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Health and social services in the internal market

Introduction

In 2006, health and social services were withdrawn from the scope of application of the services directive. However, in spite of this withdrawal, and probably also due to the initial inclusion of these services in the directive, stakeholders became aware, more than ever, that these services are not sheltered from the application of the internal market rules. The call from Member States, the European Parliament and concerned stakeholder organisations for more legal certainty and for a legal initiative by the Commission became louder and louder. These actors want rules on the specific application of the free movement provisions to their sector. Despite this, the European Commission is reluctant to launch clear legal proposals, and seems unable to find a consensus among the different DGs on the scope and content of such an initiative. The Commission services responsible for the internal market continue to favour an approach that creates as few specific rules or criteria as possible for the application of internal market rules. Their main concern is to oblige Member States to comply with the European Court of Justice's judgements. They are supported by right-wing Members of the European Parliament and some of the new Member States, hoping to create more room for commercial actors in the field of health and social care.

1. Health and social services excluded from the scope of the services directive

As discussed in the chapter by Éric Van den Abeele in this volume, one of the most controversial aspects of the initial proposal for a Directive on Services in the internal market was its scope, applying general rules on the free movement of services and the freedom of establishment, without any distinction, to services of general (economic) interest and more specifically to social and health services, just as to any commercial service. It soon became clear that there was no public and political support to keep health services in the Directive. In spring 2005, the European Council and the European Commission announced that the proposal should be readjusted in order to safeguard the European Social Model.

After two years of lively policy debate, the European Parliament at its first reading in February 2006 excluded healthcare services from the scope of the Directive (European Parliament, 2006a). The European Commission incorporated this parliamentary amendment into its amended proposal in April 2006 (CEC, 2006a). At the same moment, the Commission announced that it would come forward with a separate legal initiative on the health sector.

Regarding social services, the Commission did not completely follow the position of Parliament at first reading. Whereas the Parliament excluded social services from the scope of the Directive and for purposes of clarity provided an indicative list of social services, the European Commission adopted this as a definitive list. Thus the Commission in its amended proposal excluded only social services relating to social housing, childcare and support of families and persons in need (CEC, 2006a).

In the next steps of the decision-making process, no further changes were made with regard to the exclusion of these two sectors from the scope of the Directive. The Council adopted its common position in July 2006 (Council of the European Union, 2006a). Amendments tabled by rapporteur Evelyne Gebhardt (PSE, Germany) in the European Parliament's Internal Market and Consumer Protection Committee at second reading, to broaden out once again the definition of the social

services to be excluded from the scope of the Directive, were rejected together with all the other proposed amendments. These amendments were aimed mainly at excluding legal and complementary social protection regimes (European Parliament, 2006b). A wider exclusion of social services was not acceptable for the conservatives in the European Parliament; furthermore, the Finnish presidency and Commissioner McCreevy had insisted on not jeopardising the Council compromise. Evelyne Gebhardt refrained from reintroducing her amendments in the plenary session after a commitment from Commissioner McCreevy to make a declaration clarifying the main issues that Ms Gebhardt thought needed to be amended, such as consequences for social services. This declaration was presented in a speech by Commissioner McCreevy preceding the final vote on 15 November. With regard to social services the Commissioner declared, “*Concerning the impact of the Services Directive on Social Service, social services relating to social housing, childcare and support of families and persons in need are a manifestation of the principle of social cohesion and solidarity in society and are provided by the State, by service providers on behalf of the State or by acknowledged charitable organisations. These services have thus been excluded from the scope of application of the Services Directive. It is clear that this exclusion also covers services provided by churches and church organisations which serve charitable and benevolent purposes.*” (CEC, 2006b: 5).

The exclusion of these two sectors from the scope of the Directive finally reads as follows:

Article 2 - Scope

2. “*This directive shall not apply to the following activities:*

(...)

(f) Healthcare services whether or not they are provided via healthcare facilities, and regardless of the ways in which they are organised and financed at national level or whether they are public or private;

(...)

(j) *Social services relating to social housing, childcare and support of families and persons permanently or temporarily in need which are provided by the State, by providers mandated by the State or by charities recognised as such by the State*” (European Parliament, 2006c: 52).

In the recitals it is made clear that healthcare covers “*healthcare and pharmaceutical services provided by health professionals to patients to assess, maintain or restore their state of health where those activities are reserved to a regulated health profession in the Member State in which the services are provided*” (Recital 22).

With regard to social services, a recital clarifies that these concern services “*with the objective of ensuring support for those who are permanently or temporarily in a particular state of need because of their insufficient family income or total or partial lack of independence and for those who risk being marginalised*” (Recital 27). This recital refers in addition to the fundamental right to human dignity and integrity and the principles of social cohesion and solidarity.

We can thus conclude that the exclusion of healthcare services from the scope of the services directive is defined very broadly and covers all services in this field. For social services the picture is somehow less clear. It has proved problematic to give a clear definition of social services. Whereas the European Parliament proposed a wide and open definition, the European Commission imposed a narrow definition. It is feared that the notion “*persons in need*” in the definition might not include services provided to the whole population. Furthermore, there seems to be a major concern about the inclusion of complementary social protection regimes. It is not clear how Commissioner McCreevy’s declaration in the European Parliament could alleviate these concerns for social services.

2. Policy initiatives following the exclusion of health and social services

Since the launch of the proposal for a services directive, in January 2004, several ongoing processes, initiatives and debates concerning the relationship between health and social services and the internal market had been blocked. The European Commission was awaiting the outcome of the European Parliament’s vote at first reading and the

Council's opinion on the scope of the Directive before taking any new steps. Once this corner was turned, in spring 2006, there was a surge of activity in this respect.

2.1 Social Services of general interest

In April 2006, the European Commission released its long-awaited Communication on social services of general interest. This Communication had been promised in the 2004 White Paper on services of general interest. In the White Paper, the Commission stressed that the personal nature of many social and health services leads to requirements that are significantly different from those in networked industries (such as the distribution of gas, electricity, postal services, telecommunications). The Commission argued 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. It proposed setting out this approach in a Communication on health and social services of general interest, to be adopted in the course of 2005.

As a contribution to the drafting of the Communication, Member States reported at the end of 2004 on the situation of social and health services in their countries through a questionnaire prepared in the Social Protection Committee (SPC) ⁽¹⁾. This questionnaire concerned the following sectors: statutory and supplementary social protection schemes; health and social services; support for families: child care; services to promote social integration and to support people in difficulties (e.g. homelessness, drug dependence, disability, mental or physical illness); social housing; other services such as employment services, access to placement and education and training). The questionnaire included questions concerning the characteristics of these services, their definition and specificity; the impact of EC internal market rules or competition rules on them, and what further steps should be taken at European level.

¹ "Social Services of General Interest", Questionnaire (http://ec.europa.eu/employment_social/social_protection/docs/questionnaire_en.pdf); and Member States that replied to the SSGI questionnaire (http://ec.europa.eu/employment_social/social_protection/answers_en.htm).

The publication of the Commission's Communication was delayed several times. It seems that it proved extremely difficult to reach an agreement between the Commission's different DGs on the content of the Communication. Finally, the European Commission awaited the outcome of the first reading of the services directive in the European Parliament and in particular the decision on the Directive's scope of application. If health and social services had not been excluded from the services directive, this might have removed some important arguments in favour of a specific approach for this sector.

According to the Communication, social services can include statutory and complementary social security schemes and essential services provided to persons that consist of customised assistance to facilitate social inclusion and safeguard fundamental rights. It clarifies the sectors, including services for persons faced by personal challenges or crises; activities aiming at reintegration in society and labour market; support for families in caring for younger and older members; activities to integrate persons with long-term health or disability problems, and finally social housing.

The Communication does not deal with health services. This is rather surprising, since for two years it had been announced as a Communication on health and social services. Apparently the decision to exclude healthcare services was the result of last-minute negotiations within the European Commission and is linked to the fact that the Commission intends to bring forward a specific legal proposal on health services. Illustrative in this respect is the fact that the Annexes to the Communication still include comments on health services.

The Communication aims to consider how the specific characteristics of social services of general interest can be taken into account at European level, and to clarify the Community rules applicable to them. It presents an open list of specific characteristics of social services of general interest (SSGI). In addition to the traditional general interest criteria (universality, transparency, continuity, accessibility, etc.) recognised for social service activities, these characteristics refer to the organisational conditions and modalities applying to them. These characteristics include the services being personalised and their aims being directly connected with access to fundamental social rights and

the achievement of social cohesion. To achieve those aims, social services of general interest are based on solidarity and frequently require the voluntary participation of citizens and of not-for-profit organisations. They also need to be developed as close as possible to the users, which explains why local authorities play an important role in ensuring that development. Finally, they are characterised by an asymmetric relationship (relationship of dependency and need) between providers and beneficiaries that cannot be likened to a “normal” supplier/consumer relationship and requires the participation of a financing third party.

The Communication then describes how SSGI can modernise, open up and diversify across the EU, thus operating in a more competitive environment. In a second section, the application of Community rules to these services is analysed. The Communication states that “*almost all services offered in the social field can be considered ‘economic activities’ within the meaning [...] of the EC Treaty*” (CEC, 2006c: 6). In this section the Communication is rather didactic, explaining how Court rulings and Community legislation apply in this sector, with regard to state aid, the principles of freedom to provide services and freedom of establishment, and public procurement rules. It sets out suggestions for specific application in certain fields.

To gain a clearer picture of each EU country's approach to social services of general interest, the Commission launched a study to look at the situation in each Member State⁽²⁾. The scope of this study, although defined in the initial tender as a study on “*The Situation of Social and Health Services of General Interest in the European Union*”, was limited soon after the launch of the Commission Communication to social services only (although including long-term care). This study aims to analyse the functioning of the sector and its socio-economic importance, as well as the implications of the application of Community law.

Additionally, the Commission announces in the Communication a consultation of all the actors concerned: Member States, service

² <http://www.euro.centre.org/shsgi>.

providers and users. On the basis of the results of this study, as well as the consultation, the Commission intends to launch a monitoring and dialogue procedure in the form of biennial reports, describing the latest modernisation trends, case law and developments. The first report is due to be published at the end of 2007.

The Communication ends by concluding that “*in the light of this experience, the Commission will decide how to follow up this process and identify the best approach to take, including giving consideration to the need and legal possibility for a legislative proposal*” (CEC, 2006c: 10). The question as to whether a legal proposal will be presented in the future has thus been left open. It seems that DG Employment and Social Affairs, which has the lead over initiatives concerning social services of general interest, did not receive endorsement from the College of Commissioners to start preparing a legal framework. At a conference organised by the Austrian presidency, only few days before the draft Communication was discussed and approved by the College of Commissioners⁽³⁾, Commissioner Špidla launched the idea of a legal framework. This suggests that he proposed the establishment of a legal framework to the College of Commissioners but did not get backing.

With respect to the consultation process, a new questionnaire has been sent out to Member States. The scope of the questionnaire encompasses:

- *“basic compulsory social security schemes based on the principle of national solidarity that do not carry out economic activities;*
- *other schemes, especially complementary social security schemes, organised in various ways (mutual or occupational organisations), covering the main risks of life, such as those linked to health, ageing, occupational accidents, unemployment, retirement and disability;*

³ Conference on “Social Services”, co-financed by the European Commission, Vienna, 20 April 2006 (<http://eu2006.bmsg.gv.at/cms/eu2006EN/liste.html?channel=CH0608>).

- *other essential services provided directly to the person as assistance in case of personal challenges or crisis, to support social integration, to tackle long-term health or disability problems, or to support housing?*

The questionnaire further states that “*although health issues are not directly covered by the scope of this exercise it is not always easy to distinguish social from health services?*”.

The questionnaire broadly tackles the same issues as the 2004 questionnaire of the Social Protection Committee. However, the 2006 questionnaire takes the Commission’s spring 2006 Communication as its starting point and asks for clarification, assessment and additions to the points made in the Communication. Answers are due by early 2007.

In a reaction, the Social Platform (the Platform of European Social NGOs) welcomed the Communication, but said that the Commission should have taken bolder steps towards proposing legal instruments on social SGIs, to clarify how they are treated in EU rules in a context of urgent modernisation of social services in Member States (Social Platform, 2006). The ETUC likewise considers that the Commission must go further with its proposals in this regard, in order to establish greater legal certainty, through a framework directive on services of general interest, which should also make it possible to take account of the specific character of social services. The ETUC pointed out that social services were not provided only to the poor or the excluded, but often had to meet the needs and expectations of all individuals; hence the need to expand the definition given by the Commission (ETUC, 2006). The European Centre of Enterprises with Public Participation (CEEP) and the European Federation of Public Service Unions (EPSU) similarly expressed disappointment. Most of these stakeholders also regretted the fact that health services were excluded. The Committee of the Regions, in its opinion on the Communication, also questions the decision not to include health services in the Communication; it asks the Commission to clarify the nature of the legislative proposals on SSGI as soon as possible, and urges the Commission to deliver on its commitment to give consideration to the need and legal possibility for a legislative proposal on SSGI at the end of the open process of consultation (Committee of the Regions, 2006).

The European Parliament has not yet delivered its opinion on this Communication, but in its resolution on the Commission White Paper of services of general interest, it “*calls on the Commission to create more legal certainty in the area of social and healthcare SGIs and to formulate a proposal for a sector-specific directive of the Council and the Parliament in those fields in which it is appropriate to do so*” (European Parliament, 2006d: point 17). On the eve of the vote on the report, José Manuel Barroso announced that, following approval of the Rapkay report, the Commission would adopt a Communication by the end of 2006 and propose sectoral initiatives ⁽⁴⁾.

Why has healthcare been excluded from the scope of this Communication? The European Commission seems to favour a different approach for the two sectors: on the one hand a legally binding initiative for the healthcare sector (see below), and on the other hand clarificatory Communications with vague principles for the social services, and this in spite of the fact that Commissioner Špidla was in favour of a legal initiative for social services as well. Several factors have probably played a role in this decision for a different approach for health and social services. Firstly, one important difference between the two sectors is that the European Court of Justice has issued a series of rulings with regard to healthcare services, making plain that these services are to be considered as an economic activity and laying down rules on the reimbursement of care received in another Member State. The Commission services responsible for the internal market want to force Member States to comply with these rulings through a legally binding instrument, comparable with the initial Article 23 of the services directive. For social services, however, there are no Court rulings (yet). Therefore, it might well be that these Commission services prefer to await further Court rulings before issuing a legal proposal on social services. Another factor that probably played a role is the competition between the Commission services responsible for social affairs on the one hand and public health on the other to claim the lead in this debate. A Communication on health and social services would imply close cooperation between both DGs and a common approach in

⁴ Bulletin of the European Union, No.9274, 28 September 2006.

solving the problems. DG Sanco (the Commission services responsible for public health) announced long ago a specific initiative on the health sector after a wide consultation of all the stakeholders. A joint Communication might slow down this process and might make it more difficult to have a specific approach, including a subsequent legal proposal on healthcare. By excluding health services from the scope of the Communication, the situation is avoided whereby the DG responsible for social affairs would have its say on the initiative on health services. The debate on social services of general interest would on the other hand become the exclusive domain of the social affairs actors and has in the meantime been integrated in the Social Protection Committee.

With respect to the definition of the services included in the Communication and the subsequent consultation, it is striking that complementary social security schemes are included, even though they are not excluded from the scope of the services directive. With respect to the content of the Communication, it remains very much a descriptive and analytical document, with limited possibility to create more clarity for stakeholders on how internal market rules should be applied in their sector. As to the process of Commission initiatives on social services of general interest, we are seeing a proliferation of questionnaires and consultations. It might well be that the Commission services responsible for social policy hope to raise even more awareness of the issues at stake through these consultations, thus increasing pressure on the Commission services responsible for internal market to accept the idea of a legal proposal.

2.2 A legal initiative on health services?

The European Commission announced in April 2006, in its amended proposal for a services directive, when it accepted the exclusion of healthcare services from the scope of the directive, that it would come forward with a separate legal initiative on healthcare services (CEC, 2006a). Since the making of this pledge, speculation about the scope of this initiative has been rife. The main question is whether such an initiative would be limited to the rules applicable for the funding of care received in another Member State (former Article 23 of the services directive) or whether such an initiative should also include other issues

related to the interaction between internal market rules and healthcare services, concerning freedom of establishment and the freedom to provide services.

Several initiatives were taken with the aim of guiding the debate.

2.2.1 Council Conclusions on common values and principles

The Ministers of Health of the 25 Member States adopted, at the Council of 1-2 June 2006, Conclusions on common values and principles which guide EU health systems (Council of the European Union, 2006b). In their declaration, the Ministers agreed that health services are underpinned by a set of values shared across Europe. These are the values of universality, access to good quality care, equity and solidarity. The Ministers stated that different Member States have different approaches to realising these values, but that all systems aim to make them financially sustainable in a way which safeguards the values for the future.

Besides values, they outlined a set of operational principles that are shared across the European Union, in the sense that all EU citizens would expect to find them, and structures to support them, anywhere in the EU. These include quality; safety; care that is based on evidence and ethics; patient involvement; redress and privacy and confidentiality.

The Ministers concluded that health systems are a fundamental part of Europe's social infrastructure. In discussing further strategies, the shared concern should be to protect these values and principles. They invite the European institutions to ensure that their policies will protect these values as work develops to explore the implications of the European Union for health systems as well as the integration of health aspects into all policies.

The Council invites the European Commission to ensure that the common values and principles contained in the Statement are respected when drafting specific proposals concerning health services.

2.2.2 Proposal launched by the Belgian Health Minister

In the meantime, after close consultation with some like minded colleagues from other Member States, the Belgian Minister of Social Affairs and Public Health, Rudy Demotte, launched a "non-paper"

stressing the need for a specific approach for the healthcare sector and proposing a specific directive on healthcare services⁵). The basic presumption of this paper is that, in order to organise their healthcare systems, Member States need a steering capacity and some genuine regulatory responsibilities. The paper proposes a directive that:

- describes the common values and principles that underpin European healthcare systems;
- outlines their objectives;
- defines the different types of instruments public authorities use to properly manage their systems (such as planning, tariff setting mechanisms, authorisation schemes for providers etc.);
- identifies the conditions under which the use of these instruments is in conformity with the Treaty provisions.

The document suggests that, if such instruments are used by Member States to safeguard the common values and principles, and to achieve the objectives and redress market imperfections in this sector, their use should be regarded as justified as this constitutes an overriding reason relating to the public interest. Furthermore, the directive should clarify how the principles of non-discrimination and proportionality should be applied in this sector. The paper proposes the inclusion of rules with regard to reimbursement of care provided for within another country. Finally, the paper argues for closer cooperation and exchange between Member States on issues such as patient rights, quality of healthcare, patient safety and liability.

This paper obtained the support of eight Member States with social-democrat health ministers which regularly meet to discuss problems of European legislation interfering with their countries' health systems. These countries, Germany, Spain, Belgium, Luxembourg, Portugal, Sweden, Italy and the UK which form the so called "Aachen group" – after the location of their first session in Germany last year - presented their views at an informal meeting of health ministers in July. They

⁵ Non paper, presented at the Informal Council Meeting of the Employment, Social and Health Ministers, Helsinki, 6-8 July 2006.

argue cogently for a legislative proposal that goes beyond the issue of patient mobility, and for the establishment of a legal framework that provides a basis to justify the use of management tools needed by health authorities to steer their health systems and to guarantee the quality, accessibility and financial sustainability thereof.

2.2.3 Commission consultation

At the end of September 2006 the European Commission launched a public consultation document with regard to EU action on health services (CEC, 2006d).

The Communication seeks input in two areas:

- how to *ensure legal certainty* regarding cross-border healthcare under Community law;
- whether and how to *support cooperation* between the health systems of the Member States.

According to the Communication, cross-border care includes a healthcare provider who moves temporarily or permanently to another Member State, a patient who moves, or a service that moves such as in the case of telemedicine. The Communication highlights the fact that cross-border care has consequences for all health services, whether provided across borders or not. It stresses that Community action in this field does not mean harmonising national health or social security systems.

The consultation contains questions on issues such as:

- the current impact of cross-border healthcare on accessibility, quality and financial sustainability of healthcare systems, both for “sending” and “receiving” countries;
- where greater legal certainty is required to facilitate cross-border healthcare in practice (including issues such as terms and conditions under which cross-border healthcare must be authorised and paid for; whose rules apply; and what happens when things go wrong);
- areas where European action can support Member States such as networks of centres of reference, health innovation and impact assessment of EU policies on health systems. In this context the

Communication also suggests initiatives on “*improving the availability and comparability of healthcare data and indicators*” with the aim of comparing outcomes across Europe, monitoring and cooperating;

- what tools would be appropriate to tackle these different issues at EU level – whether binding legal instruments, “soft law” or other means;

The Communication indicates some options for these tools:

- a legal binding instrument through a regulation or a directive, which could be based on Article 95 of the EC Treaty is put forward as the best option to ensure legal certainty;
- the proposal for a regulation on the coordination of social security systems (CEC, 2006e);
- an interpretative Communication on the case law could provide additional clarification;
- practical cooperation through the High Level Group on health services and medical care (on issues such as networking of centres of reference) and the Open Method of Coordination in the field of health and long-term care.

Although the Communication claims to deal with all forms of cross-border care, the focus of the questions lies in particular on patient mobility, i.e. the patient who seeks care in another Member State.

Based on the responses to this consultation, which are sought for early 2007, the Commission plans to bring forward proposals later in 2007.

At an informal ministerial meeting held by the European Commission on 29 November 2006, in the context of this consultation, all Member States except the Netherlands were in favour of a legal instrument. Many health ministers expressed the wish to encompass issues ranging beyond patient mobility. They hoped that a legal instrument would bring more legal certainty and ensure legal stability of healthcare systems. With regard to reimbursement of care provided abroad, countries such as the UK and Sweden argued for reimbursement to be based on prices of the country where the care is given. Central and Eastern European countries saw patient mobility rather as an

opportunity to attract patients, thus developing a health services economy. With regard to other issues, such as quality of care, Member States tend to prefer intergovernmental cooperation ⁽⁶⁾.

This Communication, although focusing very much on the issue of patient mobility, leaves all doors open with regard to a subsequent (legal) initiative from the Commission. The Commission probably wants to see how strongly the stakeholders will make their point on the scope of a legal proposal. A consultation is also a tool to legitimise further initiatives and to generate ownership of the final proposal among the stakeholders.

2.3 Infringement procedures of the European Commission

Once it was clear that healthcare would be excluded from the services directive, the European Commission's DG Internal Market became particularly active in launching infringement procedures against Member States.

The Commission started infringement procedures against three Member States, with regard to legislation that would limit the opening and running of pharmacies, just a few days after the Council reached a political agreement on the exclusion of healthcare services from the services directive. For details of these cases see Box 1.

It is striking that the legislation under scrutiny in these infringement procedures includes several authorisation procedures and conditions that were listed in Article 15 of the services directive and that Member States would have had to screen for compliance with the requirements of non-discrimination, necessity and proportionality; these should have been abolished or changed if they did not comply. As a reminder, the restrictions listed in Article 15 of the services directive included:

“- quantitative or territorial restrictions, in particular in the form of limits fixed according to population or of a minimum geographical distance between service-providers;

⁶ Bulletin of the European Union, No.9320, 5 December 2006.

- *an obligation on a provider to take a specific legal form, in particular to be a legal person, to be a company with individual ownership, to be a non-profit making organisation or a company owned exclusively by natural persons;*
- *requirements, other than those concerning professional qualifications or provided for in other Community instruments, which reserve access to the service activity in question to particular providers by virtue of the specific nature of the activity”* (CEC, 2004: 53).

Thus, whereas the European Commission stated during the debate on the services directive that healthcare regulators should not bother about Article 15, as they would in principle be able to justify restrictions in the healthcare sector as being in the general interest, these infringement procedures show a different picture. The infringement procedures thus give a good illustration of the legal uncertainty in which health authorities and regulators find themselves, even after the exclusion of healthcare from the services directive.

It is felt that, after having failed to oblige Member States to comply with the rules on freedom of establishment through the inclusion of healthcare in the services directive, the European Commission wants to realise this aim through Court rulings and to make clear that the withdrawal of these services from the services directive does not change much. These initiatives illustrate once again the paradoxes within which the European Commission operates. Whereas its internal market services start legal proceedings against Member States which are considered not to comply with the EU rules, the Health DG tries to launch a debate on more legal certainty for the regulatory authorities. Some Member States consequently called on the Commission services to block the infringement procedures until more clarity about a political initiative could be achieved. The refusal of the Commission services to take this political process into account suggests that they will not approve a legal initiative that would shelter this kind of national legislation from internal market provisions.

Box 1: Infringement procedures started by the European Commission

Italian legislation prevents companies active in the distribution of medicines (or having links with companies active in this area) from acquiring holdings in private pharmaceutical companies or community pharmacies. The legislation also prevents individuals who do not hold a pharmacist's diploma from having holdings in pharmacies, thus reserving ownership of pharmacies to pharmacists or legal entities consisting of pharmacists. The Commission considers that the restrictions in question go beyond what is necessary to achieve the objective of health protection. According to the European Commission the Italian rules are incompatible with the freedom of establishment (Art. 43 of the EC Treaty) and the freedom of movement of capital (Art. 56 of the EC Treaty). Therefore the Commission has taken the matter to the Court of Justice.

Austria has been sent a reasoned opinion because its national legislation restricts freedom of establishment as a pharmacist. The Commission is challenging the following restrictions, among others: discrimination on the basis of nationality, which prevents non-Austrian nationals from operating a pharmacy that has been open for less than three years; the ban on opening a pharmacy in areas without a doctor's surgery; limiting the choice of legal form for a pharmacy (no companies are allowed); the ban on operating more than one pharmacy and limitations on the number of pharmacies according to a minimum number of inhabitants and a minimum distance between the pharmacies.

Another reasoned opinion has been sent to Spain because of the following national restrictions on the setting-up of pharmacies: territorial planning rules based on a minimum number of inhabitants (minimum module between 2,800 and 4,000 inhabitants) and a minimum distance (250 metres) between community pharmacies; giving priority in certain Autonomous Communities, such as Valencia, to pharmacists with professional experience in the same community in the administrative licensing procedure; and ownership rules whereby only pharmacists can hold a pharmacy. The European Commission considers these restrictions to be either disproportionate or discriminatory. (CEC, 2006f)

An infringement procedure was opened against Belgium for its legislation on PET Scans (medical imagery system particularly used to detect cancers). Belgian legislation defines criteria of approval limiting the number of services in which a PET scan can be installed on Belgian territory to 13 for a 10.5 million population. A complaint was submitted to the European Commission against the Belgian measure on the grounds that it creates an obstacle to the free movement of goods, lodged by the non-approved hospitals and the scanner manufacturers.

Belgium received a formal request to submit its observations on Belgian sickness funds that provide supplementary health insurance (i.e. on top of the basic social security cover) in competition with commercial insurance providers. In Belgium, sickness funds operate under specific national rules and are not subject to EU rules relating to the solvency, supervision and funding of insurance providers. The Commission is concerned that this could result in differing levels of policyholder protection and market distortions. Belgium is asked to send its reply within two months. Depending on the analysis of this reply, the Commission will decide whether or not to issue a 'reasoned opinion' formally calling on the Belgian Government to amend the relevant legislation (CEC, 2006g)

Concluding remarks

Whereas in the past we described a picture of action and reaction between the economic players and the social players in the field of healthcare at EU level, with the economic players in the driving seat and the social players not able to reach a consensus on an appropriate political response (Baeten, 2003 and 2005), in 2006 the dividing-line seems rather to run between the different EU institutions. The European Parliament and the Council are largely in favour of a legally binding initiative to clarify the relationship between the internal market and health and social services (of general interest), and thus to generate more legal certainty for the players concerned. Most players in the relevant services sector are also calling for a legal initiative. The Commission however remains very cautious in this respect and takes a different approach for health and for social services. As only the Commission has the right of initiative for legal proposals, however, the European Parliament and Council are dependent on its willingness to act.

The *European Commission* is indeed favour of a legally binding initiative for the healthcare sector, most probably to include provisions on the reimbursement of healthcare provided in another Member State. To what extent this legal proposal would go beyond this and also deal with issues related to freedom of establishment and the deregulating effect of the free movement provisions on the healthcare sector is highly questionable. For the social sector the European Commission limits itself to clarificatory Communications.

The different European Commission DGs involved take a different approach. Whereas those DGs responsible for health and social policies and having the closest contacts with the sectors concerned argue for more legal certainty, DG Internal Market is mainly concerned to compel Member States to comply with the Court rulings and the internal market provisions. Although they are willing to accept a specific directive for the healthcare sector, their aim is to exact compliance from Member States with regard to patient mobility. The infringement procedures launched against certain Member States have the same aim. DG Internal Market is not in favour of legislation setting out a specific approach for the application of the internal market provisions to the

health and social sector going beyond the Court rulings. As there are no Court rulings with regard to the social sector, it opposes legal initiatives in this sector. DG Internal Market seems to be in the strongest position to impose its viewpoint and to obstruct further initiatives.

Although the DGs responsible for health and social policies seem to share the same concern, they are proving unable to join forces. The competition to claim leadership over the policy initiatives under discussion keeps them from cooperating effectively. Their approach is mainly to increase awareness from the stakeholder groups concerned through consultation and questionnaires.

Member States and *the European Parliament* are broadly in favour of a wider initiative, providing clarity on the steering capacity of public authorities and giving more indications on how national regulations can be set in conformity with the internal market rules. The coalition of Member States in favour of such a wider initiative for healthcare might seem surprising. Indeed, countries such as the UK and Sweden, traditionally extremely reluctant to allow EU intervention in their national policies on health and social protection, are among those spearheading the group of Member States calling for a legal initiative going beyond the issue of patient mobility. We have come a long way since the first Court rulings defining healthcare services as an economic activity and the cautious initiation of EU level debates on a policy response to this development. In 2006 there was a judgement in the Watts case (see chapter by Dalila Ghailani in this volume)⁽⁷⁾ clarifying that when a patient of a National Health Service system (such as the UK and the Swedish healthcare systems) has the right to go abroad to receive treatment, the rules on the free movement of services also apply to these systems, as the care provided abroad is provided against remuneration. It thus became clear that NHS systems are no longer sheltered from internal market rules, which increased pressure in these countries to deal with these issues at EU level.

⁷ CJEC, Case C-372/04, *The Queen on the application of Yvonne Watts v Bedford Primary Care Trust and Secretary of State for Health*, Judgment of the Court, 16 May 2006.

When we compare the policy debates in the sector of social services on the one hand and of healthcare services on the other, we perceive different accents in the issues discussed. Whereas for the healthcare sector the debate focuses very much on patient mobility and on the deregulating effects of the internal market rules, the debate in the social services sector focuses much more on the application of the rules with regard to state aid, concessions, public procurement and public private partnership. Striking too is the fact that in the social services sector the need to entrust these services formally with a mission of general interest is a more prevalent concern than in the healthcare sector. This can probably be explained by the different angles from which these sectors have been confronted with the impact of EU law. For the healthcare sector these have been the Court rulings on the one hand and the services directive - more particularly Article 15 of this directive on freedom of establishment - on the other. Social services, often more closely linked with local authorities, are more aware of and concerned about the Court rulings on state aid, such as the *Altmark* judgement on public funding as compensation for a mission of general interest⁸, and the Decision of the Commission with regard to state aid in the form of public service compensation granted to undertakings entrusted with the operation of services of general economic interest (CEC, 2005; see also Baeten, 2005). In the social sector the link with services of general interest is made more explicitly. This probably has to do with the fact that in the healthcare sector, in most Member States, there exists a parallel, for-profit, commercial circuit that does not necessarily function with public funding. These providers do have to comply with minimum quality standards, but not with rules on tariff setting, and do not have to guarantee equal access. Although usually these services can thus hardly be seen as services of general interest, Member States are in favour of maintaining their steering capacity for these services too, not least because they are experimenting with opening up their publicly funded systems to these commercial providers. This tendency to open up publicly funded systems to commercial providers also explains the focus in the Council initiative on common values and principles. Whereas the

⁸ CJEC, Case C-280/00, *Altmark Trans GmbH, Regierungspräsidium Magdeburg*, Judgment of the Court of 24 July 2003.

“*values*” refer to the “classic” basics of publicly funded healthcare systems, the “*principles*” focus on characteristics that “*EU citizens would expect to find and structures to support them anywhere in the EU*”. These principles include quality, safety; care that is based on evidence and ethics; patient involvement; redress and privacy and confidentiality. It is not a coincidence that Member States which are opening up their systems to these commercial providers, such as the Netherlands and the UK, have taken the lead in this initiative. The need to create EU level minimum guarantees on these requirements might not only serve patients going abroad, but also patients moving to the domestic private commercial system. These developments push for EU level initiatives guaranteeing basic level standards for patients shopping around as consumers, and this approach coincides very much with the approach of the “internal market” actors in the European Commission.

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