act were a “selective political spillover” related to the market purposes of the SEA.

The Maastricht Treaty in 1992, which formally created the European Union, again extended QMV to the policy areas of: health and safety at work, working conditions, information and consultation of workers, equality between men and women, and integration of persons excluded from the labour market (Kleinman, 2002). In the areas of social security and social protection of workers for instance, decisions remained having unanimous agreement. Each Member State therefore kept a veto right in decision making. A vital point to be raised is the emphasis on the principle of subsidiarity the Treaty placed. According to Article 5 *“the Community shall act within the limits of the powers conferred upon it by this Treaty and of the objectives assigned to it therein. In areas which do not fall within its exclusive competence, the Community shall take action, in accordance with the principle of subsidiarity, only if and in so far as the objectives of the proposed action cannot be sufficiently achieved by the Member States and can therefore, by reason of the scale or effects of the proposed action, be better achieved by the Community. Any action by the Community shall not go beyond what is necessary to achieve the objectives of this”*. For social policy, falling outside the Community’s exclusive competence, this emphasis meant a more rational and cautious approach in which a top-down harmonization had no room. Member States had always been sensitive towards an interventionist social policy and this time the EU’s institutions had accepted the Member State’s aversion to a harmonization of their social systems.

The Amsterdam Treaty as the Treaty of Nice too did not bring groundbreaking changes to social policy and the division of competences. The Amsterdam Treaty reaffirmed that social policy is a shared competence of the Community and its Member States. Therefore, the EU was empowered to support and complement the Member State’s actions. The recent Lisbon Treaty distinguishes between three main types of competences: exclusive competences, shared competences and supporting competences. Regarding social policy, this field again is characterized as shared competence based on Article 4 of the TFEU and both the Community as the Member States are authorized to adopt binding acts.

Throughout the years it becomes clear that the EU’s social policy role and authority remains restricted to market-related issues focussing upon minimal labour market regulations (Bailey, 2008). The completion of the internal market and the principle of free movement continue to have the highest preference. Therefore, social policy making at the European level differs significantly from traditional mainstream social policy issues of the Member States in which the welfare state is responsible for supplying social goods such as healthcare, social insurance and welfare services (Hix, 2005).

1.2 The Role of the European Court of Justice in Social Policy

The process of Community (social) policy has awarded EU citizens several socio-economic rights based on the Treaties. If we consider the Treaties as the primary source of law, the

European Court of Justice comes into play as the Member States have given it the right to apply this fundamental origin.

The Treaties have given the European Court of Justice the power to interpret EU law and to make sure it is applied in the same way in every Member State. It is allowed to settle legal disputes between Member State governments and EU institutions. Individuals, organisation and companies also hold the right to bring a case before the ECJ when their rights have been infringed by the EU (Europa.eu, 2012). In sum, the ECJ has jurisdiction in three main areas: infringement proceedings, judicial review and preliminary rulings.

Because the Treaties are the primary source of EU law, which Hix (2005) acknowledges as “incomplete contracts”, the ECJ holds the view that its task is to accomplish the Treaty objectives (Fennelly, 1996). Moreover, it sees itself as being involved with the development of Community law with the Treaties guaranteeing individual rights beyond solely economic aims. As a powerful supranational court the ECJ will therefore always try to enforce the legal system with the Treaty provisions at heart. Because the treaties can hardly account for all possible developments, they will always be incomplete, as mentioned before. This creates a competency gap in which the ECJ can use its discretion and thus shape policy outcomes beyond the legislator’s intention. Throughout the years however, the ECJ has not only shaped policy outcomes but has established certain competencies of their own that Member States, when signing the original Treaties, did not aim for. In this regard it is questionable, whether the EU’s founding fathers ever realized the potential long-term implication of the legal system created by the Treaty of Rome (Hix, 2005).

Concerning social policy the Court is basically out of range. Especially welfare systems, as mentioned before, remain Member State responsibility. However, Wasserfallen (2008) and Martinsen (2005) have noticed several policy fields where the ECJ has become active despite a prevailing formal responsibility of the Member States. One policy field in which the Court’s activism stands out is healthcare. Traditionally, health has been an area of sole Member State competence and is an essential part of government welfare provision (Brooks, 2012). EU action is limited to aspects of public and occupational health which are connected to the EU’s internal market. Therefore, healthcare constitutes a core aspect of the national welfare state and the EU has no formal competence to regulate national healthcare according to the Treaty. Nevertheless, the ECJ’s activism and its judgements in this field have expanded the EU’s role in health policy and established competencies – a creation of EU competency that Member States never aimed for (Greer, 2006).

1.3 The ECJ and EU Health Policy

Over the years, the Member State’s authority in healthcare has been questioned several times which lead to momentum judgements by the European Court of Justice. In this regard, the *Kohl/Decker* cases in 1998 can be seen as landmark rulings which will be explained later in this research. On the political side, a newly adopted EU 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 evolved. The so called “patient mobility Directive” (Niggemeier, 2011) is supposed to cover all EU citizen that wish to receive medical treatment in another Member State and pursues to bring a clear framework for cross-border treatment in which the

reimbursement of costs that arise abroad becomes more transparent to patients. It needs to be clarified, that the EU Directive has not been implemented yet. It has been adopted on 9 March 2011 but implementation by the 27 Member States is still awaited.

This shift or delegation of power to the supranational level has been recognized to a high extent in the literature and voices have been raised towards a “Europeanization” of healthcare (D. S. Martinsen, Vrangbaek, K. , 2008) especially when it comes to patients seeking healthcare in another Member State. Martinsen et al. (2008) argue that EU intervention in the field of healthcare has developed through extensive rulings of the European Court of Justice (ECJ). Its judgments have brought European patients’ rights into focus and intervene in the national sphere of governance. Thus, over the years a delegation of power to the supranational level has been noticed by several scholars such as Greer (2006) and Mossialos and Palm (2003). Sandholtz and Stone Sweet (2010) argue that the ECJ as well as the European Commission have produced rules and policies that the Member States would not have adopted through intergovernmental bargaining. Therefore, the “rules of the game”, as Sandholtz and Stone Sweet (2010) put it, have not only been challenged but have changed significantly. Especially the European Court of Justice has succeeded in expanding its own zone of discretion through the doctrines of supremacy and direct effect in the past. By so doing, the Treaty of Rome has been constitutionalized steadily. With regard to the healthcare sector it becomes clear that the ECJ has too extended EU rules in this policy field. Martinsen (2005) states the ECJ has applied internal market rules embodied by the four freedoms into the healthcare sector which created EU authority in this field even though Member States had been opposed to this development energetically. When taking a closer look at the ECJ’s judgments concerning patients seeking healthcare abroad, Member State governments have been brought in many opinions and joint together to oppose these ruling (D. S. Martinsen, 2005). The ECJ has thus intervened in the national autonomy while the Courts’ autonomy and authoritative position has increased considerably

1.4 Problem Statement and Research Questions

When we take a closer look at the developments of judicial power in healthcare at EU level, we become aware of a certain paradox: Even though there is no exclusive EU competence in healthcare and the Member States are clearly against an intervention into their health systems, there has taken place more and more healthcare integration at EU level with the ECJ playing a central role. The policy domain of healthcare is by no means an “island beyond the reach of Community law” (D. S. Martinsen, 2005) anymore. Therefore, the question arises: how can we explain this paradox? This research will dig deeper into that issue and will study the following research questions:

How can we explain that even though there is no exclusive EU competence in healthcare and Member States have been opposing Community intervention, the ECJ has been able to boost healthcare integration?

1. What is the role of the Court in EU policy-making?

This question will provide an overview about the general role of the European Court of Justice in the EU and in EU policy-making. Therefore, it will explain Treaty provisions according to which the Court presides and on which grounds its jurisdiction is based.

2. What is the role of the Court in EU health policy?

This question will take the sample of patient mobility at heart and analyzes the most relevant case-law in cross-border healthcare such as the *Kohll/Decker* cases. The Courts' reasoning will be analyzed in order to compare its range to the general role and authority of the ECJ.

3. What is the role of the Member States in (cross-border) healthcare integration and what are their opinions?

As every new Treaty has reaffirmed that healthcare is left for the Member State, it should be clear that governments never actually pursued Community intervention into this field. This question will analyze the Member States' involvement and its (opposing) opinions regarding cross-border healthcare. It will do so by analyzing Member State observations included in the Court's judgments.

1.5 Theories to Support the Research

To describe the role of the European Court of Justice in healthcare policy, the following research will use neo-functionalism and intergovernmentalism theory and delegation – or “Principal-Agent”- theory which has been the most used framework by social scientists in research on the ECJ. Principals are actors who create Agents through conferring or delegating some authority to govern and to make legally-binding decisions. In the case of the EU, the Member States are the Principals in that they designed the Community framework and in the sense that they are able to revise the Treaty under unanimity. While Pollack (1997) focused more on the Commission than the Court, scholars such as Stone Sweet (2010) put emphasis on the ECJ as Agent. A sophisticated and neo-functional account of the standard Principal-Agent theory began to develop proposing a model of “Trusteeship” (A. Stone Sweet, 2010) in which the European Court of Justice is seen as Trustee or “super-Agent” rather than an Agent. This model is used for situations in which the Member State governments have transferred rights to EU organs. Hence it applies to the Commission but also to the ECJ which therefore holds the capacity to extend its own zone of discretion by interpreting the law and the scope of its own powers (A. Stone Sweet, 2010).

1.6 Structure

This chapter has given an introduction about the shift or delegation of power to the supranational level in health policy and has provided an overview about the theory the

research uses. The following chapter provides the theoretical framework, while chapter 3 grants the research methodology including how data is collected, cases selected, how the analysis is conducted and a short description of methodological issues. Chapter 4 gives a brief historical insight about the development of the mobile patient in the EU in order to give an understanding of the concept of cross-border healthcare policy used in this research. Chapter 5 provides the main part of the research, the analysis. It uses neo-functionalism, intergovernmentalism and Principal-Agent theory to explain how more and more healthcare integration could take place despite Member States' aversion. Chapter 6 provides a critical discussion on the ECJ as Trustee in healthcare. As healthcare is only one aspect of social Europe, it will discuss implications of the Court as Trustee in the Social area. In Chapter 7 the research will draw a conclusion.

CHAPTER 2

Theoretical Framework

Intergovernmentalism vs Neofunctionalism

Principal-Agent Theory

The Court as Trustee

Theories combined

Critique

The previous chapter gave an insight about cross-border healthcare and the policy side thereof as laid down in the evolvement of EU 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. What is somewhat hidden though is the fact that, as stated in the introduction, European healthcare integration has led to national healthcare becoming regulated by Community competences. Whereas politicians of the Member States have been strongly against a European healthcare dimension, EU citizens now have access to medical treatment everywhere in the European Union while being reimbursed by their national insurance institution as laid down in the new EU Directive. In chapter 2 the research already referred to the Kohll and Decker cases as part of extensive ruling of the European Court of Justice that led to a first ground-breaking modernization of cross-border healthcare regulation. Therefore this research argues in line with Martinsen (2005), de Burca (2005) and Haas (1970) that the EU ever came to regulate national healthcare did not occur as an effect of political decision-making, but rather as a side effect or spillover of the ECJ's legal regulation from the narrowly economic provisions into healthcare. The following chapter outlines the two-folded theory behind this argument which will be used in this research.

2.1 Intergovernmentalism vs Neofunctionalism

When theorizing European integration, neo-functionalism and intergovernmentalism are undoubtedly the most famous theoretical narratives. Both theories serve to explain why and how supranational institutions are established and developed. However, in their explanation they take on very opposing arguments which will be described in the following.

Intergovernmentalism is an approach to European integration that treats states and national governments as the primary actors (Rosamond, 2000). Therefore, states pursue their interests within an anarchic environment and will use the institutional framework of the EU to push forward their preferences. They not only do so to pursue their interests, but also for the purpose of domestic legitimation. Consequently, the behavior of supranational actors such as the Commission, the European Parliament and the European Court of Justice mirrors the self-interest and preferences of Member States. States use institutions to establish their personal, advantageous positions and to secure their interests. By doing so, compliance from other Member States is ensured, too. This explains why Member States are willing to give away

sovereignty to supranational institutions as it leads to a “positive sum game”; a win-win situation (A. Moravcsik, 1998).

A competing theoretical account of European integration that has been critiquing Moravcsik and other advocates of intergovernmentalism is neofunctionalism, built on the work of Ernst Haas (1958) and Leon Lindberg (1963). Neofunctionalism maintains that integration and the growth of authority at the supranational level develops as a long-term consequence of economic integration (Rosamond, 2000). Integration in one sector, the completion of the European single market for instance, generates pressures for integration in another related sector. This specific development is described as *functional spillovers* that are stimulated by supranational institutions. Therefore, EU bodies will always work to create pro-integrative policies and function as “engines of integration” even when these are opposed by the most powerful Member States (Pollack, 1997; Sandholtz & Stone Sweet, 2010).

In summary, we can see clearly that these theories provide an excellent explanation of the healthcare integration paradox mentioned in the problem statement. Both theories describe (healthcare) integration and provide for two different angles towards an explanation of how healthcare policies are developed. Whereas intergovernmentalism points at the central role of the Member States in EU policy-making and underlines Member State preferences are being mirrored in supranational institutions, neofunctionalism takes on a competing view. Neofunctionalism puts supranational institutions first that stimulate functional spillovers. This means that integration in the healthcare sector can be explained by pressures for integration in another related sector. Both theories allow us to extract two hypotheses in order to answer the first research question:

Intergovernmentalism: EU Healthcare policies develop by mutual agreement, mirroring Member States’ preferences.

Neofunctionalism: EU Healthcare policies develop by spillovers that are stimulated in another related policy area through supranational actors.

2.2 Principal-Agent Theory

Contemporary delegation – or “Principal-Agent”- theory (P-A), which originated in the economics of organization, has been the most used framework by social scientists in research on the ECJ. In EU studies, variants of this theory started to appear in the 1990s with Pollack’s (1997) research, while focusing mainly on the European Commission than the ECJ, being one of the most sophisticated. By definition, delegation of authority takes place by one or more principals to one or more agents (Pollack, 1997). Principals are actors who create Agents through conferring or delegating some authority to govern and to make legally-binding decisions. In the case of the EU, the Member States are the Principals in that they designed the Community framework and in the sense that they are able to revise the Treaty under unanimity. While Pollack (1997) focused more on the Commission than the Court, scholars such as Stone Sweet (2010) put emphasis on the ECJ as Agent. But why delegate?

Pollack (1997) identifies four reasons or “functions”, as he puts it, that explain why principals choose to delegate authority. To begin with, supranational agents are able to

monitor participant's compliance with Treaty provisions. Because principals do not have access to perfect information on every participant, agents can bundle information and provide it to all actors. By doing so, transaction costs are reduced and cooperation is encouraged. Second, agents can resolve problems of incomplete contracting. Whether it is an agreement between two companies concerning the design of a new product or an agreement between Member States to establish a single market, both can be regarded as a contract. However, Milgrom and Roberts (1990) view agreements between contracting parties as merely framing their relationship instead of laying down all possible events. This suggests constructing general expectations, procedures to direct decision-making and displays how disputes are settled. The creation of an agent might not be necessary at all times. Nevertheless, if uncertainty about future decision-making is great, actors delegate authority to agents such as a Court which can then fill in the gaps of an incomplete contract. Third, principals delegate authority to an agent in order to adopt complex regulations that could not be dealt with by all the different actors involved and because an independent regulator would possibly be more restrictive than the agents as they will tend to be more lenient with their domestic partners. Fourth, delegation of authority occurs in order to prevent an endless series of policy proposals. When every actor has the right to initiate proposals, equilibrium is hard to be reached. Therefore, the power of agenda-setting is delegated to an agent who is then allowed to initiate policy proposal on behalf of the principals.

Delegating authority to a higher level of jurisdiction can make things easier but contains certain risks which can be defined as “agency losses” (Pollack, 1997). The Agent is supposed to share the same preferences as the Principal, but an Agent can develop own interests leading to an interest conflict. Moreover, the structure of delegation can provide incentives for the Agent to behave contra Principal preferences which Pollack (1997) calls “slippage”. This inimical behavior can be intensified through information asymmetry which means that the Agent is likely to hold more information about itself than the Principal.

2.2.1 The Court as Trustee

A sophisticated and neo-functionalist account of the standard Principal-Agent theory began to develop proposing a model of “Trusteeship” (A. Stone Sweet, 2010) in which the European Court of Justice is seen as trustee or “super-Agent” rather than an Agent. It got proposed by many scholars such as Stone Sweet and Carporaso (1998) and Majone (2001) as they started to question the applicability of the standard Principal-Agent framework to EU judicial politics. Especially because they noticed the supranational organ's authority to monitor governments' compliance with EU law and their ability to discipline Member States for non-compliance, Majone (2001) introduced the model of Trusteeship which is used for situations in which the Member State governments have transferred rights to EU organs. Hence it applies to the Commission but also to the ECJ which therefore holds the capacity to extend its own zone of discretion by interpreting the law and the scope of its own powers (A. Stone Sweet, 2010). Trusteeship assumes that the European Court of Justice can act independently from EU governments and is therefore able to govern the Principals themselves (Sandholtz & Stone Sweet, 2010; Tallberg, 2000). Therefore, a Trustee court holds the power to expand its

own zone of discretion by interpreting provisions and the scope of its own powers (A. Stone Sweet, 2010). On this basis, the research formulates a third hypothesis:

In healthcare policy, the European Court of Justice acts as Trustee.

Stone Sweet (2010) views this concept to be appropriate as three criteria are met:

- | |
|--|
| a. The Court possesses the authority to review the legality of, and to annul, acts taken by the EU’s organs of governance and by the Member States in domains governed by EU law. |
| b. The Court’s jurisdiction, with regard to the Member States, is compulsory |
| c. It is difficult or impossible for the Member States-as-Principal to “punish” the Court, by restricting its jurisdiction, or reversing its rulings. |

The research will use this theoretical explanation in order to answer the second research question. To underline the neofunctionalist narrative and to make analyzing case-law better approachable, the research will add a fourth criterion;

- | |
|--|
| d. The Court is able to govern the principals themselves, thereby generating policy outcomes that would not have been adopted by the MS, given existing decision-rules. |
|--|

2.3 Theories Combined

In order to answer the third research question, the following presents a theoretical narrative that explains how Member States against all odds seem to allow the ECJ to take the lead in healthcare.

The research will again use intergovernmentalism vs neofunctionalism and Principal-Agent theory, thereby applying the spillover concept and considering the Member States as Principals. Intergovernmentalism lets the Member States in complete control of the Agent. Governments that sign European treaties therefore know exactly what they are doing and hold irrefutable discretion; they are “in the driver’s seat” (Tsebelis & Garrett, 2001). EU bodies are just carrying out the Member States’ wishes (G. Garrett, 1992).

Whereas intergovernmentalism emphasizes Member States as central actors that remain in complete control in EU policy making and seem to allow supranational actors to take the lead, neofunctionalism argues that Member States play a rather subordinated role. It also claims that supranational actors play an essential and even independent role in promoting integration (Sandholtz & Stone Sweet, 2010). Therefore, the Agent does not only reflect the Member States’ preferences but also its own agenda. As an effect, EU bodies have achieved

considerable autonomy and are able to expand their own authority. Consequently, while Member States delegated authority to supranational organizations in order to improve the credibility of their agreements, they generated the possibility for EU organs to act in their own interest. This created unintended consequences or spillovers meaning that outcomes occurred which would not have produced by the Member States. The development of more and more healthcare integration is therefore the central unintended consequence being dealt with in this research. Neofunctionalism questions, whether Member States de facto allowed the ECJ to boost healthcare integration.

In Hass' original version of neofunctionalism, law did not play a significant role in transferring authority. Still, De Búrca (2005) points at the central concept of spillover that can be used for the expansionary nature of EU law. Spillovers can therefore be identified in the way the Court interpreted main provisions of the Treaties to cover situations which were outside their usual application. This can be seen for instance in the application of free movement principles to the area of health. Moreover it can be recognized in the way EU legislative competences affecting the internal market were used by political entrepreneurs to adopt measures in fields that were originally left for the Member States.

Based on the above, the research formulates a fourth hypotheses:

In healthcare policy, the Member States act as Principals.

To sum up, there are two approaches explaining healthcare integration and supranational power in the EU. Whereas an intergovernmentalist narrative of the Principal-Agent construct gives the Member States a central role and leaving them in complete control over the Agent, the neofunctionalist account maintains that integration and the growth of authority at the supranational level develops as a long-term consequence of economic integration (Rosamond, 2000). Integration in one sector, the completion of the European single market for instance, generates pressures for integration in another related sector; healthcare. This specific development is described as *functional spillovers* that are stimulated by supranational institutions. Therefore, EU bodies will always work independently to create pro-integrative policies even when these are opposed by the Principals. Because Member States have initially agreed to take steps towards integration, the process “took on a life of its own” (George, 2004).

In result, the concept of spillover combined with the original Principal-Agent framework provides a valuable explanation of the expansionary role of ECJ in healthcare. The combination of the two is essential also because the Principal-Agent framework by itself does not provide a fully causal theory (A. Stone Sweet, 2010). The Principal-Agent framework has been used in conjunction with intergovernmentalism (G. Garrett, 1992; A. Moravcsik, 1998) and neofunctionalism (Alec Stone Sweet & Carporaso, 1998) before and will therefore be used in combination with both theories in this research.

2.4 Critique

Intergovernmentalism and neofunctionalism, as well as Principal-Agent Theory, seem to be the most famous accounts of European integration and of the dynamics between national and

supranational actors. But do they deserve this extraordinary recognition or should we allow for alternative explanations? Put differently, what are the limits to these theories?

Neofunctionalism is a theory of integration. It is able to explain why states delegate power and authority to supranational institutions. It therefore also explains how the ECJ was able to receive such great power in healthcare. On the other hand, it does not give us a proper understanding of why governments first agreed to delegate authority and seem to refrain from it nowadays (Schmitter, 2004). Moreover, some scholars hold the view that neofunctionalists are not particularly good in predicting the development of European integration (Hoffmann, 1964; Rosamond, 2000). Hoffmann (1964) argues that neofunctionalism puts more emphasis on the integration *process* and therefore neglects the (historical) *context*. By doing so, he gives more leeway to an intergovernmentalist approach which would argue that Member States have always been in control of the integration process. When we take a look at the very beginning of the EU, this argument can actually be confirmed. For instance, in the early 1960s integration faced a slowdown due to intensive opposition by French President Charles de Gaulle and Member States were not willing to compromise their sovereignty which in return left them autonomous (Rosamond, 2000; Webb, 1983). On the other hand, Treaty engagements made in Maastricht, Amsterdam, Nice, Lisbon and the commitment to common policies in foreign affairs and economic affairs turn attention to a very different experience of European integration. All these developments can serve as examples where governments freely and willingly gave up control over certain parts of national sovereignty (Rosamond, 2000). As Ben Rosamond (2000) describes in his interpretative account of European integration, the European Union is a highly complex construct.

Still, intergovernmentalists remain rival and accuse neofunctionalists of “alleged implausibility” (Rosamond, 2000). As outlined before, intergovernmentalists claim that the Member States continue to have relevance and whatever happens this will never change. Nevertheless, neofunctionalism keeps its strength which lies in its “simplicity and testability” (McGowan, 2007). Despite intergovernmentalists arguments, neofunctionalism seems to offer the most plausible account and logic of European integration and supranational power. To what extent this argument can be presumed, will be tested in this research.

As shown in the above, intergovernmentalism and neofunctionalism are the most popular theories in theorizing the EU. But are there alternative explanations of European integration and the of the power play between the national and supranational level? Whereas intergovernmentalism underlines the important role of the state and conceptualizes the EU in “a single-level model of intergovernmental interactions” (Scharpf, 2001), neofunctionalism treats supranational institutions as central in the European policy process. Therefore, both theories argue from two very different starting points.

Multi-level governance (MLG) literature tries to combine both accounts and discusses the complexity of the EU’s system (Rosamond, 2000). Belonging to the second phase of theorizing the EU, it states that Member State’s autonomy is indeed at stake, just as intergovernmentalism has argued before. Rosamond (2000) shows that Marks et al (1996) put this reasoning in perspective as states “are melded into the multi-level polity by their leaders and the actions of numerous subnational and supranational actors”. A multi-level polity refers to different sorts of jurisdictions a given territory, say Member State, has and defines several levels such as local, regional, national and supranational level (Hooghe & Marks, 2003).

Therefore, Member States maintain being of vital importance within a multi-level system but lose some control and authority as it is distributed between these different levels and especially at the supranational level. Using Multi-level governance in this research is problematic as it does not provide a proper theory but merely a framework (Rosamond, 2000). Moreover, it is only able to describe a multi-level system and cannot direct or predict the relationship of nation states and supranational actors. The delegation of sovereignty is also not something being dealt with in particular, whereas intergovernmentalism and neofunctionalism do address Member State sovereignty specifically. This research wants to explain healthcare integration and the dynamics of delegation. Therefore, MLG does not present a suitable explanation of the power puzzle being addressed in this Bachelor thesis. Intergovernmentalism and neofunctionalism illustrate the best theoretical explanation for the topic being dealt with in this thesis.

Next to theories of integration, this thesis uses the Principal-Agent framework. This chapter already mentioned that it is more a framework than a theory and will therefore be used in combination with the theories of intergovernmentalism and neofunctionalism. Scholars such as Garrett and Weingast (1993) have used a general Principal-Agent approach before to explain the ECJ as Agent, which shows features of an intergovernmentalist approach. Karen Alter (1998) underlines this but also states that this general account is rather “misleading” as it misses the significance of the Court’s power. She argues that the Member States intended a European Court that could not considerably jeopardize national sovereignty or Member State preferences. Though originally thought as fulfilling only a “checking role” (Alter, 1998) and administrating Member State interest, the ECJ as Agent developed having its own and different agenda. Especially with regard to the doctrines of direct effect and supremacy that were introduced by the ECJ, the Court aimed at receiving as much delegated powers and autonomy as possible. In this regard, the risks Pollack (1997) summarized as “agency loss” need to be considered intensely and it should be clear that the criticism of the general, more intergovernmental account of the Principal-Agent framework is based on neofunctionalist reasoning.

This research uses the Principal-Agent framework as an explanation of the ECJ’s role and of the role of the Member States. Especially because it will be used together with intergovernmentalism and neofunctionalism, this results in a problem. Kassim and Menon (2003) warn against a “collapse into the intergovernmentalism–neofunctionalism rivalry”. While an intergovernmentalist approach could overlook the organizational imperfection of Member States, neofunctionalists could disregard government’s ability to “learn” and to limit the ECJ’s powers. Another problem of the P-A framework is the limited amount of Agent. As mentioned earlier, Pollack (1997) focused on the European Commission as Agent in the EU. On the other hand, Stone Sweet (2010) focused on the ECJ as Agent in Europe. Kassim and Menon (2003) view this as problematic as it disregards a possible interaction of multiple Agents. Therefore, this thesis will regard these aspects and treat them carefully.

A possible alternative to the P-A framework is Sabatier’ top-down and bottom-up implementation or policy network (1999). According to Weible (2012), it is one of the most influential theoretical approaches of policy processes that aims to explain the change and development of a policy but also the change and evolvement of related actors. As the theory’s name already depicts, Sabatier’s theory (1999) has been triggered by a debate on whether

decision-making is top-down or bottom-up hence whether policy reflects the interest of “governing elites” (Walt, 2008) or the preferences from the lower level. Again, this is just a framework and does only provide us with a descriptive manner of analyzing. Certainly, the P-A framework is not a theory either but receives its strength from the interaction with integration theories.

An alternative way to explain the role of the Member States is the so-called “joint-decision mode” (Alter, 1998; Scharpf, 2001) which is a mechanism that combines aspects of intergovernmentalism and neofunctionalism. Scharpf (2001) states that policy choices depend on “strategies of supranational actors, and on the convergence of preferences among national governments (...)”. This means that if Member States unite in their aversion towards the ECJ, supranational decisions can be blocked. If governments’ preferences diverge and decision cannot be reached through unanimity or QMV, they are trapped and the supranational actors prevail. This situation is also called “joint-decision trap” (Alter, 1998).

Despite criticism towards intergovernmentalism, neofunctionalism and the P-A framework, this research will use a combination of them as they provide a very consistent and logical theoretical foundation. The critical arguments being raised are not making them mutual exclusive. As the joint-decision mode is a mechanism which is closely related to intergovernmentalism and neofunctionalism, the research will use this as additional explanation on the role of the Member States.

CHAPTER 3

Research Methodology

Data Collection

Case Selection

Data Analysis

Reliability

The previous chapter provided a detailed outline of the theoretical framework used in this research. It explained the Principal-Agent framework and pointed at two competing accounts of European integration and the extension of supranational power; intergovernmentalism and neofunctionalism. This chapter will give a layout of the research methodology. It will sketch out the data collection, data analysis and will give a brief description of methodological issues.

3.1 Data Collection

Data collection will be conducted in order to answer the research question. Therefore, treaty provisions on the ECJ, hence the grounds for its jurisdiction, will be collected in a first instance. The research will do so in order to provide an overview about the ECJ's composition, role and powers in the EU and to answer the first research question. Secondly, the most relevant case-law in cross-border healthcare will be collected in order to extract the ECJ's judgments and to compare them to the ECJ's general role and authority. By doing so, the second research question can be answered.

As every new Treaty reaffirmed that healthcare is left for the Member State, it should be clear that governments never actually pursued Community intervention into this field. To analyze the Member States and their (opposing) opinions regarding cross-border healthcare, the research will collect Member State observations included in the Court's judgments.

3.2 Case selection

In the process of healthcare integration there are several ECJ judgements. This research could have chosen more than ten different case-laws but had to make a decision due to the limited scope of a Bachelor thesis. An orientation took place by analyzing and screening the literature on the developments in healthcare. The *Kohll/Decker* case was by far the most cited and emphasized case at all followed by the *Vanbraekel* Case, *Geraets-Smits/Peerbooms* Case and *Müller-Fauré/Van Riet* judgement (Greer, 2011; D. S. Martinsen, 2005; Mossialos & Palm, 2003; Paulus et al., 2002). The *Kohll/Decker* Cases was presented as momentum case and can in its importance for EU law be compared to the *van Gend en Loos* Case and the *Costa v. ENEL* judgement concerning direct effect and supremacy. The other Cases just mentioned lead to an extension of the reasoning made in *Kohll/Decker*. What was important in the case selection was that all cases had to show the Court's grounds for or against further healthcare integration and the Member State's observations and had to concern cross-border healthcare. More than ten judgments fulfilled this condition but due to the raised importance of four

particular cases, this research chose for *Kohll/Decker*, *Vanbraekel*, *Geraeta-Smits/Peerbooms* and *Müller-Fauré/Van Riet*. Among experts these judgments were highly emphasized, which confirmed and supported the choice.

Overview data collection:

- Treaty provisions laying down ECJ authority and scope of jurisdiction
- Case-law on cross-border healthcare:
 - Kohll and Decker rulings*
 - Smiths-Peerbooms ruling*
 - Vanbraekel ruling*
 - Müller-Fauré & Van Riet ruling*
- Member State observations included in these rulings
- Scientific articles on (cross-border) healthcare and the role of the ECJ in (healthcare) integration

3.3 Data Analysis

The analysis will be divided in three parts, each focussing on one research question. In a first instance the analysis will examine the ECJ's authority in the EU by analyzing Treaty provisions laying down the scope of the Courts' jurisdiction. Second, the analysis will investigate the ECJ's role in EU health policy by taking the sample of patient mobility. Case-law such as the *Kohll and Decker* rulings will be analyzed by the ECJ's judgements and the Member State observations, comparing the ECJ's role in cross-border healthcare to its original given authority based on the Treaties. By analyzing Member State observations within the judgments, Member States' opinion will be extracted as well, comparing them to the ECJ's reasoning.

3.4 Reliability

Due to the limited scope of this bachelor thesis, the research will not include all possible case-law in its analysis. This however could lead to a sort of fishing to the data set to find significant results in order to make the ECJ really look like an Agent. However, the research will keep this threat to validity in mind and threat the judgements carefully and critically. Another methodological issue to be raised is that cross-border healthcare is only one example of EU health policy. Therefore, the thesis will be careful in generalizing the results towards an overall EU healthcare policy. With regard to the theory there is an additional flaw. By taking the P-A framework the research only focuses on two actors meaning one Principle and one Agent. As already mentioned in the theoretical framework, Kassim and Menon (2003) view this as problematic as it disregards a possible interaction of multiple Agents. Eventually, the theoretical framework is strong as intergovernmentalism and neofunctionalism can be viewed as the most popular theories to explain integration in the EU. Moreover, the Principal-Agent framework has been the most used account by social scientists to explain judicial power. All together, they illustrate a strong and consistent theoretical construct which is able to balance out the methodological flaws of this research. Nevertheless, in the discussion, the research will try to resume all the methodological issues and treat them carefully.

CHAPTER 4

The Development of the Mobile Patient

Free Movement of Patients in the EU
New Developments in Healthcare

To fully understand the development of cross-border healthcare in the EU it is vital to get an insight to the very beginning. Basically, health policy includes several aspects of health such as preventing diseases, pharmaceuticals and access to medical treatment everywhere in the EU. The latter is what this research will focus on when it talks about healthcare policy or cross-border healthcare – patient mobility. The following presents an overview about the history of cross-border healthcare and the free movement of patients in the EU from the very beginning to the newest development.

4.1 Free Movement of Patients in the EU

The provision that gave impetus to develop a legal framework for the free movement of patients can be found in Article 69(4) of the ECSC Treaty which originally provided for the free movement of coal workers:

“They (the Member States) shall prohibit any discrimination in remuneration and working conditions between nationals and immigrant workers, without prejudice to special measures concerning frontier workers; in particular they shall endeavour to settle among themselves any matters remaining to be dealt with in order to ensure that social security arrangements do not inhibit labor mobility” (Jorens, 2010)

With this provision in mind, Regulation No 3 was adopted by the Council on 25 September 1958 and operated within the framework of the EEC. This measure was taken in order to coordinate social security throughout the Union by following the four principles that had been evolved: discrimination on grounds of nationality is prohibited; rules are laid down to determine which member country’s legislation the person is subject to; rights in the course of acquisition are protected through aggregation of periods of insurance and/or residence spent in each of the respective countries; and rights already acquired are protected by allowing certain benefits to be exported (Jorens, 2010). Regulation No 3 was special at that time as it granted a general rule to export certain benefits.

With Regulation No 3 being one of the first EU laws it soon became apparent that it was a very complex instrument inside social security law which needed to be simplified and revised. After extensive negotiations and numerous redrafts, Regulation (EEC) No 1408/71 emerged from the Council on 14 June 1971. Based on the same four principles as Regulation No 3, Regulation 1408/71 removed restrictions from sickness benefits and healthcare and limited the situations in which prior authorization to get medical treatment abroad could be refused. Its scope covered sickness and maternity benefits, invalidity benefits, old-age benefits, survivor’s benefits, benefits in respect of accidents at work, death grants,

unemployment benefits and family benefits. As Regulation No 3 defined the personal scope as wage earners and other assimilated workers, the new Regulation redefined it as “employed persons who are or have been subject to the legislation of one or more Member States and who are nationals of one of the Member States or who are stateless persons or refugees residing within the territory of one of the Member States, as well as to the family members and their survivors” (European Commission, 1971). Those of them residing in a Member State other than their own for work or to attend a study program “are subject to the same obligations and enjoy the same benefits under the legislation of any Member State as the nationals of that state” (Sieveking, 2007). This means, that especially migrant workers are eligible to have the right to take their benefits with them across the border and have access to the healthcare system in which they work.

1992 a first modernization of social security coordination and hence a simplification of the Regulation 1408/71 was proposed. This was due to extensive ruling of the European Court of Justice (e.g. Kohll and Decker case) and the “continually evolving welfare systems of the member countries” (Jorens, 2010). Eventually, Regulation (EC) No 883/2004 was adopted by the European Parliament and the Council on 29 April 2004 “and will coordinate social security for people exercising their right to free movement in the EU” (Jorens, 2010). The new Regulation is not severely different from Regulation (EEC) No 1408/71 but extended the personal and material scope of coordination and introduced the Health Insurance Card in 2004. EU citizen that need emergency treatment during temporary stays abroad like on holidays, fall under the scope of the Regulation 883/2004 as well and obtain the right to request a European Health Insurance Card from their national social security body. In case of emergency abroad, this card ensures medical benefits which will be reimbursed by the country of origin.

To sum up the above, Regulation 883/2004 has been the statute on which cover for healthcare abroad has been based traditionally and covers migrant workers, emergency treatment during temporary stays and patients obtaining preauthorized care.

4.2 New Developments in Cross-border Healthcare

Due to case-law and extensive interpretation of Regulation (EEC) No 1408/71 a new category of mobile patients evolved which is not regulated explicitly by the Regulation. It illustrates a situation in which an ordinary EU citizen travels to another EU Member State, without residing in that territory for work or study, to receive medical treatment without prior authorization of its health insurance institution (Wunder, 2009). This constellation is being dealt with by the new EU 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. This newly adopted Directive is also called the “patient mobility Directive” (Niggemeier, 2011) and is supposed to cover all EU citizen that wish to receive medical treatment in another Member State. It pursues to bring a clear framework for cross-border treatment in which the reimbursement of costs that arise abroad becomes more transparent to patients.

In result, there are two different legal basis for patients to seek medical treatment abroad; Regulation 883/2004 and EU Directive on patients’ rights in cross-border healthcare. It needs

to be clarified, that the EU Directive has not been implemented yet. It has been adopted on 9 March 2011 but implementation by the 27 Member States is still awaited.

The above presented a short overview about the history of cross-border healthcare in the EU from 1958 until 2012. In total, the process of cross-border healthcare can be divided into four consecutive periods:

1. Period marked by authorization procedures (before 1998)
2. Period of Kohll-Decker proceedings (1998)
3. Post Kohll-Decker era (1998-2001)
4. EU Directive on patients' rights in cross-border healthcare

CHAPTER 5

Analysis

The European Court of Justice – General Analysis

The ECJ in Health Policy – The Patient Mobility Case

The Role of the Member States

The previous chapter presented an overview about the history of cross-border healthcare and the free movement of patients in the EU from the very beginning to the newest developments. What is remarkable in Community healthcare is the gradual and sort of creeping evolvement of the EU Directive on patients' rights in cross-border healthcare. As being argued throughout the research, Member States have always disapproved Community intervention into their healthcare systems. A Directive however would address Community legislation into each Member State which would be binding and had to be transposed into national law (Hix, 2005). The ECJ judgments created an EU competence that governments never aimed for when signing the founding Treaties.

The following chapter provides an analysis of the institutional foundations of judicial authority in the EU which gives a better understanding of judicial power and how the ECJ works from the inside. Second, the research will take the case of patient mobility at hand to analyze the ECJ's role in health policy. It will do so by examining most relevant case-law such as the Kohll and Decker cases. In a third instance, the research will analyze the Member State's role and opinions in cross-border healthcare by looking at their observations included in the ECJ's judgements. It will close with an overview about the findings.

5.1 The European Court of Justice – General Analysis

The European Union is based on the rule of law which is fundamental to the EU's existence. Acceptance and compliance by Member States, individuals and institutions is vital (Hix & Hoyland, 2011; Nugent, 2010). The following part provides an analysis of the Court's composition, the institutional foundations of judicial authority and will eventually ask what role the ECJ plays in EU policy making.

The Composition of the ECJ

The ECJ is composed of judges and advocates general (AGs). In Karen Davies' introduction to EU law (2007), she refers to the judges as being the Court's decision-makers while the eight AGs assist the judges by giving advises. Each Member State appoints a judge for a term of six years who are, despite their nationality, expected to act independently of any government or interest group (Davies, 2007). The advocates general are being appointed the same way as are the judges and are also considered independent from any external influence. As mentioned above, there are eight AGs in total which means that the largest Member State each appoint one of them and the other places keep rotating between the smaller Member

governments (Hix, 2005). Hix and Hoyland (2011) state that the judges' independence is sometimes compromised as there is a possibility of explicit political appointments to the ECJ. Even though there is only little evidence supporting this assumption, some Member States do have appointed so called "academic lawyers" which is after all allowed by the Treaty (Davies, 2007; Hix & Hoyland, 2011).

The Zone of Discretion

The following part describes the institutional foundations of judicial authority in the European Union and tries to define the ECJ's role in EU policy making. Treaty articles being mentioned are based on the numeration of the most recent Lisbon Treaty meaning of the Treaty on the Functioning of the European Union (TFEU) and the Treaty on European Union (TEU).

First of all, the general role given to the court according to the Treaties is to "ensure that in the interpretation and application of the Treaties the law is observed" (Article 19 TEU). According to Hix and Hoyland (2011), the Treaties provide the Court jurisdiction in three main areas: infringement proceedings (Article 258-260 TFEU), judicial review (Article 263 TFEU and 265 TFEU) and preliminary rulings (Article 267 TFEU).

Article 258 TFEU lays down actions known as "infringement proceedings" (Hix & Hoyland, 2011) in which the Court is enabled to hear actions brought against Member States for non-compliance with their obligations given by the EU treaties and EU legislation. Infringement proceeding, or "enforcement actions" as Stone Sweet (2010) calls them, may be initiated by the Commission or another member state. Moreover, the ECJ is allowed to fine Member States for failure to comply with the ECJ's infringement judgement (Hix, 2005; A. Stone Sweet, 2010).

Second, under Article 263 TFEU and Article 265 TFEU, the ECJ presides over the power of "judicial review" (Hix, 2005). This means that the Court is enabled to review legislative and executive acts by EU institutions such as the EP, the Commission and the European Central Bank, but can also review the legality of acts submitted by Member States, individuals and EU bodies. A striking point to mention is the ECJ's ability to annul actions. Through this motion, the plaintiff can request the legality of an act and the Court is allowed to annul the act if it infringes EU law.

Third, under Article 267 TFEU the ECJ obtains jurisdiction to give a formal interpretation of EU law requested by national courts which is called a "preliminary reference" or "preliminary rulings" (Davies, 2007; Hix, 2005; A. Stone Sweet, 2010). A national court can therefore ask the Court to interpret a case and to provide a ruling that relates to EU law. Although national courts remain some formal discretion to decide in what way they translate the Court's ruling, the ECJ generally interprets the EU's legal orders in a way that gives national courts little discretion to apply the Court's ruling.

Given the specific jurisdiction outlined in the above, it is considerably hard though to draw a clear line about the ECJ's given role yet. Whereas Hix (2005) characterizes the ECJ as a "powerful supranational court" that enforces the EU's legal system and Burley and Mattli (1993) even consider it an "unsung hero", Davies (2007) holds a more careful view by stating that "the Court has the rather general function of ensuring the law is observed". Whatever the

judgement, it mirrors the interest of the (most powerful) Member States (G. Garrett, 1992). Therefore, the question in the debate around the ECJ's role has always been whether the Court adopts a purposive, teleological interpretation or a literal one (Davies, 2007; Fennelly, 1996). This means that according to some scholars such as Fennelly (1996), the Court sometimes needs to consider not only the literal wording of the EU's legal provisions, but has to take the entire context into account when making a judgement. Despite all the scholars arguing, one landmarking development cannot be denied – the doctrines of direct effect and supremacy – which will be explained shortly in the following.

Direct Effect and Supremacy

Whilst being “tucked away in the fairyland Duchy of Luxemboug” (Stein, 1981), the ECJ has been able to use its merely broad grounds of jurisdiction outlined above to expand its supranational authority. In 1963, a first significant conflict between EU law and national law arose and the question came up, which source of law would take precedence. Concerning the doctrine of direct effect, the Case 26/62 *van Gend en Loos* stands out as example. In this case, the private firm *van Gend & Loos* had imported chemicals from Germany into the Netherlands and was requested to pay custom duties by the Dutch fiscal authorities (*Nederlandse Administratie der Belastingen*). The firm however claimed that this procedure constituted a violation of Art 12 EC (now Art 30 TFEU) and in result, the Dutch court advised the ECJ under the preliminary ruling procedure and asked which source of law applied (Davies, 2007; Hix, 2005; Hix & Hoyland, 2011). Although several Member States opposed and argued that Article 12 on a free custom union did not have direct effect, the Court decided that the Treaties confer rights and duties upon the Member States as well as on individuals and those national courts have to ensure these rights. Put differently, the EU law does have direct effect and individuals were allowed to draw on EU law directly in national courts (Alter, 1998). What is interesting in this case is that the ECJ interpreted “in the light of the law as a whole” (Davies, 2007) which means that in its ruling it used a purposive, teleological method and put the EU's legal provisions into context. The results of the *van Gend en Loos* case were surprising as the original Treaties never discussed the possibility of conflicting constitutional rules. Member States always believed that they themselves could determine the Treaties' implications for their country in the end.

In 1964, Case 6/64 *Costa v. ENEL* constituted another landmark judgement followed in the discussion around conflicting EU and national law. Again, the ECJ had to give a preliminary ruling on a contradiction between EU and national law, this time in Italy (Hix, 2005). In that year, the entire electricity sector in Italy was supposed to be nationalized. Mr Costa however, who held shares of an Italian electricity company, protested with this development by withholding his payment to the electricity company ENEL. On grounds of non-payment, ENEL sued Mr. Costa who went straight to the national court to invoke his rights given by EU law. Eventually, the case was referred to the ECJ who stated that when national and EU law conflict, EU law is supreme and must take precedence

Although several scholars and the Member States had doubt about the ECJ getting seriously active, the doctrines of direct effect and supremacy show clearly a judicial activism that was never actually intended, as these principles were never laid down in the Treaties. The

van Gend en Loos Case and the Case *Costa v. ENEL* can therefore be seen as landmark rulings concerning supranational hence judicial authority and as groundbreaking reasons for the ECJ pushing European integration forward.

Conclusion

When we go back to the initial theoretical background, we had two competing theories that explained the ECJ's general role in EU policy-making. These were intergovernmentalism and neofunctionalism. Both resulted in a hypothesis:

Intergovernmentalism: EU (healthcare) policies develop by mutual agreement → Member States (MS) in control

Neofunctionalism: EU (healthcare) policies develop by spillovers → ECJ stimulates spillovers

The general analysis on the ECJ showed already that it is hard to provide for an explicit definition of the ECJ's role in the EU. From an intergovernmental view the ECJ might be established originally as a supranational actor but composed as intergovernmental construct. As every Member State provides one judge to the ECJ, intergovernmentalists could argue that this mirrors an ECJ that has the Member States' interests working from the inside. Even though the judges are supposed to be independent, any judgement would reflect a mutual agreement. Moreover, when signing the Treaties, the Member States assigned the Court a more broad function of guaranteeing the law is observed. Thus, EU policies develop by Member States being in control and mirror their mutual agreement. If Member States do not want a certain EU policy to develop, they won't get one. The ECJ is merely an observer to ensure the law is not violated. Judicial activism is not something that is explicitly mentioned or aimed at.

From a neofunctionalist view, the ECJ is absolutely a powerful and even active supranational actor in EU policy-making and judicial activism can be proved through the doctrines of direct effect and supremacy. On its own, the Court took action in situations where national and EU law conflicted and was being motivated by the necessity to secure the integration of EU law instead of ensuring Member State interests (Davies, 2007). Therefore, an EU policy can develop by spillovers stimulated by the ECJ (the need for integration in every sector and the preservation of Treaty law) despite Member States' opposition.

It should be clear by now, that the ECJ's given role is a quite vague and contradictory one. On the one hand it is supposed merely to be a general observer, but on the other hand the Court is able to get judicially active. The seeming intergovernmental construct which leaves Member State in control, and this vague Treaty base of the ECJ might be the reason, on grounds of intergovernmentalism, why Member States might not have been scared of judicial power pushing forward and why they assumingly never really expected the Court furthering integration. Consequently, findings in healthcare should have developed in accordance with the interest of the Member States or put differently, if Member States did not want an EU health policy, they had not got one. But as we have seen already with the evolvement of direct

effect and supremacy, a first groundbreaking step towards judicial activism was made. In that regard, neofunctionalism serves as the most logic explanation.

From a neofunctionalist view, an EU health policy would develop despite Member State interests. In the following, the research analyzes the case for patient mobility and the ECJ's role in it. It will do so in order to solve the ongoing puzzle and to give a clearer answer on the ECJ's role in the EU as can be given now.

5.2 The ECJ in EU Health Policy – The Patient Mobility Case

Although intergovernmentalists have argued that the Member States' control in EU policy-making prevails and if they do not want a certain policy, they will not get one, the ECJ has expanded its authority as seen in the development of direct effect and supremacy. A policy-field in which a further "uninvited Europeanization" took place, is Community health policy (Greer, 2006). Throughout the years, Member States have tried to isolate their health policy and health systems from the EU's influence. The EU has originally been built on economic tasks and its role in the Member States' welfare systems is weak. Still, the ECJ's competencies in healthcare have developed steadily. The following part analyzes the ECJ's role in EU health policy and takes patient mobility as example. It will do so by examining four different judgements on patient mobility in the EU and will extract the Court's reasoning, especially the Treaty provisions that were used for the rulings.

Kohll and Decker rulings

In order to receive healthcare in another EU Member State, patients could use the authorization procedure until 1998. A patient could get the so called E112 form from their health insurances who, if applicable, allowed them to receive medical treatment abroad. This procedure was heavily challenged in 1998 by two rulings; the *Kohll* and *Decker* cases. Both *Kohll* and *Decker* are Luxembourg citizen and were insured by a health insurance in that country. Mr. *Kohll* had received orthodontic care for his daughter in Germany, whereas Mr. *Decker* had purchased a pair of spectacles in Belgium. Back in their home country they wanted reimbursement by their health insurances despite the insurance had never previously authorized *Kohll's* and *Decker's* treatment (Mossialos & Palm, 2003; Paulus, et al., 2002). *Kohll* had asked for authorization before the treatment but was refused, because dental treatment was seen as non-urgent and could have provided in their home country, *Decker* in turn had not asked for prior authorization at all. Because neither *Kohll* nor *Decker* had received medical treatment and services abroad with prior authorization, they obtained no reimbursement. *Kohll* stated that purchasing medical services in another Member State was restricted by the prior authorization procedure and thus violated Articles 49 EC and 50 EC (now Art 56 TFEU and Art 57 TFEU). *Decker* argued that hindering his acquisition violated Article 28 EC (now Article 28 TFEU) on the free movement of goods. As we will see later in the Member States' opinions within the ECJ's judgements, many Member States reacted highly sensitive in these cases and the *Kohll* and *Decker* cases received great political and legal attention (D. S. Martinsen, 2005). Despite Member State antagonism towards the application of the free movement principle, the ECJ was highly unaffected and reasoned that

“Community law does not detract from the powers of the Member States to organise their social security systems” (para. 17 *Kohll*; para. 21 *Decker*). Nonetheless, the principle of free movement does still apply even though the case concerned a certain service of social security (paras. 20-21 *Kohll*; paras. 24-25 *Decker*). Therefore, the Member States do hold authority in social security policy but are faced with restrictions. Moreover, the ECJ criticized the national prior authorization procedures in that it presented a barrier to the free movement, since it encourages insured persons to seek services and goods abroad (para. 36 *Decker*).

For the research’s theory this has several implications. As outlined, the thesis argues in its third hypotheses that in healthcare policy, the ECJ acts as Trustee. The *Kohll/Decker* Case illustrated how the Court had the authority to review a national case in a first instance. Although it concerned healthcare which is a domain governed by the Member States, the ECJ was able to push through and generated an outcome that Member States were opposed to. This clearly reflects a neofunctionalist account of the P-A framework as criteria for Trusteeship are met. Moreover economic integration principles, thus free movement rules, were applied to further healthcare integration leading to a first revelation of a spillover.

The Smits/Peerbooms ruling

Whereas *Kohll* and *Decker* related to services received outside the hospital (orthodontic treatment and glasses), the *Smits* and *Peerbooms* case concerned hospital treatment. Without obtaining prior authorization from its Dutch health insurance, Mr. Smits, a Dutch national, received special medical treatment for his Parkinson’s disease in Germany (D. S. Martinsen, 2005; Mossialos & Palm, 2003; Paulus, et al., 2002). When trying to be reimbursed, the Dutch health insurance refused paying by stating that the special treatment she had received was unusual and adequate treatment would have been available in the Netherlands. Mr *Peerbooms*, also a Dutch national, received intensive neurostimulation in Austria. Although the treatment was seen as normal and effective in Austria, the Dutch health insurance refused to reimburse the costs of treatment on the grounds that it comprised an experimental procedure. With regard to the *Kohll* and *Decker* rulings, the ECJ thus faced the question, whether the free movement also applied to hospital care and whether the prior authorization procedure constituted a violation of Treaty provisions. Many Member States agreed in their general opposition but disagreed on the scope of economic activity. There was no consistent view about whether hospital care or non-hospital care would form an economic activity and would be affected by ECJ ruling.

Despite Member States’ aversion and stating that hospital services do not form an economic activity, the Court argued that all medical activities, either inside or outside of a hospital, fall inside the scope of Article 50 EC, which now is Article 57 TFEU (paras. 53-54 *Smits et Peerboom*). Referring to *Kohll*, the ECJ also stated in paragraph 69 that the procedure to apply for prior authorization mirrors, again, a barrier to the principle of free movement of services. However, the ECJ argued that prior authorization could be justified if proved to be necessary and reasonable in order to maintain a balanced medical and hospital service open to all (paras. 73-80 *Smits et Peerbooms*).

Also in *Smits/Peerbooms*, the Court possessed the authority to judge in a policy field that officially is governed by the Member States. It not just judged, but decided against the

Meber States preferences and applied again the free movement principles. By relying on these internal market rules, which is an area where supranational power is high, the ECJ expanded its scope of jurisdiction against the interests of the Member States. Again, we see neofunctionalism all over.

The Vanbraekel ruling

In 2001, the reimbursement of medical treatment received abroad again was challenged. This time however, the ECJ connected the procedure build on the coordination of social security systems, Regulation 1408/71 with the principle of free movement (Mossialos & Palm, 2003). This was new as the *Kohll* and *Dekcer* Case and the *Smits-Perboom* Case too had constituted only an alternative procedure to obtain care abroad. In the *Vanbraekel* Case, a Belgian citizen (Vanbraekel) was refused reimbursement by her Belgian health insurance because she had not requested authorization before her orthopaedic treatment in France and because she had received such treatment without a French expert's opinion. If such an expert would have certified that treatment abroad had been inevitable, the French health insurance would have reimbursed. Moreover, the problem arose that the French national court was not sure according to which tariffs she had to be reimbursed (Mossialos & Palm, 2003). The Court ruled again in favour of the patient (paras. 36 and 45 *Vanbraekel*) and made sure that an insured person that received medical treatment abroad was reimbursed in a first instance, and should be reimbursed according to the law of the country of affiliation (Paulus, et al., 2002). The ECJ reaffirmed that it is "settled case-law that medical activities fall within the scope of Article 60 of the Treaty" and that no matter what kind of medical treatment it is, it falls under the fundamental principle of freedom of movement (paras. 41-42 *Vanbraekel*).

Also in this judgment, the Court ruled against the Member States and reaffirmed that any medical treatment fall under the fundamental principle of freedom of movement. Repeatedly, the ECJ made clear that as long a matter at stake falls under internal market rules, it concerns an EU law domain. Therefore, the ECJ possesses enough authority to expand its scope of jurisdiction even into healthcare and is able to generate outcomes that would not have been adopted by governments. In result, this mirrors again criteria of Trusteeship and underlines neofunctional spillover.

The Müller-Fauré & Van Riet ruling

The *Müller-Fauré & Van Riet* Case in 2003 can be seen as one great confirmation of the previous rulings (D. S. Martinsen, 2005). Müller-Fauré, a Dutch national, sought dental treatment in Germany without prior authorization. Van Riet, also a Dutch national, received hospital care in Belgium because treatment could be supplied much earlier than in the Netherlands. In result, both patients' health insurances refused to reimburse the costs by arguing that no prior authorization was requested (*Müller-Fauré*) and that suitable care could have been available in the Netherlands in due time (*Van Riet*). The ECJ, by referring to the *Kohll* and *Decker* Case as well as to the *Smits/Peerboom* ruling, found that Dutch rules constituted a barrier to the freedom to provide services (para. 44 *Müller-Fauré & Van Riet*).

Needless to say, Müller-Fauré & Van Riet confirmed previous rulings and therefore accentuates the neofunctional approach. The Court repeatedly emphasized economic integration principles, even if it concerns a matter that does not directly connect to the EU's internal market. Indirectly it does – as it does not concern medical aspects in the first place, but rather the mobility of the patient and medical services. Mobility, or put differently, the freedom of movement, is one of the EU's cornerstones. Therefore, if this principle is at stake, the ECJ will always try to ensure perpetuation.

Conclusion

When analyzing the case-law above, it becomes obvious that the principle of free movement, an internal market rule, was applied to the health sector which is a domain originally left to the Member States and intergovernmental governance (Greer, 2006; D. S. Martinsen, 2005; D. S. Martinsen, Vrangbaek, K. , 2008). As we remember from neofunctionalist theory, integration in one sector, the completion of the European single market for instance, generates pressures for integration in another related sector. This specific development is described as *functional spillovers* that are stimulated by supranational institutions. Consequently, the application of the free movement principle into healthcare can be viewed as spillover. As an effect, the ECJ is able to make decisions based on its own preferences, because it is interested in the perpetuation and the further integration of the internal market.

Neofunctionalism thus accounts for an appropriate theory to explain healthcare integration, as illustrated in the above. Intergovernmentalism and hence a intergovernmentalist account of the P-A framework would have predicted that in healthcare policy Member States' interest would have prevailed and the ECJ would have decided in Member State preference. However, this did not happen, strengthening the foundation of neofunctionalism.

But how can we describe the ECJ's role specifically? In what way is it different to its original given role in the Treaties? The research argues in a third hypothesis that:

In healthcare policy, the European Court of Justice acts as Trustee.

Trusteeship is a neofunctionalist approach to Principal-Agent theory in which the Court's zone of discretion is almost unlimited (A. Stone Sweet, 2010). The following will analyze Stone Sweet's criteria on Trusteeship in order to answer the second research question and to answer the third hypotheses.

- a. The Court possesses the authority to review the legality of, and to annul, acts taken by the EU's organs of governance and by the Member States in domains governed by EU law.**

As we have seen in the case law, the ECJ was able to discharge national rules on seeking medical treatment abroad. This criterion however, states it is only applicable if the Court is able to do so in a domain governed by EU law and healthcare originally falls out of the ECJ's competence. Nevertheless, it is applicable as the Court based its reason on the domain of the internal market (spillover). The internal market is an area where supranational power is high.

Although discussable, it never really put health aspects first and prioritized the free movement principle. This can be seen in every single judgement.

b. The Court’s jurisdiction, with regard to the Member States, is compulsory.

The Treaties do not literally mention a compulsory effect of the Court’s jurisdiction. However, in Article 260 TFEU it is outlined that “If the Court finds that the Member State concerned has not complied with its judgement it may impose a lump sum or penalty payment on it” (para. 2). Moreover, this paragraph states that also the Commission is allowed to bring a Member State before the ECJ if it has not complied with the Court’s judgement. Consequently, it is obvious that the ECJ’s jurisdictions, its judgements, are compulsory. Furthermore, Article 280 TFEU explains that “the judgements of the Court of Justice of the European Union shall be enforceable (...)”. On the one hand this means that the ECJ’s judgements are (directly) effective but also bring an obligation with it for the Member States as they “may proceed to enforcement in accordance with the national law” (Article 299 TFEU). Concerning healthcare and the case-law analyzed above, it becomes clear that the Court’s judgements have been compulsory and by non-compliance member States would face serious penalties.

c. It is difficult or impossible for the Member States-as-Principal to “punish” the Court, by restricting its jurisdiction, or reversing its rulings.

Defending the Member States, they certainly are able to re-establish the discretionary power of national states (D. S. Martinsen, 2005). Although not in the analysis above, the *Pierik* ruling in 1978 showed that Member States opposition lead to a joint action against the ECJ. In that Case, Dutch national Pierik was refused prior authorization by its national health insurance on the grounds that the treatment he wanted to receive in Germany was not covered by that insurance. The ECJ stated that the treatment in Germany would improve the patient’s health and forced the insurance to confer authorization. Member States reacted immediately and by voting unanimously, they could amend the Court’s interpretation. The Court’s expanded competencies were thus turned back to Member State preferences. However, it needs to be clarified that the Union at that time comprised far less Member States (nine in total) than in the 1990s or in the 2000s. Voting unanimously became harder with every single Member. Therefore, any revision of a judgment or a restriction of the Court’s jurisdiction in the Treaties in order to punish the ECJ is “virtually impossible” (Sandholtz & Stone Sweet, 2010).

d. The Court is able to govern the Principals themselves, thereby generating policy outcomes that would not have been adopted by the Member States, given existing decision-rules.

As we have seen with healthcare, the Court is able to review the legality of a Member State act even if it does not fall within its scope. When introducing the doctrines of direct effect and supremacy it already made a first great step towards changing the rules of the game, but with

case-law in (cross-border) healthcare it underlined even more its judicial autonomy. Originally thought as Agent based on the traditional Principal-Agent theory and mirroring the Principal's interest, the ECJ developed into a Trustee, possessing the authority to expand its own zone of discretion, interpreting the law in its own view and thereby governing the Principals themselves (A. Stone Sweet, 2010). The result was policy outcomes such as the most recent EU Directive on patients' rights in cross-border healthcare that would not have been adopted by the Member States in the original Principal-Agent set-up.

From the Court's judgements we have already concluded that neofunctionalism provides the most convincing explanation of the ECJ's role in healthcare. In addition, all criteria for Trusteeship are met and this research concludes that the ECJ acts as Trustee in healthcare policy. Put differently, and on grounds of its unusual strategic behaviour and its nearly unlimited power, the ECJ can be seen as "Super-Agent" (A. Stone Sweet, 2010). The zone of discretion for a Trustee court seems very different to the original and intergovernmental powers of the ECJ. In the first analysis we saw that the Court is rather given a "checking role" (Alter, 1998). Still, it was able to expand its authority through the doctrines of direct effect and supremacy. Therefore, it was quite difficult to assign a definite role to the ECJ. The example of patient mobility in the second part of the analysis brought light into this puzzle. It is not the Member State interests that prevail in this power puzzle but the very own preferences of the Court. Healthcare policy developed due to spillovers and the resulting expanded authority lead to the ECJ being a Trustee instead of an ordinary Agent. Again, neofunctionalism serves as best theoretical explanation.

5.3 The role of the Member States

So far, this research has argued that Member States always opposed European healthcare integration. The following part will shortly analyze the Court's judgements mentioned above but this time it will extract Member State observations within the judgements. It will do so in order to identify Member States' arguments and to prove whether Member States actually allowed the Court to rule against them or not. This will serve as the third and last part of the analysis and is supposed to further untie the power puzzle.

Intergovernmentalism would state that the Court's judgements were in line with the Member States' preferences. Neofunctionalist though would argue that the Court's judgements allowed the ECJ to make decisions against the Member States. Governments had submitted their opinions towards the Court's judgements on patients seeking healthcare abroad. In the *Kohll-Decker* Case (paras. 18 and 20 *Decker*; paras. 13 and 16 *Kohll*), several European governments such as Belgium, France, the UK, Greece and Luxembourg introduced observations underlining that the principle of free movement was not applicable to the prior authorization procedure as it regarded the social security system of the Member States (Földes, 2009). They further contested that the prior authorization rule represented an essential tool to maintain the financial equilibrium of their healthcare systems, to guarantee the equality of provided health goods and services in order to protect public health and to preserve medical and hospital services available to everyone (D. S. Martinsen, 2005).

In the *Smits/Peerbooms* Case, ten Member States submitted their observations to the ECJ. In Paragraphs 48-49 *Smits-Peerbooms*, governments argued that “hospital services cannot constitute an economic activity within the meaning of Article 60 of the Treaty” and that hospital care did not comprise a service within the meaning of the Treaty. In this regard, the Member States argued that the principle of free movement did not apply (D. S. Martinsen, 2005).

In the *Vanbraekel* Case, the Netherlands, Belgium, Denmark, Germany, Spain, Ireland, Italy, Sweden, United Kingdom, Iceland and Norway submitted their observations – the majority of the Member States. The central argument of several Member States was that “hospital services cannot constitute an economic activity for the purpose of (...) the Treaty” (para. 39 *Vanbraekel*).

In the Case *Müller- Fauré & Van Riet* again, the majority of the Member States submitted their observations. Especially the United Kingdom was obviously scared of the Court’s judgement in that it feared negative consequences for the organization of its health system and its insurance body and pointed at their specific National Health Service (NHS) (para. 55 *Müller-Fauré & Van Riet*). The United Kingdom moreover asked the Court “to uphold the principle that health care provided under such a national sickness insurance scheme does not fall within the scope of Article 60 of the Treaty and that the NHS, which is a non-profit-making body, is not a service provider for the purposes of the Treaty” (para. 59 *Müller-Fauré & Van Riet*). The expansion of the free movement principle was something that was apparently feared throughout the Member States.

What has been kind of neglected above is the ability of Member States to join forces within the so-called “joint decision mode” (Alter, 1998; Scharpf, 2001). This could serve as another way of describing the role of the Member States. The *Pierik* Case that was briefly described in the above illustrated how Member States were actually able to join forces against the ECJ. In the end, the Court’s expanded competencies were turned back to Member State preferences. Therefore, Member States theoretically do have control to a certain extent but lose this power if they become trapped in the joint-decision trap. To the knowledge of this research, there is not a lot of scientific literature dealing with the joint-decision trap in healthcare. However, Martinsen’s research (2005) on an European healthcare dimension proves this argument as it states that if Member States do not support a Court’s judgment, Member States can and “will seek to mobilise joint action against the Court’s interpretative course”.

Conclusion

As a reminder, intergovernmentalism supposed that the Court’s judgements mirror Member State interest. If they want an EU health policy they get one, but if they do not want such thing, they won’t. However, in every mentioned Case, governments tried to make clear that they opposed healthcare integration and that they by no means wanted an EU health policy. Nevertheless, the ECJ was able to decide against them. This clearly mirrors a neofunctionalist account of the Principal-Agent theory which thereby can explain the role of the Member States in healthcare the best. Member States remained the ordinary Principal but by referring authority to the Agent it became a much stronger Agent than ever intended and evolved into a

Trustee. This Trustee had the free-way, the power to expand its discretion and applied internal market principles into healthcare – a seemingly unintended consequence.

Nonetheless, what remains is one strong argument for intergovernmentalism. Outlined with the joint-decision mode, Member States remain having the theoretical power and control over the ECJ's judgments. In the Pierik Case this had worked. Contrary to neofunctionalism, intergovernmentalism is able to take into account the historical context. In this regard, it needs to be mentioned that the Pierik Case in 1978 was the very first judgement on healthcare and patient mobility in the EU. Member States were probably alarmed right away and joint together. Moreover, there was only few Member States compared to 27 governments today. With the development of Kohll/Decker, Vanbraekel and others, the content (e.g. hospital-care v. non-hospital care) expanded. It must have been much more difficult to create a supporting coalition between the Member States especially with an enlarged amount of Member States throughout the years. Otherwise they could have joint and revise the Court's judgements and could have restricted the ECJ by revising the Treaties.

Whereas neofunctionalists would argue that governments don't have any powers at all and puts the ECJ central, an intergovernmentalist view confirms that Member States did have a chance to solve the power puzzle in favour of their interests, but ended up in the joint-decision trap. Therefore, this serves as a very good explanation of the research's paradox. Trapped in "intergovernmental haggling" (Scharpf, 2001), it is almost impossible to change anything and leaves the ECJ as Trustee.

5.4 Findings

The following presents an overview about the research's findings and will answer the research questions as well as the hypotheses.

The first subquestion was: What is the role of the Court in EU policy-making? This was hard to answer as both intergovernmentalist and neofunctionalist views could be confirmed. Whereas the first illustrates the ECJ merely as an observer of EU law on behalf of the Member States, neofunctionalism showed that the Court indeed can react actively, as seen in the doctrines of direct effect and supremacy. As the evolvement of these doctrines cannot be denied, this research argues that neofunctionalism proves to be the most plausible theory to answer the subquestion. EU policies and therefore also healthcare policies develop with the ECJ in control, which is able to stimulate spillovers.

The second part of the analysis examined the role of the ECJ in EU healthcare and raised another hypothesis: In healthcare policy, the ECJ acts as Trustee. The thesis concluded that it is not the Member States preferences that prevail in this power puzzle but those of the Court. Healthcare policy evolved by the Court stimulating spillovers and the expanded authority lead to the ECJ being a Trustee instead of an ordinary Agent. Again, neofunctionalism serves as best theoretical explanation.

The last part of the analysis dealt with the role of the Member States in healthcare and examined their role and opinions. In a fourth hypothesis it stated that the Member States act as Principal in healthcare. This hypothesis can be confirmed. The MS remained an ordinary Principal and did not have the capability to evolve in something even more powerful and did

not put their opposition into action. Because they were imprisoned in the joint-decision trap, they could do nothing but watch the ECJ develop into a Trustee.

The key in solving the research's power puzzle lies in the relationship of Principal and Agent; or rather Principal and Trustee. Though having a serious chance in resuming their authority, they were not able to achieve this and remained an ordinary Principal, based on intergovernmental characteristics. Having received delegated authority by the Member States but without a serious questioning of their powers, the ECJ was enabled to stimulate spillovers by pushing economic integration forward and applied internal market principles into healthcare. Slowly, the Court evolved into an extraordinary Agent, Trustee – Super-Agent. A Trustee does not need an exclusive EU competence based in the Treaties. It is the pure characteristics of Trusteeship, which awards such great authority.

CHAPTER 6

Discussion

Findings and Theories
 Further Explanations
 Implications for the Literature
 The Court as Trustee – Implications for Social Europe
 Benefits and Losses

The previous chapter provided the analysis to solve the power puzzle around healthcare in the EU. It found that the ECJ is a Trustee in healthcare policy and was able to expand its own zone of discretion and to govern the Member States despite their opposition. By doing so, it applied internal market rules, the free movement principle, to healthcare and furthered European healthcare integration. The Court as Trustee – this is the key to the main research question. Now we can explain the paradox of the ECJ being able to boost healthcare integration even without an exclusive competence and despite Member State opposition.

6.1 Findings and Theories

When looking at the findings, neofunctionalism results in being the most conclusive theory in explaining the power puzzle in healthcare. Member States have obviously lost the Principal-Agent game which is a strong argument against intergovernmentalism. Neofunctionalism was capable of explaining that healthcare integration developed as a spillover stimulated by the ECJ. By doing so, it slowly developed into a Trustee and started governing the Member States against their interest. Because the Member States were unsuccessful in joining forces, they remained an ordinary Principal.

Usually, intergovernmentalism and neofunctionalism are its rivals. Kassim and Menon (2003) warn against this which this research tried to keep in mind at all stages. Indeed, neofunctionalism does explain the power puzzle best, but it cannot be fully understood without an intergovernmentalist reasoning as well. The joint-decision mechanism, which is a situation within the integration theories, has a very convincing point. Scharpf's intergovernmental model of this joint-decision making illustrates the potential power of Member States to overrule any supranational rules. Within cross-border healthcare, the *Pierik* Case showed that if Member States join forces, they can resume their original control and slow down the healthcare integration process. A more neofunctionalist view of the joint-decision mode points at the possible threat of becoming trapped, if Member States are not able to come to a common conclusion. Needless to say – this is what happened apparently. Thus, neofunctionalism prevails and serves as the best explanation of the power puzzle. However, the theoretical intergovernmentalist power should not be underestimated.

6.2 Further Explanations

Multiple Agents

One aspect of the relationship between Principal and Agent that has not been addressed so far, is the possibility of multiple Agents (Kassim & Menon, 2003). For brevity's sake, the thesis only focused on one Agent. It could have been important and interesting to include additional Agents such as the European Commission and analyze their interaction with the Member State and with each other. The European Commission is responsible for proposing measures that improve the EU's development hence it is an advocate of European integration (Nugent, 2010). Consequently, it is also an advocate of the ECJ. The Commission has also been conceptualized as Agent in the EU (Pollack, 1997). This raises the question what influence the Commission might have had in healthcare integration. As the ECJ is an Agent as well, what does it mean for their overall power against the Member States? It might have been interesting to analyze this dynamic triangle as this could have led to another conclusion.

Healthcare vs. Economics

From the view of an ordinary patient, healthcare integration seems to help him personally in improving his health and in his rights in healthcare throughout the Union. However, if we look closer at the ECJ's judgements it is not the health aspect that is underlined but the EU's central economic principle – the freedom of movement. From an intergovernmentalist view, the ECJ deciding against the MS interests should not have happened at all. From a neofunctionalist perspective though, the Court's reasoning and its expanded power is logical. Neofunctionalism is not only a theory of integration but also a powerful economic ideology. Haas claims that decisions to integrate economically leads to political spillovers – “unintended or unwanted consequences of earlier decisions” (Haas, 1958) (A. Moravcsik, 2005). Economic matters are the real source that pushes any European integration forward. This argument can be confirmed as the analysis of case-law showed. It was economic rules that illustrated the Court's judgment.

This raises another question. The ECJ Europeanized only economic aspects of the Member States' welfare state. What it comes down to is the free movement principle that enables European patients to be more mobile and receive medical treatment in another Member State. In this regard, do the governments really need to worry? Do they really need to be scared of the EU invading their national healthcare systems? Do they really need to be scared of an intrusion into their welfare systems?

All these new dynamics bring up further questions that are certainly interesting but would need to be addressed in follow-up studies.

6.3 Implications for the Literature

The literature only gave a review of the most important case-law in healthcare (see (Sieveking, 2007) and its implications for patients' rights but not specifically for the power play between Principal and Agent. Stein (1981) has conducted a case-law analysis by

analyzing MS observations relating to the expanded powers of the Court but not for healthcare and focused more on the doctrines of direct effect and supremacy. All aspects have been treated separately so far; healthcare integration, neofunctionalism, intergovernmentalism, the ECJ as Agent within the P-A framework. Greer (2006) did go into the direction of this research by introducing an “internal healthcare market” and underlined the economic aspects within healthcare integration. This research brought all aspects together and showed the powerful role of the Court not only as perceived in general but applied to a specific policy field and the dynamics between the Court and the MS.

Furthermore, the thesis showed again that it is very hard to choose in favour of intergovernmentalism or neofunctionalism. Most literature on healthcare policy focuses on neofunctionalism as explanation of healthcare integration and an internal healthcare market but neglects intergovernmentalist aspects. This research wants to stress that the Member States quasi control through the joint decision mode conforms an intergovernmentalist reasoning which cannot be neglected.

6.4 The Court as Trustee – Implications for Social Europe

Healthcare is just one aspect of Social Europe. Therefore, what are the implications of the Court as Trustee for Social Europe? The following will take another short example of social policy in which the ECJ has also played a pivotal role. Additionally, the discussion will close with benefits and losses the Court as Trustee brings with it.

In Chapter 5, the research already mentioned Regulation 1408/71, coordinating social security schemes of the Member States. This Regulation was supposed to guarantee intra-European migrants to move freely in the EU (Wasserfallen, 2008). Coordination law forced Member States to treat their nationals and migrants equally which meant that both were entitled to receive social rights equally and Member States had to export welfare entitlements. Despite national resistance, the ECJ supported coordination law more and more. In 1983, the Court ruled against Italy and France who refused to pay social aid pension to their nationals that were living in another EU Member State (*Piscitello Case*). In a first instance, France initiated political objection and succeeded by remaining control over its welfare entitlements. Even though the Court raised the free movement principle, the Member States together were powerful enough to override the supranational actor. This clearly reflects another example of an intergovernmentalist account of the joint-decision mode. However, in 2001, two new Cases occurred in which the Court had to rule on the exportability of social benefits. This time, the rules were changed as the Court argued and reaffirmed that the territorialisation of social benefits violated the free movement of workers (Wasserfallen, 2008). Whereas in the first Case Member States were able to override the Court and intergovernmentalism is able to explain this outcome, this time the ECJ was powerful enough. Member States might have been caged in the joint-decision traps which lead to no common decision to override the ECJ.

Can we conceptualize the ECJ as Trustee also in the case of social benefits? Basically, all four criteria that were used to analyze the Court in healthcare do also apply in this case. The only criterion that again is somewhat difficult to answer is (c) *It is difficult or impossible for the Member States-as-Principals to “punish” the Court, by restricting its jurisdiction, or*

reversing its rulings. As can be shown in the first ruling mentioned on social benefits, Member States were successful in joining forces, underlining an intergovernmentalist view. In 1983 the Court's ruling was reversed whereas in 2001 politics prevailed. As argued in the analysis, we need to consider the specific time of the rulings in order to answer this question properly. In this intergovernmentalist regard it is the Member States' inability to find a common reasoning. Intergovernmentalism does not neglect historical importance which lead us to the fact that the amount of Member States has risen constantly throughout the years. In that regard we can explain why less Member States in 1983 were able to find a common reasoning, while in 2001 a higher number of Member States made it harder to mutually stand up against the Court. Social policy has thus evolved with a powerful play inside – the ECJ as Trustee.

6.5 Benefits and Losses

Who is the winner of the Court being a Trustee and who is the loser? First, Member States are certainly not happy about the ECJ being so powerful. As shown in the analysis on healthcare and in the example of social benefits, Member States argued against the judgements. It is comprehensible that governments were frightened as the Court's decisions meant an intrusion of EU law on national law. When it comes to their welfare systems they of course wish to keep their power. In that regard, Member States obviously loose the Principal-Agent game, which emphasizes an argument against intergovernmentalism.

The Court as Trustee is one of the winners it was able to promote European integration. Moreover, by stimulating spillovers and applying the free movement principle to healthcare and social benefits, it acquired a positive advance in the process of creating an internal healthcare market (Paulus, et al., 2002). Eventually, the overall winner of the ECJ being such a powerful Court is the EU citizen. Whereas the Member States lost certain rights and control over the ECJ, nationals of the Member States received more rights as they are allowed to be more mobile throughout the Union. Not only can they obtain medical treatment anywhere in the EU without prior authorization and their health insurance paying, also their social benefits are not bound to a given territory. This leaves the European citizen a wider choice of health services and a greater mobility in the EU. Wherever they are, they can be assured that they will receive medical treatment and social benefits. European social policy, including healthcare and social benefits, has therefore seen an overwhelming, positive development over the years.

CHAPTER 7

Conclusion

To solve the research's power puzzle, this research untied the relationship of Principal and Agent. While Member States remain in their role as ordinary Principal, the ECJ was enabled to stimulate spillovers by applying internal market principles into healthcare and expanded its authority. Governments had a serious chance in getting their authority and control over the ECJ back, but were not able to find common reasoning to overrule the Court. By doing so, the ECJ could slowly develop into a Trustee or hence Super-Agent. Due to the characteristics of Trusteeship, this Super-Agent is awarded such great authority and does not need an exclusive EU competence based on the Treaties.

In this regard, intergovernmentalism can explain the visible paradox in which the Member States seem to allow the Court to establish a competency in Community healthcare. They do not actually allow for further healthcare integration but are simply trying joining forces. A more neofunctionalist approach defines this more clearly – Member States are caged in the joint-decision trap. Being with 27 different governments does not make decision-making easier.

On the other hand, a neofunctionalist approach to delegation theory recognizes another explanation, as forwarded by Tallberg (2000) and points at conflicting interests and information asymmetry within their delegation relationship (Tallberg, 2000). When delegating, Principals tend to assume that the Agent will act only in the Principals' interest. However, Agents have their own interests, too which they try to maintain. Moreover, Agents tend to possess more information about their preferences and actions than the Principals do. This results in an informational benefit for the Agent. As shown in the Member States' observations within the ECJ's judgements on cross-border healthcare, there sure is some resistance to the ECJ rulings in favour of more healthcare integration and against Member State interests. Therefore, Member States were definitely aware of what was happening and were surely afraid to a certain extent. So why did they never try to mitigate this problem?

The Principals, hence the Member States, could have reduced this problematic by designing control mechanisms that would monitor and sanction the ECJ and would have forced the Court to comply (Tallberg, 2000). However, as we have seen in the criteria on Trusteeship, it is difficult or almost impossible for Member States to punish the Court as Trustee and to reduce its power. Of course, governments could join together and amend the Treaty provisions on the ECJ, but for this to happen it needs a unanimous vote – which is hard to reach with 27 Members. Therefore, the ECJ resides freely to act and to pursue its interest and is able to operate in an “exceptionally broad zone of discretion” (Sandholtz & Stone Sweet, 2010). This zone of discretion is the sum of the powers conferred to the Court by the Treaty provisions and those powers that the ECJ has received through its own judgements. Both powers together are capable of overriding all the Member States' control instruments (Sandholtz & Stone Sweet, 2010; A. Stone Sweet, 2004). The Court as “engine of integration” (Pollack, 1997) was powerful and pushed healthcare integration forward.

Moreover, the concept of spillovers underpins this argument. Economic integration has always been the most highlighted aim on the EU's agenda and Member States agreed on this

when signing the founding Treaties in 1958. However, it was never laid down explicitly to what extent these economic aims apply, referring to the Treaty as “incomplete contract” (Pollack, 1997). This allowed the Court to use economic provisions such as the principle of free movement to use in healthcare. It was not even the health aspects the judges perceived as central, but the pure violation of economic freedoms. Consequently, a neofunctionalist approach of the Principal-Agent construct serves as the best and most realistic account to explain the paradox.

Whilst EU Member States never intended to create a European healthcare policy and it is discussable whether they are happy about the latest developments, it nevertheless has one great positive consequence this research (and I personally) wants to highlight: The empowerment of the EU citizen. Even though some analysts might not consider the development in cross-border healthcare as generalizable to an overall Community health policy, the case definitely showed that patients’ rights have been strengthened and account at least for an “internal healthcare market” (D. S. Martinsen, Vrangbaek, K. , 2008). The Member States still obtain the general right to organize their health systems without Community rules, but when it comes to the supply of healthcare and the territorialisation of it, the national monopoly is seriously questioned (D. S. Martinsen, 2005). The process of healthcare integration confirms that by using Community law as supranational source in healthcare, the framework of EU citizenship is improved (D. S. Martinsen, 2005). In the end, the winner is - the European citizen.

CHAPTER 8

Literature

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