



INSIGHT

WHEN MEDICAL TREATMENT AND RELIGIOUS BELIEFS INTERSECT: THE CASE OF *VESELIBAS MINISTRIJA*

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ABSTRACT: This *Insight* comments the judgment of the Court of Justice in *Veselibas ministrija* (case C-243/19 ECLI:EU:C:2020:872) with a view to highlight its contribution to the effectiveness of equality in access to healthcare within the Union. After a brief introduction and contextualization of the case, this *Insight* dwells on the interpretative efforts made by AG Hogan and the Second Chamber of the Court to distinguish the scope and reach of Regulation 883/2004 on the coordination of social security systems, from those of Directive 2011/24 on patients' rights in cross-border healthcare, as well as to determine the degree to which these two acts, read in light of art. 21 of the Charter of Fundamental Rights of the European Union, require Member States to accommodate patients' choices based on religious beliefs. This *Insight* then moves on to assess the judgment taking into account that other similar, and similarly delicate, cases may reach the Court of Justice in the near future indicating a possible, readily available, normative solution capable of ensuring greater equality in access to healthcare.

KEYWORDS: cross-border healthcare – Jehovah's Witnesses – equality – indirect discrimination – freedom of religion – Charter of Fundamental Rights of the European Union.

I. INTRODUCTION

Cross-border healthcare in the Union has progressively gained momentum and it was only a matter of time before hard cases like *Veselibas ministrija* reached the Court of Justice (ECJ).¹ Here the Luxembourg judges are confronted with the balance to be struck between the right to access medical treatment on a non-discriminatory basis and the financial and organizational burden borne by the Member States to ensure the sustainability of the social security system and an orderly and balanced provision of effective healthcare.

Once the cross-border healthcare phenomenon is framed (section II), attention will be paid to the factual background of the case (section III) and, subsequently, to the applicable

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¹Case C-243/19 *Veselibas ministrija* ECLI:EU:C:2020:872.



legal framework; most notably, to the differences between the rules laid down in Regulation 883/2004 on the coordination of social security systems² and those that can be found in Directive 2011/24 on patients' rights in cross-border healthcare³ (section IV). As will be seen, the specificities of the rules on reimbursement under the two regimes are pivotal in determining the margin of discretion enjoyed by the Member States when denying medical treatment abroad on account of the particular religious beliefs of the interested individuals (section V). In this regard, *Veselibas ministrija* underscores the intimate link between free movement law and fundamental rights, confirms the driving force of art. 21 of the Charter of Fundamental Rights of the European Union (CFREU) and highlights the ineptness of the current legislation on access to cross-border healthcare services raising the issue of how to adapt it to the emerging economic and social context and needs dictated by the ongoing pandemic (section VI).

II. SETTING THE SCENE: CHRONICAL OF A DEATH FORETOLD

Although limited in absolute terms, patient mobility was on the rise before COVID-19 struck.⁴ Among the factors that contributed to this state of affairs: the Schengen agreements, the liberalization of air transport, the diffusion of the Internet and the implementation of new therapies and health technologies. Still, under the treaties the choice as to which medical costs are to be covered by the national healthcare system, as well as the list of publicly funded healthcare benefits (medical treatments and medicines), and the modalities and timing of delivery, are left entirely to the Member States.⁵

Scheduled care in another Member State is governed by Regulation 883/2004/EC on the coordination of social security systems and by Directive 2011/24/EU on the application of patients' rights in cross-border healthcare.

The complementarity of these two instruments will be examined in greater detail below. For present purposes, it should nonetheless be noted from the outset that under the regulation and the directive personal preferences are irrelevant when seeking prior authorization for treatment abroad, and claiming reimbursement for the pertinent expenses. Yet, the patients' choice is deeply influenced by health conditions, medical costs, language, as well as by the social environment and, naturally, religious beliefs. In

² Regulation (EU) 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems.

³ 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.

⁴ As is well known, since March 2020 many COVID-19 patients have been treated in another Member State. On cross-border healthcare during the pandemic, see Communication COM(2020) 2153 final from the Commission, Guidelines of 3 April 2020 on EU Emergency Assistance in Cross-Border Cooperation in Healthcare related to the COVID-19 crisis. Many examples of medical assistance between the Member States can be found on the European solidarity tracker portal European Council on Foreign Relations: ecfr.eu.

⁵ See to that effect art. 168(7) TFEU.

this respect, if it is certainly true that the national healthcare systems of the Member States share the fundamental values of universality, access to good-quality healthcare, equity and solidarity, discriminations when trying to access medical treatment are well documented.⁶ The victims are the most vulnerable, to begin with the elderly and persons belonging to minorities, be it by reason of their ethnicity, sexual orientation or religious beliefs. Regrettably, after more than a decade since the Commission presented it back in July of 2008, the proposal for a directive extending the material scope of the provisions against discrimination on the grounds mentioned in the Employment Equality Directive (i.e., religion or belief, disability, age, sex, or sexual orientation) to the areas covered by the Racial Equality Directive and the Gender Equality Directive, including healthcare, is still on the table of the Council.⁷

Hence, in the absence of a specific piece of legislation covering all grounds referred to in art. 19 TFEU, outside the scope of application of Directive 2000/43⁸ and Directive 2004/113⁹ individuals can rely exclusively on the Charter when facing discrimination in accessing medical treatment in the Member State of affiliation.

Against this background, and even though the answer given by the Second Chamber to the questions put forward by the *Augstākā tiesa (Senāts)* (Supreme Court, Latvia) will most likely be of no comfort to the applicant in the main proceedings, the decision ultimately challenges the predominantly economic approach to healthcare services resulting from the courageous and far-sighted case law of the ECJ that brought cross-border medical treatment within the realm of the internal market.¹⁰ In this respect, the case represents the first of its kind. Indeed, it appears to pave the way for a number of preliminary references coming from national judges asked to review administrative decisions denying authorization and/or reimbursement to those who seek in other Member States medical treatments available at home but delivered in ways that are incompatible with their religious beliefs.

With this in mind it is now possible to turn our attention to the facts of the case and the legal issues raised by the Latvian Supreme Court.

⁶ European Council Conclusions of 2 June 2006 on Common values and principles in European Union Health Systems.

⁷ Communication COM(2008) 426 final from the Commission of 2 July 2008, Proposal for a Council Directive on Implementing the Principle of Equal Treatment between Persons Irrespective of Religion or Belief, Disability, Age or Sexual Orientation.

⁸ Directive 2000/43/EC of the Council of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin.

⁹ Directive 2004/113/EC of the Council of 13 December 2004 implementing the principle of equal treatment between men and women in the access to and supply of goods and services.

¹⁰ See generally, J Baquero Cruz, 'The Case Law of the European Court of Justice on the Mobility of Patients: an Assessment', in JW Van De Gronden, E Szyszczak, U Neergaard and M Krajewski (eds), *Health care and EU law* (Springer 2011) 79.

III. FRAMING THE FACTS AND THE LAW: SOME OPEN QUESTIONS OF THE CASE

In a nutshell, *Veselibas ministrija* is about the refusal by the Latvian National Healthcare Service to grant an authorization to the son of a Jehovah's Witness who suffers from a congenital heart defect to receive medical treatment in another Member State (Poland) where that treatment is available in Latvia but is not delivered in accordance with the religious beliefs of the applicant. Consequently, the costs borne in Poland by A., the father of the minor in question, to obtain an open-heart surgery without recurring to a blood transfusion – the refusal of blood transfusion (cells, white cells, platelets and plasma) is an integral part of the religious beliefs of Jehovah's Witness – were not reimbursed. The legal action that followed triggered the preliminary reference advanced by the Latvian Supreme Court. In essence, the national judge wonders whether, read in conjunction with art. 21(1) CFREU, the regulation (question n. one) or the directive (question n. two) allow a Member State to deny authorization where effective hospital care is available in the Member State of residence, but the method of treatment used is contrary to the religious beliefs of the interested person.

According to A. the State must guarantee that its healthcare system is adaptable “to the personal circumstances of the patient, which includes taking into account the religious beliefs of the parents or guardians of a patient who is a minor”.¹¹ The refusal to authorize and reimburse the surgery performed in Poland implicitly forced him to renounce his religious beliefs and amounts to a discrimination “because the State has treated him and other patients – who are in different circumstances and who do not need their method of treatment to be adapted – in the same way”.¹²

The case predominantly builds upon undisputed facts: A. submitted an S2 form for his son B. to seek prior authorization under (the law giving effect to) Regulation 883/2004; the treatment is among the benefits covered by the national healthcare system; the treatment is available in Latvia within a clinically acceptable period of time; the operation performed in Poland was both necessary and effective. There are, however, open questions concerning the applicability of the directive in the case at hand. In particular, there is no evidence that A. applied for authorization, and then timely sought for reimbursement under the (domestic legislation implementing the) directive.¹³ Moreover, it appears that the domestic system of prior authorization set up in accordance with art. 8 of the directive was abolished six months before the reference was introduced before the Court (1 September 2018 - 20 March 2019).¹⁴

¹¹ Case C-243/19 *Veselibas ministrija* ECLI:EU:C:2020:325, opinion of AG Hogan, para. 27.

¹² *Ibid.*

¹³ *Ibid.* para. 38. Latvian law implementing the directive supposedly requires that the action for reimbursement be introduced within one year from the medical treatment.

¹⁴ *Ibid.* The decision whereby the health service refused to issue the S2 form is dated 29 March 2016.

These factual elements are paramount in answering question n. two: on the one side, they call into question its admissibility; on the other side, they impinge on the necessity and proportionality test carried out to determine the compatibility with EU law of the refusal to grant authorization and reimbursement. Asked to verify the relevance of the directive for the solution of the case in the main proceeding, as well as the non-hypothetical nature of the problem raised by *Augstākā tiesa*¹⁵ the Court reckons that it can give a useful answer. The reply is offered on the assumption that “a request for reimbursement within the limits laid down in Article 7 of that directive is, implicitly but necessarily, contained in a request for full reimbursement under Regulation No 883/2004”.¹⁶ The ECJ thereby confirms the complementary nature of the two instruments and indicates that whilst the regulation normally takes precedence, the directive must in principle find application when authorization to receive planned care in another Member State cannot be granted in accord with the former.¹⁷

The answer to question n. two, albeit welcome from a broader perspective, will most probably be of no avail to A. for procedural reasons and discharges on the national judge many difficult determinations besides those explicitly stated in the judgement, namely the determination of whether the repealed transposing rules observe the strict conditions laid down in the directive concerning authorization and reimbursement, as well as the necessity and proportionality of the refusal by the Latvian health based on overriding reasons connected to treatment capacity and medical competence. Actually, the national court will also have to ascertain whether the government duly notified the Commission of its decisions to require prior authorization on account of planning requirements and limit reimbursement on those grounds, as required by the directive.¹⁸ In addition, when assessing the standing of the applicant pursuant to the latter, it will be necessary to determine whether Latvia complied, inter alia, with its information duties under art. 8(7), thereby making the requirement of prior authorization publicly available to A., and whether the statutory limitations applicable to reimbursement claims for cross-border healthcare were appropriate. More generally, the possibility for A. to effectively exercise his rights under the directive depends firstly and foremost on

¹⁵ Most notably upon request by the Ministry of Health and the Latvian and Polish Governments, *Veselības ministrija* cit. para. 57.

¹⁶ *Veselības ministrija* cit. para. 63.

¹⁷ Art. 8(3) of Directive 2011/24 cit. prescribes that if the conditions set out therein are met, the prior authorization will be granted pursuant to the regulation “unless the patient requests otherwise”. This is because under the regulation the whole process is managed by the two interested administrations and it usually does not require the patient to pay and wait for reimbursement; which also explains why it is generally preferred by patients: European Commission, ‘Member State data on cross-border patient healthcare following Directive 2011/24/EU’ (2017) 6-7 and Report COM(2018) 651 final from the Commission of 21 September 2018 on the operation of Directive 2011/24/EU on the application of patients’ rights in cross-border healthcare, 7-8.

¹⁸ Cf. arts 7(11) and 8(2) Directive 2011/24 cit. respectively. See also art. 8(7) Directive 2011/24 cit.

the correct reception in the domestic legal order of the duty to ensure the transparency of the rules on cross-border healthcare pursuant to art. 5(b).¹⁹

Although an additional reference cannot be ruled out *a priori*, it is lamentable that no measure of enquiry under art. 24 of the Statute of the Court of Justice was issued in an attempt to gather more information and that the Latvian legislation transposing the directive was not included in the relevant normative framework, which perhaps would have enabled the ECJ to better direct the referring court in its delicate task.

IV. DISENTANGLING THE COMPLEMENTARITY OF REGULATION 883/2004 AND DIRECTIVE 2011/24

Before we engage in a more detailed analysis of the judgment and how it attempted to reconcile the right to cross-border healthcare, the general principle of equality and the overriding general interest of treatment capacity and financial stability, it is important to clarify the commonalities and differences between the regulation and the directive.

The former serves free movement law. It only concerns medical treatment delivered in the context of the national healthcare system and subjects the entire process to the law of the country of stay, including the costs related to the service. Since these may be higher than those in force in the Member State of affiliation, prior authorization procedures are envisaged. However, authorization cannot be denied when the medical treatment included “among the benefits provided for by the legislation in the Member State where the person concerned resides and where he/she cannot be given such treatment within a time limit which is medically justifiable, taking into account his/her current state of health and the probable course of his/her illness”.²⁰

The Directive, instead, is aimed at securing the reception of cross-border healthcare services. It applies independently of the service provider and harmonizes the rules relating to prior authorization and reimbursement. Here, prior authorization is the exception and can only be foreseen to secure sufficient and permanent access to a balanced range of high-quality treatment and when the cost of the treatment is significant or poses a threat to the patient’s health.²¹ On the other hand, if the individual is entitled to the benefit in kind in the Member State of affiliation, reimbursement cannot be denied save when there is a risk for the patient or, again, the treatment can be provided at home “within a time limit which is medically justifiable, taking into account the current state of health and the probable course of the illness of each patient concerned”.²² In stark contrast with the regulation, however, the directive limits the level of reimburse-

¹⁹ Multiple disfunctions in this regard have been reported by the Commission, see Report COM(2018) 651 final cit. 4 and 12.

²⁰ Art. 20(2) Regulation 883/2004 cit.

²¹ Cf. recital 43 and art. 8(2) Directive 2011/24 cit.

²² *Ibid.* art. 8(6)(d).

ment to that of the actual healthcare received and, in any case, to that applicable in the Member State of affiliation.²³ As will become apparent, this is a decisive factor in the conclusion reached by the ECJ.

Once the entitlement of B. is accepted, it follows from the above that authorization under the regulation exclusively depends on the availability of timely treatment in Latvia taking into account the patient's medical condition; personal choices as regards medical care are irrelevant.²⁴ Since the treatment is available at home within a clinically acceptable period of time, the refusal is believed to be compatible with the regulation.²⁵ But, assuming it is applicable in the main proceedings (and provided the Latvian system of prior authorization in effect before September 2018 is found to be justified), refusal could also be admitted under the directive. Indeed, the ECJ deems there is no reason to differentiate the medical criteria relevant for the purposes of obtaining the authorization pursuant to former and those that must recur in order to justify prior authorization in accordance with the latter.²⁶ On the other hand, as pointed out by the Latvian government, the directive admits restrictions based on the financial and the organizational prerogatives of the Member States in relation to healthcare.²⁷

As to the former prerogatives, the two-fold limit to reimbursement foreseen in art. 7 of the directive makes it possible to assume that "the Member State of affiliation will not, *as a rule*, be exposed to any additional financial costs with respect to cross-border healthcare".²⁸ Hence, the intention to avoid additional costs "cannot, *as a rule*, be relied on to justify the refusal to grant the authorisation provided for in Article 8(1) of Directive 2011/24 in circumstances such as those in the main proceedings".²⁹ The ECJ does not rule out the possibility that authorization and reimbursement may generate *in concreto* additional costs. However, despite the poised formulation, the interpretation effectively leaves the national judge free to confirm the denial whilst remaining within the boundaries of EU law.

²³ In *Vanbraekel* the ECJ opined that denying the patient "at least an equally advantageous level of coverage when hospital services are provided in another Member State" constitutes a restriction to the freedom protected under art. 56 TFEU (case C-368/98 *Vanbraekel and Others* ECLI:EU:C:2001:400 para. 46). This effectively meant that the competent national authorities would have to compensate the individual for the difference between the (lower) cost of the treatment in the country of affiliation and the (higher) cost in the host Member State. When adopting the directive, the EU legislator departed from that rule and foresaw a double limitation to the financial burden which can be expected from the Member State of affiliation.

²⁴ *Veselības ministrija* cit. para 30.

²⁵ *Ibid.* paras 30-32.

²⁶ *Ibid.* para. 82.

²⁷ *Ibid.* para. 71.

²⁸ *Ibid.* para. 77 [A/N: emphasis added].

²⁹ *Ibid.* para. 78 [A/N: emphasis added].

As to the latter prerogatives, AG Hogan doubts that the measure adopted by the Ministry of Health could in fact be justified for organizational or structural reasons less than 18 months before the mentioned legislative changes.³⁰ The Court, in turn, completely ignores this aspect and ultimately leaves the Latvian Supreme Court the difficult task of determining the conformity of the national statutory provisions with the directive in that respect. This is perfectly in line with the spirit of art. 267 TFEU, but the aloofness of the ECJ is somewhat surprising. Ten years after the entry into force of the directive only five Member States have a prior authorization procedure in place for planned care in another EU country (Estonia, Finland, France, Lithuania, The Netherlands, and the Czech Republic), with no documented significant economic loss for their public finances, which in itself seriously undermines the argument advanced by the Latvian government in that regard.³¹

V. BALANCING ECONOMIC FREEDOMS, FUNDAMENTAL RIGHTS, TREATMENT CAPACITY AND FINANCIAL STABILITY

With its two questions the Senate of the Latvian Supreme Court, in essence, asked the Luxembourg judges to clarify whether, and if so to what extent, Member States must under EU law accommodate patients' choices based on religious beliefs. The Court decided exclusively on the basis of the principle of non-discrimination enshrined in art. 21 CFREU, without mentioning art. 10 CFREU. Such discrepancy illustrates the (wise) reticence of the Court to interfere with the normative synthesis reached by the national legislator in the attempt to adequately balance the social, cultural and religious components of society. As argued by Hogan himself in his Opinion, secular courts such as the ECJ and the Latvian Supreme Court "cannot possibly choose in matters of this kind",³² but should be "prepared to protect a diversity of views in matters of conscience, religion and freedom of thought".³³ And this is exactly what that Court of Justice does in this instance.

Indeed, A. may suffer an indirect discrimination in that patients who undergo a medical procedure with a blood transfusion are assumed by the social security system of the affiliation whilst patients who, for religious reasons, decide to be treated in another Member State that offers a treatment which is compatible with their religious beliefs must bear the costs of that choice.³⁴ This difference in treatment must be founded on "an objective and reasonable criterion".³⁵

³⁰ *Veselības ministrija*, opinion of AG Hogan, cit. para. 79. As noted by the AG in his Opinion, the Latvian Government itself admitted at the hearing that the need for prior authorization was abolished because it had proved to be unnecessary.

³¹ *Veselības ministrija* cit. para. 71.

³² *Veselības ministrija*, opinion of AG Hogan, cit. para. 5.

³³ *Ibid.* para. 2.

³⁴ *Veselības ministrija* cit. para. 42.

³⁵ *Ibid.* para. 43.

With respect to question n. one – that pertaining to the regulation, read in light of art. 21 CFREU – the Latvian legislator is dispensed from extending coverage on account of the threat posed by that rule to the financial stability of the health insurance system. The EU judges insist on the importance of health protection in the EU legal order, but acknowledge the disparities at the national level and accept that “in the absence of a prior authorisation system based exclusively on medical criteria, [Member States] face an additional financial burden which would be difficult to foresee and likely to entail a risk to the financial stability of its health insurance system”.³⁶ This is because such requests are based on subjective choices falling within the *forum internum* of the individual.³⁷ To be honest, the threat to the financial stability posed by the rule on reimbursement laid down in the regulation is more potential than actual, and in any case presumed. The Advocate General believes that an empirical verification of such financial factors is needed in order to assess the necessity and proportionality of the refusal *vis à vis* the freedom to manifest one’s religious beliefs,³⁸ but the ECJ refuses to admit that financially advantageous situations (i.e., where the cost of the services received in the country of treatment is lower than that applied in the country of affiliation) cannot be excluded. This is certainly reassuring for those Member States worried about the negative effects that a large number of requests for authorization based on religious grounds (as opposed to the insured’s medical situation) could generate,³⁹ but displays a rather disappointing formalistic stance.

With respect to question n. two – concerning the directive, read jointly with art. 21 CFREU⁴⁰ – the ECJ leaves the Latvian Supreme Court with the difficult task of assessing whether valuing patient’s choices based on their religious beliefs “gives rise to a risk for the planning of hospital treatment in the Member State of affiliation”.⁴¹ Perhaps by virtue of the factual uncertainties surrounding the case, the ECJ stops short of recognizing the right of A. to be reimbursed, but reminds the national judge that the measures

³⁶ *Ibid.* paras 45, 53 and 54.

³⁷ *Ibid.* para. 50.

³⁸ *Veselības ministrija*, opinion of AG Hogan, cit. paras 86-88.

³⁹ See to that effect the written observations submitted by the Italian government (para. 51), according to which: “it is possible that national health systems may face a large number of requests for authorisation to receive cross-border healthcare which are based on religious grounds rather than on the insured person’s medical situation”. See also *Veselības ministrija*, opinion of AG Hogan, cit. para. 79.

⁴⁰ More concretely, the ECJ must ascertain whether the refusal to authorize and reimburse B. for the treatment received in Poland can be justified on the ground that basis of art. 8(5) and (6)(d): i.e., that the treatment to which the individual is entitled can be provided on at home within a time limit which is medically justifiable.

⁴¹ *Veselības ministrija* cit. para. 84.

adopted to pursue the legitimate aim of maintaining treatment capacity or medical competence must be appropriate and necessary.⁴²

VI. LOOKING AT THE CASE AND BEYOND THE CASE AT FUTURE CROSSROADS IN CROSS-BORDER HEALTHCARE

The answers to the questions put forward by the Senate of the Latvian Supreme Court entail delicate balancing operations. While ritual slaughter has long been part of EU internal market legislation and the Court of Justice has already been required to determine the margin of discretion of the Member States with respect to choices based on religious beliefs,⁴³ limited medical treatment is not expressly addressed in secondary law and the Luxembourg judges are here for the first time requested to combine the need to avoid (indirect) discriminations in accessing healthcare services grounded on those beliefs with the national responsibility in the management and financing of the healthcare system.

Notwithstanding the profound differences in their funding and management, the national healthcare systems of the Member States are all predicated on the principles of universality, non-discrimination and solidarity. The degree of accessibility of medical services, including emergency and primary care, however, varies considerably within the Union.⁴⁴

The objective, scope and content of the regulation suggest that Member States cannot be required “to assume positive financial obligations which would be additional to those based on an existing medical need”.⁴⁵ The same cannot be said for situations caught by the directive, that, *as a rule*, averts “any significant effect on the financing of the national healthcare systems”.⁴⁶ It is only where medical treatment and capacity are endangered that – in a situation such as A.’s – reimbursement can be denied, provided the relevant measures are appropriate and necessary.

The judgement should be celebrated for bringing to the forefront the social dimension of healthcare and cross-border healthcare in the Union. On the one hand, it signals the absence of an adequate legislative framework at the EU level to ensure that discriminations such as the one lamented in this case are tackled directly by the nation-

⁴² This conclusion is shared by the AG, who, however, sets a more definite judicial standard for the referring court, namely the determination of the likelihood of “an increase in applications for cross-border healthcare based on religious grounds which would be capable of undermining in an appreciable manner the orderly and balanced provision of effective healthcare in that Member State”: see *Veselibas ministrija*, opinion of AG Hogan, cit. para. 98.

⁴³ Most recently, case C-336/19 *Centraal Israëlitisch Consistorie van België and Others* ECLI:EU:C:2020:1031.

⁴⁴ See further European Commission, *Health at a Glance: Europe 2020. State of Health in the EU Cycle* (OECD 2020) 203 ff.

⁴⁵ *Veselibas ministrija*, opinion of AG Hogan, cit. para. 88.

⁴⁶ Recital 29 Directive 2011/24 cit.

al legislator in compliance with the common standard defined at the supranational level pursuant to art. 19 TFUE. On the other hand, it reveals the disruptive potential of art. 21 CFREU for the economic approach to patient mobility. In this sense, the fact that neither the regulation, nor the directive specifically address personal choices dictated by religious beliefs for the purposes of benefiting from cross-border healthcare at the expense of their Member State of affiliation does not detract from the fact that such individual preferences may nonetheless come into play in their implementation insofar as the national choices concerning entitlement to reimbursement in cross-border healthcare hinder the general principle of equality enshrined in art. 20 of the Charter, “of which the principle of non-discrimination laid down in Article 21(1) [...] is a particular expression”.⁴⁷ Above and beyond the numerous legal issues it raises for the referring court, the case presents the EU legal order with a political problem, that of an incomplete legislative framework; the adoption of the mentioned Equal Treatment Proposal should be considered a priority, especially by reason of the social inequalities exacerbated by the pandemic.⁴⁸

Although the judgement weighs the overriding reasons of organizational and financial sustainability of the healthcare system against the principle of equality, without mentioning the freedom to observe one’s religious beliefs, it is submitted that the real stone guest here is not art. 10 CFREU, but art. 35 CFREU according to which: “[E]veryone has the right of access [...] to benefit from medical treatment under the conditions established by national laws and practices”. The reference to *Eggenberger* and *Cresco* – both relating to the direct horizontal effects of art. 21 CFREU in the field of occupation – is clearly intended to confirm the axiological pervasiveness of the provision *vis à vis* the discretion enjoyed by the domestic lawmaker – *à la Åkerberg Fransson*, so to speak.⁴⁹ In the field of healthcare, art. 35 CFREU can act as a parameter to review national legislation when the situation falls within the scope of application of EU law. This is particularly so in vertical disputes opposing the individual to the domestic administration after medical treatment received in another Member State, as in the case of *Veselības ministrija*.

Well before the adoption of the directive (and the binding nature of the Charter), in *Stamatelaki* Advocate General Ruiz-Jarabo Colomer acknowledged that the right of citizens to health care proclaimed in art. 35 CFREU was becoming increasingly important in

⁴⁷ *Veselības ministrija* cit. para. 35.

⁴⁸ As argued more extensively elsewhere, in the absence of a piece of EU legislation protecting individuals against discrimination based on the grounds indicated in article 21 CFR in all sectors, or of a specific directive applicable in the field of healthcare, it is up to the ECJ to correctly balance between economic freedoms and fundamental rights, see G Di Federico ‘Access to Healthcare in the European Union: Are EU Patients (Effectively) Protected against Discriminatory Practices?’ in LS Rossi and F Casolari (eds), *The Principle of Equality in EU Law* (Springer 2017) 229, 251.

⁴⁹ *Veselības ministrija* cit. para. 36. See also case C-617/10 *Åkerberg Fransson* ECLI:EU:C:2013:105 para. 19.

the Community sphere. His conclusion was that: "being a fundamental asset, health cannot be considered solely in terms of social expenditure and latent economic difficulties. This right is perceived as a personal entitlement, unconnected to a person's relationship with social security, and the Court of Justice cannot overlook that aspect".⁵⁰ Interestingly, this passage is echoed – not quoted – in the Opinion of AG Hogan, who considers it is "the primacy of patient choice" enshrined in the directive that should inform the national judge's decision as to whether to grant the reimbursement.⁵¹ The attention towards the need of the individual is after all part of the broader patient-centred approach, which has long been accepted by the Commission, the Council and the Parliament as a driving principle of EU action in the field of healthcare. The ECJ decided not to endorse the argumentative path followed by the AGs, but independently of the shortcomings of the judgement related to the factual uncertainties (accepted in order to reply to the second question) the Member States are warned: even in the absence of a specific piece of anti-discrimination EU legislation, they will be required under art. 21 CFREU to duly balance their organizational responsibilities with the right to observe one's religious beliefs concerning medical treatment when implementing the directive on patient's rights.

⁵⁰ Case C-444/05 *Stamatelaki* ECLI:EU:C:2007:24, opinion of AG Ruiz-Jarabo Colomer, para. 40. The case, it will be remembered, concerned the request for reimbursement advanced by a Greek citizen to his insurance fund on the basis of art. 56 TFEU for treatment received at a private hospital in the United Kingdom.

⁵¹ *Veselības ministrija* cit. paras 95-97.