

*Rita Baeten*

## **Health care: After the Court, the policy-makers get down to work**

### **Introduction**

With the start of 2004 it seemed as if a general signal was given to deal with national health care systems. The starting shot came from DG Internal Market of the European Commission with the proposal for a Directive on services in the internal market (CEC, 2004a). This general horizontal Directive, in its 2004 version <sup>(1)</sup> aims at removing trade barriers for services between Member States and is explicitly applicable to health care services. DG Competition followed by launching its ideas on the abolition of restrictions on competition in professional services, tackling regulations on price fixing, recommended prices, advertising, entry requirements and reserved rights (CEC, 2004b). At the same time rules on state aid were proposed, including rules on subsidies in the health care sector. The Ecofin Ministers discussed for the first time at a breakfast meeting issues of health care spending and its impact on the sustainability of public finances.

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<sup>1</sup> In this contribution we refer to the Directive on services in the internal market as it has been presented by Commissioner Bolkestein on 13 January 2004. Let us remember that the spring Summit of March 2005 has declared that "*In the light of this ongoing debate which shows that the directive as it is currently drafted does not fully meet these requirements, the European Council requests all efforts to be undertaken within the legislative process in order to secure a broad consensus that meets all these objectives*" (European Council, 2005: point 22).

These developments ring in a new phase. For many years Member States watched jealously to ensure that EU policies did not interfere with their national health care systems. Slowly, the awareness dawned that even though the EU has no formal responsibility in the field of health care, EU law in other areas, mainly the internal market, does affect national health care systems. Once the European Court of Justice defined health care provision as an economic activity in 1998, the health ministers at EU level tried to reach agreement on a political answer to the problems this might cause. In the meantime however the EU internal market players and those responsible for competition law took over the initiative and launched politically and legally binding proposals to apply market principles in the health care sector. Social and health players are thus put on the defensive. The public authorities responsible for health care are more aware than ever of the risks inherent in these developments. They fear losing the capacity to steer their own health systems, without the EU taking over their responsibilities to guarantee equal access to high-quality care for all their citizens. In response, the Health Ministers agreed for the first time to establish at EU level a permanent mechanism to discuss health care issues and to enforce cooperation and coordination in this field, applying the open method of coordination. Also, the debate about the definition of a specific role for social and health services of general interest was brought to the fore.

In this article we will discuss these developments, beginning with the initiatives taken by the economic players, followed by the initiatives of the social players, and finally drawing some conclusions.

### **1. Economic players raise the temperature in early spring**

The tone for the discussions on health care was set early in 2004. In January, February and March the Commissioners responsible for the Internal Market, Competition, and Economic and Monetary Affairs competed with each other to launch proposals and debates targeting health care services and the national health care systems. The basic assumptions on which the different policy initiatives were based, did not always seem very coherent, as we will indicate. Some policy lines seemed to be rather contradictory, even among the economic players. In any case these initiatives raised many concerns among the public authorities responsible for national health care systems and increased the need for a policy response from their side.

## **1.1 Health included in the proposal for a services directive**

The first move was undoubtedly made by the Commission's DG Internal Market, when it launched its proposal on services in the internal market on 13 January 2004 (see article by Éric Van den Abeele in this volume). This horizontal Directive, in its 2004 version, is supposed to apply in its entirety to health care services just as to any other type of commercial service. Moreover, it contains an article specifically devoted to the question of reimbursement for the cost of health care received in another Member State. The inclusion of health and social services within the scope of the Directive, together with the potential consequences thereof, provoked unprecedented reactions from the public authorities responsible for health policy and from the organisations concerned. In this section we shall first of all describe the political context in which health care was included in this proposal. We shall then explain the specific aspects of the health care sector which justify a separate approach. We shall look at those provisions of the draft Directive which are potentially the most problematical for the health care sector in terms of legal uncertainty and deregulation before, last of all, drawing some conclusions.

### **1.1.1 The policy context**

The Directive, as proposed by the Commission, is applicable to any economic activity. Indeed, the Court had decided in a series of judgements that health care provision is an economic activity and that the free movement provisions of the Treaty thus apply (<sup>2</sup>).

Since the aforementioned Court rulings, Member States have been considering how to cope with the situation brought about by these rulings and how to accept free movement principles whilst preserving the characteristics of their national systems and their steering capacity.

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<sup>2</sup> Case C-158/96, *Raymond Kohll v. Union des caisses de maladie*, Judgement of 28 April 1998; Case C-120/95, *Nicolas Decker v. Caisse de maladie des employés privés*, Judgement of 28 April 1998; Case C-157/99, *B.S.M. Geraets-Smits v. Stichting Ziekenfonds VGZ and H.T.M. Peerbooms v. Stichting CZ Groep Zorgverzekeringen*, Judgement of 12 July 2001; Case C-385/99, *V.G. Müller-Fauré c/ Onderlinge Waarborgmaatschappij O.Z. Zorgverzekeringen UA and E.E.M. Van Riet c/ Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen*, Judgement of 13 May 2003.

Member States are clearly wrestling with the obligation to integrate the free movement principles into their national health care regulations. They hoped to formulate policy responses at EU level through the debates in the high level process on patient mobility (see below). The Health Ministers had laid down their recommendations in the report on this high level process in December 2003 and were awaiting the Commission's reply that was promised for the spring of 2004 in the form of a Communication. This Communication would include proposals to improve legal certainty following the Court of Justice jurisprudence concerning the right of patients to benefit from medical treatment in another Member State. In spite of the fact that DG Internal Market participated in the high level process on patient mobility, it did not at any point reveal its intention to launch the Directive on services in the internal market, including health care services. Nevertheless, the Services Directive tackles crucial issues that were discussed during the high level process, such as the reimbursement of costs for care received in another Member State.

Furthermore, the debate aimed at defining the specificity of services of general (economic) interest, including health care services was also in full swing (see below).

The proposal for a Services Directive bypassed all these processes. No attempt was made to apply a specific approach to health care services. The general rules apply in an even stricter way to the health sector than to some public utilities such as electricity and gas distribution, postal services and water distribution services, which are partially exempted from the proposal.

It seems that DG Internal Market was displeased by the fact that most of the Member States had not adapted their legislation in an appropriate way to the Court's rulings on the reimbursement of care received in another Member State (CEC, 2003a). Lobbying by commercial interests, such as commercial hospital groups and laboratories that hope to expand their activities across borders within the EU, has undoubtedly also played a role.

### ***1.1.2 Why is the inclusion of health care problematic?***

The underlying concept of the proposal is a simple relationship between a consumer and a provider. However, health care services form part of complex systems involving interactions and structural links between many involved players. Furthermore, in the health care sector not only do consumers and suppliers operate, but also a third, mainly public party, which pays the major part of the bill. Consequently price mechanisms, based on the relationship between supply and demand, do not function properly. Therefore, health care financiers make agreements with care providers on the price, content and volume of the care provided to their clients. These contracts are designed to prevent care providers from steering the demand for care in their own interest and to prevent more, or more expensive, medical services than necessary from being used, due to the fact that not the patient but the financier bears (a part of) the costs.

Another specific feature of the health care sector is the information asymmetry between patients and health care providers. Health care is increasingly complex, and patients in general lack the necessary background knowledge to make an informed decision about the care they need and the quality and effectiveness of the service they receive. Since health care providers may have other interests than their patients, the information asymmetry makes the relationship very precarious. As it is difficult for patients to assess their own needs properly and in time, public authorities have to provide these guarantees.

Furthermore, access to high-quality health care is considered in Europe as a fundamental right. European health care systems are therefore based on principles of social solidarity and universal coverage and are embedded in social protection systems. The provision of high-quality care equally accessible to all citizens is considered a core task of the public authorities. In order to be able to provide these guarantees, large amounts of public money are invested in this sector. These systems enjoy broad public support.

For all these reasons public authorities need legal instruments to guarantee the most effective use of the limited budgets available, to keep prices down, to guide choices between comparable treatments and to guarantee access for all to high-quality care.

We will now illustrate in what ways the proposal for a Services Directive would put these necessary regulatory powers of the public authorities under pressure.

### ***1.1.3 Potential impact on health care systems***

As drafted by the Commission, the provisions of the Directive devoted to freedom of establishment oblige Member States to simplify and remove a large number of authorisations and licensing procedures and to limit the number of documents required for access to a health care service activity and to the exercise of health care provision.

Member States are expected to set up a major screening exercise to identify and assess procedures and conditions that care providers have to comply with. They should verify that these requirements are non-discriminatory, necessary and proportional. If not, the conditions should be changed or abolished. The conditions that need to be screened include the basic instruments of the health care authorities. We would mention the rules on planning, necessary to guarantee a balanced geographical spread of health care supply, the price fixing mechanism, guaranteeing affordable prices, the legal form of the health care provider such as being a non-profit making organisation, staff norms in health care institutions and referral systems. After the entry into force of the Directive, Member States would no longer be able to introduce any new requirements of this sort, unless the need for it were to arise from new circumstances. The Commission would examine the compatibility of any new requirements with Community law, and could request that Member States refrain from adopting or abolish the requirement.

It is not specified how the criteria for non-discrimination and proportionality, but most importantly necessity, would apply to the health care sector. Consequently, the provisions could create considerable legal uncertainty for health care authorities.

The European Commission would have the power to oblige national health care authorities to abolish or change regulations. However, the Commission can only verify whether the health care regulations are in conformity with the internal market rules, but not whether they are necessary and effective to achieve their basic objectives, that is to guarantee their citizens high-quality services accessible to all. The Commission thus could not take over the responsibilities and

obligations of the Member States, but the national level for its part would lose its capacity to steer the system.

For service providers who wish to provide services in another Member State on a temporary basis, the proposed Directive introduces the principle of the country of origin. According to this principle, health care providers wishing to provide care on a temporary basis in a Member State other than the one where they are established would be allowed to do so without being subject to the national provisions of the Member State where they provide this care, but only to those of the Member State of establishment. This would for instance apply to provisions related to access to and exercise of care provision, in particular those requirements governing the behaviour of the care provider, the quality or content of the care, advertising, contracts and the provider's liability. Member States would not be able to impose on health care providers established in another Member State an obligation, for example, to make a declaration or notification to the competent authorities; to apply specific contractual arrangements between the care provider and the recipient or to possess an identity document issued by its competent authorities specific to the exercise of the service activity. They could not forbid the provider to set up a certain infrastructure such as an office with consulting rooms.

The extent to which the exercise of regulated health care professions (e.g. doctors, nurses, pharmacists, midwives) would be exempted from this principle is not clear in the Commission proposal and depends also on the outcome of the negotiations concerning the review of the legislation on the recognition of professional qualifications <sup>(3)</sup>.

Many crucial questions remain unanswered. If a health care provider supplies care on a temporary basis in another Member State, does the social protection system of the host Member State have to fund this

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<sup>3</sup> The Commission's proposal for a framework Directive on the recognition of professional qualifications, launched in 2002 (CEC, 2002) also included the "country of origin principle", allowing the temporary provision of services by regulated (health) professionals based on the legislation in the country of establishment. This concept was debated intensively in the European Parliament and the Council and they introduced restrictions to this principle, in particular for professions having a public health or safety impact (Council of the European Union, 2004a and European Parliament, 2004).

care? If so, at what tariff and under what conditions? If a health care provider temporarily provides for instance pharmaceutical products or laboratory tests (e.g. on wheels), what prices do they have to apply, and what regulations on advertising, prescriptions, quality and information to patients apply?

If the 2004 version of this proposal were to become law, health care providers established in a Member State that imposes lower conditions on the provision of health care could, based on the legislation of this Member State, provide care in other Member States, competing with the health care providers of host Member States who do have to comply with more legal requirements. This would bring about reverse discrimination and would consequently put pressure on regulations in host Member States and could provoke a spiral of deregulation. Health care systems that opt for more private and for-profit care provision in their country could easily export these private elements to other countries.

According to the initial proposal for a Directive, the Member State of origin is also responsible for supervising the provider and the care provided abroad. Apart from the question as to the feasibility of supervision by the Member State of origin, we can question the legitimisation and motivation of a public authority to control health care services provided abroad to citizens of another Member State. The authorities of the Member State of origin do not have to account for their conduct to the citizens of the host Member State who are receiving the care.

Member States must also ensure that patients can obtain in their Member State of residence information on the legislation applicable in other Member States related to the access to and exercise of the (health care) service activity. However, health care systems are extremely complex and it is not easy to make citizens understand the health care system of their own country. Enabling a citizen to understand the systems of 25 countries, all potentially operational on the territory of his country, and expecting him to make an informed choice between providers could be highly problematic. Moreover, patients need this information at a time when they are in a vulnerable and dependent position, because they need care.

In Article 23 the Commission's proposal for a Directive defines the conditions under which national social security systems must reimburse

the costs of medical care received in other Member States. These draft provisions are based on the European Court of Justice's case law. However, where Member States complained about the lack of legal certainty, due to the Court rulings, the Commission proposal for a Directive does not add clarity.

It is not clear what conditions and formalities health care funders may require for the reimbursement of ambulatory care received abroad. The distinction between ambulatory care and hospital care is not at all clearly defined. The relationship between the proposal for a Directive and Directive 1408/71 on the coordination of social security systems, also including rules on the assumption of the costs for health care received abroad, is not clear. It also remains unclear whether financing institutions can apply different reimbursement rates for contracted and non-contracted care (AIM, 2004).

The proposed Directive moreover lifts bans on advertising for regulated (health care) professions. However, advertising aims to increase consumption, not necessarily of the best quality care for the best price.

In conclusion, the initial Commission proposal does not take into account the specificity of the health care sector, where extensive regulation is needed to redress market imperfections and to guarantee the accessibility of high-quality care to all citizens. The proposal does not take into account the involvement of a third party in the health care sector, the (public) financier of the care service. This financier needs to be able to impose cost-effective behaviour on providers, in order to guarantee the financial viability of the system.

The Commission's proposal would lead to legal uncertainty for public authorities, providers and patients and could result in deregulation in this sector where regulation is a crucial element for quality- and cost control. Deregulation could lead to more exploitative behaviour by care providers and thus to higher prices, provision of more unnecessary care and of needless highly specialised care. In short, (public) health care financiers would lose control over their expenditure and this would harm the financial viability of national health care systems, as well as the EU macro-economic policy objectives.

## **1.2 Rules on state aid for (health) services of general interest**

At around the same time as the Services Directive was proposed, the Commission's DG Competition launched proposals governing state aid<sup>4</sup> (the so called "Monti package"). This package included a proposal for a Commission Decision and a draft for a Community framework for state aid in the form of public service compensation (CEC, 2004c and 2004d). State aid that distorts competition in the common market is prohibited by the EC Treaty. The Treaty, however, allows exemptions to the ban on state aid where the proposed aid schemes may have a beneficial impact in overall Union terms. The proposals aim to increase legal certainty for Member States and for undertakings entrusted with the operation of services of general interest, spelling out the conditions under which public service compensation constitutes state aid that is compatible with the common market in accordance with the EC Treaty if it is necessary to the operation of Services of General Interest (SGEIs).

The draft Decision would apply to services that constitute services of general economic interest in all the sectors governed by the EC Treaty. The rules set out in the proposal would apply to small amounts of compensation granted to smaller undertakings providing SGEIs on the one hand and to hospitals and social housing undertakings entrusted with tasks involving SGEIs on the other hand. The draft Decision sets out conditions for the entrustment, compensation and transparency of the state aid awarded. If the aid is awarded according to these criteria, it is considered compatible with the Treaty and this aid is exempted from the requirement of prior notification to the Commission of the intention to grant state aid.

The proposal for a Community framework on the other hand sets out the conditions under which state aid to other undertakings entrusted with SGEIs is in conformity with the Treaty. This is thus applicable to "bigger" SGEIs, not being hospitals or social housing undertakings. These state aids remain subject to prior notification to the Commission.

These proposals have been submitted for informal consultation to the Member States, the European Parliament and other stakeholders involved. The Commission intends to adopt these proposals by July

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<sup>4</sup> [http://europa.eu.int/comm/competition/state\\_aid/others/](http://europa.eu.int/comm/competition/state_aid/others/).

2005. The aim of the proposals is thus to set out rules for exemptions to the state aid rules, applicable in principle to the SGEIs affected. Nevertheless, in practice the notification requirements were up until then not applied to SGEIs and certainly not to health care services. Health care and hospital services were for the first time explicitly mentioned in relation to the EC state aid rules. For the first time EU legislation concerning the health care sector was based on the Treaty articles on competition (Article 86), i.e. on the Treaty provisions serving as a basis for market liberalisation. This again raised awareness and concern among Member States about the fact that health care services were defined as an economic activity in the meaning of the Treaty and consequently were not exempted from common market and competition rules.

### **1.3 More competition in professional services**

During the same period, early 2004, Commissioner Monti also launched in a report the discussion about abolishing unjustified restrictions on competition in professional services (CEC, 2004b). The potentially restrictive regulations referred to here concern price fixing, recommended prices, advertising, entry requirements and reserved rights and regulations governing business structures and multidisciplinary practices in these professional services. In its report the European Commission calls on Member States, the professions concerned and their regulatory bodies to reform or eliminate restrictions that prevent competition in these professional services, unless clearly justified by public interest considerations. The Commission also suggests exploring together with all relevant actors the need to put in place pro-competitive and transparency enhancing accompanying mechanisms. From May 2004 onwards, administrative enforcement of the EC competition rules in the liberal professions became mainly the task of national competition authorities. The Commission would report in 2005 on progress in eliminating restrictive and unjustified rules.

The same discourse as for the proposal for a Services Directive is used, stressing the importance of the service sector as the engine of growth in the European Union and highlighting professional services as an important part of it. Yet the scope of the report is not very clear. It concentrates on the professions which have so far been analysed in some detail by the Commission, namely lawyers, notaries, accountants,

architects, engineers and pharmacists. It mentions that similar conclusions could be reached concerning allied professions, where they exist. It states explicitly that medical professions are not covered by the provisions. This exclusion of medical professions is a crucial difference from the proposal for a Services Directive. It is noteworthy that the attention paid to the exclusion of the medical professions from the scope of the report is limited to 8 words (CEC, 2004b: 7, point 6) and a footnote saying that the OECD is carrying out complementary work. No justification at all is given for the exclusion of medical services. The arguments for excluding medical services from this report could in all probability be used in the same way to exclude them from the Services Directive. By not giving any justification, any contradictions in the Commission's position and maybe differences in policy approach by the different Commission DGs are thus covered up.

On the other hand, pharmacists are included in the scope of the report. This suggests that the definition of medical services is interpreted rather narrowly. Nor is any justification given for making a distinction between pharmacists and other medical professions.

#### **1.4 Macro-economic policies and health care**

Health care systems were not only subject to policy initiatives in the context of internal market and competition law in the spring of 2004. The guardians of the EU's macro-economic policies likewise targeted health care systems. At a breakfast meeting, in the margins of the Economic and Financial Affairs Council of 11 May 2004, the Ministers of Finance discussed for the first time the impact of health care spending on public finances. This discussion was prepared for by the Economic Policy Committee from January 2004 onwards and followed up by a Commission document to the Economic Policy Committee in March (CEC, 2004e). This note provides an overview of developments in the health care sector of EU Member States; examines the main drivers of health care spending and considers experiences with reform measures. It states that there is a strong economic rationale for some public sector involvement in the financing and provision of health care on the grounds of both efficiency and equity. It states that aggregate cost-containment measures to control volume, prices and wages have helped to constrain expenditure and are key elements in comprehensive health care strategies for Member States. This analysis contrasts with the assumptions of the Services Directive whereby less public

intervention and more free movement would lead to higher quality and lower prices, including for health services.

The Ministers agreed that there is likely to be considerable pressure for increased public spending on health, driven largely by ageing and public expectations, and that this would pose a challenge for budgetary management. However, no clear declaration of intent for future work in this field was made.

## **2. Social and health players aim for closer cooperation in the field of health care**

The above-mentioned initiatives of the economic players interacted with ongoing processes launched by the social players at EU level.

We will look into three policy debates: on patient mobility; on the integration of health care in the process for modernising social protection and on the definition of social and health services as services of general interest (see also Baeten, 2003). The economic players' initiatives influenced developments in these fields to a considerable extent.

### **2.1 Patient mobility and health care developments in the European Union**

The issue of patient mobility was brought to the political agenda of the Health Council, mainly because Member States were concerned about the consequences of a series of judgements of the European Court of Justice, applying the rules on the freedom to provide services to health care provision and reimbursement<sup>5</sup>. The Health Council of 26 June 2002 recognised that developments such as those relating to the single market have an impact on health systems. This Council expressed the concern that these developments should be consistent with the Member

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<sup>5</sup> Case C-158/96, *Raymond Kohll v. Union des caisses de maladie*, Judgement of 28 April 1998; Case C-120/95, *Nicolas Decker v. Caisse de maladie des employés privés*, Judgement of 28 April 1998; Case C-157/99, *B.S.M. Geraets-Smits v. Stichting Ziekenfonds VGZ and H.T.M. Peerbooms v. Stichting CZ Groep Zorgverzekeringen*, Judgement of 12 July 2001; Case C-385/99, *V.G. Müller-Fauré c/ Onderlinge Waarborgmaatschappij O.Z. Zorgverzekeringen UA and E.E.M. Van Riet c/ Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen*, Judgement of 13 May 2003.

States' health policy objectives, and with the principles of solidarity, equity and universality on which all the systems are based. The Council conclusions invited the Commission to launch a High Level Process of reflection on these issues. This was the first time that the Member States, traditionally extremely reluctant to allow EU debate on health care, accepted that an EU body would discuss health care issues. The awareness that Europe is entering the national health care systems by the back door of the internal market undoubtedly explained this development.

The High Level Process involved Health Ministers from 14 Member States, as well as EU level civil society groups. The acceding countries also took part in the second half of the reflection process. On 9 December 2003 the final report of the reflection process was presented (CEC, 2003b). It contained 19 recommendations for action at EU level. They are based around five themes:

- European cooperation to enable better use of resources;
- information requirements for patients, professionals and policy-makers;
- access to and quality of care;
- reconciling national health policy with European obligations;
- health-related issues and the EU's Cohesion and Structural Funds.

The recommendations included developing information systems to enable Member States to share spare capacity in each other's health care systems and to make it easier to purchase medical or other health services across borders; developing proposals for a framework for cross-border health care purchasing; cooperation on health technology assessment; the identification of European centres of excellence in high technology treatments or treatment of rare diseases; developing a common understanding of patients' rights, entitlements and duties; addressing the issues of data protection and confidentiality in the exchange of patient information between Member States, as well as the issues surrounding the provision of "e-health services" over the Internet; studying the flows of patients and health professionals within the EU and internationally and an analysis of how the EU can contribute to promoting both quality of and access to health care.

The Commission was invited in the report to explore how legal certainty could be improved following the Court of Justice jurisprudence concerning the right of patients to benefit from medical treatment in another Member State. The report pointed out that options for secondary legislation could include further provisions updating the coordination of social security systems, general provisions on the free movement of patients or specific clarifications on the application of Community law to health services.

The expectations of the high level process were considerable. It was hoped that it would outline policy initiatives ensuring that Member States would maintain their steering capacity over the organisation and the financing of their systems. The report of the High Level Group did not really meet these expectations. It succeeded in singling out the issues at stake and calling for further information gathering and analysis, but did not come up with concrete proposals for action. Instead, it invited the Commission to put forward proposals on some of the topics.

Several explanations can be given for this lack of clear policy conclusions. *In the first place*, there seemed to be a broad consensus among Member States on the analysis of the problems caused by the impact of the internal market on health care systems. However, there was much less consensus on how to deal with these problems. Some Member States were paralysed by the idea that their national health care systems would have to comply with European standards. They preferred rather general statements on the need to maintain their national responsibilities. *In the second place* the outcome of the negotiations on the European Constitution only gradually became clear during the high level process. Some partners hoped that the draft Constitution would give more guarantees to balance social and internal market objectives. *Last but not least*, in the phase of drafting the final Conclusions of the process, the European Commission was in the driving seat. Although the process was coordinated within DG Sanco, it was clear that DG Internal Market watched jealously to ensure that the final report would not contain any proposal running counter to their intentions to include health care provision in the Directive on services in the internal market. The Member States participating in the process agreed for instance on a statement listing the most important policy instruments they need to be able to steer their health care systems. The

Commission's text added to this list the words "while respecting Community law". The Member States participating in the process were not able to oppose this wording, as this would mean that they would have to come up with alternative proposals for changing Community law, and they were not able to reach an agreement on this. It is clear that the proposal for a Services Directive was in the drawers of DG Internal Market awaiting the final outcome of the High Level Process. It was launched straight after the approval of the final report of the Process.

On 20 April 2004 the European Commission presented its answer to the recommendations of the High Level Process, in the form of a Communication on patient mobility (CEC, 2004f). This Communication was adopted together with a Communication on the application of the "open method of coordination" (OMC) to health care and long-term care (CEC, 2004g) (discussed below). These two Communications aim to encourage cooperation among Member States in the field of health care.

The Commission proposes European cooperation in the following fields:

- rights and duties of patients;
- sharing spare capacity between health care systems and cross-border care;
- the mobility of health professionals;
- European centres of reference;
- health technology assessment.

The Commission Communication mainly proposes actions concerning information gathering, developing better understanding and mapping the situation. In a next step it proposes to define common objectives for applying the open method of coordination to some of the issues listed. In response to the request for more legal certainty, voiced by the Member States in the recommendations of the high level process, the Commission refers to the proposal for a Services Directive. The Commission also invites Member States to take initiatives to improve legal certainty. Furthermore, the Communication pleads for improving information and knowledge about health systems and identifying and exchanging best practices.

To drive forward this process of cooperation, the Commission created a High Level Group on Health Services and Medical Care (CEC, 2004h). The Group consists of senior representatives of Member States and the Commission, calling on external experts as necessary. DG Sanco has been very enterprising in setting up this High Level Group quickly. The speed with which this initiative was taken mirrors the competition between the “health” and “social” players at EU level to take the lead in the process of European cooperation on health care.

The Health Council of 1 and 2 June 2004 welcomed the setting up of this High Level Group and invited the European Commission to ensure that this Group would work, as appropriate, in cooperation with other relevant bodies, in particular the Social Protection Committee and the Economic Policy Committee. The Health Council also underlined the need to explore how legal certainty could be improved following the European Court of Justice jurisprudence concerning the right of patients to receive reimbursement for medical treatment in another Member State. The Council makes clear that the Commission’s answer, i.e. to refer on the issue of legal certainty to the proposed Directive on services in the internal market, does not meet these needs. Many Member States voiced concerns at the Council with respect to the inclusion of health care in this Services Directive.

A first note on the activities of the High Level Group was sent by the Commission to the Council in December 2004, setting priorities for work in 2005 (Council of the European Union, 2004b).

The High Level Group may become an important instrument for cooperation in the field of health care and cross-border care. It could become a forum for reaching consensus on policy initiatives to provide more legal certainty to the Member States and patients. However, progress has been very slow. 2.5 years after the setting up of the High Level Process, no concrete policy output has been achieved.

The High Level Group also has its structural limitations. It was set up by the Commission’s DG Sanco, based on the Article 152 EU powers on public health. Contrary to the Social Protection Committee (SPC) (see below), it is accountable to the Commission and not to the Council, and is created by a Decision and not embedded in the Treaty. This has two consequences. In the first place the High Level Group cannot serve as a place for political debate on the impact of EU policies in other

fields on national health care systems. This was strongly felt by the Member States in relation to the debate on the Services Directive. Secondly, the central role played by the Commission in this High Level Group makes the Member States somewhat suspicious of it, for example as concerns the draft Services Directive. A Commission-led body is not the right place to discuss proposals put forward by the Commission. There was therefore no appropriate forum where they could discuss the concerns of the national health care authorities with regard to this proposal.

This explains why the Council again decided in June 2004 to set up another permanent mechanism, which reports to the Council, on patient mobility and health care developments in the European Union and to assess the impact of the European Union on health systems. In order to avoid a proliferation of working parties, this new body became the existing Council Working Party on Public Health (composed of attachés from the Member States' permanent representations to the European Union and preparing the Health Council negotiations), but in a different composition. High level senior officials would attend these meetings of the Council Working Party. This Working Party on Public Health, meeting at senior official level, is expected to offer advice and political guidance on horizontal issues related to health care, in particular on:

- assessing the impact of the European Union on health systems, patient mobility and health care developments;
- promoting exchanges of information, experience and good practice;
- considering long-term perspectives for health care.

By the end of 2004, this group had met only once and discussed some potential input into the debate on social and health services of general interest, prepared by the Social Protection Committee, and the proposal for an EU health strategy put forward by Commissioner Byrne. Contrary to the strong pressures to create this working party, it thus seems not really to be able to provide any specific input into the ongoing debates and provide countermoves to the moves of the economic players. On the contrary, it seems to be turning into one more body that gives advice on initiatives of the social players.

## **2.2 Open method of coordination in the field of health care**

As mentioned earlier, the European Commission also launched a second Communication in April 2004, proposing the application of the open method of coordination to health care (CEC, 2004g)<sup>6</sup>. This Communication builds further on earlier decisions to involve health care in the process of modernising social protection. The Lisbon European Council in 2000 highlighted the need to reform and adapt social protection systems, including health care, in order to meet the challenge of demographic ageing and ensure social cohesion. Since then, several reports and Communications on health care and care for the elderly have been drafted and presented to the European Council. During this process three common objectives for European health care systems have been identified: to guarantee access for all to health care of good quality; to improve the transparency and quality of health care systems; and to ensure the financial viability of the systems. The reports proposed closer cooperation and exchanges of views between Member States, but did not propose applying the open method of coordination (OMC). Indeed, Member States have always been extremely reluctant to give the EU scope to act on health care issues. Health authorities have always, for cultural and historical reasons, jealously sought to keep the responsibility for health care provision within their national borders.

The current Commission Communication is thus the first clear proposal to use the open method of coordination for health care. It aims to define a common framework to support Member States in the reform and development of health care and long-term care, which would allow them to define their own national strategies and to learn from the experiences and good practices of others. The Communication proposes a series of joint objectives for developing care systems, built on the previously formulated common principles of European health care systems:

- ensuring access to high-quality care based on the principles of universal access, fairness and solidarity and providing a safety net

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<sup>6</sup> This method involves fixing European-level common objectives in a given policy area and quantitative benchmarks and indicators as a means to compare best practices; translating the guidelines into national and regional action plans by setting specific targets, and periodic evaluation as a mutual learning process.

against poverty or social exclusion associated with ill health, accident, disability or old age;

- promoting high-quality care in order to improve people's state of health and quality of life;
- ensuring the long-term financial sustainability of high-quality care accessible to all.

Two cross-cutting issues can be distilled from the proposed objectives: human resources management, including training, and cost-effective management of the available resources. The Communication announces that the open method of coordination will contribute to involving the many actors in this sector, particularly the social partners, the health care professions and patient representatives. How the stakeholders of the health care sector will be involved in the process is however not yet very clear. The Communication includes a timetable. The Council of 4 October 2004 supported the main thrust of the Commission's Communication, without taking a position about the proposed objectives. The Council considered that the Communication went into too much detail and endorsed the opinion of the SPC, stating that the OMC should be introduced in a progressive and flexible manner; should not impose an excessive administrative burden; should involve health ministries directly; and should avoid overlap with the High Level Group on Health Services and continue working jointly with the Economic Policy Committee (EPC). The proposed timetable will be adapted in order to start the process cautiously and to formulate the objectives on a "bottom up" basis, starting from national reports.

The Member States did thus call for an OMC "light", an inter-governmental process with qualitative rather than quantitative objectives. They stressed the subtle balance between all the stakeholders in national health care systems and expressed their fear that over-specific EU guidelines could upset these balances. They mainly stressed the need for an exchange of national experiences.

### **2.3 Why closer cooperation?**

As described above, the process of patient mobility on the one hand and the process applying the open method of coordination to health care on the other hand started out as two separate processes, each based on a different series of issues and each involving another set of players (Baeten, 2003).

The patient mobility process reflects the concern of the health ministers in the Health Council about the growing impact of the internal market on national health care systems and the fear that this could put pressure on the social nature of these systems. This process is further pushed forward by the Commission DG responsible for health (DG Sanco), seizing on the issue of patient mobility to legitimise more EU action in the field of health care.

The application of the open method of coordination to the health care sector is embedded in the process for modernising social protection. This process was the reaction of the “social” players (Council formation, Commission DG) to the “economic” players (Ecofin Council and DG Ecfm). The latter, which oversees public finances, exerted pressure on the national social protection systems to control expenditure, in order to be able to cope with the ageing of the population. The “social” players wanted to add to this discussion issues relating to quality of and access to social protection systems, in order to avoid straightforward cutbacks in spending. The reluctance among Member States to apply this open method of coordination in the field of health care has always been substantial. If the preparedness to accept European cooperation in this field and the OMC is growing, this can equally be attributed to the concern among Member States as to the potential impact of the internal market and of the “internal market” players on their national systems.

The willingness of Member States to accept structured and institutionalised EU level cooperation in the field of health care is very new. The proposal for a Services Directive has been mentioned by many Member States as an argument for accepting closer cooperation. Member States hope that with closer cooperation in this domain they can face up to these interventions, have their say in the debates and achieve more coherence in EU policies towards health care systems.

Whether the established bodies and processes are adequate to achieve this objective remains to be seen. The profusion of bodies involved in closer cooperation does not really strengthen the position of the social players. Although all the players involved stress that close coordination between the different committees and processes is necessary, a good deal of energy will be invested in providing opinions on advice given by other bodies. There is a risk of losing sight of the main objectives of the processes as too much time and effort is spent on endlessly

coordinating the cooperation processes and on cooperation between the coordination processes. The national civil servants responsible and stakeholder representatives are already now complaining that they are hardly able to study in depth all the documents circulated on which they have to give advice.

Whether the acceptance in principle of the application of the open method of coordination in this sector will continue once concrete macro and micro level common objectives have to be formulated in the health care sector also remains to be seen. The diversity of systems is so great that it will be a major policy challenge to reach consensus on such objectives.

#### **2.4 Health care within the debate on services of general interest (SGIs)**

The debate on services of general interest has been discussed extensively in the editions of 2002 and 2003 (see Social Developments 2002 and 2003).

In 2003 the European Commission launched a consultation on the policy options to be taken in the form of a Green Paper (CEC, 2003c). Concerning health care services, it is noteworthy that nowhere does the Green Paper classify them as being potential economic services. On the contrary, the Green Paper states explicitly “*Furthermore, the future of non-economic services of general interest, whether they are related to prerogatives of the State or linked to such sensitive sectors as culture, education, health or social services, raises issues on a European scale, such as the content of the European model of society*” (CCE, 2003c: 15, point 47). The distinction between the economic and non-economic nature of a service is crucial, as non-economic services are not covered by the internal market, competition and state aid rules of the Treaty. The only sectors discussed in the Green Paper as economic services of general interest are the services provided by large network industries and services such as waste management; water supply or public broadcasting. This is remarkable at a time when the Court of Justice has over several years, in a series of judgements, held consistently that health care provision is an economic activity. It is hard to imagine that the Commission services were not aware of these judgements. Maybe they hoped not to provoke a policy debate on a specific approach to the application of internal market and competition rules for health and social services. The approach of the Green Paper contrasts sharply with the approach in the Services

Directive, where health and certain social services are not only labelled as economic, but where no specific approach is foreseen at all. The Green Paper stresses nevertheless that the distinction between economic and non-economic activities is dynamic and evolving and that for an increasing number of services this distinction has become blurred. The Green Paper also stresses the need for more legal certainty.

The reactions to the Green Paper were massive. It raised awareness of the issues at stake among categories of players up until then barely mobilised around the potential impact of the internal market and competition rules on their sector. This certainly applies to the not-for-profit health and social services. They mainly called for a reinforcement of subsidiarity in the sector of health and social services. No calls for a Community framework for social services were voiced. Various commentators – largely from the social sector, trade unions and the regions – considered that a distinction between economic and non-economic services based solely on the market would be too narrow. They argued in favour of broader criteria, such as social and environmental objectives, an absence of profit or the involvement of volunteers, in order to determine whether a service is economic or non-economic in nature (Van den Abeele, 2003). Concerns were expressed about the lack of legal certainty for social and health services of general interest.

In May 2004 the European Commission launched its White Paper on services of general interest, drawing on the conclusions of the debate on the Green Paper. It presents the main elements of a strategy for services of general interest (CEC, 2004i).

The Communication pays much attention to social and health services of general interest. The Commission supports the views stressed in the consultation that the personal nature of many social and health services leads to requirements that are significantly different from those in network industries and stresses that any Community policy in the area of services of general interest must take due account of the diversity that characterises different SGIs and the situations in which they are provided. Again, this position contrasts with the Commission's approach on the Services Directive, where no differentiation is made between services of general interest and commercial services, and certainly not among services of general interest.

A specific section is dedicated to social and health services of general interest. The Commission argues for a systematic approach in order to identify and recognise the specific characteristics of social and health services of general interest and to clarify the framework in which they operate and can be modernised. The Commission announces its intention to set out this approach in a Communication, to be adopted in the course of 2005. This Communication would take stock of the Community policies that are related to the provision of social and health services of general interest and describe the ways in which these services are organised in the Member States. The Communication would also set out a mechanism for a regular assessment of the national frameworks for the provision of social services of general interest.

The Commission also declares that it will subject any legislative proposals, such as a potential framework Directive on services of general interest, to prior extended impact assessment of its economic, social and environmental implications. Again, no social or environmental impact assessment has been made of the Services Directive. Remarkably, contrary to the Green Paper, the White Paper does not pay any attention to the difference between economic and non-economic services of general interest. This might be because it is difficult to draw a clear line between the two and because the distinction is dynamic and evolving. To draft the Communication on health and social services of general interest, close cooperation has been instituted with the Member States via the Social Protection Committee and the High Level Group on health services and medical care. A questionnaire has been sent to the Member States with the aim of collecting input for the Communication.

### **Conclusions**

Developments in 2004 regarding EU policies to tackle health care issues have been extremely rapid. The tone has undoubtedly been set by the economic players, launching proposals for enforceable hard law. The proposal for a Services Directive is the caricature of this approach. No consultation, no debate, no coordination, but action. No impact assessment of this proposal on health care services and health care systems has been carried out, not a single word has been written on the potential impact of the proposal on the health care sector. Other Community proposals regarding the internal market take a more balanced approach towards the health care sector. But even then, the

impact assessment remains poor, as are the justifications for a specific approach for the health care sector. The different initiatives of the economic players do not always express a coherent view either. This is most striking between the Services Directive on the one hand and the analysis of the Commission's DG Ecfm on the impact of health care spending on public finances on the other hand. DG Ecfm states that there is a strong economic rationale for some public sector involvement in the financing and provision of health care on both efficiency and equity grounds. This analysis contrasts with the assumptions of the Services Directive stating that less public intervention and more free movement would lead to higher quality and lower prices, including in the health care sector.

This divergence of views is somehow predictable as the different actors have different objectives. The EPC has to monitor public spending; the internal market actors have to boost economic activity. As long as health care is mainly funded from public resources, these actors will have divergent views...

The social and health players are disconcerted by these initiatives. They feel the need to react. This drive for action at EU level is becoming stronger than the fear of too much EU interference in their national health policies. The discourse is changing and the argument for subsidiarity to avoid EU level debate on health care systems is less often voiced. However, the slowness of the processes for closer cooperation in the field of health care contrast with the time pressure that is put on the concrete legal initiatives to liberalise the market in health services, such as the proposal for a Directive on services in the internal market. Those responsible for health care policy are thus put on the defensive and are not able to give an adequate and clear political response to developments. The cooperation processes risk drowning in a proliferation of bodies, contradictory advice, streamlining initiatives etc. They stick mainly to data collection and assessment of existing experiences but have not so far been able to draw up any clear policy lines or concrete proposals, let alone make legal proposals. There seems to be a consensus among Member States on the analysis of the problems. However, there is much less consensus on ways of dealing with these problems.

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