

### **Workshop 3 : impact of the single market rules on health care systems**

Conclusions of the rapporteur

Health care systems carry in themselves economic as well as social elements. In principle, the single market also concerns goods and services, the use of which has an influence on people's health ; they may be goods and services for the benefit of health care. Protection of health and security plays an important role in the harmonisation of legislation and in the advancement of free movement of goods and services. A quarter of all EU rules on completion of the single market is related to security and health. We only have to look at the EU rules on medicines, devices, food, tobacco products, hazardous materials, toys, biocides and certificates of doctors or other medical professionals.

Nevertheless, a normal market of suppliers and consumers does not exist in the health care sector. In the EU states, health care services are in most cases offered through collective, legal arrangements. In order to assure access to health care, national governments have intrusively dealt with the funding of health care, sometimes by organising a compulsory health insurance, including compulsory affiliation, a legally set package and a legally set contribution scheme, sometimes by organising a national health service, financed by tax revenues. In all the EU countries, governments and executors of health care insurance act as major payers of care, using of course the money paid by the citizens in taxes or contributions. Such payment systems have obviously an influence on the supply and demand of health services and products. From the very outset it has been accepted that Member States remained autonomous as far as the organisation of their health care system as part of the social security is concerned. Harmonisation of strongly diverging social security systems has been considered a mission impossible.

According to the jurisprudence of the Court of Justice of the EC, the fact that the organisation of the social security system, including a legal health care system, belongs to the competence of the Member States does not mean that one does not have to take into account the EC Treaty. Within the framework of such a system, some restrictions on the freedoms provided by the Treaty (free movement of persons, goods and services) can be justified if required by a compelling need for the public interest, viz. insofar as, from the point of view of public health, it is necessary to guarantee access to health care which is of sound quality and affordable. This jurisprudence has nevertheless caused a lot of disturbance in the health care sector because the Court put an end to the widespread opinion that Member States, against the background of e.g. the EC Regulation on social security (n° 1408/71), were free to limit, on territorial grounds, claims to health care and reimbursements in national rules, in the public interest. According to the Court, legal provisions on dispensation or reimbursement may, in principle, not discriminate as to the origin or place of establishment of the care provider within the European Union. Rules requiring that an insured person asks for authorisation from his legal health insurer in order to get a refund for health care received abroad, are in principle not allowed if this authorisation is not required in one owns country. In the judgements Decker and

Kohll, the Court pushed aside the Luxembourg reimbursement rules because it considered discriminating rules not justified in this case. In the recent judgement *Smits and Peerbooms*, the Court considered justified the rules valid in the Netherlands for obtaining authorisation to receive health care from non-contracted care providers. Still, the Court specified that the conditions under which this authorisation is given may not go beyond what is objectively considered as necessary and reasonable. The jurisprudence of the Court of Justice of the EC has unmistakably contributed to the growing awareness that a patient/insured person can, should the occasion arise (e.g. shortage or waiting lists), exercise his right to health care in another country of the EU, as it is legally provided at a national level. The workshop also argued that the growing cross-border movement compels Member States to pay more joint attention to the quality of health care; moreover, more transparency in price setting is desired. By means of the open method of co-ordination, common objectives can be pursued as far as quality of care is concerned.

Social security systems in which insurance claims and contributions are set by the government and the implementation depends on non profit institutions under governmental supervision, fall beyond the scope of EU competition law. As part of the modernisation of the social security, some Member States have introduced competition elements in their health insurance. In Belgium, Germany and the Netherlands, people are free to choose their sickness fund. These sickness funds contribute to systems of equalisation of costs, but they dispose of a small margin to set (a part of) the premium themselves. In the workshop, the development in the Netherlands has been taken as an example. The sickness funds compete with each other in a bid for the insured persons' favour. Sickness funds have no influence on the income-related part of the premium unlike the nominal part of the premium that can be fixed by every sickness fund individually. The objective is that the amount of the nominal premium should reflect the degree of efficiency of the sickness fund in implementing the insurance, as well as the degree of efficiency achieved in purchasing health care. Towards the provider of ambulatory care there is no longer an obligation to contract. Sickness funds have an economic relation with these care providers. The Dutch Competition Authority has taken the position that competition law is applicable on the economic activities of the sickness funds (notably the activity of buying health care).

The discussion revealed that there is only limited space for competition in the health care sector. One must permanently make sure that competition does not lead to exclusion or other unwanted social effects. Competition in the health care sector is only justified insofar the public interest (accessibility, quality and financial viability) is not at stake. Uncertainty persists on the degree of competition possible in a social security system. It has been acknowledged that when a social security system allows competition between (risk taking) executors, the European non-life insurance Directives are applicable. If that were the case, the possibility for Member States to regulate the insurance for the social common interest would remain limited. The uncertainty about the relation between social security and competition law leads to frustration. New cases at the Court of Justice of the EC, which could elucidate matters, must be awaited.

The Ministers of Public Health feel as if they are subsidiary to the Court of Justice of the EC. It appears that all the initiatives on European health (care) policy seem to be taken by the European judge. Sometimes, this influence is blown out of proportion. However, jurisdiction of the Court of Justice of the EC has led to the application of internal market principles in the health care sector. The workshop participants made a plea for bridging the gap between internal market principles and the social values that are important in the health care sector. The principles of social protection, which are widely upheld in the health care sector, should be secured in the EC Treaty. It is of the utmost importance that a political platform is created in which both social affairs and public health affairs are dealt with. At the European level, services in the health care sector are too often purely considered as financial and economic matters for which the Ministers dealing with internal market affairs are competent. Europe must no longer be seen as a threat to health care systems, but rather as a challenge.

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