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**Access to Health Care in an Internal Market: Impact for Statutory
and Complementary Systems**

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PREFACE

Fernand LEPAGE

*VICE-PRESIDENT OF THE LUXEMBOURG ASSOCIATION
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Ladies and Gentlemen, dear readers,

The 18th volume of the Luxembourg bulletin of the social questions is devoted to the contributions of the international conference on "Access to Health Care in an Internal Market: Impact for Statutory and Complementary Systems" which was organized within the framework of the Luxembourg EU Presidency.

The objective of the conference was to create a better insight in the impact of the existing and projected Community Law in the field of health and social protection.

At a moment when the discussions about the Bolkestein proposal for a Directive on services in the internal market were booming and when in France, in the Netherlands and in Luxembourg the campaign for the referendum about the Treaty establishing a Constitution for Europe started, the conference took place on 8 April 2005 in Luxembourg.

The board of directors of the Luxembourg Association of Social Security Institutions (aloss) is proud to have taken part in the organisation of the conference, together with the Ministry of Social Security, the International Association of Mutual Benefit Societies (AIM) and the Luxembourg High Council of Mutuality (CSML).

The following publication consists of two parts. The first part reproduces the remarkable basic report of professor Yves JORENS from Ghent University. In the second part you find the interventions of the experts, in the original language, gathered around the subjects of the three working sessions, namely: "Health services and the internal market", "Health insurance and the internal market" and "The notion of social services of general interest as counterweight to the internal market rules".

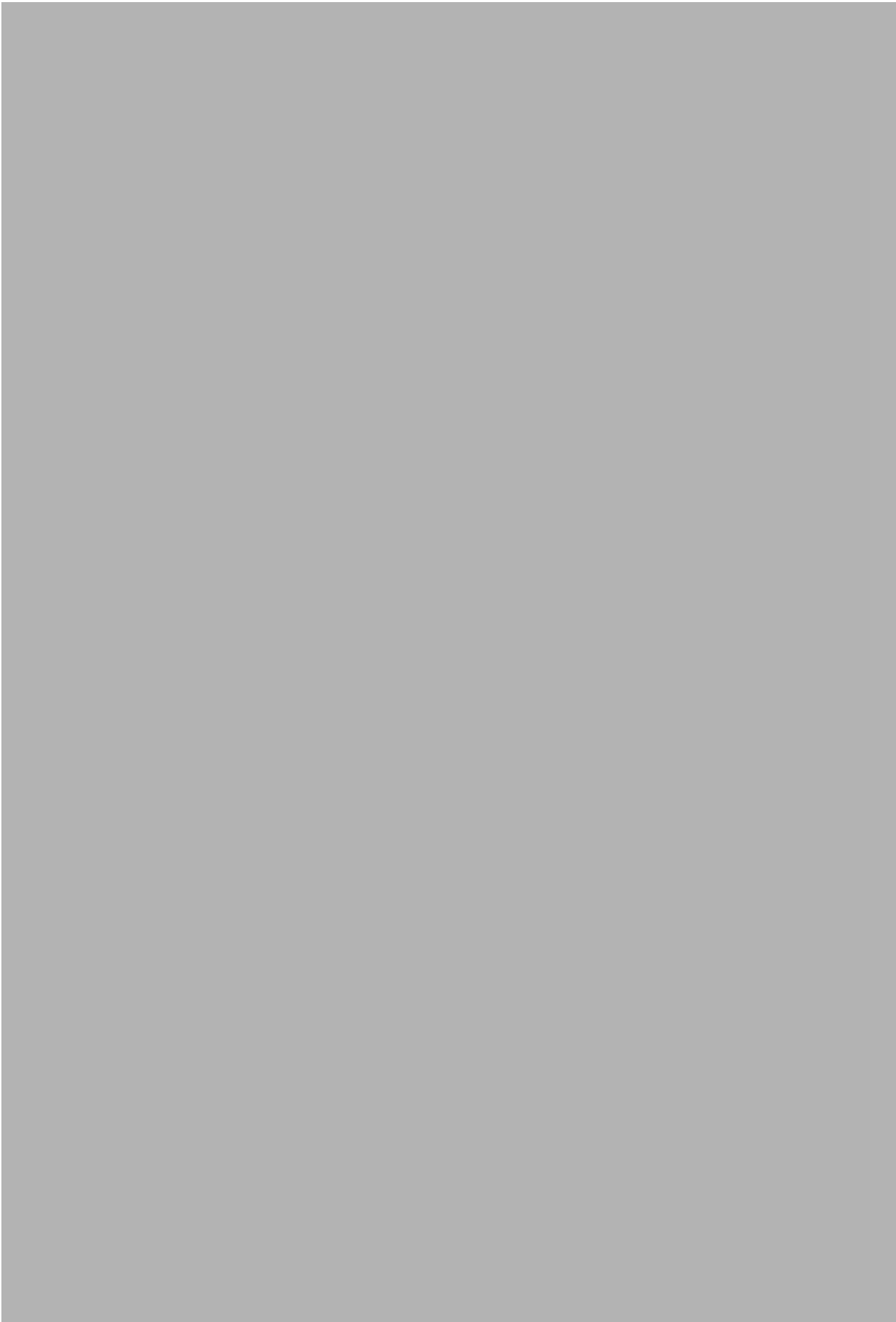
My thanks and compliments go to all those who contributed to the success of the conference and the realisation of this publication.


To conclude, I hope that the present publication will constitute a useful input for a better notice of access to health care in an internal market.

PART I

**ACCESS TO HEALTH CARE IN AN
INTERNAL MARKET:
IMPACT FOR STATUTORY AND
COMPLEMENTARY SYSTEMS**

BASIC REPORT





Access to health care in an internal market: impact for statutory and complementary systems

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General introduction

Welfare states are national states. Social security, and in particular health care, was and still is considered as belonging to the core elements and competences of national states. The organisation of health care systems, their funding and planning as a function of the needs of the population are therefore a matter for the Member States, notwithstanding the gradual, but limited expansion of the competences of the European Union in the field of social policy and public health. Although for example the Treaty clearly shows that the European Community will ensure a high level of human health protection,¹⁾ it leaves the organization of the system to the national legislation. Article 152 (5) of the Treaty foresees that **"Community action in the field of public health shall fully respect responsibilities of the Member States for the organisation and delivery of health services and medical care."**

But far more important than the increase in competences attributed in the European Treaty to the European Union, has been and is the influence of the internal market rules. As a result of internal market rules, the EU has reduced the sovereignty (i.e. legal authority) and autonomy (de facto capacity to act) of the Member States' social protection system. The gradual expansion of EU law has gradually eroded national control on beneficiaries (Member States can no longer

restrict welfare access to their own citizens only); spatial control on consumption (the insured of a given national system can increasingly shop around and consume services of other EU systems); the exclusivity of coverage on their own territory (Member States are increasingly obliged to accept infiltration within their territory of other countries' regimes); control of access to the status of benefit producer (states must grant foreign providers access to their national welfare systems) and control over administrative adjudication cases (Member States must accept that the determination of beneficiary status such as being sick will be carried out by bureaucratic agencies of other Member States).²⁾ European welfare states have therefore witnessed an increasing erosion of their external boundaries and of their capacity to control them; states have become semi-sovereign entities.

However limited the direct influence may be of European Community law on national social protection law and in particular national health policy, this by no means implies that the social security sector is an island beyond the reach of Community law and that as a consequence all national rules relating to social security fall outside its scope.³⁾

The impact of European law on the national health care systems has become a burning issue since the landmark cases on the mobility of European patients affirmed that health care is a service according to the Treaty establishing the European Community. Although long expected, it applied for the very first time the fundamental economic freedoms to the health care sector.

As the Court of Justice emphasised that health care is an economic activity that falls under the field of application of the principles of free movement of goods and services, it is clear that also other fields of EU law and in particular competition law, will apply to health care systems.

From then on, it became very clear that the influence of the European Union on "health matters" would not remain restricted to the field of "public health", dealing with communicable and rare diseases, blood and tissues, injury prevention, tobacco and nutrition, etc. European law had proven itself capable of having a direct impact on the way health care, and in particular the reimbursement of costs of health care, is organised in the Member States, even with Article 152(5) of the EC Treaty clearly stating the opposite. Health care suddenly became a much more "European issue".

Some of these issues related to the influence of the Common market on health care⁴⁾, will be discussed in this report.⁵⁾

The cases on cross-border health care made it clear that health care providers as well as private health care insurers can benefit from the provisions of free movement of persons and services. Health care should not only be regarded from the supplier's side where responsibility was taken in order to keep the financial balance, increasingly the patient himself can now choose where to take his medical treatment.⁶⁾ But not only the patient can

benefit from this Europeanisation of health care. Member States will also have to open their system to foreign medical providers. Many directives have been adopted to facilitate this free movement.⁷⁾ The way foreign medical providers can offer services gained particular interest last year with the proposal for a Directive on Services in the Internal Market. These elements are further discussed in Part II of our report.

Insofar as they can be classed as undertakings within the meaning of the relevant ECT provisions, health care providers' and health insurers' activities may be scrutinised under the competition rules. This topic will be dealt with under Chapter III of this report.

It cannot be denied that health care is an economic market where goods and services are delivered and that in principle could be supplied by private actors operating in a purely commercial market. On the other hand, health care is not a normal market as there is information asymmetry: suppliers still determine demand, rather than the well-informed consumers. In health care, users are still not in the position that they can be trusted to make decisions on their own and in their own best interests. In addition, health care is regarded as an essential facility, access to which should not be determined by ability- or willingness to- pay. On the contrary, it is a fundamental right, laid down in most European constitutions. Indeed, all Member States endorse the fundamental goal of access to necessary health care for the whole population, irrespective of individual health and financial status.⁸⁾

The health care market, therefore, cannot be left completely open to free competition. This partly explains why European health care systems are to a large extent, organised and funded by public authorities.⁹⁾ In all of the health care systems, Member States have a widely developed system of collective responsibility and solidarity. Dealing with the topic of competition law in social security and health care, is therefore a very complicated matter, not least because competition law and social policy seem to be two completely different concepts and contrary to each other. Where competition law just wants to pull down every possible barrier and limit to the fundamental principle of free trade and the individual freedom to take initiative and choices, social policy seems to go the opposite direction.¹⁰⁾ Social protection seeks to cover and protect the population against so-called social risks. However, state intervention, embodied in the principle of compulsory membership within public schemes for nationals (or residents) of a given territory implies collective action and certain mechanisms of financial redistribution between individuals or categories of people.

The combination of these two elements of solidarity on the one hand and more economic oriented elements from the free market on the other hand, requires legal fine-tuning. This fine-tuning is an ongoing process, where the European Court of Justice plays the most important role. It has to be admitted that in its case law, the Court of Justice has sought to find a delicate balance,

perhaps not always in a very understandable way, between the common market and the concerns of the Member States to guarantee national solidarity.

This fits in a particular kind of evolution where the EU is increasingly engaged in a kind of activist social policy, affirming itself as source of market breaking social rights. In order to avoid a full application of the internal market rules to the health care sector, the idea is to examine if health care could be considered as a service of general (economic) interest. This issue is further developed in Part IV of our report.

Before exploring in more detail the influence of the internal market on health care, we first want to examine how the EU reacted politically to national and European developments on health care.

I. Health policy on the European political agenda

The EU's approach to health care (excluding the "public health" responsibilities) can roughly¹¹⁾ be divided into two different but interconnected influential policy trends, namely health care systems as a core issue in the "Lisbon Strategy" on the modernisation of social protection systems and health care as a discussion topic in a new reflection process on "patient mobility and health care developments", the latter being more directly related to the Court's *Kohll & Decker*-jurisprudence.¹²⁾

Health care is not "new" on the EU Policy Agenda. As early as 1992, a Council Recommendation on the convergence of social protection objectives and policies called on the Member States **"to maintain and, where necessary, develop a high-quality health care system geared to the evolving needs of the population, and especially those arising from dependence of the elderly, to the development of pathologies and therapies and the need to step up prevention"**.¹³⁾ In the late nineties several reports and subsequent communications of the Commission relating to social protection in Europe and in 1999, the European Parliament called on the Commission to set in motion a process of voluntary alignment of objectives and policies in the area of social protection, modelled on the European Employment Strategy.¹⁴⁾ In November of the same year, health care was designated by the Council as one of the four fields of social protection where closer cooperation between the Member States was needed. Presidency Conclusions of successive European Councils made references to the need to reform and adapt social protection systems. The important Lisbon European Council¹⁵⁾ of March 2000, adopting an integrated approach to employment, economic reforms and social cohesion, set the goal (2000-2010) for the European Union to **"become the most competitive and dynamic knowledge-based economy in the world, capable of sustainable growth with more and better jobs and greater social cohesion"**. According to these conclusions, reiterated and elaborated in almost all of the following European Council meetings, the social protection systems needed to be adapted as part of an active welfare state to ensure that work pays, to secure their long-term sustainability in the face of an ageing population, to promote social inclusion and gender equality, "and to provide quality health services". This way, the development of the health care systems in the Member States was incorporated in an overall EU process, the "Lisbon Strategy", presumably under the influence of the 1999 Broad Economic Policy Guidelines, recommending that the Member States should review their pension and health care systems in order to cope with increased welfare spending on an ageing population and to influence the supply of labour in the future.¹⁶⁾ Accessibility, highquality and financial sustainability were pointed out by the Commission¹⁷⁾ as the essential points in this modernisation process for social protection. For health care, these

three cruces were approved by the Barcelona European Council¹⁸⁾ in March 2002.

On the basis of these conclusions the Social Protection Committee¹⁹⁾ (SPC) has also been working intensively on the future of health care and care for the elderly. Being a part of the Council and functioning as an advisory committee, the SPC was established in 2000 to strengthen cooperation between Member States on social protection policies.²⁰⁾ The main tasks of the SPC are to monitor social protection in the Member States and the Community and to foster an exchange of information, experience and good practices between Member States and the Commission and thus it is directly involved in the process of modernising health care systems, in close cooperation with the Employment Committee (EMCO)²¹⁾ and the Economic Policy Committee (EPC),²²⁾ as one of its four objectives is to "ensure high quality and sustainable health care". The open method of coordination, "**spreading best practice and achieving greater convergence towards the main EU goals**", is the method of governance that seems to be gaining importance also in health care matters. Instituted at the Lisbon European Council of 2000, it was designed to help the Member States develop their own policies but towards commonly defined targets. It usually includes the establishment of quantitative or qualitative benchmarks between the Member States and involves monitoring, evaluation and peer review, organised as a mutual learning process between the Member States. Not being legally binding and lacking sanctions, the "peer pressure" through the open method of coordination nonetheless encourages the Member States to compete and to improve their performance, by establishing high standards and agreeing to recommendations and feedback. In the field of health care and care for the elderly, the Lisbon European Council of March 2000 stressed that social protection systems needed to be able to continue providing good quality health services. Subsequently, in June 2001, the Göteborg European Council²³⁾ called on the Council, "**in conformity with the open method of coordination and on the basis of a joint report of the Social Protection Committee and the Economic Policy Committee (...) to prepare a progress report for the Spring 2002 European Council on guidelines in the field of health and care for the elderly**", which was based on a Commission Communication on the future of health care and care for the elderly.²⁴⁾ The Council delivered an initial Orientation Report on health care and care for the elderly to the 2002 Barcelona European Council,²⁵⁾ which assigned the Commission and the Council to explore further the issues of accessibility, high quality and sustainability in the domain. Subsequently, the SPC and the Economic Policy Committee distributed a questionnaire²⁶⁾ to all the Member States, which formed the basis for a Joint Report "Supporting national strategies for the future of health care and care for the elderly",²⁷⁾ accepted at the Brussels Spring European Council of March 2003.²⁸⁾

Finally the Commission continued cooperation in the field by issuing its Communication on the modernisation of social protection for the development of high-quality, accessible and sustainable health care and long-term care in April 2004, giving support for the national strategies using the open method of coordination. After the European Parliament, in a Resolution of March 2004, had called for greater cooperation on health and long-term care and called on the Commission to present relevant proposals²⁹⁾ and as announced in the Spring Report 2004, the Commission issued this communication in order to define a common framework to support the Member States in the reform and development of health care and long-term care, borne by the social protection system, using the "open method of coordination". In this Communication the Commission expressed its desire to come to an agreement on the joint objectives in 2004. The Member States were instructed to present 'preliminary reports' covering the challenges facing their systems at national level, current reforms and medium-term policy objectives by March 2005. These reports should include statistical data and, where relevant, quantified objectives. At this preliminary stage, they would be concise. They would subsequently be analysed by the Commission, to be taken into account when the joint objectives of the streamlined social security process are established. This streamlining should lead in 2006 to an initial series of "development and reform strategies" in health care and long-term care for the period 2006-2009. The conclusions of the assessment of these strategies will be presented in the **Joint report on social protection and social inclusion** in 2007. Given the wide range of topics and issues tackled by the joint objectives, the SPC and the other competent bodies (EMCO, EPC, the future High Level Group on Health Services and Medical Care³⁰⁾ created in parallel by the Commission) should forge close links, including the establishment of a work programme to identify the topics relevant to each.

Next to this work, which is to be situated in and around the "Lisbon Process" concerning the modernisation of social protection systems, there is a closely linked but still discernable process going on that is focusing more on the impact of the internal market on the national health care systems, and in particular on patient mobility in the European Union facilitated by the ECJ's case law. Raising many health policy issues, such as quality and access in cross-border care, information requirements for patients, health professionals and policy-makers, cooperation in health matters and the reconciliation of national health policy with European obligations, these rulings have caused a considerable interest and activity from the EU in health care matters EU involvement in health care matters. As a direct product of the fundamental freedoms on which the Community is based, patient mobility and related health care developments received priority on this agenda. After exchanges regarding the implications of these judgments had already taken place during a Conference organised by the Belgian Presidency in Ghent in

December 2001³¹⁾ and the High Level Committee on Health in its report of December 2001 on the internal market and health services had already identified important concerns (Health in the European Union, The Coordination of Social Security Payments Systems, Recent Developments concerning the Free Movement of Patients, Cross Border Care Projects, the Internal Market and Health Care), further discussions were organised by the Spanish Presidency at an informal meeting of health ministers in February 2002 in Malaga. This meeting considered questions on highly specialised reference centres sharing spare capacity, facilitating care in neighbouring countries for people living in border areas and providing care for those who reside for a long time in another Member State. The meeting made it clear that action was imperative. The diversity of the health care systems in Europe was recognised in the report, and the principles of solidarity, equity and universality were deemed to be shared by all these systems. The Ministers maintained that health care policy should be the result of the work of politicians and not of judges. A work programme was developed. They agreed to take up the discussion again at an expert meeting to be held in Menorca in May 2002. This meeting studied the options presented by Regulation 1408/71 on the coordination of social security systems for the free movement of patients and identified whether the Regulation covers all possible situations that might arise. Other subjects were information needs, a review of cross border care and the quality of health services at a European level. Proposals for a basic benefit package that would be reimbursed without prior authorisation, a European quality policy and a European alert system on health care safety, patient information networks, exchange of medical care information and protocols for patients and medical personnel are examples of the initiatives discussed that seem to clear the path for a "European health care approach".

Still it was mainly the following Health Council of June 2002 that really boosted a process of reflection on the interaction between health systems within the European Union. This Council, in its conclusions, recognised fully the emerging interaction between health care systems, the Member States' responsibilities for the organisation and delivery of health services and medical care, but it also recognised the impact of other developments, such as those relating to the single market, on health systems. The Council considered that there was a need to strengthen cooperation in order to promote the greatest opportunities for access to high quality health care while maintaining the financial sustainability of health care systems in the European Union. To this end **"the Council and the representatives of the Member States meeting in the Council recognise that there would be value in the Commission pursuing in close cooperation with the Council and all the Member States – particularly health ministers and other key stakeholders - a high level process of reflection", which should aim at "timely conclusions for possible further action"**. In this "High level

reflection process on patient mobility and healthcare developments in the European Union", the Commission brought together Health Ministers of the Member States with representatives of patients, professionals, providers and purchasers of health care and the European Parliament to develop a shared European vision in the health area, whilst respecting national responsibility. The High level reflection experts met three times, supported by additional meetings of their personal representatives, and concluded in December 2003 with 19 specific recommendations on European cooperation to enable better use of resources (rights and duties of patients, sharing spare capacity and transnational care, European centres of reference, Health Technology Assessment); information requirements for patients, professionals and policy makers (EU Framework for information); access to and quality of care (improving knowledge on access and quality issues, analysing the impact of European activities on access and quality); reconciling national health policy with European obligations; and on health related issues and the Union's cohesion and structural funds. The Commission, after the production in July 2003 of a synthesis report³²⁾ on the application at national level of the Court's case law on the issue of reimbursement for medical services incurred in another Member State, recently responded to the challenges issued by the High level reflection process through an overall strategy set out in two communications: the abovementioned communication on the application of the open method of coordination in the field of health care and long-term care and the Communication from the Commission as a follow-up to the high level reflection process on patient mobility and healthcare developments in the European Union.³³⁾ A further communication sets out an "e-Health action plan"³⁴⁾ within the framework of a European e-Health Area for using information and communication technologies to help improve access, quality and effectiveness for health services across the Union. In addition, in the light of the Court of Justice's jurisprudence mentioned above, the Proposal for a Directive on Services in the Internal Market³⁵⁾ together with the modernised and simplified Regulation (EC) No 883/2004,³⁶⁾ which will replace Regulation No 1408/71 on the entry into force of a new implementing regulation, on the application of social security schemes to employed persons and their families moving within the Community, provides the legal framework for reimbursement of healthcare costs incurred in another Member State than the patient's Member State of insurance. Together, these initiatives should enable patients to exercise their rights under Community law to healthcare in other Member States and to facilitate European cooperation on health systems whilst respecting the responsibilities of the Member States for the organization and delivery of health services and medical care.

Also important was the meeting of the first EU Health Policy Forum in November 2002, another informal mechanism in the field of health care at the European level.³⁷⁾ The aim of the Forum is to bring together umbrella organisations representing stakeholders in the health sector to ensure that

the EU's health strategy is open, transparent and responds to the public concerns. The EU Health Policy Forum is a part of a three-tiered structure also consisting of an Open Health Forum (extending the work of the Health Policy Forum to a broader set of stakeholders having approximately 300 participants, held for the first time on 17 May 2004 in Brussels³⁸) and, in the future, a Virtual Health Forum.

II. Access to health care in an internal market: impact for statutory and complementary systems

1. Free movement of patients: the relation between the Treaty-based and the Regulation-based Method of Patient Mobility

A. Two methods of mobility

Up until 1998, Community nationals seeking medical treatment in another Member State at the expense of their national health insurance institution had no choice other than to rely on Article 22 § 1 (c) of Regulation (EC) No 1408/71. Pursuant to that provision, insured persons who obtained authorisation to receive appropriate medical treatment in another Member State are entitled to health care on behalf of their competent institution by the institution of the place of stay or residence in accordance with the provisions of the legislation which it administers, as though they were insured with it. By virtue of paragraph 2 of Article 22, authorisation cannot be refused when the treatment would be available under the legislation of the Member State on whose territory the insured person resides and the treatment which that person intends to undergo in another Member State could not be given to him within the time normally necessary for obtaining the treatment in question in the Member State of affiliation, taking account of his current state of health and the probable course of the disease³⁹⁾.

The 1998 *Kohll* judgment⁴⁰⁾ of the Court of Justice (hereinafter referred to as "ECJ" or "Court"), the ambit of which was clarified in subsequent rulings,⁴¹⁾ paved the way for a second method of planned health care abroad, stemming directly from the Treaty establishing the European Community (henceforth "ECT" or "Treaty"), in particular from its Articles 49 and 50. The gist of this case law is well-known and can be briefly summarised. Medical treatment, provided both in and outside a hospital environment,⁴²⁾ constitutes a service within the meaning of the Treaty, irrespective of the way Member States organise and finance their social security systems. The requirement for an authorisation for the reimbursement of medical costs incurred in another Member State is an obstacle to the free provision of services for both patients and providers of medical services. However, as regards intramural care, the Court indicated that the authorisation requirement is justified in the light of hospital planning, which is necessary in order to ensure sufficient and permanent access to a balanced range of high quality hospital treatment as well as to control cost and prevent wastage of financial, technical and human resources. By contrast, in respect of extramural care, the Court pointed out that the authorisation requirement could not be justified, as material barriers (e.g. of a geographic or linguistic nature) would prevent large numbers of patients from seeking extramural care abroad and in any event, reimbursement of costs for such care would be limited to the cover provided by the sickness insurance scheme in the Member State of affiliation. Given its

limited financial impact, the removal of the prior authorisation requirement would not seriously affect the financial balance of national social security systems.⁴³⁾

B. The compatibility of Article 22 of Regulation 1408/71 with the ECT

In *Kohll*, *Geraets-Smits and Peerbooms* and *Müller-Fauré* and *Van Riet*,⁴⁴⁾ the disputed national rules were tested only against the ECT provisions on services. For various reasons, none of these cases fell within the ambit of Article 22(1) (c) of Regulation 1408/71. However, in *Kohll*, the issue of the validity of the said Article was raised in an indirect manner. In response to the logical contention of the Luxembourg authorities - whose legislation constituted an accurate implementation of Article 22 of the Regulation - that the challenging of the former amounted to calling into question the validity of the latter, the Court indicated that the fact that a national measure may be consistent with a provision of secondary legislation does not have the effect of removing that measure from the scope of the provisions of the Treaty. The ECJ went on to state that Article 22 of the Regulation is intended to regulate the assumption of health care costs incurred in another Member State "in accordance with the provisions of the legislation of the State in which the services are provided".⁴⁵⁾ The Court, interpreting the said Article in the light of its purpose, concluded that "[it] is not intended to regulate and hence does not in any way prevent the reimbursement by Member States, at the tariffs in force in the competent State, of costs incurred in connection with treatment provided in another Member State, even without prior authorisation."⁴⁶⁾

In the recent *Inizan* ruling,⁴⁷⁾ the Court was directly asked to give its opinion on the compatibility with the Treaty Articles on services of the prior authorisation scheme set up by Article 22 of Regulation 1408/71. In his Opinion, Advocate General Colomer extensively highlighted the differences between the Regulation- and the Treaty-based method, stressing that only under the former was the border-crossing patient entitled to be treated in the same manner as the affiliates of the national social security scheme.⁴⁸⁾ He concluded that Article 22(1) (c) was not incompatible with Article 49 ECT. The Court, on its part, reached the same conclusion. Having reiterated its findings in *Kohll*, it stated that Article 22, instead of constituting an obstacle to the free provision of services, helps to facilitate the free movement of patients and the cross-border provision of medical services between the Member States. This is so because insured persons thus have access to treatment in the other Member States on conditions of reimbursement as favourable as those enjoyed by insured persons covered by the legislation of those other States. Accordingly, the beneficiaries of Article 22 are granted rights which they would not otherwise have since, as they involve reimbursement by the institution of the place of stay in accordance with the legislation administered by it, those rights cannot by definition be guaranteed to those persons under the legislation of the competent Member State alone.⁴⁹⁾ The circumstance

that the Community legislature has made the benefit of these rights subject to stringent conditions is immaterial in the Court's view, as Article 42 ECT does not prohibit the EC legislative institutions from attaching conditions to the rights and advantages which they accord in order to ensure freedom of movement for workers or from determining the limits thereto.⁵⁰⁾

As a result of the Court's refusal to invalidate Article 22 (1) (c) of Regulation 1408/71, two different procedures - the one having no primacy over the other⁵¹⁾ - govern the assumption of health care costs incurred in another Member State. Leaving aside the complexity to which this coexistence gives rise,⁵²⁾ one can wonder whether the Court was right to uphold the validity of the Regulation-based procedure. After all, it is difficult to understand how the prior authorisation scheme established by the Regulation could alleviate the free provision of services where the Court consistently condemns such schemes falling outside the scope of Article 22 as barriers to that fundamental freedom. Some authors contend that the Court should have qualified Article 22 as a *prima facie* restriction to Articles 49 and 50 ECT and then have proceeded to analyse the possible justifications.⁵³⁾

However, the option chosen by the Court becomes understandable when one considers the alternative, i.e. setting aside the relevant provisions of the Regulation as incompatible with a hierarchically superior norm. As it is argued, such an approach would not have tallied with the present trend of judicial deference to the Community legislature.⁵⁴⁾ Indeed, rather than declaring secondary legislation altogether inconsistent with the Treaty, the Court currently tends to "neutralise" any undesirable effect that legislation may produce by directly applying Articles of primary law.⁵⁵⁾ Besides, the Court has consistently held that, when the wording of secondary Community law necessitates interpretation, preference should be given to the interpretation that renders the provision consistent with the Treaty.⁵⁶⁾

1. "Facultative" interpretation of the Regulation

Apparently, the Court has not remained oblivious to these considerations when asserting the validity of Article 22 of Regulation 1408/71. It did so by interpreting the Regulation in a "**facultative**" way, emphasising its merits, its added value vis-à-vis the Treaty-based procedure. Manifestly, the Court did not think of Article 22 (1) (c) as an imperative provision, compelling the competent institution to reimburse the health services **exclusively** in accordance with the tariffs applicable in the Member State where the treatment was obtained. If it had taken such an approach, the Court would have inevitably had to judge the compatibility of the Article with the Treaty, in that it not allowed for reimbursement of medical costs according to the tariffs applicable in the Member State of affiliation.⁵⁷⁾ Rather, the Court's reasoning is centred around the advantages the Regulation offers its beneficiaries, as compared to the situation of those relying directly on the Treaty. The former are entitled to treatment in the other Member States "on conditions as

favourable as those enjoyed by insured persons covered by the legislation of those other States".⁵⁸⁾ In particular, a patient equipped with an authorisation within the meaning of Article 22 of the Regulation may obtain cross-border health care without incurring any additional expenditure. This is so even where the foreign medical bill exceeds the amount that would have been covered if the patient were treated in the Member State of affiliation. More than that, he may even, on account of the competent institution, undergo treatments which are not refundable in the Member State of affiliation.⁵⁹⁾

Admittedly, these are advantages which the Treaty-based procedure does not offer, and it is contended, cannot offer, for lack of a restriction to the free provision of services. Indeed, the mere fact that the national health institution or sickness fund refuses to pay for health care expenses incurred abroad is not sufficient to hold it liable for restricting the free movement of services. Such a refusal would only amount to a restriction if there is some prior "national" obligation to pay. As mentioned, what is otherwise to stop frivolous suits insisting that the government pay for holiday villas for all?⁶⁰⁾ Consequently, if a certain medical treatment is covered by the national health scheme of the Member State of affiliation, be it under certain conditions, the rules of this Member State should allow this same medical treatment, provided in another Member State under the same conditions, to be covered to the same extent in default of which the rules of the Member State of affiliation will represent a barrier - in need of justification - to the free provision of services. If, on the other hand, that Member State refuses to pay the amount exceeding the level of coverage under its own scheme, or denies reimbursement for cross-border treatment which is not included in its benefits package, the patient is not deterred, let alone prevented, to have recourse to a health care provider established in another Member State.

Thus, by granting rights which the patient would not have under the Treaty-based method, the Regulation can be seen as complementing Articles 49 and 50 ECT, as interpreted by the Court in *Kohll* and subsequent cases. However, "the right to be treated in the same manner as affiliates of the [...] social security scheme [of the Member State where the treatment is obtained]",⁶¹⁾ granted by Article 22 (1) (c) of the Regulation, does not always work out to the benefit of the insured person. For one thing, the amount reimbursable under the legislation of the Member State where the treatment is received may be lower than that reimbursable under the legislation of the Member State of affiliation of the patient. Such was the setting in *Vanbraekel*.⁶²⁾ In that case, the patient had (eventually⁶³⁾ been granted authorisation in the sense of Article 22 of the Regulation and was thus entitled to receive reimbursement on the basis of the tariffs applicable in the Member State of treatment. However, these happened to be lower than the ones applicable in Belgium, the Member State of affiliation. The Court, reiterating its "facultative" interpretation of Article 22, stated that this provision "does not have the effect of **preventing** extra reimbursement, additional to that resulting from the

application of the system of the Member State [of] treatment [...], when the system [of the Member State of affiliation] is more beneficial" (emphasis added). Yet, it neither has the effect of **requiring** such additional reimbursement.⁶⁴ The Court then examined whether Articles 49 and 50 ECT could entail an obligation to provide for additional reimbursement covering the difference between the - more advantageous - system of cover laid down by the Member State of affiliation and the system applied by the Member State of treatment, and concluded in the affirmative.⁶⁵

2. Partial incompatibility in respect of extramural care

In *Vanbraekel*, the Regulation was clearly at risk of being incompatible with the fundamental freedom to provide services. However, the non-compelling reading of Article 22 allowed the Court to call in the Treaty Articles on the free provision of services to "come to the rescue" of the Regulation. In this regard, the Treaty can be seen as complementing the Regulation.

Vanbraekel was concerned with intramural care for which, even under the Treaty-based procedure, prior authorisation must be obtained. Let us consider now a hypothetical case, which is identical in terms of facts with *Vanbraekel*, except that the cross-border receipt of **extramural** care is at stake.⁶⁶ If the system of cover which is in place in the Member State of treatment is more beneficial to the patient than that in force in the Member State of affiliation, it can be argued that the added value of the Regulation-based procedure makes up for the prior authorisation requirement associated with that procedure. By contrast, if the amount of reimbursement provided by the system of the Member State of treatment is less than the amount which application of the legislation in force in the Member State of affiliation would afford to the patient concerned, Article 22 (1) (c) of the Regulation falls foul of the Treaty provisions in relation to services. Indeed, not only would the patient have a lower level of cover when he received outpatient care abroad than when he underwent the same treatment in the Member State of affiliation - which may deter or even prevent him from applying to foreign health care providers^{67) 68)} - but in addition, he would not have been required to request prior authorisation. Therefore, in such a case, the Regulation would be incompatible with the free provision of services, and this incompatibility could not just be offset by the granting of an additional reimbursement within the meaning of *Vanbraekel*.⁶⁹⁾

3. Attuning the authorisation procedures

Under the current wording of Article 22 (2) of Regulation 1408/71, Member States retain considerable discretion to authorize treatment abroad. As mentioned above, authorisation cannot be refused only where "(i) the treatment in question is among the benefits provided for by the legislation of the Member State on whose territory the person concerned resides" and where " (ii) he cannot be given such treatment within the time normally

necessary for obtaining the treatment in question in the Member State of residence taking account of his current state of health and the probable course of his disease". Member States' discretionary power to authorise treatment abroad can even be based on an "administrative" criterion, rather than on criteria relating to medical necessity.⁷⁰⁾ However, in its ruling in *Inizan*, the Court has re-interpreted the second condition in the light of its case law in relation to the Treaty-based method of patient mobility, in which it had linked the appraisal of the timeliness of an equally effective treatment to the patient's state of health. Thus, "clarifying the scope" of that condition, the ECJ held in particular that "such a condition is not satisfied whenever it is apparent that treatment which is the same or equally effective for the patient can be obtained without undue delay in the Member State of residence".⁷¹⁾ In order to determine this, regard is to be had to "all the circumstances of each specific case" and account is to be taken "not only of the patient's medical condition at the time when authorisation is sought and, where appropriate, of the degree of pain or the nature of the patient's disability which might, for example, make it impossible or extremely difficult for him to carry out a professional activity, but also of his medical history".⁷²⁾ Consistent with this case law, the medical criterion is also brought to the fore in Regulation (EC) No 883/2004 on the coordination of social security systems, which will replace Regulation 1408/71 on the entry into force of a new implementing regulation.⁷³⁾ Its Article 20 (2) provides that "[the] authorisation shall be accorded where the treatment in question is among the benefits provided by the legislation in the Member State where the person concerned resides and where he cannot be given such treatment within a time-limit which is medically justifiable, taking into account his current state of health and the probable course of his illness".

Finally, in *Inizan* the Court made clear that the procedural requirements which national authorisation schemes outside the scope of Article 22 of the Regulation must meet, are fully applicable to national prior authorisation systems constituting the implementation of that Article. Accordingly, such systems must be easy accessible and capable of ensuring that a request for authorisation be dealt with objectively and impartially within a reasonable time-limit. Refusals must also be capable of being challenged in (quasi-) judicial proceedings.^{74) 75)}

4. Outlook

With its judgments in *Vanbraekel* and *Inizan*, the Court has sketched the framework of the relationship between the two methods of patient mobility. As regards the cross-border receipt of intramural care, the two methods are mutually complementary and their application should be merged as much as possible,⁷⁶⁾ in order to ensure not only legal certainty and coherence, but also to strengthen patient rights. If a patient wishes to obtain hospital treatment in another Member State, he will in any case have to apply for authorisation. As

shown above, the conditions⁷⁷⁾ and the procedural modalities under which authorization must be granted pursuant to both methods have been attuned. Where the patient has been granted an authorisation accordingly, he is entitled to intramural care in accordance with the legislation of the Member State of treatment, at the expense of the Member State of affiliation, on the understanding that the latter has to provide for additional reimbursement covering the difference between the level of cover under the legislation of the Member State of treatment and the (higher) amount which application of its legislation would afford to the patient had he received the intramural care concerned in its territory.⁷⁸⁾ In practice, it implies that this additional reimbursement will cover co-payments the patient may have incurred in the Member State of treatment, in pursuance to the legislation of that State. However, the same reasoning cannot be maintained in relation to the cross-border receipt of **extramural** care. In the judgment rendered in *Müller-Fauré* and *Van Riet*, the ECJ has unequivocally indicated that prior authorisation requirements for outpatient care constitute an unjustified restriction to the free provision of services. Therefore, the application of Article 22 (1) (c) of Regulation 1408/71 in respect of extramural care should be limited to cases where it offers its beneficiary some added value, **in the form of rights which cannot be obtained by virtue of Articles 49 and 50 ECT, as interpreted by the Court in the aforementioned cases** (e.g. a benefit not included in the package of the Member State of affiliation or a more advantageous level of cover⁷⁹⁾).

C. The proposal for a directive on services in the internal market and patient mobility

Article 23 of the Proposal for a Directive on services in the internal market [COM(2004) 2] is intended to codify the case law of the Court of Justice relating to the Treaty-based method of patient mobility. The Commission's objective of dealing with this issue in the Proposal is threefold: strengthening the rights of patients, increasing legal certainty and transparency, and giving the opportunity to the Community legislature to deal with practical issues left open by the Court's case law.⁸⁰⁾ The scope of Article 23, especially its relationship with Regulation 1408/71, has been clarified by the Commission services in an explanatory note.⁸¹⁾ The gist of these clarifications has been taken up in the Working Document No 1 of 15 November 2004, containing elucidations on the basis of discussions in the Working Party on Competitiveness and Growth. The Luxembourg presidency has circulated a consolidated text including these elucidations as well as the Articles and recitals of the Commission's proposal which were not included in the said Working Document.⁸²⁾ This consolidated text, hereinafter referred to as the Draft services directive, will serve as a basis for our discussion. Where appropriate, reference will be made to the text of the initial Commission Proposal.

Article 23 § 1 subparagraph 1 stipulates that Member States may not make the assumption of the costs of non-hospital care in another Member State subject to the granting of an authorisation, where the cost of that care, if it had been provided in their territory, would have been assumed by their social security system. The second subparagraph adds that the conditions and formalities to which the receipt of non-hospital care in their territory is made subject by Member States may be imposed on a patient who has received non-hospital care in another Member State. As examples are cited the gate keeping role of a general practitioner and the terms and conditions relation to the assumption of costs of dental care. The first paragraph of Article 23 of the Proposal seems to be an accurate codification of the Court's ruling in *Müller-Fauré* and *Van Riet*.

Paragraph 2 of Article 23 deals with hospital care and states that the authorisation to receive such care in another Member State shall be granted in accordance with Article 22 of Regulation 1408/71 and, for the future, with Article 20 of Regulation (EC) No 883/2004. The Draft services directive thus advocates the full application of the Regulation-based method as far as hospital care is concerned.⁸³⁾ The *Vanbraekel* case law is taken into account in the third paragraph, treating of the level of assumption.⁸⁴⁾ In recital 53 it is elucidated that Article 22 of Regulation 1408/71 continues to fully apply to hospital care where according to the jurisprudence of the Court of Justice Member States can maintain requirements of prior authorisation for the assumption of costs received in other Member States. According to that recital, it also continues to fully apply to non-hospital care if patients ask an authorisation in order to benefit from the special scheme applicable under Regulation 1408/71; by contrast, Article 22 does not seek to regulate, nor in any way to prevent, reimbursement, at the rates applicable in the Member State of affiliation, of the costs of non-hospital care provided in another Member State, in the absence of a prior authorisation.

Pursuant to paragraph 3 of Article 23, Member States shall ensure that the level of assumption by their social security system of the costs of health care provided in another Member State is not lower than that provided for by their social security system in respect of similar health care provided in their territory. Here too, the Court's case law is implemented in that patients are always entitled to reimbursement according to the tariffs in place in the Member State of affiliation, provided, where intramural care is concerned, they have been granted authorisation. In respect of intramural care, paragraph 3 encompasses the ECJ's judgment in *Vanbraekel*. Where extramural care is concerned, as indicated supra, there is no need for a *Vanbraekel*-like judgment, as the Regulation, on pain of running counter to the Treaty, cannot apply in case the assumption under the legislation of the Member State of treatment is less beneficial to the patient than that under the Member State of affiliation.⁸⁵⁾

Some authors contend that paragraph 3 of the Draft services directive goes beyond the Court's case law, as it guarantees patients a level of assumption equal to that provided by their national legislation. They assert that the ECJ in *Müller-Fauré* and *Van Riet*⁸⁶⁾ left room for reimbursing foreign health care providers at a lower level than national contracted ones, as long as it is based on objective, non-discriminatory and transparent criteria.⁸⁷⁾ We do not think that this conclusion can be inferred from the Court's assertion. Indeed, the Court has unambiguously stated that "the fact that a person has a lower level of cover when he receives hospital treatment in another Member State than when he undergoes the same treatment in the Member State in which he is insured may deter, or even prevent, that person from applying to providers of medical services established in other Member States and constitutes, both for insured persons and for service providers, a barrier to freedom to provide services". Such a restriction would not qualify for justification as reimbursement up to the level provided for by the national legislation does not in theory impose any additional financial burden on the national sickness insurance and thus is not liable to have a significant effect on the financing of the social security system.⁸⁸⁾ Rather, it would seem that the Court intended to enable Member States which do not operate a reimbursement system - and which therefore do not have clear-cut national reimbursement tariffs - to fix thresholds for reimbursement of cost for cross-border treatment, that is to calculate the nominal cost of the treatment which they would normally assume for a certain treatment provided in kind.⁸⁹⁾ We will come back to this issue infra.

The Draft services directive further provides that "the assumption of costs is limited to the actual costs of the health care received". This provision, which does not appear in the initial Commission Proposal, is anything but contentious; indeed, although it does not explicitly stem from the Court's rulings, there seems to be a large consensus that a patient cannot make a profit out of his treatment abroad.⁹⁰⁾

The Draft services directive, unlike the initial Commission Proposal, expressly states that Member States are not required to assume travel expenses (recital 57).

By virtue of paragraph 4 of Article 23, Member States must ensure that their authorisation systems for the assumption of costs of health care provided in another Member State are in conformity with the Draft services directive's general provisions on authorisation schemes, in particular its Articles 9 to 11 and 13. These Articles are tailored to the active provision of services and are not suitable for governing the authorisation requirement for the assumption of health care costs incurred abroad. It would be better if the fourth paragraph were deleted.⁹¹⁾ The procedural requirements established by the Court provide sufficient guarantees for patients seeking authorisation for cross-border treatment.

1. The distinction between intra- and extramural care

To end with, some brief remarks should be made concerning the distinction between intramural and extramural care, which runs like a thread through the case law of the Court in relation to patient mobility. The Court itself recognised that the distinction may be difficult to draw. It did indicate, however, that it is willing to give a broad interpretation of the concept extramural care, where it stated that "certain services provided in a hospital environment but also **capable** of being provided by a practitioner in his surgery or in a health centre could for that reason be placed on the same footing as non-hospital services" (emphasis added).⁹²⁾

As the classification of care greatly impacts the scope of patient mobility, there is clearly a need for a Community definition of intramural care, in order to prevent Member States from denoting treatments as such at their own discretion.⁹³⁾ This definition should have regard to the intrinsic characteristics of hospital care, characteristics that make it impossible for such care to be provided outside a hospital environment. In the Commission's view, the clearest criterion to assess this is that the treatment concerned requires overnight accommodation.⁹⁴⁾ Accordingly, Article 4, 10° of the initial Proposal defined hospital care as "medical care which can be provided only within a medical infrastructure and which normally requires the accommodation therein of the person receiving the care, the name, organisation and financing of that infrastructure being irrelevant for the purposes of classifying such care as hospital care". Spurred by some Member States who felt that overnight accommodation is not the only reason for which certain types of treatment are reserved to hospitals,⁹⁵⁾ the definition in the revised version has been extended to medical care which "can only be provided within a hospital infrastructure because it is highly specialised or presents a manifest risk to the patient".

The initial Proposal failed to address the important question of the geographical area for consideration of what cannot be provided outside a hospital environment. The "capability rule", inaugurated by the Court in *Müller-Fauré* and *Van Riet*, can hardly assist in this regard, for its potential range of consideration is virtually unlimited.⁹⁶⁾ Narrowing down the issue, the essential question is whether it is the Member State of actual treatment, or the normal location of that treatment in the Member State of affiliation, which is decisive. The latter may seem more logical. Indeed, the basis of permitting restrictions is the need to maintain domestic hospital infrastructure, which suggests that treatment that would be in that infrastructure may be confined there.⁹⁷⁾ Accordingly, authorisation would be required for the assumption of costs of what is considered to be hospital care in the Member State of affiliation, even though this treatment is considered non-hospital care in the Member State of treatment. This is the approach advocated by the Commission⁹⁸⁾ and which found its way to the Draft services directive. The

definition of hospital care, which has moved to Article 23 § 1 a, now reads as follows: "[...] medical care which, in the **Member State of affiliation of the patient**, is provided in a hospital infrastructure either because the care requires accommodation of the patient or it can only be provided within a hospital infrastructure because it is highly specialised or presents a manifest risk to the patient. The name, organisation and financing of that infrastructure is irrelevant for the purposes of classifying such care as hospital care" (emphasis added). Still, opinions are divided on the matter as to which Member State should be taken as the point of reference. As it is argued, the reference point should be the Member State of actual treatment. That takes the view that the very fact that the care was provided elsewhere indicates that it could have been. Therefore, the need for infrastructure is clearly not as great, if existent at all.⁹⁹⁾ A similar conclusion was reached by the Dutch Health Care Insurance Board (CVZ), which also considers that authorisation may be required if the health care (to be) obtained abroad involves admission there.¹⁰⁰⁾

D. The new Regulation (EC) No 883/2004 versus the health care cases and Article 23 of the proposal for a directive on services in the internal market

During the revision process of Regulation 1408/71, the issue was raised as to whether the Court's health care rulings should be incorporated into the new coordination regulation. In our view, integrating the case law into the coordination regulation is not desirable. As mentioned before, the Articles of the coordination instruments dealing with planned health care abroad confer upon their beneficiaries provided they have been granted authorisation, rights which the ECT provisions on services cannot grant. Curtailing this procedure, for instance by confining it to in-patient treatment, would mean a step backwards in terms of the **acquis**. On the other hand, getting rid of the inconsistency indicated above in respect of extramural care requires the application of the Regulation-based method to be limited to cases in which it offers its beneficiaries some added value. Translating this into a legal text is not an easy task. Moreover, in addition to matters of a "politico-institutional" nature (legislative procedure requiring unanimity within the Council), further problems arise because of the distinct features (e.g. personal scope), economies and indeed legal bases of the two methods of patient mobility.

However, this does not mean that the Community legislature should disregard one method while regulating the other, as Article 23 (2) of the Draft services directive satisfactorily demonstrates. In this context, it is regrettable that the Community legislature did not seize the opportunity, on adoption of the new coordination regulation, to at least implicitly refer to the Treaty-based method of patient mobility, instead of making it appear as if Regulation (EC) No 883/2004 is the one route for patients wishing to be treated in another Member State at the expense of the national health insurance institution.¹⁰¹⁾

The European Parliament adopted an amendment in first reading by including in the first paragraph of the Article dealing with authorisation to receive treatment outside the competent State - which later became Article 20 - a reference to the case law of the Court: "[save] as otherwise provided under this Regulation, an insured person travelling to another Member State with the purpose of receiving benefits in kind during the stay shall seek authorisation from the competent institution where such **benefits involve in-patient treatment**" (emphasis added).¹⁰²⁾ This clause could be read as implying that patients travelling to another Member State in order to receive benefits in kind which involve extramural treatment do not - or not necessarily - have to apply for authorisation, while the second paragraph of the said Article, which treats of the rights of insured persons who are authorized by the competent institution to go to the territory of another Member State, apparently would still encompass both in- and out-patient care. Accordingly, the amendment would demonstrate that there is an alternative, a procedure enabling patients to obtain non-hospital treatment in another Member State at the expense of the national health insurance institution without having to seek authorisation, even if the Article concerned does not mention that procedure. If, however, the amendment would have the effect of confining the scope of the second paragraph to in-patient treatment, it would deprive patients wishing to obtain out-patient treatment abroad from the definite benefits of the Regulation-based method. Furthermore, insofar as it was the intention of the European Parliament to take into account the Court's case law, it can be questioned whether it is appropriate to qualify out-patient treatments received abroad - which, in accordance with this case law, have to be pre-paid by the patient - as "benefits in kind".

Be that as it may, the relevant part of the Parliament's amendment, which was accepted by the Commission,¹⁰³⁾ has not been retained by the Council. The Council has indeed preferred to maintain the principle of prior authorisation for extramural care, to the Commission's regret,¹⁰⁴⁾ and has deleted the italicised clause. In the draft Statement of the Council's reasons accompanying the adoption of the common position, it is stated that the Council was not in a position to limit the scope of the competent institution's authorisation to receive appropriate treatment outside the State of residence to in-patient treatment and that in its view, the effects of such a restriction, in particular on the reimbursement arrangements between Member States, would also have had to be subject to specific provisions.¹⁰⁵⁾

2) The active provision of services by foreign medical service providers

In this chapter, we will try to outline some aspects of the European legal framework in relation to the mobility of medical doctors, in particular where they temporarily provide services in another Member State without being established there.¹⁰⁶⁾ Doctors, like many other health care professionals, can hardly be regarded as ordinary service providers. Indeed, service provision in

the health care sector is complicated by aspects of social security. Doctors can be seen as operating in a triangle, the third party being a national health service or a sickness fund, which bears - directly or indirectly - the major part of their bill.¹⁰⁷⁾ Different contracting systems, either inclusive or exclusive, are in place in the Member States. How do these systems articulate with the temporary and occasional provision of services by migrant doctors?

A. The minor contribution of the recognition instruments

The mobility of medical doctors has been the subject of Community secondary legislation, in the form of Directive 93/16/EEC of 5 April 1993 to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications.¹⁰⁸⁾ This Directive, hereinafter referred to as the Doctor's Directive, is chiefly concerned with the removal of obstacles arising from the imposition of national qualification requirements on migrant doctors. These restrictions, which are dealt with in the Directive through the concepts of harmonisation and mutual recognition, are outside our purpose.

In addition, the Doctor's Directive, in its chapter VI, provides for a partial coordination of national requirements to the taking up and the pursuit of professional activities of doctors. Articles 17 and 18 are specifically concerned with the free provision of services and lay down a less stringent framework for doctors who only temporarily and occasionally provide medical services in the territory of the host Member State, as opposed to their colleagues who establish themselves in the host Member State, either in an employed (Article 39 ECT) or self-employed (Article 43 ECT) capacity. The gist of these provisions is reiterated in Title II of the common position adopted by the Council on 21 December 2004 with a view to the adoption of a Directive on the recognition of professional qualifications (hereinafter referred to as the Common Position).¹⁰⁹⁾ According to Article 5 (3) of the Common Position, the service provider "shall be subject to the disciplinary provisions of a professional or administrative nature which are directly linked to professional qualifications, such as the definition of the profession, the use of titles and serious professional malpractice which is directly and specifically linked to consumer protection and safety, which are applicable in the host Member State to professionals who pursue the same profession in that Member State". As is apparent from recital 8 of the Common Position, these disciplinary provisions include "the scope of activities covered by a profession or reserved to it", thus endorsing and codifying the principle set out in the Court's ruling in *Gräbner*.¹¹⁰⁾

Pursuant to Article 6 (a) of the Common Position, the host Member State must exempt service providers established in another Member State from the requirements which it places on professionals established in its territory relating to authorisation by, registration with or membership of a professional organisation or body. However, in order to facilitate the application of the

disciplinary provisions of the host Member State, the latter may provide for either automatic temporary registration with or for pro forma membership of such a professional organisation or body, provided that such registration or membership does not delay or complicate in any way the provision of services and does not entail any additional costs for the service provider.

Furthermore, Member States may require that, upon the first provision of services in his territory, the service provider concerned shall inform the competent authority in the host Member State in a written declaration to be made in advance including the details of any insurance cover or other means of personal or collective protection with regard to professional liability. Such declaration shall be renewed once a year if the service provider intends to provide temporary or occasional services in that Member State during that year. The service Member State may require that the declaration be accompanied by proof of the nationality of the service provider, by an attestation certifying that the holder is legally established in a Member State for the purpose of pursuing the activities concerned and by evidence of professional qualifications (Article 7(2)). A copy of the said declaration and, where applicable, of its renewal, accompanied by a copy of the documents referred to in Article 7(2), shall be sent by the competent authority to the relevant professional organisation or body, and this shall constitute automatic temporary registration or pro forma membership within the meaning of Article 6 [Article 6 (a)].

Finally, under Article 6 (b) of the the Common Position, the host Member State must exempt the foreign service provider from registration with a public social security body for the purpose of settling accounts with an insurer relating to activities pursued 17 for the benefit of insured persons. However, the service provider shall inform in advance or, in an urgent case, afterwards, this body of the services which he has provided.

It would of course be erroneous to assume that the aforesaid provisions regulate the cross-border provision of medical services exhaustively. A significant part of the plethora of regulations to which Member States tend to subject health care professionals in their territory, is left untouched by the Doctor's Directive and indeed by the amended Proposal on the recognition of professional qualifications. Common Position.

The scope of Article 5 (3) of the Common Position, like that of the second subparagraph of Article 17 (1) of the Doctor's Directive, to which it bears a resemblance,¹¹¹ is less than crystal-clear. It is regrettable that the Council has retained the reference to the notion of "disciplinary rules of a professional and administrative nature", which is vague to the extreme and lends itself to divergent national interpretations. A clearer definition of the host State rules with which the service provider has to comply at any rate would certainly be acclaimed, not least in the light of the Draft services directive. Indeed, if both instruments were adopted as they stand at present, the said notion, which

dates back to 1975, would delimit the range of the country of origin principle in respect of the temporary cross-border pursuit of numerous professional activities, including that of doctors. The additional requirement that the disciplinary provisions have a direct and specific link to professional qualifications, even if it is coherent with the scope of the Common Position, does little to clarify matters. If "serious professional malpractice" meets this requirement, then why not rules regarding advertising and multi-disciplinary activities? Be that as it may, the condition that there be a direct and specific link with professional qualifications shows a desire on the part of the Council to reduce the body of disciplinary regulation of the host Member State which has to be complied with by the service provider. In its Statement of reasons accompanying the Common Position, the Council has indicated that, "for reasons of proportionality", [Article 5 (3) and recital 8] limit the disciplinary provisions applicable to those which are strictly relevant".¹¹²⁾ It would seem that the host Member State's non-disciplinary regulations as well as its disciplinary provisions which lack a direct and specific link with professional qualifications are covered by the rule contained in the third recital,¹¹³⁾ and thus have to be observed by the service provider only in as far as they are objectively justified and proportionate. In the context of the free provision of services, this means theoretically, as we shall see below, that these host State regulations will apply only exceptionally.

As concerns the consequences of the incidence of aspects of social security, the recognition instruments do not contribute much either. Stating on the obligation to exempt foreign service providers from registration with a public social security body [Article 6 (b) of the Common Position], which is currently laid down in Article 18 of the Doctor's Directive, the Court held that "neither [that Article] nor any other provision of [the Doctor's Directive] seeks to eliminate all obstacles that might exist in the Member States relating to the reimbursement of the cost of medical services by an insurance body to which the doctor established in another Member State does not belong".¹¹⁴⁾

Accordingly, Member States remain, in principle, competent to regulate the taking-up and the pursuit of professional activities of doctors. However, when doing so, they must respect the fundamental freedom of service provision. This means that the imposition of national rules on foreign service providers will have to comply with Articles 49 and 50 of the Treaty, as interpreted by the Court of Justice.¹¹⁵⁾

B. The general case law on Articles 49 and 50 ECT

Article 50, last paragraph of the ECT grants the service provider the right to temporarily pursue his activity in the State where the service is provided, "under the same conditions as are imposed by that State on its own nationals". However, the Court of Justice soon indicated that a mere right to national treatment might not suffice to enable the beneficiary to effectively exercise the freedom laid down in Article 49 ECT. Indeed, the service provider

moves, if at all, to the host Member State only temporarily. He is already established in another Member State, to whose legislation he remains subject. In those circumstances, the imposition of the rules of the host Member State means that the service provider might be subject to a double regulatory burden, having to satisfy both the rules imposed by the Member State of establishment and those of the Member State of destination.^{116) 117)} The specificity of the provision of **services** was **explicitly** recognised by the Court in **Webb**, where it stated that the non-discrimination principle "does not mean that all national legislation applicable to nationals of the [host Member State] and usually applied to the permanent activities of undertakings established therein may be similarly applied in its entirety to the temporary activities of undertakings which are established in other Member States".¹¹⁸⁾ Only in *Säger*¹¹⁹⁾ was the non-discrimination principle completely "abandoned" in the field of services, for the benefit of a wide application of the country of origin principle.¹²⁰⁾ In that case, the Court of Justice confirmed that a Member State may not make the provision of services in its territory subject to compliance with all the conditions required for establishment on pain of depriving "of all practical effectiveness the provisions of the Treaty whose object is, precisely, to guarantee the freedom to provide services".¹²¹⁾ It then turned to the question whether Articles 49 et seq of the ECT could also be infringed by indistinctly applicable measures. Replying in the affirmative, the Court stated that "[Article 49 of the Treaty] requires not only the elimination of all discrimination against a person providing services on the ground of his nationality but also the abolition of any restriction, even if it applies without distinction to national providers of services and to those of other Member States [...]". The national measures which come under the Articles 49 et seq of the ECT are positively defined as those which are "[...] liable to prohibit or otherwise impede the activities of a provider of services established in another Member State where he lawfully provides similar services".¹²²⁾ The latter clause offers the key to the Court's reasoning. The service provider in question was established in a Member State and fulfilled all the conditions laid down by the legislation of that State for the access to and the exercise of his professional activities.¹²³⁾ Because of his **legally** carrying on similar activities in the Member State of **establishment**, he automatically acquires the right to provide his services in the territories of the other Member States. This implies an acknowledgement on the part of the host Member States that the Member State in which the service provider is established regulates the activity concerned appropriately and to an adequate extent. The lawful pursuit of similar activities in the Member State of establishment constitutes minimum, yet sufficient proof of the provider's aptitude as well as of the quality of his services.¹²⁴⁾ Only exceptionally and subject to certain conditions should Member States, in which the services are occasionally and temporarily provided, be allowed to impose their own rules on non-established providers.¹²⁵⁾ This will be the case if those rules are non-discriminatory, objectively necessary and suitable for attaining a legitimate

aim - either an express derogation listed in Article 46 ECT or an imperative reason relating to the public interest - which is not sufficiently protected by the legislation to which the service provider is subject in the Member State of establishment. Accordingly, the legitimacy of the host Member State's action must be proven on a case-by-case basis, in accordance with the interests at issue and taking into account the legislation of the other Member States.^{126) 127)}

C. The "Activation" of the health care cases

It is submitted that the health care cases discussed in the previous chapter can provide useful guidance to our present purpose, which is to describe the relation between national health insurance schemes and the temporary provision of services by medical doctors established in another Member State. The health care cases were concerned with the "passive" provision of services, in that the claimants, as recipients of medical services, asserted rights conferred upon them by Article 49 ECT. Nonetheless, the Court has not failed to refer to the situation of the providers of the services at issue, i.e. the foreign health care providers. It has consistently held that the requirement of prior authorisation for the assumption of health care costs incurred abroad constitutes a barrier to the freedom to provide services, not only for insured persons, but also for service providers.

Taking the health care cases as a point of departure, we will first highlight some crucial aspects of this case law and then attempt to sketch the European legal framework in which foreign health care professionals providing services in the host Member State operate.

1. The case-law of the Court

The first matter, whose significance should not be underestimated, relates to the ease with which the Court classified the medical treatment received abroad as a service within the meaning of Article 50 ECT. Admittedly, ever since the judgments in *Luisi and Carbone*¹²⁸⁾ and *Grogan*,¹²⁹⁾ (private) medical services are deemed to fall within the ambit of the free provision of services. In the health care cases however, the Court applied the ECT Articles regarding services to State-organised provision of health care, that is health care funded (and often provided) by the welfare state. To do so, the Court had to establish the existence of an exchange of services for consideration. The ECJ found that the relationship between the patient and the national social security institution (the "payer") was not relevant to its assessment.¹³⁰⁾ In *Geraets-Smits and Peerbooms*, in response to arguments raised by intervening governments and the Advocate General, the Court looked into the relationship between the payer and the (hypothetical) national provider, only to conclude that "the payments made by the sickness insurance funds under the contractual arrangements provided for by the ZFW, albeit set at a flat rate, are indeed the consideration for the hospital services and unquestionably

represent remuneration for the hospital which receives them and which is engaged in an activity of an economic character".¹³¹⁾ However, in both *Geraets-Smits and Peerbooms* and *Müller-Fauré and Van Riet* the Court made clear that the intrastate, *in casu* Dutch setting was not relevant. Irrespective of whether or not health care provided by Dutch providers and paid by Dutch sickness funds constitutes a service within the meaning of the Treaty, medical treatments obtained outside the national territory can be regarded as such because the patient has paid the foreign provider directly.¹³²⁾ It is thus the interstate relationship between the insured person and the foreign health care provider, the latter being paid by the former for the services provided, which is decisive. The significance of this pragmatic approach should not be underestimated. It clearly demonstrates that, at least at this stage, the Court does not treat the public provision of health care, with its triangular structure and its involvement of a third-party payer, any differently than other service sectors. What is more, the approach adopted by the Court renders irrelevant, for the purpose of the qualification as a service within the meaning of the ECT, the nature of the domestic health care system.

The third party, the national payer, only comes to the fore upon the examination of the restrictive effect of the national measures at issue. By making the assumption of health care costs incurred abroad subject to restrictive conditions, such as a prior authorisation requirement, or by providing for a lower reimbursement of these costs than the insured person would have obtained if he had undergone the same treatment under the same conditions in the Member State of affiliation, Member States erect an obstacle to the freedom to provide services, both for the patient and the foreign provider. In general, Member States will be held liable of restricting the free provision of services whenever they deter patients from seeking medical treatment from a health care provider established in another Member State. This will be the case where patients are put at a disadvantage for the sole reason of having applied to a health care provider established in another Member State. Consequently, an insured person who has received (and paid for) a certain medical treatment obtained abroad which, if it had been obtained within the national borders, under the conditions under which it is delivered, would have given rise to a financial intervention of the payer amounting to a given sum, should be granted a reimbursement totalling that sum without having to apply for an authorisation, in default of which the national measures will constitute a restriction to the free provision of services. In respect of the interstate provision of extramural care, these restrictions cannot in principle be justified.¹³³⁾

This said, the actual implications of the Court's repeated assertion that Community law does not detract from the powers of the Member States to organise their social security systems and, particularly, of its even more recurrent statement that Member States must still comply with Community law when exercising their powers, become clear. Whereas application of

Article 49 ECT, consistent with the former assertion and with Article 152 (5) ECT, appear to leave intact national power to determine who can become affiliated to a social security scheme (personal scope), the conditions to be fulfilled in order to receive benefits and what these benefits will be (material scope),¹³⁴⁾ compliance with Community law seems to entail for the Member States a loss of spatial control over the medical consumption of their citizens¹³⁵⁾ and a Europeanisation of the range of providers whom the patient is entitled to visit.

2. Europeanisation of the range of providers: about contracted and non-contracted providers and its reimbursement

In our opinion, this Europeanisation should not be construed by reference to the nature of the national health care system, as some authors, following the judgments in *Kohll* and *Geraets-Smits and Peerbooms*, have contended. In their view, Member States operating a reimbursement system, such as Luxembourg and Belgium, reimbursing treatment from any doctor established in the territory, should henceforth cover the medical services provided by any doctor established in the European Union. For Member States with a benefits-in-kind system, such as the Netherlands, where sickness funds enter into agreements with health care providers which provide treatment free of charge to those affiliated with it, the translation into "Eurospeak" would have smaller repercussions. It would merely mean that the sickness funds cannot discriminate between domestic providers and providers established in another Member State. In particular, it should be just as easy for foreign providers to become contracted as it is for domestic ones. Furthermore, if the sickness fund were to avail itself of the services of non-contracted institutions, it would be just as easy to obtain treatment from a non-contracted provider established in another Member State as it is to obtain care from its non-contracted colleague in the Member State of affiliation. Member States with a national health service, such as the Scandinavian Member States, would only be affected to the extent that they recognise the patient's right to be treated by a private provider at their expense; in that case, they cannot discriminate against foreign health care providers.¹³⁶⁾

We do not think that the Eurospeak argument is well-founded. As regards Member States operating health care schemes which do not provide benefits in cash - the major part of the European Union's twenty-five Member States - the impact of Articles 49 and 50 ECT, as interpreted by the Court, goes well beyond a mere application of a national treatment rule to the contracting of health care providers. Obviously, Member States cannot disregard applications from health care providers established in other Member States. It is self-evident that the evaluation criteria should be objective, transparent and non-discriminatory. On the other hand, it is materially impossible for national health insurance institutions to enter into agreements with all

European health care providers. Besides, it would seem unreasonable to oblige health care institutions to contract foreign health care providers where their services would not meet a demand on the part of the insured persons.

The ruling in *Geraets-Smits* and *Peerbooms*, even if it left unclear whether the **justification** of the prior authorisation requirement was founded on the aspect of planning of hospital services or rather on the specific nature of the Dutch benefits in kind system,¹³⁷⁾ demonstrated that Member States, regardless of the nature of their national contracting system and irrespective of the type of care received (intra- or extramural), should reimburse the health care costs incurred abroad, on pain of **restricting** the free provision of services.

Member States operating exclusive contracting systems cannot veil the restrictive effect of the prior authorisation requirement by putting forward that it applies to (domestic and foreign) non-contracted health care providers and therefore has no nationalistic or territorial undercurrent.¹³⁸⁾ As the Court held in *Geraets-Smits* and *Peerbooms*, in response to the argument made by the Dutch government and the Commission that it was open to the sickness funds to enter into agreements with providers outside the Netherlands, "it will be mainly hospital establishments in the Netherlands that will strike contractual arrangements with the sickness insurance funds" and "it seems unlikely that a significant number of hospitals in other Member States would ever enter into agreements with the Netherlands sickness insurance funds, their prospects of admitting patients insured by those funds remaining uncertain and limited".¹³⁹⁾ In order to decide that the Dutch rule constituted a restriction to the free provision of services, the Court accepted that "in the majority of cases the assumption of costs, under the [Dutch legislation], of hospital treatment provided by establishments in Member States other than the Member State in which a person is insured will have to be subject to prior authorisation."¹⁴⁰⁾ In other words, **even if foreign health care providers have an equal opportunity to conclude agreements with the national health insurance institution, the prior authorisation requirement for noncontracted care will still work to the detriment of foreign health care providers** and impact them disparately¹⁴¹⁾ A disparate impact is of course particularly evident in the case of the Luxembourg inclusive contracting system, under which authorization to practice medicine cannot be detached from accession to the collective agreement with the **Union des Caisses de Maladie** (UCM). Hence, the authorisation requirement will in principle only affect foreign health care professionals.

We submit that the same line of reasoning should apply with respect to the **level** of assumption of the medical services supplied by foreign health care providers. Member States cannot evade the prohibition contained in Article 49 ECT by reimbursing the costs incurred abroad to the (lower) level of cover they happen to employ in respect of care provided by domestic non-contracted providers (see also *supra*). It simply cannot be expected from

foreign health care providers, in their capacity of beneficiaries of the freedom to provide services, to have entered into contracts with any health insurance institution with which their potential patients may be insured, to be placed on the same footing as competing health care providers established in the Member State of affiliation of the patient, the majority of whom are contracted and for whom it is far easier to meet this condition.¹⁴²⁾

Consequently, we believe that it can be inferred from the ruling in *Geraets-Smits* and *Peerbooms*, as confirmed and elucidated by *Müller-Fauré* and *Van Riet*, that Member States, even if they operate a selective contracting system domestically by virtue of which appealing to the services of domestic non-contracted providers is contingent upon prior authorisation or results for the patient in a lower level of cover, are liable of restricting the free provision of services if they fail to equate the rights of insured persons who applied to a foreign health care provider with the rights of those who visited a domestic contracted provider.

The rulings in *Geraets-Smits* and *Peerbooms* and *Müller-Fauré* and *Van Riet*, especially when interpreted in the manner we advocate, do not sit well with national contracting systems for extramural services. Where Member States are to grant patients who visited a foreign provider the same treatment as those who obtained treatment from a domestic contracted provider, it is not surprising that domestic providers, both contracted and non-contracted, will feel wronged, the former because their foreign competitors allegedly do not have their hands tied by all sorts of regulations and the latter because the services they provide do not give rise to the same benefits as those of the foreign providers, who are no more bound by agreements with the national health insurance institution than they are. As far as the discontent of domestic contracted providers is concerned, this holds true as well for Member States operating an inclusive contracting system in which providers are automatically included, such as Luxembourg.¹⁴³⁾ It is well-known that the Luxembourg medical profession, following the *Kohll* judgment, has called into question this compulsory contracting system. Discussions were held, at the end of which it was decided to maintain the compulsory contracting system but to comply with certain subsidiary demands of the Luxembourg medical and dentist profession.¹⁴⁴⁾

For the time being, the Court does not seem amenable to objections raised by Member States that fear the declining interest of the medical profession in cooperating in a contracting system.^{145) 146)} As mentioned above, the Court rejected the reasons put forward to justify the requirement for prior authorisation in respect of the assumption of the costs of cross-border extramural care.¹⁴⁷⁾

D. The temporary provision of extramural care by medical doctors in the host member state

In our opinion, there is no valid cause for fundamentally overthrowing the scheme depicted above for the sole reason that, instead of the patient travelling towards the foreign health care provider, it is the latter that moves temporarily to the patient's Member State of affiliation in order to provide medical services there.

Accordingly, a health care provider established in a Member State where he lawfully provides medical services, is entitled to provide those services on a temporary and occasional basis in the host Member State. If these services, had they been provided by a contracted provider established in the host Member State, would have been assumed by the national health insurance institution, the patient, recipient of the medical services provided by the foreign doctor, is entitled to reimbursement, the amount of which may not be lower than the level of assumption of that care as provided by a domestic contracted provider. The patient who visits a foreign doctor providing services in the territory of the Member State of affiliation does not need to apply for prior authorisation, save where this would constitute a condition on which the benefits concerned are granted in that Member State, and consequently, would also be required had the patient obtained the care from a domestic contracted provider.

The foreign doctor should be given an equal opportunity to participate in the contracting system applicable in the host Member State. His application should be assessed on the basis of objective, transparent and non-discriminatory criteria. However, it seems unlikely that many foreign doctors, who are engaged in the temporary and occasional provision of medical services in the host Member State, will want to take part in the contracting scheme of that State. In our view, it cannot be imposed upon the foreign doctor to participate in the contracting system of the host Member State in order for the costs of his medical services to be reimbursed, even if joining this system is not a matter of choice for domestic doctors, such as is the case in Luxembourg. **Whilst condemning a foreign doctor to private practice would directly affect his access to the market in the host Member State,¹⁴⁸⁾¹⁴⁹⁾ requiring him to enter into agreements with a national health insurance institution would appear a too cumbersome procedure in proportion to the temporary nature of the service provision, depriving it of all practical effectiveness.** This conclusion not only stems from the *Säger* case law, but can as well be inferred from the "activated" health care cases.¹⁵⁰⁾

Patients visiting a foreign medical doctor who is not bound by a contract with the health insurance institution in the host Member State must pay the medical bill up front, and then file a claim for reimbursement.

As an intrinsic corollary of the qualification of health care professionals as service providers, the Articles 49 and 50 ECT, as construed in the health care cases, **have detracted** from the powers of the Member States to define, in the presence of an intra-Community situation,¹⁵¹⁾ the range of providers who are entitled to supply medical services at the expense of the national health insurance schemes. The services of foreign health care professionals who lawfully provide health care in their Member State of establishment are eligible for coverage under the national health insurance scheme of the Member State of affiliation of the patient, irrespective of whether the insured person travels to the Member State of establishment of the health care professional to receive these services or whether the latter provides these services temporarily in the territory of the host Member State, in which the patient is insured. On the other hand, they appear to leave intact Member States' power to define the personal scope of these schemes, their power to determine the treatments which are covered and the extent to which they are covered, and lastly, their power to lay down the conditions on which benefits are granted.¹⁵²⁾ Member States retain full competence to regulate these matters as they see fit, provided they do not discriminate against nationals or goods of the other Member States.¹⁵³⁾ The effect of these regulations might well be to impede or render less attractive the provision of services by foreign doctors. As such, these rules are at risk of being covered by the broad *Säger* formula. Even so, and leaving aside the case of discrimination, we submit that the foreign medical service provider should not be able to challenge the legislation of the host Member State establishing these parameters of statutory health insurance. This legislation cannot be qualified as a restriction to the free provision of services within in the meaning of Article 49 ECT. To take a different view would amount to allowing the Community to exceed its competence and would render completely nugatory the Court's sustained assertions on Member States' powers in these fields. As far as the said parameters are concerned, the foreign medical service provider should basically take the statutory health insurance system of the host Member State as he finds it. Accordingly, although it is liable to hinder the cross-border provision of his services, a Luxembourg-based specialist doctor practicing temporarily in the Netherlands cannot call into question the Dutch referral system. By the same token, a dentist holding a lucrative practice in the Member State of establishment, whose statutory health insurance system generously reimburses the costs of dental care, cannot challenge the decision of the host Member State to cut back on expenses for dental care and, in view of that, not to assume the costs of certain types of treatments or to assume them only for minors.

By contrast, the imposition on the foreign medical service provider of host State regulations which are not such as to define the boundaries of health care cover, is to be assessed under the *Säger* case law. To require the foreign medical service provider to comply with regulations which are not closely

connected to patients' entitlement to health care benefits, even if they are indistinctly applicable, is tantamount to restricting the free provision of services. The regulations concerned, which would include, in the Luxembourg setting, the rules which affiliation of the mandatory contracting system brings about for domestic doctors, deal with a vast array of issues and include, in addition to rules of a purely professional nature¹⁵⁴⁾ such as those governing multidisciplinary activities and commercial communications, rules relating to the organisation of the profession,¹⁵⁵⁾ good medical practice, tariffs,¹⁵⁶⁾ cost containment, etc.

Undoubtedly, the bulk of these restrictions is eligible for justification under Article 46 ECT (the protection of public health) or under the judicially-created exceptions to the free provision of services. The Court has construed the scope of the express public health exception broadly so that it encompasses the objective of maintaining a high-quality and balanced medical service open to all as well as the objective of maintaining treatment capacity or medical competence on the national territory.¹⁵⁷⁾ The risk of seriously undermining the financial balance of the social security system constitutes, despite its economic connotation, an overriding reason of general interest.¹⁵⁸⁾ The same appears to hold true for the essential characteristics of the national health insurance scheme.¹⁵⁹⁾

National restrictive measures must be proportionate to the aim pursued; in particular, they must be suitable for securing the attainment of the imperative general interest requirement they pursue and must not go beyond what is necessary in order to attain it. In that context, and even in the absence of a common standard created by the Community legislature, regard must be had to the legislation to which the foreign medical service provider is subject in the Member State of establishment, in which he lawfully provides similar services.¹⁶⁰⁾ In order to be able to impose its own indistinctly applicable rules, in compliance with the principle of proportionality, the host Member State must demonstrate the failure of the legislation of the Member State of establishment to safeguard the general interest, e.g. the protection of public health. This supposes, theoretically, an assessment of both the objective and abstract proportionality of the envisaged measure to the aim pursued and the subjective and concrete proportionality in relation to the protection of this aim by the relevant legislation of the Member State of establishment.¹⁶¹⁾

However, faced with national measures pursuing objectives of public health or social policy, the Court tends to employ a lighter-touch proportionality test and to grant the Member State a wider margin of appreciation.¹⁶²⁾ In *Gräbner*,¹⁶³⁾ the Court acknowledged that Article 49 ECT does not preclude national regulation reserving the exercise of certain activities to medical doctors, thus confirming previous case law in relation to Article 43 ECT.¹⁶⁴⁾ It was held in particular that the decision of a Member State to restrict to a group of professionals with specific qualifications, such as qualified doctors, the right to carry out medical diagnoses and prescribe treatments for illness

or to alleviate physical or mental disorders may be considered to be a **suitable** means of achieving the objective of safeguarding public health.¹⁶⁵⁾ Having recalled its consistent case law according to which the mere fact that a Member State has chosen a system of protection different from that adopted by another Member State cannot affect the appraisal of the need for and proportionality of the provisions adopted, the Court found the measure not to go beyond what is **necessary** to achieve that objective, stating that each Member State may decide, in accordance with its understanding of the protection of public health, whether or not to authorise practitioners without such qualifications to exercise activities of a medical nature, laying down, where appropriate, requirements relating to experience or qualifications which such practitioners must fulfil.¹⁶⁶⁾

Even so, whereas the home Member State's regulations on health care tariffs and, perhaps, on the organisation of the medical profession cannot be seen outside the social and legal context of that Member State and may hardly be relevant in the territory of the host Member State, this is not the case for requirements aimed at quality assurance and cost control. Accordingly, the host Member State must not disregard quality guidelines or requirements relating to continuous professional development to which the foreign medical service provider is subject in the home Member State. Likewise, against the backdrop, common to all Member States, of scarce financial resources having to satisfy increasing health care needs, the home Member State will most probably have issued legislation to ensure efficient spending of public money. Even if such rules are destined to safeguard another public purse, they will produce a favourable effect on that of the Member State to which the foreign medical service provider moves and will have to be taken into account by that Member State.¹⁶⁷⁾

E. The proposal for a directive on services in the internal market¹⁶⁸⁾

We already mentioned that, if the Draft services directive were to be adopted, it would become the frame of reference within which the free provision of medical services is to take place. The showpiece of the Draft's chapter on the free movement of services is the country of origin principle, pursuant to which Member States shall ensure that providers are subject only to the national provisions of their Member State of origin which fall within the coordinated field.¹⁶⁹⁾ This coordinated field is all-encompassing, covering "any requirement applicable to access to service activities or to the exercise thereof", whether or not it falls within an area harmonised at Community level and regardless of the legal field to which it belongs under national law.¹⁷⁰⁾ The Member State of origin shall be responsible for supervising the provider and the services provided by him.¹⁷¹⁾ According to paragraph 3 of Article 16, Member States may not, for reasons falling within the coordinated field, restrict the freedom to provide services in the case of a provider established in another Member State. Several requirements, the imposition of which is

prohibited, are mentioned in particular, such as (e) an obligation on the provider to comply with the requirements, relating to the exercise of an activity, applicable in their territory and (i) restrictions on the freedom to provide the services referred to in Article 23 (1) first subparagraph (prior authorisation for the assumption of the cost of non-hospital services).¹⁷²⁾

Several general derogations from the country of origin principle relate to services with health- or health care-related repercussions. To ensure coherence with the future Directive on the recognition of professional qualifications, a general derogation is laid down in Article 17, 8°, as regards Title II of the future recognition Directive (cf. supra). Pursuant to Article 17, 16° of the Draft services directive, the country of origin principle shall not apply to services which, in the Member State to which the provider moves in order to provide his services, are prohibited, when this prohibition is justified by reasons relating to public policy, public security and public health. Recital 42 adds to that reasons relating to the protection of human dignity and clarifies that this derogation also covers cases where services are prohibited but are allowed under certain specific circumstances.¹⁷³⁾ With this derogation, national bans on euthanasia, abortion or medically-assisted procreation techniques can be maintained. Article 17, 17° provides for a derogation with respect to "specific requirements of the Member State to which the service provider moves, that are directly linked to the particular characteristics of the place where the service is provided, or to the particular risk created by the service at the place where the service is provided, and with which compliance is indispensable for reasons of public policy or public security or for the protection of public health or the environment". Several examples of such "specific requirements" are cited in recital 43, such as "requirements relating to the organisation of public events or requirements relating to the safety of building sites". The significance of this exception for our purpose remains wholly unclear. In particular, the question arises whether it would cover the parameters defining the boundaries of health care cover, as mentioned above. Would it perhaps extend to rules fixing health care tariffs? The fact is that the derogation contained in Article 17, 17° is referred to in recital 47a as an important general derogation from the country of origin principle for cross-border health services and as including "standards of hygiene (sic)".¹⁷⁴⁾ Lastly, Article 17, 18° exempts from the application of the country of origin principle the authorisation system for the reimbursement of hospital care.

Apart from these general derogations from the country of origin principle, Article 19 of the Draft services directive allows Member States to intervene on a case-by-case basis to take measures relating to (a) the safety of services, including aspects of public health, (b) the exercise of a health profession and (c) the protection of public policy. This summary list, which completely passes over all the overriding general-interest reasons recognised by the ECJ,¹⁷⁵⁾ contains two grounds on which the host Member can rely to impose its rules on the foreign medical service provider. However, before doing so,

the host Member State has to follow a laborious and time-consuming procedure of mutual assistance, laid down in Article 37 of the Draft. This involves a notification to both the Member State of origin (which can take corrective measures) and the Commission (which can adopt a decision asking the Member State concerned to refrain from taking the proposed measures or to put an end to the measures in question). In addition to that, the conditions set out in Article 19 (2) have to be complied with.¹⁷⁶⁾

To a large extent, the Draft services directive draws the consequences of the case law of the Court of Justice. Indeed, the country of origin principle in the field of services, the key principle of the Draft services directive, does not appear out of thin air. On the contrary, it is firmly established in the case law on Article 49 ECT.¹⁷⁷⁾ In view of that, the mere exclusion from the Draft's scope of the provision of health-care-related services, as a steadily lengthening list of interest groups and advisory bodies recommends, would not place the provision of health care outside the ambit of the internal market, save modification of the Treaty. However, the operation of the principle in the Draft services directive goes significantly beyond that under the Treaty provisions. It applies to the entire field of service regulation, which is only declared coordinated, without prior harmonisation of the general interest.¹⁷⁸⁾ Whereas under the Treaty provisions, the host Member State may impose its legislation if and to the extent that the general good is not sufficiently protected by the rules to which the foreign provider is subject in the home Member State, and room is left for a wider margin of appreciation in the presence of sensitive matters and/or diverse standards, the Draft services directive, without instituting it, almost irrefutably presumes a European-wide equivalence in the protection of the general interest.

Combining market access with enduring regulatory control¹⁷⁹⁾ in a field as delicate and highly regulated as that of health care provision, which is moreover interrelated with solidarity-based social security and lacks common standards, is a difficult assignment. Whereas the current situation - a "qualified" home State model combined with legislative instruments prescribing application of aspects of the legislation of the host State - is unremarkable for legal certainty, the virtually absolute and unconditional implementation of the home State model in the Draft services directive disowns the legitimate interest of Member States to impose their own legislation on foreign medical service providers. Derogations are unclear or their use is strictly framed. Alternative models of market integration, however, are not abundant. With the creation, at Community level, of a single set of harmonised regulatory requirements come thorny issues of democratic legitimation, attribution of powers and subsidiarity.¹⁸⁰⁾ While detailed harmonisation does not seem conceivable, minimum harmonisation of certain requirements to the access to and the exercise of a medical profession, as provided for in Articles 47 paragraphs 2-3 jo. 55 ECT, could provide the basis for a systematic application of the country of origin

principle. On the other hand, a pure model of host State control, as the wording of Article 49 ECT suggests, would undoubtedly increase legal certainty, but would shut the door on the development of the temporary provision of cross-border health services.¹⁸¹⁾

One way or another, priorities will have to be established.

3) The Free Provision of Ambulatory Non-Medical Care Services within the Framework of the Luxembourg Care Insurance

A. Conformity with EU law

For the provision of services of domiciliary aid (non-medical care) to dependent persons, such as elderly people or handicapped persons, the Luxembourg care insurance scheme resorts to health professionals employed by aid and care networks (réseaux d'aides et de soins, hereinafter referred to as "network"). A network is defined as **"un ensemble organisé d'une ou de plusieurs personnes physiques ou morales, dispersé dans une zone territorialement donnée, de compétences différentes et complémentaires pour assurer et coordonner la prise en charge de la personne dépendante"**.¹⁸²⁾ In order to be able to exercise the activities in question,¹⁸³⁾ the network has to obtain a double authorisation (**agrément aide à domicile et soins à domicile**).¹⁸⁴⁾ The conditions for the granting of these authorisations are laid down in grand-ducal regulations¹⁸⁵⁾ and include staff requirements (in casu three full-timers) and requirements aimed at ensuring continuity of aid and care (in casu provision of services on every day of the year during at least 14 hours a day). In addition to these authorisations, the network has to enter into agreements with the UCM (**contrat d'aides et de soins**).¹⁸⁶⁾ This contract contains commitments on behalf of the providers concerning quality, invoicing, book keeping, the definition of the circle of persons covered,¹⁸⁷⁾ the extent of the services to be provided, continuity, etc.

Can an undertaking, legally established in another Member State where it provides similar services, rely on Article 49 jo. Articles 48 and 55 ECT to gain access to the activity of domiciliary non-medical care and exercise it in the Luxembourg territory? If so, what are the requirements it has to comply with?

There can be no doubt that home aid services constitute services within the meaning of the Treaty. In *Sodemare*, the Court considered a private company running old people's homes to be engaged in an economic activity within the meaning of Articles 2 ECT.¹⁸⁸⁾

Trickier is the question whether the provision of home aid services by a foreign-based company in the Luxembourg territory comes within the scope of the Treaty Articles on services, or whether Article 43 ECT applies. The decisive criterion for the application of the Treaty chapter on services is the absence of a stable and continuous participation by the person concerned in the economic life of the host Member State.¹⁸⁹⁾ A Community national who

pursues an activity on a stable and continuous basis in another Member State where he holds himself out from an established professional base to, amongst others, nationals of that Member State, must be regarded as exercising the right of establishment. On the other hand, the provision of services within the meaning of the Treaty is characterised by its temporary nature, which, according to a well-established case law, must be determined, not only in the light of duration of the service provision, but also of its regularity, periodical nature or continuity.¹⁹⁰⁾ The Court has interpreted these criteria broadly and has qualified as a service provider a business, established in a Member State, which supplies with a greater or lesser degree of frequency or regularity, even over an extended period, services to persons established in one or more Member States. It has observed that no provision of the Treaty affords a means of determining, in an abstract manner, the duration or frequency beyond which the supply of a service in another Member State can no longer be regarded as the provision of services within the meaning of the ECT.¹⁹¹⁾

Although the provision of services of domiciliary aid does not necessitate an infrastructure in Luxembourg, as opposed to the running of an establishment accommodating dependent persons, the services in question, by their very nature, imply a certain degree of continuity and regularity, which seems to go beyond mere considerations of desirability.¹⁹²⁾ In view of that, we believe that there is a case for Luxembourg authorities to assess the application of a foreign provider of home aid services to supply similar services on a regular basis to a large population of unspecified dependent persons (e.g. a municipality), under Article 43 ECT, even if the provider in question is not established in Luxembourg. Anyhow, such a provider should not benefit from the low standards of transgression of Article 49 ECT. Such will also be the case where the foreign provider directs his activities entirely or principally towards the Luxembourg territory, intentionally attempting to evade the obligations laid down by Luxembourg legislation.¹⁹³⁾ On the other hand, where he seeks to provide those services temporarily to specified dependent persons attracted from the place of establishment,¹⁹⁴⁾ or where he supplies to cover temporary shortages,¹⁹⁵⁾ the Treaty provisions on services will apply.

The question arises whether the Luxembourg authorities can impose upon a foreign provider of home aid services seeking to provide those services temporarily and occasionally in the Luxembourg territory, compliance with the rules to which Luxembourg-based providers are subject. In other words, can access to the Luxembourg market for non-medical domiciliary care¹⁹⁶⁾ be made contingent upon the foreign service provider setting up as a network, obtaining the authorisations required and entering into agreements with the UCM? Indubitably, imposing compliance with these regulations is liable to hinder or render less attractive the free provision of services, and thus constitutes a restriction within the meaning of Article 49 ECT. Still, in *Sodemare*, a case which - because of its parallels with the issue under

consideration - cannot be left aside in this context, the Court took a particularly reserved approach. In this case, the Court was asked to assess the compatibility with inter alia Articles 43 and 48 ECT of an Italian rule allowing only non-profit-making private operators to participate in the running of the social welfare system by concluding contracts which entitle them to be reimbursed by the public authorities for the cost of providing social welfare services of a health care nature. The Court, having observed that the non-profit-condition forms part of the social welfare system, which is based on the principle of solidarity, stated that "as Community law stands at present, a Member State may, in the exercise of the powers it retains to organise its social security system, consider that a social welfare system of the kind at issue [...] necessarily implies, with a view to attaining its objectives, that the admission of private operators to that system as providers of social welfare services is to be made subject to the condition that they are non-profit making".¹⁹⁷⁾ In view of that, and having pointed out that the condition was not discriminatory, the ECJ judged that the non-profit condition cannot be regarded as contrary to Articles 43 and 48 ECT.¹⁹⁸⁾ The judgment in *Sodemare* is a remarkable one. Whereas the Court, in the vast majority of internal market cases, immediately identifies restrictions and only then looks for any justifications, in this case, it discontinued its reasoning at an earlier stage and refrained from examining whether the contested measure was restrictive, which it clearly was.¹⁹⁹⁾ However, it is questionable whether the Court would reiterate this lenient approach if it were to assess the imposition of national measures such as the Luxembourg rules in question, on foreign companies providing temporarily and occasionally home aid services in the Luxembourg territory. *Sodemare* was concerned with free establishment, to the (explicit) exclusion of Article 49 ECT, and the ECJ might have been of the opinion that an economic actor should abide the nondiscriminatory rules issued by its only regulator.²⁰⁰⁾ Besides, in the subsequent health care cases, the Court has interpreted Article 49 ECT as entailing a Europeanisation of the scope of health care providers in situations bearing an intra-Community specificity. There seems to be no good reason why this should not hold true in respect of social care. National measures hindering the Europeanisation of the scope of social care providers constitute barriers to the free provision of services and are in need of justification.²⁰¹⁾

For the reasons stated above, the foreign service provider should not be able to challenge the Luxembourg rules determining the definition of dependence, the circle of beneficiaries, the range of benefits and the conditions on which these are granted.

The regulatory framework imposed by the Luxembourg authorities is aimed at achieving public health and social policy objectives. For one thing, the network structure allows the dependent person to address herself to a single interlocutor and ensures continuity of care.²⁰²⁾ Both the conditions for the granting of the authorisations as the obligations laid down in the accession

contract with the UCM pursue aims of quality of aid and care, as regards structural or process requirements respectively,²⁰³⁾ accessibility of these social services and more generally, the proper functioning of the care insurance scheme. Still, the application of these national rules to service providers established in other Member States must be appropriate for securing attainment of these objectives and must not go beyond what is objectively necessary in order to achieve the intended goals. In that regard, due consideration must be had to the legislation to which the provider is subject in the Member State of establishment, in that the intended goals must not already be safeguarded by that legislation.²⁰⁴⁾ To put it another way, is the national mould into which Luxembourg wants to force the foreign provider, wishing to supply home aid services on a temporary and sporadic basis, suitable for attaining the legitimate general interest objectives it is said to pursue? Can these objectives not be reached by lesser restrictive means? Does the legislation of the home Member State not exhibit equivalence as to the protection of the general interest, even if its precise content - inevitably - differs?²⁰⁵⁾ Yet given the context of the restrictions at issue and the nature of the justifications put forward, it is plausible that the Court will adopt a more reserved attitude. Still, even if the Court may not enforce such a wide-ranging application of the mutual recognition principle as it does in less "sensitive" fields, it is clear that the Luxembourg authorities cannot expect the foreign provider to comply with all the detailed rules to which it subjects domestic providers. As for the latter, Luxembourg legislation may well require that they have at their disposal three full-time employees. However, if - for the sake of argument - the authorities of the French speaking Community of Belgium deem the continuity of care safeguarded where Walloon home aid service providers employ 2.5 full-time equivalents, and this rule actually enables them to ensure continuity of care to dependent Luxembourgers, the Luxembourg authorities are to tolerate it. In the same way, where the French bookkeeping rules allow for sound clerking and can be easily understood by the UCM, Luxembourg will have no case to impose its own.

The requirement to obtain authorisation would probably pass the proportionality test. In *Commission v. France*, the Court stated that the defendant was entitled require that, in order to provide services to persons residing in France, should they wish to do so, bio-medical analysis laboratories which have their place of business in another Member State comply, in accordance with French rules, with the requirement to obtain authorisation.²⁰⁶⁾ However, the competent authorities will have to make sure that the conditions to be satisfied in order to obtain such authorisation do not duplicate the equivalent statutory conditions which have already been satisfied in the home Member State.²⁰⁷⁾ Likewise, it cannot be excluded that the Court would not find it disproportionate to oblige the foreign service provider to make certain arrangements with the UCM regarding the nature of

the services provided, the recipients of these services and their administrative completion.

An obligation to have a place of business in Luxembourg,²⁰⁸⁾ which could be dictated by the need to ensure continuity of care, would most probably be condemned as going beyond what is necessary to achieve that goal. The Court has indeed consistently held that "[...] the requirement of a permanent establishment is the very negation of [the freedom to provide services]" and that "[i]t makes a dead letter of Article [49] of the Treaty, a provision whose very purpose is to abolish restrictions on the freedom to provide services of persons who are not established in the State in which the service is to be provided".²⁰⁹⁾ While undoubtedly the nature of the services concerned demand a degree of proximity between the service provider and the dependent person, this legitimate aim, given also the limited size of the Luxembourg territory, could be attained by less restrictive means, such as an obligation to be able to attend the dependent person at all times within a fixed period of time.^{210) 211)}

Upon assessment of the proportionality of the Luxembourg restrictive measures, account ought to be taken of the fact that the care insurance scheme embraces a level of choice. It provides for a partial replacement of the aid and care services by benefits in cash, which allows the dependent person to remunerate an informal helper (aidant informel).²¹²⁾ It goes without saying that these informal helpers do not need to obtain the authorisations nor are they obliged to conclude an agreement with the UCM.²¹³⁾ Furthermore, pursuant to Article 393 last paragraph of the Code des Assurances Sociales, the network secures the cooperation of other providers if it is not capable of delivering the aid and care by its own resources. The subcontractor exercises his activity under the responsibility of the network, which remains the single interlocutor of the UCM.

B. The proposal for a directive on services in the internal market

The draft Directive, in its recital 14, exemplifying the concept of service, refers explicitly to "household support services, such as help for the elderly". Accordingly, where these services are supplied by a provider established in another Member State, the country of origin principle will apply. The obligation to obtain an authorisation is expressly prohibited. As to the derogations from this principle in relation to the provision of home aid and care services, only the exceptions contained in Articles 17, 8° and 17° and 19 (1) (a) and (b) seem available.

4) Concluding remarks

The Draft services directive states in its recital 7a that "[t]he Directive does not affect the freedom of the Member States to define, in conformity with Community law, what they consider to be services of general economic

interest, how those services should be organised and financed and what specific obligations they should be subject to".

In addition, recital 7c stipulates that "[this] Directive does not deal with the funding of services of general economic interest and does not apply to systems of aids granted by Member States, in particular in the health and social fields [...]".

These recitals, which do not occur in the initial Commission Proposal, could be read as invalidating to a large extent the deregulatory effects of the Directive in the health and social fields. However, the tardy appearance - in the preamble - of these recitals addressing such a cardinal issue as well as the overall design of the Proposal - which is preserved in the Draft - lead one to suspect that this reading might not correspond to the Commission's intention. The relationship of the Draft services directive to services of general economic interest should be further clarified, preferably in an article. This matter will be further explored in the third section of the present report.



III. Health insurance and the internal market

1) Competition in health care systems

Health care systems are increasingly nearing their financial limits and reforms are therefore foreseen in all of the Member States. While it is true that the social protection systems in all EU Member States are the result of a historical process and are imbedded in a nationally determined economic, social or legal context, there are nevertheless some general tendencies and problems. This is the consequence of general problems encountered all over Europe: the demographic evolution of society with an increasing number of older people which means rising health care costs, the financial problems encountered in social security systems and increasing health care costs as a result of medical innovation. The need for social protection is increasing, while the financial environment is deteriorating.²¹⁴⁾

When studying the changing European welfare states, one sometimes distinguishes, depending on the approach, between first, second and third order changes.²¹⁵⁾

First order changes refer to incremental and quantitative changes, such as the slight reduction in the increase of benefit levels, benefit periods, etc. Second order changes refer to institutional changes, qualitative changes, e.g. changes in financing a scheme from the public purse to social partner contributions or vice versa. Changes of a third order indicate changes in policy goals or policy objectives. In the framework of health, second order changes are predominant. We note a greater individualization and influence of the free market. The rapid development of new kinds of therapies and treatments, implying increasing costs, and the growing number of older people and persons in need of health care, poses great challenges to the systems. Consequently, in many countries there is ongoing debate about the individualisation of health care. Individual responsibilities and competition between private insurance companies and public institutions are being established, allowing individual choices in health care about coverage or the extent of coverage. This could lead to severe pitfalls. The segregation between "good" and "poor" or "bad" risks could even lead to "two-speed health care protection".

Despite the diversity in structures and financing of health care systems, most structural reforms sought to introduce market mechanisms into their health care system. Such reform seeks mainly to encourage health actors to pursue the objectives defined and pursued by health care policy.²¹⁶⁾

The essential issue is establishing the actor best equipped to assume governance of the health care system, given the major challenge of keeping spending under control. Reform projects have been introduced to increase rationality and efficiency in health care systems by means of introducing competition among its actors. Market mechanisms have been incorporated

in all of the systems. This assumes changing the state's role. While the state retains governance of the system by inserting objectives to be achieved and defining rules and imitations on competition among actors, it is nonetheless expected to withdraw from practical management of the system.²¹⁷⁾

The introduction of market regulation into national health services leads to a dissociation of the function of production of services from that of financing of care ("the purchaser-provider split"). Reforms of the National Health Service in the United Kingdom and in Italy and Greece have given service providers and care establishers on the one hand and the authority managing the budget on the other, more autonomy of management. The creation of an internal market where service providers must negotiate the contract with a health authority on the basis of the quality, effectiveness and price of care on offer, is intended to create competition among care providers. In Spain it is either the autonomous communities or public organization called INSALUD that purchase services from health care institutions. A contract system has been adopted by some of the autonomous communities containing agreements about target levels of production and the setting of budgets. A similar division can be seen in the UK, where district health authorities are responsible for ensuring that adequate levels of health care are available in their regions. They signed contract with any NHS trusts (independent public hospitals), private commercial hospitals and non-profit making hospitals in order to cover their regional health care requirements. This creates a kind of internal market where institutions compete for health authority contracts. A general practitioner fund holder was introduced. General practitioner fund holders are groups of primary health care doctors, who are allowed to manage a budget in order to supply their patients with specialised services. Where normal general practitioners will have to refer their patients to specialists and institutions, with which the health authority has signed an agreement, general practitioner fund holders are allowed to sign their own agreements with hospitals and specialists. In Slovenia the health insurance institute has issued calls for tenders, aimed at private and public providers, for public service contracts for care programmes and services.

Regulatory measures based on market forces in compulsory social insurance systems have focussed above on all health insurance bodies. By making health funds financially accountable for the health care costs of those they insure, the intention is to encourage these funds to negotiate contracts with providers for a rational delivery of quality care. Policy makers increasingly became convinced of the need of powerful incentives to improve efficiency and achieve more effective cost control. Increasing self-responsibility of both consumers and funds were tools in this respect. In Belgium, for example, in order to stimulate the funds' financial self-responsibility, the traditional system of full retrospective reimbursement was gradually replaced by a new system based on a combination of retrospective and prospective reimbursement. By making some room for prospective reimbursement, funds

could make a profit but also incur a loss that had to be covered by a flat-rate premium charged to the insured.²¹⁸⁾

Also in Germany one of the prime goals of health insurance reform in the 90s was to stimulate market competition among the funds in order to achieve more effective cost control and to give the population greater freedom of choice. The segmented structure of social health insurance worked as an effective barrier to market competition and through the reforms the substitute sickness funds were opened to all applicants. Insured people were given the right to shift easily between funds. Market competition and free choice or open enrolment had enormous effects on market share. Where the AOKs lost 12.8% of their share over the period 1996-2001, the BKKs gained 65.4% over the same period.²¹⁹⁾

A risk-pooling arrangement with transfer payments between the funds was implemented to facilitate their market competition. Risk-pooling was considered a prerequisite for fair market competition because of the pre-existing differences in risk profile between the funds. As of 2007, risk solidarity will be based purely on mobility and pathology criteria and no longer on risk factors. These reform programmes also affected the scope of solidarity in social health insurance. Some medical services in the fields of dental care, homeopathic drugs or Kurorte were removed from the package.

The Dutch health care systems, strongly influenced by private insurance, will introduce a new health insurance system from 1 January 2006, which will be operated by private health insurance companies that can make profits and pay dividends to shareholders. Insured people make a choice on the basis of the nominal insurance premium, the performance of the company and the level of personal access. Health insurance companies are obliged to accept everyone resident in the area of activity and the system of risk equalisation has been introduced to make the acceptance obligation possible and to prevent direct or indirect risk selection. Health insurers have a duty to provide health care, but the insured can choose their care in kind from care providers with which the health insurers have concluded contracts or opt for a reimbursement of costs incurred with care providers that they have chosen themselves. Policies can also provide for a mixture of these two approaches.

Linked to this introduction of market competition, there is also a growing tendency to involve the private commercial sector in the execution of health care, even in public systems. Open competition based on public financing is increasing. In the United Kingdom the NHS has concluded a concordat with the private sector to treat patients at NHS expenses in private hospitals. Also in France the private hospital sector is acquiring an increasingly important role in the health system.²²⁰⁾

The question remains however to what extent public and private hospitals can compete with equal arms and whether competition is unfair as public hospitals receive more generous funding.

Notwithstanding a more market-driven health care system, it is still felt that solidarity elements should play a very important role in the reform processes. Health is not an ordinary economic good, but access to necessary care is a fundamental right that must be provided to everyone, regardless of their state of health or financial situation.²²¹⁾

This is definitively why all health systems have some form of state intervention.

Many Member States therefore base their health care systems on the principle of compulsory membership within public schemes. Compulsory membership is the core element of a welfare state and the central tenet of domestic social sovereignty.²²²⁾

However, this coercive state monopoly is being threatened by the rules of EC competition law.

The main question to be answered is how do competition law on the one hand and social law on the other hand relate to each other? "The whole problem of the application of competition law to social security regimes deals with one fundamental issue: is the state or are other organisations authorised to set up any form of solidarity between the members of a certain collective group confronted with certain risks? If it is allowed, solidarity is inevitable and excludes any form of competition. If it is not allowed, all legal and conventioned systems should be abolished".²²³⁾

EU law of course does not force the Member States to introduce competition rules in their health care systems. However, the more Member States introduce forms of market regulation in their health care systems, the greater the possibility that the EU competition rules will apply. As various Member States introduce elements of competition, in an attempt to increase efficiency and cost-reduction, this makes them vulnerable for application of competition rules.

2) Competition Law

A. Are social security institutions undertakings?

Antitrust law in the EU provides for a complete set of legal instruments to prevent distortions of competition regardless of whether they are caused by private undertakings, by public undertakings²²⁴⁾ or by Member States themselves. The addressees of the competition rules are therefore undertakings.

Also public undertakings are covered by the competition rules. Irrelevant is whether the undertaking has its own legal personality, is an integral part of a Member State's administration or how it is financed.²²⁵⁾

The first question to be answered, therefore, is if social security institutions and in particular health institutions, can be considered as undertakings?

The term "undertaking" as such is not defined. The Court of Justice therefore adopts a rather broad definition by stating that Article 81 is aimed at economic units which consist of a unitary organisation of personnel, tangible and intangible elements which pursue a specific economic aim on a long-term basis.²²⁶⁾ It covers any entity engaged in an economic activity, regardless of the legal status of the entity or the way in which it is financed.²²⁷⁾ The Court follows a substance-oriented approach, where "substance" prevails over form. The key feature of an undertaking shifts thus from the criteria associated with the entities' autonomy or legal status to considerations of economic activity. Consequently, the court looks at functional criteria in that it focuses on the type of activity performed rather than on the characteristics of the actors which perform it or the social objectives associated with it. So whether the institutions concerned are classified as bodies subject to public law or as part of the administration of the State, is of no concern.

What is important is that economic activities are performed. Economic activities are commercial activities. The basic test appears is whether the activity, at least in principle, could be carried on by a private undertaking in order to make profits and it faces actual or potential competition by a private company.²²⁸⁾ If there were no possibility of a private undertaking carrying on a given activity, there would be no purpose in applying the competition rules to it.²²⁹⁾

Any activity consisting in offering goods and services on a given market is an economic activity and as health care providers perform economic activities, i.e. as they offer medical services and goods, it cannot be ignored that they have to be qualified as undertakings. Natural persons may therefore also be undertakings if they engage in business activities. Self-employed medical specialists who act as self-employed economic operators are therefore undertakings. Also their national association is an association of undertakings.²³⁰⁾ Pharmacists, physiotherapists, medical doctors, suppliers of medical devices... all can be considered as undertakings. It is not necessary that the activities are performed with the objective of making a profit.²³¹⁾

Since nowadays all activities can be performed by private undertakings, the Court of Justice has developed various exclusions in order to limit to a certain extent the spectrum of competition law. This is in particular the case for activities resulting from the exercise of sovereign powers and social activities.

B. Exemptions

1. Imperium

Activities resulting from the exercise of sovereign powers are not economic activities, as there is no actual or potential competition by private companies.

This exercise of imperium can by definition never be an economic activity.²³²⁾ Imperium implies the power of enjoying the prerogatives outside the general law, privileges of official power and powers of coercion over citizens.²³³⁾ Health care institutions that perform a sovereign activity, could therefore escape from application of the competition rules. Could it e.g. be said of the German Health Care Institutions that they are not subject to the anti-competition rules as they have a statutory duty to provide benefits in kind?

A simple declaration of the state, however, is not sufficient in this respect as it is the nature of the activity that is determinant.²³⁴⁾ It is a necessary consequence of the functional approach that an activity neither loses its economic nature by the mere fact that it is exercised by the state or by a state body, nor becomes economic by virtue of the fact that it is performed by a private company.²³⁵⁾ The state can therefore have a twofold capacity, as it might act either by exercising public powers or by carrying on economic activities. In order to make such a distinction it is therefore necessary to consider the activities by the state and to determine the category to which those activities belong.²³⁶⁾ So entities to which a Member State has conferred the task of public interest, which forms part of the essential functions of that state, are not subject to the competition rules of Article 81-82, whereas those parts of the activities of such an entity that can be separated from those are subject to Articles 81 and 82.²³⁷⁾ But a sovereign exemption does not apply even when a body is exercising official authority, if it trades products or services alongside private undertakings that seek to make a profit.²³⁸⁾ So it is not because certain health institutions- as in Germany- act under public law and form part of the administration that they would not fall under the anti-competition rules.

As in health care, so much can be provided in the private sector, it might be difficult to argue that health care institutions or providers perform tasks typically for public authority.

In many health care systems, associations of medical health care providers play an important role and are granted specific powers. Quite often in different Member States professional associations will be the main and only responsible organization to license and register practitioners and they will determine who may and may not practice. Or the remuneration/fees of the health care providers are negotiated between their professional associations and the state. Sometimes these associations will just give a recommendation, while in other cases there is real collective bargaining. Its decision may sometimes be adopted by law or made binding upon the whole profession.

It cannot be excluded that such decisions fall under the anti-competition rules.

In this respect the questions arises whether a high degree of state intervention leads to the conclusion that such associations lack the necessary autonomy to be engaged in economic activities or rather carry out their tasks

as executor of the state? National regulations often stipulate who must be accepted as a benefit provider, thereby establishing the admission criteria in a binding and conclusive manner. Do these institutions act on their own initiative or not? In many cases it may be difficult to establish who is responsible for the anti-competitive conduct: the state by requiring the conduct or influencing it in a decisive way or rather the undertaking by engaging in anti-competitive activities based on its own initiative notwithstanding the backing it may receive from the state, or perhaps even both?²³⁹⁾ According to the Court of Justice, the legal framework within which such agreements are made is irrelevant and the adoption of a measure by a public authority making an agreement binding on all the traders concerned, even if they were not parties to the agreement, cannot remove the agreement from the scope of Article 81.²⁴⁰⁾

So it is only when the institution's conduct is so fundamentally restricted that the anti-competition rules cannot be considered to apply to these institutions. This is the case when they act like an arm of the state working in the public interest. This would be the case where the members of the professional organisation can be characterised as experts who are independent of the economic operators concerned and they are required, under the law, to set tariffs taking into account not only the interests of the undertakings or associations of undertakings in the sector which has appointed them but also the public interest and the interests of undertakings in other sectors or users of the services in question.²⁴¹⁾ Or if a Member State were to require or favour the adoption of agreements, decisions or concerted practices contrary to Article 81 or to reinforce their effects, or to deprive its own legislation of its official character by delegating to private institutions responsibility for taking decisions affecting the economic sphere. An example could be a concerted action on the fixing of tariffs, which afterwards have to be formal and compulsory approved by the government.²⁴²⁾

It is clear that concerted action infringes on competition while the government's formal approval procedure creates a link between the government and the practice of the undertakings.

The issue therefore is not that these activities would not be economic activities, but who is responsible for the distortion of competition: the state under Article 86 or undertakings under Articles 81 and 82?

Indeed also the State could infringe on the competition rules. Article 86 (1) provides that Member States shall neither enact nor maintain in force any measure contrary to the rules of the EC Treaty, in particular to Article 12 and the competition rules of the EC Treaty with regard to public undertakings or undertakings to which the Member States grant special or exclusive rights. This article was included in the Treaty mainly because of the influence governments may exert over commercial decisions of public enterprises or undertakings with close links to the state, causing them to distort competitive

conditions within the Community. While private firms determine their industrial and commercial strategy mainly by taking into account in particular requirements of profitability, decisions of public undertakings, on the other hand, may be affected by factors of a different kind within the framework of the pursuit of objectives of public interest by public authorities which may exercise an influence over those decisions.²⁴³⁾

Distortion may in particular be expected if the government decides to give only to some organisations - if they are considered as undertakings - the exclusive right to supply health care insurance. The mere existence of an exclusive right is not in principle incompatible with the Treaty, but abuse is. While Article 86 (1) clearly contemplates the creation of exclusive rights,²⁴⁴⁾ developments in the case law of the Court of Justice reveal that the grant or broadening of exclusive rights is valid only if it is objectively necessary for the performance of a task of general economic interest within the meaning of Article 86 (2). In the *Ambulanz Glöckner* case²⁴⁵⁾ the Court observes that the authorisation needed to provide ambulance transport services may be refused by the competent authority where its use is likely to have adverse effects on the operation and profitability of the public ambulance service, the running of which has been entrusted to the medical aid organisations. The question to be determined is whether the restriction of competition is necessary to enable the holder of an exclusive right to perform its task of general interest in economically acceptable conditions. The Court has held that the starting point in making that determination must be the premise that the obligation, on the part of the undertaking entrusted with such a task, to perform its services in conditions of economic equilibrium presupposes that it will be possible to offset less profitable sectors against the profitable sectors and hence justifies a restriction of competition from individual undertakings in economically profitable sectors.²⁴⁶⁾

2. Social activities

A second group of activities exempted from the application of the competition rules are purely social activities. This concept is an invention from the Court of Justice. When judging if an economic activity takes place, one should examine how much space the legislator has left for a free market system when designing the system and to what extent the solidarity principle has been developed.²⁴⁷⁾

The more clearly visible the solidarity principle, the greater the possible conclusion that we are dealing with a social and not an economic activity. However, balancing on the very thin line between the economic and the social character of an institution is not an easy task. The social aim of an insurance scheme however is not in itself sufficient to preclude the activity in question from being classified as an economic activity.²⁴⁸⁾ Also the principle of solidarity should apply.²⁴⁹⁾

In several cases the Court of Justice had the opportunity to work out these concepts. The leading case is the Poucet and Pistre case.²⁵⁰⁾ In this case both persons refused to pay their contributions to a sickness and maternity insurance scheme to which they were compulsory affiliated, claiming that they should be free to take out equivalent private insurance.

The Court clarified that an institution charged by law with the task of implementing a social security regime is not an undertaking as these institutions pursue a social objective and embody the principle of solidarity. According to the Court these follow out of elements such as: -the systems are intended to provide cover for all the persons to whom they apply, regardless of their financial status and their state of health at the time of affiliation; - the scheme is financed by contributions proportional to the income from the occupation and to the retirement pensions of the persons making them; only recipients of an invalidity pension and retired insured members with very modest resources are exempted from the payment of contributions, whereas the benefits are identical for all those who receive them; -persons no longer covered by the scheme retain their entitlement to benefits for a year, free of charge; - solidarity entails the redistribution of income between those who are better off and those who, in view of their resources and state of health, would be deprived of the necessary social cover. In the old-age insurance scheme, solidarity is embodied in the fact that the contributions paid by active workers serve to finance the pensions of retired workers. It is also reflected by the grant of pension rights where no contributions have been made and of pension rights that are not proportional to the contributions paid; - Finally, there is solidarity between the various social security schemes, in that those in surplus contribute to the financing of those with structural financial difficulties.²⁵¹⁾

Such public social security schemes entail such an element of redistribution in the interests of social solidarity that little or no scope remains for the various actuarial, investment and intermediary services which private pensions and insurance providers can and do supply on the market.²⁵²⁾

Solidarity therefore exists when contribution payments geared to income and benefits are the same for all recipients, thus leading to redistribution of income and protection for those who would otherwise be disadvantaged by virtue of their financial circumstances or health.²⁵³⁾ The Court has shown in Poucet and Pistre that three elements are essential for establishing the principle of solidarity or not: benefits are not proportional to contributions, or benefits are paid even if no contributions are paid and the existence of compensation mechanisms between the social security regimes.

Similarly, the Court decided that the organisations which run the Spanish National Health system operate according to the principle of solidarity in that it is funded from social security contributions and other State funding and in that it provides services free of charge to its members on the basis of

universal cover.²⁵⁴⁾ An Italian scheme providing insurance cover against accidents at work does not constitute an economic activity where affiliation was compulsory, where there was only a limited correlation between the level of contributions made and benefits received, and where both contributions and benefits were subject to ministerial control. Redistribution elements are available such as the fact that there is a maximum level of contributions to be paid, as well as a minimum and maximum level of benefits to be paid.²⁵⁵⁾

This last case raises another important point. The Court referred in this case to the fact that the Italian institution is expressly designated as competent institution under Regulation 1408/71 on social security for migrant workers. Does this mean that the Court would perhaps regard this inscription as a presumption of the solidarity character of a system?²⁵⁶⁾

When a free market system is introduced, one should accept the application of the competition rules.

Again the distinguishing point is if social insurance institutions compete with private insurance companies. In such a case, a social function cannot be accepted.²⁵⁷⁾ That these activities have certain social objectives is no objection, however.²⁵⁸⁾

Elements such as optional affiliation, application of the principle of capitalisation and the fact that benefits depend solely on the amount of contributions paid by the beneficiaries and on the financial results of the investments made by the managing organisation, all suggest an economic activity.²⁵⁹⁾

In other words, there is no solidarity as there is no compulsory affiliation and as private insurance companies provide for an equal solidarity.

In such schemes, the redistributive element is not such as to entail a suppression of the types of activity habitually provided by private insurance and pension companies, such as actuarial assessment and the management of investments.²⁶⁰⁾

The cases have however shown how difficult it is to draw the line between social and economic activities. This should not come as a surprise as the leading cases of the Court of Justice, *Poucet and Pistre* and *FFSA*, deal with two completely different social security systems that can be found at two extreme ends of one line. Many social security systems however can be situated between these two extremes.²⁶¹⁾ In addition there is the growing difficulty in defining the concept of social security. What are the typical social security components?

Elements such as contributions related to income, no relation between contributions and benefits, compulsory affiliation and no real possibility to influence the level of contributions, therefore seem to point in the direction that one could not speak about undertakings. This last element however has

become questionable following the ECJ's AOK case on German sickness funds.

A mix between solidarity and the free market principle could be an indication that social security institutions will have to be considered as undertakings. It seems logical that when sickness insurance funds can differentiate (part of) their level of contributions, irrespective of income, they will be considered as undertakings. However, this was not the opinion of the Court of Justice. In the AOK case the Court decided that the German sickness funds in the German statutory health insurance scheme were not undertakings.²⁶²⁾ The German sickness funds had no control on the level of obligatory benefits; however, they had control on benefits relating to complementary optional treatment and on the level of contributions paid. Sickness funds are engaged in a degree of price competition with one another where employees have a choice as to which fund they join. The funds determine for themselves the level of contribution which they require from insured persons and they differed a lot, ranging from 10.8 to 14.9% of the individual incomes.²⁶³⁾ The legislature introduced this element of competition with regard to contributions in order to encourage the sickness funds to operate in accordance with principles of sound management, that is to say in the most effective and least costly manner possible, in the interests of the proper functioning of the German social security system. Pursuit of that objective does therefore not in any way change the nature of the sickness funds' activity.

This is rather surprising as it is generally understood that one of the objectives of competition law is exactly to enhance efficiency.²⁶⁴⁾ In addition one could say that the German sickness funds therefore supply goods or services in return for a price, because are contributions not to a certain extent the financial compensation for delivering services? This is surely an indication of being an undertaking. For the Court, therefore, this one element of competition is not sufficient.

In this respect the AOK case deviates from the famous *Poucet* and *Pistre* case. Indeed, in this last case the Court referred to the fact that the institutions could not influence the level of contributions, as feature of solidarity.

According to the Court, the activities of the sickness funds are therefore not of an economic nature. The Court however pointed out that the funds might engage in operations that were not social, but economic in nature. Indeed "the possibility remains that, besides their functions of an exclusively social nature within the framework of management of the German social security system, the sickness funds and the entities that represent them, namely the fund associations, engage in operations which have a purpose that is not social and is economic in nature. In that case the decisions which they would be led to adopt could perhaps be regarded as decisions of undertakings or of associations of undertakings".²⁶⁵⁾ Organisations therefore can partly be an

undertaking and partly not. This was not the case in casu as the determination of fixed maximum amounts for medical products was considered by the Court as being an integral part of the activities of the sickness funds within the framework of the German statutory health insurance scheme.

Notwithstanding the clear elements of competition between the German sickness insurance funds, the Court did not want to consider them as undertakings. Perhaps the Court herewith wanted to make clear that one should not only look at the internal organisation, but rather at the ultimate aim (solidarity and redistribution) of the system.²⁶⁶⁾ It is the basic principles that prevail.

The problem remains however that the line between entities being undertakings and entities that are not undertakings is very unclear and impossible to draw in general. One should always look at the concrete circumstance. The Court of Justice's ruling in the AOK-case therefore should not be regarded as applying *mutatis mutandis* to at first sight similar institutions in other Member States. Whereas in certain Member States health care institutions will have to observe competition law, other bodies with similar tasks will not be required to do so in other Member States.²⁶⁷⁾ Therefore no general statement can be made with respect to the application of competition rules in the health care sector. And even when the Court believes that we are dealing with an undertaking as there are not enough solidarity characteristics, this does not mean that the competition rules will fully apply.

Indeed, an exemption from the application of the competition and the abuse of a dominant position rules, could follow from Article 86 (2).²⁶⁸⁾

C. Health care institutions as purchaser of products

Health organisers act not only as suppliers of benefits, but as purchasers of health care products by contracting out or demanding certain health care services or purchasing medical equipment or pharmaceuticals. These are without any doubt commercial activities, but does the non-application of the competition rules also applies to these activities? Do the same rules that apply to the supply of benefits also apply to the demand for health care benefits? Is an activity on an upstream market (purchasing goods or services) not subject to competition law if there is no downstream activity (reselling to the citizens). Are they therefore immune to the application of the competition rules?

As these institutions have powerful positions on the market as a result of their huge demand for health care benefits, one would expect this situation to endanger the market. Indeed, as each activity must be examined on its merits an organisation is not exempt from competition law simply because some of its activities have a social character.²⁶⁹⁾

The question whether an institution qualifies as an undertaking relates not to the institution as a whole but only to each of its individual activities.²⁷⁰⁾ One could consider that in these cases the activities of the health care institutions follow economic rather than social objectives, notwithstanding the fact that the purpose of these activities is to achieve socio-political objectives.²⁷¹⁾

There seems to be hardly any difference between health care institutions when acting as purchaser and private companies.

In the Fenin case, however, the Court judged differently. The Court held that it would be incorrect, when determining the nature of that subsequent activity, to dissociate the activity of purchasing goods from the subsequent use to which they are put.²⁷²⁾ The nature of the purchasing activity must therefore be determined according to whether or not the subsequent use of the purchased goods amounts to an economic activity. Consequently, an organisation which only purchases goods - even in great quantity - not for the purpose of offering goods and services as part of an economic activity, but in order to use them in the context of a different activity, such as one of a purely social nature, does not act as an undertaking simply because it is a purchaser in a given market. The activities on the supply side determine the character of these activities on the purchaser's side. This is the upstream-downstream theory according to which only entities that form activities both as buyers and as sellers can be considered as undertakings in the context of Article 81 and Article 82.

Some people wonder why these institutions should be given carte blanche for their commercial behaviour on markets other than the one providing their core social security services.²⁷³⁾ An explanation could probably be found in the fact that as the insurance activities of these entities are strongly influenced by the solidarity principle, the entities concerned have no commercial interest when buying care on the market. The conclusion could however be different when the care they buy is not used for their patients/insured persons, but is sold to health care providers in other Member States.²⁷⁴⁾

The fact that these activities do not fall under the anti-competition rules, however, does not exclude the applicability of EU law. As we will discuss later on, the EU directives on public procurement can influence the behaviour of these entities and provide certain guarantees for companies dealing with them. And even if the directives are not applicable, certain principles of EU law such as the non-discrimination principle and the condition of transparency, will apply.

D. Prohibited conduct

After considering the question whether health care institutions could be considered as undertakings, we want to find out which conduct is prohibited by the EU rules. Not all prohibited forms could be treated here. Basically

however, the most encountered forms in the health care sector are cartel prohibition and abuse of dominant position.

1. Cartel prohibition

Article 81 forbids all formal and informal agreements, decisions and concerted practices among all other forms of business enterprise.²⁷⁵⁾ Although Article 81 of the Treaty prohibits any form of collusion which distorts competition, it does not deprive economic operators of the right to adapt themselves intelligently to the existing and anticipated conduct of their competitors.²⁷⁶⁾ The principal rule is to ensure that each enterprise determines individually and autonomously its business policies and market conduct in the Community. It prohibits the prevention, restriction or distortion of competition i.e. the restriction of the freedom of the parties individually and autonomously to decide their own market policy, contrary to the requirement of economic independence.²⁷⁷⁾ Article 81 gives a list of examples which is not exhaustive such as fixing purchase or selling prices, limiting or controlling production, markets, technical development or investment, sharing markets or sources of supply, discriminatory practices, etc.

Health care providers agree amongst each other - as in the Netherlands - not to contract under certain tariffs when negotiating collaboration agreements with the health insurance institutions. Another example was agreements with respect to the policy dealing with the licence to set up in practice and establishment and the spreading of medical providers. Professional associations of health care providers decide on the basis of a policy based on quantitative standards such as number of inhabitants or patients if a new health care provider can set up a business. This policy was declared applicable in the individual agreements on collaboration concluded between the health care providers and the health insurance institutions. New practices were only allowed if approved by these organisations. Health care providers with established practices decided therefore on the entrance of new competitors and if a practice was not established in accordance with this policy, no contract could be signed with the health care provider. This policy can be described as policy-sharing the markets which raises barriers to entry by other health care providers and therefore contrary to Article 81.

Arrangements relating to organisation, qualifications, professional ethics, supervision and liability, in order to ensure that the ultimate consumers/patients are provided with the necessary guarantees in relation to integrity and experience,²⁷⁸⁾ like e.g. deontological codes are not contrary to the anti-competition rules. If this regulation despite the restrictive effects on competition that are inherent in it, is considered necessary for the proper practice of the profession, as organised in the Member State concerned, there is no infringement of Article 81 (1)²⁷⁹⁾.

Health insurance institutions that purchase together health care from health care providers could form a forbidden cartel as this could in certain circumstances lead to forbidden joint purchasing agreements. Joint purchasing agreements aim at combining demand in order to obtain better prices and could distort competition on the demand side.²⁸⁰⁾ Another forbidden example was found in the Netherlands, where health insurance institutions agreed that the premiums for insurance policies for the oldest age-category would not be higher than 150% of the premium for a 20-year old person for the same product.²⁸¹⁾ This method aimed to install risk-solidarity by self-regulating. The Dutch Competition authority has rejected this policy as a breach with anti-competition rules as health insurance institutions would be less inclined to offer products to young people at kept premiums if they result in having to decrease prices for older people.

2. Abuse of dominant position

The second prohibited conduct is the abuse of a dominant position on the Market. In contrast to Article 81, Article 82 only applies to firms that have market power and seek to prevent the abuse of such power for anti-competitive ends.

Article 82 enumerates types of abuse without being exhaustive. We note three main categories of abuse:²⁸²⁾

- exploitative abuses: exploiting market power in trading relationships with customers or suppliers by practices such as unfair purchase or selling prices, tying arrangements, price discrimination, etc.
- exclusionary abuses: abusing market power to harm a competitor by anticompetitive means such as refusal to deal, predatory pricing, or other predatory actions.
- structural abuses: eliminating a competitor by merger or acquisition.

In order to prove the abuse of a dominant position, one must prove the following elements: one or more undertakings, that hold a dominant position conferring market power, with a relevant product and geographic market, within the common market or in a substantial part thereof, commit an abuse of the dominant position and that may affect trade between Member States.

The dominant position relates to a position of economic strength enjoyed by an undertaking which enables it to prevent effective competition being maintained on the relevant market by affording it the power to behave to an appreciable extent independently of its competitors, its customers and ultimately of the consumers.²⁸³⁾

The existence of a dominant position is the result of many factors, which taken separately, are not absolutely decisive, however, extremely large market shares are in themselves, most of the time, evidence of the existence of a dominant position.²⁸⁴⁾

Abuse of a dominant position could e.g. occur where suppliers or their associations contribute to quality standards in a way that places foreign suppliers at a disadvantage.²⁸⁵⁾ Could we also speak about abuse of dominant position in cases where a health insurance institution with a dominant position refuses to conclude a contract with a health care provider and the admission of doctors is restricted to a panel of providers who have contracts with a health authority? Imagine the situation where a health insurance fund that occupies a certain region has a dominant position and refuses to offer contracts to certain medical providers. This is as such not really forbidden. Anti-competition law does not forbid a dominant position, but abusing this position. Excluding medical providers from the health market is forbidden unless the action can be justified.²⁸⁶⁾ As demand monopolists, health care institutions are obliged to conclude contracts with physicians, as in benefits-in-kind systems, physicians are largely dependent in economic terms on health care institutions due to a lack of other potential markets. The policy used to offer contracts or not should of course be based on objective and transparent criteria and there should be justification. This could e.g. be the case when a health insurance institution concludes that demand for a certain service has not increased with respect to last year and as a result will not allow it to sign a contract with new health providers.

In this respect we also want to refer to the French CMU (Couverture Maladie Universelle) system. This system guarantees affiliation to statutory health insurance by all residents and in addition provides free access to complementary health insurance for people who have an income under a certain level. CMU beneficiaries are granted free benefits in kind, including exemption from payment in advance in coverage of co-payments for hospital stay and supplementary charges for dental care and spectacles. In the complementary CMU, beneficiaries are free to choose between either the statutory sickness fund and traditional complementary insurance, such as mutual benefit societies, provident institutions and commercial insurance companies. Does this participation of the French public sickness funds in administering free complementary health insurance not lead to a dominant position and unfair competition? Not at least because the public sickness funds are guaranteed full recovery of claims paid for under the CMU, whereas the other complementary actors only receive a capitation payment from the CMU fund. It cannot be neglected that the public sickness funds benefit from a certain dominant position, where it may be expected that beneficiaries will insure themselves with institutions where they are already insured, i.e. their statutory health insurance. According to the French constitutional Court there was no abuse of dominant position,²⁸⁷⁾ building on the differences in relation between these funds and the objective of the law. While public sickness funds have the obligation as part of their mission as public authority and on behalf of the state to take care of the complementary insurance of all who ask

to be insured, other sickness funds just have the possibility of participating and are free to withdraw. This reasoning, however, is very difficult to follow.

The same doubts could also be expressed with respect to the Flemish long-term insurance care, where commercial insurers compete with mutual health funds, responsible for the public health systems. One could also ask here if this participation of the public sickness funds does not lead to an abuse of the dominant position. Or what to be said about the fact that under Belgian law, insured people are obliged to accept the complementary services offered by the mutual health funds –responsible for the public health system–they are insured with?

According to the Court of Appeal in Brussels there is no conflict with competition law as a service of increased complementary compensation for orthodontic treatment is no economic activity. Mutual health funds are after all obliged to install these complementary services to fill the gaps in the statutory social security system.²⁸⁸⁾

E. State aid

State aid could also be contrary to EU law. Article 87 (1) contains a general prohibition against granting state aid that distorts or threatens to distort competition by favouring undertakings provided it affects trade between Member States.

For a measure to involve state aid, aid must fulfil the following criteria.²⁸⁹⁾ First, there must be an intervention by the State or through State resources. Second, the intervention must be liable to affect trade between Member States. Third, it must confer an advantage on the recipient. Fourth, it must distort or threaten to distort competition. The Court clarified that to be considered as aid, measures must, whatever their form, be likely directly or indirectly to favour certain undertakings or are to be regarded as an economic advantage which the recipient undertaking would not have obtained under normal market conditions.²⁹⁰⁾

State aid could take different forms, such as positive contributions like subsidies but also measures which mitigate the charges which are normally included in the budget of an undertaking and which, without therefore being subsidies in the strict meaning of the word, are similar in character and have the same effects, as e.g. tax relief,²⁹¹⁾ interest relief, tax deductions,²⁹²⁾ credit facilities and preferential interest rates on loans,²⁹³⁾ provision of logistical and commercial assistance,²⁹⁴⁾ etc. Or what if e.g. the state were to cover the deficit of certain hospitals?²⁹⁵⁾ Or what about the compensation paid out of a risk-equalisation fund?²⁹⁶⁾

However, as the Court pointed out in its Altmark case, 'where a State measure must be regarded as compensation for the services provided by the recipient undertakings in order to discharge public service obligations, so that those undertakings do not enjoy a real financial advantage and the measure

thus does not have the effect of putting them in a more favourable competitive position than the undertakings competing with them, such a measure is not caught by Article 87(1) of the Treaty'.²⁹⁷⁾

For assessing whether such advantages constitute state aid, the so-called "prudent investor principle" applies:²⁹⁸⁾ it is necessary to assess whether, in similar circumstances, a private investor of a dimension comparable to that of the bodies managing the public sector could have been prevailed upon to make capital contributions of the same size, having regard in particular to the information available and foreseeable developments at the date of those contributions.

This is certainly an important element in the health care sector where the state gives certain financial advantages to health insurance funds. Could they be considered as just compensation for the services in order to discharge their public service obligations? The answer to this question remained unclear not least as a result of the fact that the case law of the Court of Justice and the Court of First Instance differed.

Some judgments tended to a legal approach, which aimed at considering any financial compensation as state aid, which had to be notified but was likely to be cleared according to the specific circumstances of the case in particular where the conditions of Article 86 (2) were fulfilled.²⁹⁹⁾ Other judgments tended to a more economic approach, which aimed at considering only the amount of compensation that exceeds what is necessary for discharging the public service obligation.³⁰⁰⁾ Not being considered as state aid leads to important procedural consequences: i.e. no preliminary notification and preventive control by the Commission, and the fact that the state is not obliged to wait for the Commission's answer before payment.

In the *Altmark GmbH* case which concerned the grant of licences for scheduled bus transport services within a certain region in Germany and public subsidies for operating those services, the Court of Justice requested the national court to ascertain, whether the following four conditions are satisfied:

1. The recipient undertaking has actually required the discharge public service obligations and those obligations have been clearly defined;³⁰¹⁾
2. The parameters on the basis of which compensation is calculated have been established beforehand in an objective and transparent manner;
3. The compensation does not exceed what is necessary to cover all or part of the costs incurred in discharging the public service obligations, taking into account the relevant receipts and a reasonable profit for discharging those obligations;
4. Whether the undertaking which is to discharge the public service obligations has not chosen a public procurement procedure, the level of compensation needed has been determined on the basis of an analysis

of the costs which a typical undertaking, well-run and adequately provided with means of transport so as to be able to meet the necessary public interest requirements, would have incurred in discharging those obligations, taking into account the relevant receipts and a reasonable profit for discharging those obligations.

If one or more of these conditions are not fulfilled, the subsidies are incompatible with the prohibition of Article 88 (3) last sentence and subject to nullity resulting from a non-notified state aid. The Altmark judgement clarifies the preceding case-law of the Court of Justice and the Court of First Instance, which established somewhat divergent criteria for classifying compensation for the operation of services of general economic interest as state aid. It may be said that the Court of Justice's approach in the Altmark case is more balanced, thereby examining more closely the operation of public service obligations and the services supplied in connection with a discharge of the public service obligation, which will not be recognised whenever the undertaking's activities have no connection with the provision of public service obligations. It remains to be seen whether the approach is satisfactory or still too theoretical for relying on a typical undertaking well-run and adequately provided, except in cases of public procurement, where it is presumed that market conditions prevail.³⁰²⁾

3) The internal market and voluntary health insurance

A. The possible application of the non-life insurance directives

Notwithstanding the dominance of solidarity-based statutory health care systems in the European Union, it cannot be neglected that voluntary health insurance plays a more and more important role in health protection. The increasing cost and expenditure in health care and the problems for the government to keep pace with this development, have today led to an increasing role of voluntary health insurance.³⁰³⁾

In general it could be said that voluntary health insurance operates precisely in areas that the state does not cover. Voluntary health insurance can therefore be classified according to whether it:

- substitutes for cover that would otherwise be available from the state, the so-called substitutive voluntary health insurance;
- provides complementary cover for services excluded or not fully covered by the state, including cover for co-payments imposed by the statutory health care system, the so-called complementary voluntary health insurance;
- provides supplementary cover for faster access and increased consumer choice, the so-called supplementary voluntary health insurance.³⁰⁴⁾

The introduction of private insurance companies as executors for medical treatment results in the possible applicability of European Directive 92/49 of

18 June 1992 on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance.³⁰⁵⁾

According to this directive, a Member State which decides to open up coverage of a risk belonging to the statutory social security regime to private insurers, has to accept that any Community Insurance undertaking authorised in its home Member State, may cover that risk on the basis of the freedom of establishment and freedom to provide services.

Private insurance companies are now basically allowed freely to establish a branch or agency in another Member State, without the need to receive authorisation by the competent national authorities of that state, and provide insurance services in another Member State without the need to establish a branch office or agency. This was realised through the introduction of elements such as a single licensing and financial control system for insurance activities throughout the European Union led by the Member State where the head office is situated, the so-called home country control; the mutual recognition of authorization and prudential control systems on the financial soundness and solvency of insurers; and the abolition of contract and price controls by risk-based Member States and of any prior notification of policy conditions and tariffs. This implies that governments are no longer allowed to regulate prices and conditions of insurance products, as this could endanger fair competition among European insurers and could jeopardise the financial health of insurance undertakings.³⁰⁶⁾

However, any Member State will, even when introducing private insurance companies for the execution of their health care system, prescribe certain statutory guaranties, such as the obligation to accept insurers or the prohibition of risks selection, exactly in order to protect the consumer/insured person. To what extent is the introduction of such guarantees contrary to the principles of the non-life insurance directives? Can social objectives therefore only be guaranteed through a statutory system of social security?

1. Field of application

The non-life insurance directive does not apply to insurances forming part of a statutory system of social security.³⁰⁷⁾ This is a first exemption. Social security schemes, which are based on the principle of solidarity and require compulsory contributions, are excluded from the scope of the third non-life insurance directive.³⁰⁸⁾ The same applies to insurance where benefits and contributions are set by the national legislator at a uniform rate, independently of the risk.³⁰⁹⁾

The question if voluntary statutory health insurance falls under the field of application of the third non-life insurance directives is far from clear. Substitutive health insurance, providing private cover for persons excluded or exempted from statutory protection, seems to be included in the scope of application of EU insurance law.³¹⁰⁾

However we have one certainty. In its important case of 18 May 2000³¹¹⁾ the Court clarified that the Belgian scheme of compulsory insurance against accidents at work falls under the field of application of the third non-life insurance directive. In Belgium this insurance is executed by private insurance companies. It is of no relevance for the Court that this scheme forms part of the basic compulsory social security scheme and even Regulation 1408/71 on the social security for migrant persons. According to the Court these insurance undertakings pursue an economic activity and in the line of Article 55, this directive is applicable to insurance forming part of a statutory scheme of social security offered by insurance undertakings "at their own risk." In this case the Court explicitly referred to Article 54 dealing with health insurance, and the conclusion may be therefore drawn that in case private health insurance companies would execute the statutory health insurance system and would work at their own risk and perform an economic activity, this third non-life insurance can also be considered to be applicable to health care insurers.³¹²⁾ For the applicability of the Directives, it is important that insurances are offered at their own risk. But how should this concept be interpreted? Is the concept of "own risk" limited to the "insurance risk", i.e. the financial risk as a consequence of an uncertainty element characteristic for every insurance relation or does it refer to any company-business risk? Is there convergence between the concept of economic activity under the competition rules and the activities which fall under the field of application of the third non-life insurance directive?³¹³⁾ Can we therefore say that as soon as there is economic activity, these insurances will fall under the third non-life insurance directive and that the third non-life insurance directive does not apply when the insurers are performing a purely social activity?

2. The content of the third non-life insurance directive

The basic rules under the insurance directive follow the principle of the single license (an insurance company only needs one authorisation) and linked to that the country home control principle (implying that an insurance company is only submitted to the control and supervision of the home Member State or the country of establishment). Also the principle of specialization applies. In this respect the Court for example condemned France, because the insurance activities of the French mutual societies were not legally separate from their philanthropic activities.³¹⁴⁾ And what about the rule in the new Dutch health care system: if the insured is entitled to reimbursement of costs, there is still a duty for health insurers to provide for health care.³¹⁵⁾

Application of the non-life insurance directives could lead to possible conflicts arising from Article 29 of the third non-life insurance directive.

According to this article Member States shall not adopt provisions requiring the prior approval or systematic notification of general and special policy conditions, scales of premiums, of forms and other printed documents which an insurance undertaking intends to use in its dealings with policy holders.

For the Court of Justice the Community legislator clearly meant to secure the principle of freedom for undertakings to set the rates in a non-life insurance sector and national regulations concerning tariffs for insurance companies are therefore contrary to the directive. This principle implies the prohibition of any system of prior or systematic notification or approval or the rates, which an undertaking intends to use in its dealings with policy holders.³¹⁶⁾ However this article does not apply to a bonus-malus system, as this system does not result in the direct setting of premium rates by the state, since insurance undertakings remain free to set the amount of the basic premium. A full harmonisation in the field of non-life insurance rates was clearly not the intention of the Community legislator.³¹⁷⁾

This is a narrow interpretation of Article 29. Prohibition of price- difference on the basis of the personal risk characteristics of the insured, or the no-claim refund therefore does not seem to be contrary to article 29.³¹⁸⁾

The question remains however whether other national regulations, not dealing with the business of insurance, are also forbidden by this article? This would imply that regulations other than those concerning financial supervision (such as e.g. obligation of acceptance, a minimum package of benefits to be provided), would not be possible either.

3. Limits of Article 54: general good exception

But even when certain measures are not in conformity with Article 29, an exception and justification may be sought under Article 54 of the third non-life insurance directive.

According to this article, a Member State in which contracts may serve as a partial or complete alternative to health cover provided by the statutory social security system, may require that those contracts comply with the specific legal provisions adopted by that Member State to protect the general good in that class of insurance and that the general and special conditions of that insurance be communicated to the competent authorities of that Member State before use. The nature and social consequences of health insurance contracts therefore justify the competent authorities of the Member State in which a risk is situated and require systematic notification of the general and special policy conditions, exactly in order to verify that such contracts are a partial or complete alternative to the health care provided by the social security system.³¹⁹⁾

The particular nature of health insurance distinguishes itself from other classes of indemnity insurance and life insurance,

insofar as it is necessary to ensure that policy holders have effective access to private health cover or health cover taken out on a voluntary basis regardless of their age or risk profile. These provisions may provide for open enrolment, rating on the uniform basis according to the type of policy and life time cover. That objective may perhaps be achieved by the requirement to

offer standard policies in line with the cover provided by statutory social security schemes at a premium rate at or below a prescribed maximum and to participate in loss compensation schemes.³²⁰⁾ Additionally, Article 54 (2) establishes that Member States may require that the health insurance system be operated on a technical basis similar to that of life insurance and further determines a set of criteria that Member States could require from such health insurances.

It remains unclear however how broadly Article 54 can be interpreted and in particular, whether this article also applies when private insurance companies substitute entirely for the statutory system of social protection. Under a narrow interpretation the directive would only apply to private insurances that exist apart from the public statutory system and fulfill for a part of the population the function that the statutory public system fulfils for the rest of the population. Some authors as well as the European Commission however are in favour of a broad interpretation.³²¹⁾

Sustainability also becomes more questionable or hazardous when moving from substitutive health insurance to complementary or supplementary health insurance, which covers services of providers excluded fully or partly from the ambit of social protection.

Justification under Article 54 however implies that these rules have to be analysed against the principles of proportionality and necessity for a good health care system. Elements under the new Dutch health care system, dealing with a minimum package defined by government and to be provided by every health insurer, are an obligation of acceptance, the prohibition of differentiation between premiums on personal characteristics (like age, sex, health and social circumstances) and the establishment of a risk-equalisation fund between insurers. These are acceptable to the Commission as they appear necessary to ensure legitimate objectives.

According to the European Commission the proportionality condition is not guaranteed if these conditions are also be declared applicable to complementary insurances offered by private insurers going beyond the social security package.

The concept of general good remains unclear, however. In its interpretative communication on the general good in the insurance sector,³²²⁾ the Commission makes clear that this concept is based on the case law of the Court of Justice and that is also the basic reason why it is not defined by the third non-life insurance directive. In order to be justified on the grounds of the general good, national measures must - according to this interpretative communication - fulfill the following 6 criteria:

- must not have been the subject of prior Community harmonisation;
- must not be discriminatory;

- must be justified for imperative reasons relating to the general good (such as consumer protection, prevention of fraud, cohesion of the tax system and worker protection);
- must be objectively necessary;
- must not duplicate home country rules;
- must be proportionate to the objective pursued.

It is therefore up to the Court to decide on the interpretation of this Article 54.

4) Procurement directives

Even when social security institutions do not fall under competition law because they are not undertakings, they are not exempt from EU law. In particular, discriminatory public procurement is considered to create significant barriers to trade. Discriminatory procurement and other restrictive behaviour is prohibited by the EC Treaty and the Treaty also imposes a positive obligation to advertise contracts, to support a prohibition on discrimination.³²³⁾

Different directives have been enacted to regulate procedures for public major contracts.³²⁴⁾

These directives require entities to follow transparent procedures aimed at preventing and monitoring discriminatory behaviour and ensuring community-wide competition.

Do social security institutions, and in particular health care institutions, fall under the field of application of the procurement directives?

In this respect the definition of "contracting authority" is extremely important. The structure of the directives is such as to embrace the purchasing behaviour of all entities that have a close connection to the state.³²⁵⁾

For the public procurement directives to apply, the contracting authority must be the state or a body governed by public law.³²⁶⁾ In order to be a body governed by public law, different cumulative criteria have to be fulfilled:

- established for the specific purpose of meeting needs in the general interest, not having an industrial or commercial character, and
- having legal personality, and
- financed, for the most part, by the State, or regional or local authorities, or other bodies governed by public law, or subject to management supervision by those bodies, or having an administrative, managerial or supervisory board, more than half of whose members are appointed by the State, regional or local authorities or by other bodies governed by public law.

Notwithstanding this definition, public interest functions are dispersed through a range of organisations which strictu sensu could not fall under the

ambit of the term "contracting authority", since they are not formally part of the state, nor are all criteria for the definition of bodies governed by public law present.³²⁷⁾

The term "the state" must be interpreted in functional terms. The aim of the directive which is to ensure the effective attainment of freedom of establishment and freedom to provide services in respect of public works contracts, would be jeopardized if the provisions of the directive were to be held to be inapplicable solely, because the public works contract is awarded by a body which, although it was set up to carry out tasks entrusted to it by legislation, is not formally a part of the state administration.³²⁸⁾

In order to fall under the directives, institutions therefore do not have to be a formal part of the state, but could be said to be active in name of the state.³²⁹⁾ In addition to the elements of management or financial control, functionality, as an ingredient of assessing the relationship between an entity and the state, demonstrates the importance of constituent factors, such as the intention and purpose of establishment of the entity in question.³³⁰⁾

Public procurement deals with the public market where the state and its bodies are engaged in pursuit of the public interest.³³¹⁾ In the public market it is not the commercial characteristics of private entrepreneurship that prevail in as much as the aim of the public sector is not the maximisation of profits, but the serving of public interest.³³²⁾

Fundamental in this respect is that the entities do not have an industrial or commercial character, but are established to meet needs in the general interest. Activities in the general interest imply that someone is not acting solely in the individual interests of a particular group of people, but is envisaging a whole community.³³³⁾

The Court approached this concept by direct analogy with the concept of general economic interest as defined in

Article 86 (2).³³⁴⁾ The absence of an industrial or commercial character is a criterion intended to clarify the meaning of the term "needs" in the general interest. The question whether private undertakings might meet the same needs, is irrelevant. The public procurement directives may apply to a particular body, even if private undertakings meet or may meet the same needs, and the absence of competition is not a condition necessary to be taken into account in defining a body governed by public law. However, the existence of significant competition, and in particular the fact that the entity concerned is faced with competition in the market place, may be indicative of the absence of a need in the general interest, not having an industrial or commercial character.³³⁵⁾

By analysing the list of bodies governed by public law contained in annex 1 to the directive, the Court concludes that in general the needs in questions

are ones which, for reasons associated with the general interest, the state itself chooses to provide or over which it wishes to retain a decisive influence.

A body which is non-profit making, but is managed according to the criteria of performance, efficiency and cost-effectiveness, and which operates in a competitive environment therefore does not constitute a body governed by public law.³³⁶⁾

Consequently, whenever bodies or entities, like health care institutions, perform activities not with a commercial intention and to maximize profits, but to provide goods and services for the public and thus in the general interest, these institutions are active on the public market and therefore the public procurement laws will be applicable. This idea is very close to what has been described under the competition rules. The fact that these institutions have a double capacity in the way that they perform both social activities as economic activities, is of no relevance. What is important is that the institution is established for the specific purpose of meeting those needs in the general interest. In that respect it is immaterial that such an entity is free to carry out other activities in addition to that task, and even the fact that meeting needs in the general interest constitutes only a relatively small proportion of the activities actually pursued by the body is irrelevant, provided that it continues to attend to the needs which are specifically required to meet. The fact that a body must have been established for the specific purpose of meeting needs in the general interest, not having an industrial or commercial character, therefore does not mean that it is necessarily entrusted only with meeting such needs.³³⁷⁾

Therefore if an entity is a contracting authority, it will have to apply the public procurement rules, irrespective of whether it pursues a general interest need or just commercial interests. Health care institutions purchasing for their own purposes equipment and buildings, will therefore have to apply the public procurement directives.³³⁸⁾

In the case of health care institutions that provide benefits in kind, the public procurement directives apply to relations between the health care institutions and the performers of services. In such systems, the contracts between the institutions and the providers of services are framework contracts, in which the latter obligate themselves to provide certain services for patients on account of the institution. In the *Tögel* case, the European Court of Justice applied the public procurement directives on the contracts between social security institutions and transport undertakings which must afford insured persons and members of their families adequate access to the benefits provided for by the law and under agreements.³³⁹⁾

However, this also implies that procurement law and competition law will apply.³⁴⁰⁾

Entities that fall under the public procurement directives must normally use either open procedures (in which anyone may tender) or restricted procedures (in which only selected firms may tender).

During recent years within many Member States different forms of public/private partnerships have been set up in the form of joint ventures or the private financing of public projects. The private sector is also becoming increasingly involved in delivering public services. This applies also in the case of health. The projects in the UK under the private finance initiative (PFI) are an example of this. In these projects provision and management of assets and the provision of finance is entrusted to the private sector, which is remunerated by charging for the assets used. In this public private cooperation the state no longer delivers the services. If contracting authorities award their public contracts via private undertakings under their control, they will not come within the framework of the public procurement directives, as the entities which award the relevant contracts cannot be classified as contracting authorities within the meaning of the directives.

In a certain way the Court of Justice found a response to this by stating that where a contracting authority intends to conclude a contract for pecuniary interest relating to services within the material scope of the public procurement directives, with a company legally distinct from it, the public award procedures laid down by that directive must always be applied, whether or not that entity is in itself a contracting authority.³⁴¹⁾ In cases where a contracting authority has established an undertaking in order to enter into contracts for the sole purpose of avoiding the requirements specified in public procurement law, then the relevant directives should apply. If the realisation of a project does not contribute to the aims and objectives of an undertaking, then it is assumed that the project in question is awarded "on behalf of another undertaking", and if the latter beneficiary is a contracting authority under the framework of public procurement law, these directives should apply.³⁴²⁾

As open and restricted procedures are unsuitable for many such projects, the new public procurement directives 2004/18 EC and 2004/17 EC have foreseen a new more flexible instrument and allow contracting authorities to use the method of competitive dialogue.³⁴³⁾

5) Concluding remarks

There is no doubt whatsoever that the health care sector is not immune from the application of the EU competition rules. This applies both to the social security institutions and to the Member States. This should not come as a surprise as health care is in principle an economic activity, despite the fact that health care is not a normal market and that certain protection measures have to be guaranteed.

Competition law therefore occasionally conflicts with elements of national solidarity. The case law of the Court has shown that it is not always easy to draw the line between social and economic activities. Competition does influence the health care sector to a considerable extent. The outcome of the cases is however highly unpredictable and also the criteria used are far from clear. On the other hand however, the Court does seem to understand the Member States' fears and concerns when solidarity elements are at stake and approaches social security systems with a certain degree of caution.

And even when the Court believes that we are dealing with an undertaking as there are not enough solidarity characteristics, this does not mean that the competition rules will fully apply.

It may be that an exemption from the application of the competition and the abuse of a dominant position rules, could follow out of Article 86 (2). Article 86 (2) provides that undertakings entrusted with the operation of services of general and economic interest or having the character of a revenue producing monopoly, are subject to the rules of the Treaty, and in particular to the rules of competition, insofar as the application of such rules does not obstruct the performance, in law or in fact, of the particular tasks assigned to them, and provided that the development of trade is not affected to such an extent as would be contrary to the interest of the Community.³⁴⁴⁾

In *Joined Cases Albany, Brentjens and Drijvende Bokken*,³⁴⁵⁾ the Court after having decided that the exclusive right of the sectoral pension fund to manage supplementary pensions restricted competition and constituted a breach of Article 86 (1) ECT,³⁴⁶⁾ considered whether that breach was justified under paragraph 2 of Article 86.³⁴⁷⁾ It held that the pension scheme at issue did fulfil a "service of general economic interest" and that its exclusive right was necessary for the performance of that service. In reaching this conclusion, the Court explicitly considered matters of social solidarity.³⁴⁸⁾ The fund at issue displayed a high level of solidarity, resulting, in particular, from the fact that contributions do not reflect the risk, from the obligation to accept all workers without a prior medical examination, the continuing accrual of pension rights despite exemption from the payment of contributions in the event of incapacity for work, the discharge by the Fund of arrears of contributions due from an employer in the event of insolvency and the indexing of the amount of pensions in order to maintain their value. Moreover, the Court observed that "if the exclusive right of the fund to manage the supplementary pension scheme for all workers in a given sector were removed, undertakings with young employees in good health engaged in non-dangerous activities would seek more advantageous insurance terms from private insurers. The progressive departure of 'good' risks would leave the sectoral pension fund with responsibility for an increasing share of 'bad' risks, thereby increasing the cost of pensions for workers, particularly those in small and medium-sized undertakings with older employees engaged in

dangerous activities, to which the fund could no longer offer pensions at an acceptable cost".

Citizens can therefore be obliged to participate in a social security system executed by private companies.

But perhaps even more remarkable was the following consideration of the Court in this case:

"it is important to bear in mind that, under Article 3(g) and (i) of the EC Treaty (now, after amendment, Article 3(1)(g) and (j) EC), the activities of the Community are to include not only a 'system ensuring that competition in the internal market is not distorted' but also 'a policy in the social sphere'. Article 2 of the EC Treaty (now, after amendment, Article 2 EC) provides that a particular task of the Community is 'to promote throughout the Community a harmonious and balanced development of economic activities' and 'a high level of employment and of social protection.'"

Social objectives overrule in this case the internal market.

Article 86 (2) could thus be successfully invoked in order to set aside the application of the competition rules, in particular when the activity does not fulfil the conditions in order to qualify as a "core" solidarity activity but, still, displays enough solidarity aspects, including compulsory affiliation.³⁴⁹⁾ A balance could be found between competition law and social law.

But it is not only within the public sector that social objectives are taken into account. The broad interpretation of the general good exception of article 54 in the non-life insurance directive points in the same direction.

This tendency is important in a time where social security is more and more shifting from a public to a mixed private-public system. Even when private elements are introduced in social security systems, it doesn't seem that the free market will apply without mercy. The Court accepts that systems with certain social objectives can be safeguarded against full application of the competition rules.

The following chapter examines whether, and how this concept of general (economic) interest can be used to avoid full application of the internal market rules in health care.

IV. The notion of “social services of general interest” as counterweight to the internal market rules

1) Services of general interest

A. Situation

The notion of "service of general interest" was, ironically, first used in the American "Communications Act" of 1934 as an argument to install a telephony monopoly in the United States, when chaos ruled the US telephony market after the intellectual property rights of G. Bell had expired. Very ironic indeed, as the term "service of general interest" in Europe is strongly linked with the dismantling and privatisation of state monopolies and thus often seen as a sort of counterbalance. Where the public intervention was commonplace in all economies after World War II, in the late seventies and throughout the eighties different states shifted away from the Keynesian approach to a policy tendency of privatisation, liberalisation and deregulation. The national corporatist systems started to collapse under the pressure of exogenous economic shocks and **"the changes were enforced by economic necessity and more subtle changes in the prevalent ideological and economic paradigm"**.³⁵⁰ In 1993, privatisation started in the majority of the EU countries. The reforms in the European public sector were a central issue in the shift from a welfare state model to a post-welfare or regulatory state model.³⁵¹ In this context it was the great fear of certain interest groups that public and social services would be damaged. Through mutual consultation processes, but also as a consequence of local and regional protests and conflicts in various Member States, the issue of "public services" was picked up in the EU agenda as "services of general interest in the EU" and has gained importance ever since. However, the Commission has all this time preferred a pragmatic approach instead of the dogmatic position of certain stakeholders representing opposite interests.³⁵² Since 1993, after the Maastricht Treaty cleared the path for a more comprehensive consideration of services of general economic interest,³⁵³ the term appears more and more systematically in Community documents³⁵⁴ and the concept has grown from the notion of "services of general economic interest" as a derogation from the higher principle of undistorted competition to be "one of the pillars of the European model of society",³⁵⁵ opening the way for a beneficial interaction between general interest and the liberalised market.

The term "service of general interest" is very hard to define, as can be derived from the compilation of discussions and texts relating to the topic, produced by the different European institutions, the Member States and commentators, which isn't exactly a paragon of coherence and clarity.³⁵⁶ Indeed, **"it is difficult to define services of general interest in legal terms, but in general terms a service of general interest is one that has the following characteristics [...]"**.³⁵⁷ It is a complex and dynamic notion that is constantly

in evolution and under evaluation, which is not surprising as it is strongly related to the constantly changing view of the role of the state. The annex to the White Paper on services states that terminological differences, semantic confusion and different traditions in the Member States are a reflection of different historical, economic, cultural and political developments and the source of many misunderstandings in the discussion at European level. Therefore the White Paper repeats the EC definition of services of general interest, dating from the first Communication from the Commission on services of general interest of 1996: **"The term 'services of general interest' cannot be found in the Treaty itself. It is derived in Community practice from the term 'service of general economic interest', which is used in the Treaty. It is broader than the term "services of general economic interest" and covers both market and non-market services which the public authorities class as being of general interest and subject to specific service obligations.**"³⁵⁸⁾ Although this cannot be considered a conventional legal definition, it provides some key elements for discussing services of general interest in the European Union. First, it is not a Treaty-based concept, but derived from the sub-concept "services of general economic interest" which does appear in the Treaty in Article 86(2) EC (Treaty establishing the European Community)³⁵⁹⁾ and Article 16 EC. Secondly, the term covers not only economic activities as is the case for "services of general economic interest" and thus also relates to noneconomic services, for which compulsory education, social security and certain state prerogatives (such as security, justice, diplomacy or the registry of births, deaths and marriages) are traditionally used as examples. The most important consequence of the qualification as a non-economic service is the inapplicability of internal market and competition rules on the services concerned. According to the Commission, there are three categories of services of general interest: (1) services of general economic interest provided by large network industries (telecommunications, postal services, electricity, gas, transport) (2) other services of general economic interest (waste management, water supply, public service broadcasting) and (3) non-economic services (social security, compulsory education and state prerogatives) and services without effect on trade.³⁶⁰⁾ Non-economic services will be further elaborated in the section on social services of general interest. However, economic or not, the service must, as a third main characteristic, be categorised as of "general interest" and therefore subject to certain service obligations. Being of "general" interest, the output of the service is not only in the interest of the provider and the consumer, but also in the interest of a larger group, being "the Community as a whole".³⁶¹⁾ Indeed, these services are considered so essential in a given society that every citizen should have access to them under reasonable conditions, especially concerning quality and affordability.³⁶²⁾ Consequently, specific requirements are imposed on the service provider in order to ensure that certain public interest objectives are met. Finally, this task of classification is incumbent on

the public authority. It is still for the national, regional or local authority in the Member States to define, organise,³⁶³⁾ finance and monitor services of general interest. However, also due to the insertion of Article 16 EC³⁶⁴⁾ at the Amsterdam IGC, the enabling of services of general interest is increasingly seen as a shared responsibility of the Community and the Member States. Here, the subsidiarity principle of Article 5 EC³⁶⁵⁾ plays an important role, as it is also the Commission's opinion that services of general interest should be organized and regulated as close as possible to the citizens and it intends, whenever required, to make proposals for sector-specific regulation only in areas that have an apparent European dimension and present a strong case for defining a European concept of general interest. This Community regulation defines, as a general rule, only a regulatory framework that can be implemented and specified by the Member States, taking into account country-specific situations. In the debate on the Green Paper there was a broad consensus that it was not necessary to change this situation by giving the Community additional powers in the area of services of general interest.³⁶⁶⁾

Whether the services concerned are called "services of general interest" (EU), "services of public utility" (UK), "services publics" (FRA), "diensten van algemeen belang" (NL, B) or "Daseinsvorsorge" (D), to name a few, one simply cannot neglect that there unambiguously is a set of common values or certain shared standards in the interest of consumers underlying all of these national manifestations of the concept. These are universal access, high quality, continuity, affordability and user/consumer protection. The "universal service" aspect implies that the services concerned have to be available at a certain quality level and at affordable conditions for all users and consumers on the whole territory of a Member State, independent of their geographical location. This is a dynamic and flexible concept, but at the same time a complex and demanding task for the responsible authorities. The continuity obligation holds that the service provider is obligated to ensure that the service is provided without interruption. The continuity of electricity supply is a well-known example. The quality and affordability requirements to services of general interest entail in the first place an important role for the competent authorities to establish quality requirements and to supervise and enforce them. On the other hand, the service of general interest must also be provided at affordable conditions, which means that the services concerned should be provided to the public at a 'reasonable' price, taking into account the specific income situation of certain consumers and having attention for certain vulnerable groups in society, e.g. by means of price control or subsidising the provision of the services concerned. As a last basic principle for the provision of services of general interest, specific user and consumer protection rules normally apply. These concern basic requirements with regard to high quality of the services, a high level of safety of services, transparency (e.g. on tariffs, contracts, choice and financing of providers), satisfactory choice of service

and of supplier, existence of regulatory bodies, availability of redress mechanisms, representation and active participation of consumers and users in the definition and evaluation of services and choice of forms of payment, etc. Other principles mentioned in the context of services of general interest are equality, reliability, participation, simplification of procedures, profitability, efficiency and evaluation of results.³⁶⁷⁾ These common elements ensure there is room for defining a Community concept of services of general interest.

To this very day, at the level of the European Union, the services of general interest debate is still very closely linked to the "services of general economic interest" concept in Article 86(2) as a derogation from the Treaty rules for undertakings entrusted with a task of public interest, satisfying certain basic needs such as transport, postal services, energy and telecommunications and to other economic activity subject to public service obligations. Also the White Paper focuses mainly, though not exclusively, on issues relating to "services of general economic interest". This is not surprising, as the Treaty itself concentrates mainly on economic activities. The term "services of general interest" is only used where it is not necessary to specify the specific nature of the services concerned or where the text also refers to non-economic activities. This could lead to new Babylonian misunderstandings, as the term "services of general interest", conceived to function as a general term, thus becomes (maybe too) strongly related to non-economic services, with the risk of ending up as a synonym of "non-economic services". Nonetheless an evolution in the Commission's approach is clear after comparing its first Communication on services of general interest in 1996 and the 2004 White Paper. The former explicitly focused on the "relevant sectors" of telecommunications, postal services, transport, energy and broadcasting, as opposed to the recent White paper, which clearly opens up the issue of using a general approach and inserting important paragraphs on non-economic, social and health services, removing the debate from a purely competition-based market context. Nonetheless, when discussing services of general interest in the European Union, an overview of the role of Article 86(2) is indispensable.

B. The key role of Article 86 EC

Article 86 has been described as the "**Article reconciling Community objectives with the fulfilment of the mission of general economic interest entrusted by public authorities**". According to the Court, this provision also "**seeks to reconcile the Member States' interest in using certain undertakings, in particular in the public sector, as an instrument of economic or fiscal policy with the Community's interest in ensuring compliance with the rules on competition and the preservation of the unity of the common market**".³⁶⁸⁾ It is a derogation from the Treaty rules³⁶⁹⁾ for undertakings entrusted with a service of general economic interest and a juridical conception, "**the chief purpose of which is to delineate activities**

deserving of special treatment within the European Community legal system from those which must submit to all the rules of the internal market".³⁷⁰⁾ The article states that

- 1. In the case of public undertakings or undertakings to which Member States grant special or exclusive rights, Member States shall neither enact or maintain in force any measure contrary to the rules contained in this Treaty, in particular to those rules provided in Article 12 and Articles 81 to 89.**
- 2. Undertakings entrusted with the operation of services of general economic interest or having the character of a revenue-producing monopoly shall be subject to the rules contained in this Treaty, in particular to the rules on competition, in so far as the application of such rules does not obstruct the performance, in law or in fact, of the particular tasks assigned to them. The development of trade must not be affected to such an extent as would be contrary to the interests of the Community**
- 3. The Commission shall ensure the application of the provisions of this Article, and shall, where necessary, address appropriate directives or decisions to Member States".**

For Article 86(2) to apply, the undertakings concerned must have been entrusted with the operation of a service of general economic interest and the application of the Treaty rules must obstruct the performance in law or in fact of the tasks assigned to it, but the development of trade must not be affected to an extent contrary to the interests of the Community. The underlying principles of Article 86 are threefold. First of all, the Article is neutral towards the question of ownership, fully in line with Article 295 EC holding that the EC Treaty in no way prejudices the Member States' rules governing the system of property ownership. Community law does not require the privatisation of public-sector entities. The Commission stresses firmly that it does not question the public, private or mixed ownership of undertakings providing services of general economic interest and strongly holds that it is primarily driven by the European citizen's interest of having access to reliable, efficient and affordable services. This would also be one of the reasons why the term "public service" was replaced with the more neutral term "service of general interest" in official political discourse. It is the service itself that is protected in the EU, not its provider. Thus **"a service, [...], does not lose its general interest character merely because it is not the State that is providing it and vice versa"**.³⁷¹⁾ As already mentioned, a second principle is the freedom of the Member States to define what they consider as a task of general interest on the basis of the specific features of the activity and consequently entrust certain undertakings with their operation, granting exclusive or special rights, regulating them, funding them, etc. The Member States enjoy a wide margin of discretion and thus a freedom to shape policy is provided.

Nonetheless, they are subject to the control of the Court of Justice as regards manifest errors.³⁷²⁾ of course cases that clearly serve individual interests cannot be excluded from the application of the internal market freedoms and the competition rules. However, to invoke the derogation of Article 86(2), the tasks need to be clearly defined and must be explicitly entrusted through an act of public authority, which is broadly interpreted as this can also concern specific contracts between the authority and the entrusted undertaking. But providers of services of general economic interest are undertakings and therefore subject to the competition rules. Decisions to award special or exclusive rights to service providers, or to favour them in other ways, can amount to an infringement of the Treaty. Case law shows that this is true, in particular, where the public service requirements to be fulfilled by the service provider are not properly specified,³⁷³⁾ where the service provider is manifestly unable to meet the demand³⁷⁴⁾ or where there is an alternative way of fulfilling the requirements that would have a less detrimental effect on competition.³⁷⁵⁾ Finally, the principle of proportionality is laid down in the article as the restrictions to the rules of the EC Treaty, in particular the internal market and competition rules, cannot go beyond what is necessary to ensure the effective fulfilment of the service of general interest.

The interpretation of this article has produced a long list of complex and from time to time puzzling case law from the Court of Justice on what exactly is the meaning of services of general economic interest,³⁷⁶⁾ whether undertakings were effectively entrusted with a service of general economic interest,³⁷⁷⁾ whether the entrusted tasks are obstructed by the application of the normal Treaty rules³⁷⁸⁾ and on the scope for applying the provision of Article 86(2) to other specific Treaty rules.³⁷⁹⁾ The term "general economic interest" implies a universal service. Services of general economic interest are characterised by the obligation imposed by a Member State or its authorities to perform a service for the public within a determined geographic area and to make sure, irrespective of profitability, that all persons enjoy equal access to the service in question at affordable prices.³⁸⁰⁾

With regard to the present key question, probably the most important feature of the case law on Article 86(2) is the obvious change in approach of the Court of Justice to its interpretation. In its earliest case law,³⁸¹⁾ the Court used the economic viability of the entrusted undertaking as the decisive test to assess whether the specific tasks would be obstructed by the application of the Treaty rules. The Court indeed shifted away from this "obstruction approach", in which an economic analysis of the performance of a "fully-Treaty-complying" entrusted undertaking was the essential instrument and in which Article 86 was considered "**one of the provisions relating to infringements of the normal functioning of the competition system by actions on the part of the states**".³⁸²⁾ The Court changed its jurisprudence in favour of a looser assessment, taking other conditions under which the undertaking operates into consideration and as a result leaning more towards a "value

approach". This more benign attitude started with the 1993 Corbeau³⁸³ judgment, where the Court already based its decision on the premise that the obligation to perform the relevant services in conditions of economic equilibrium presupposed that it would be possible to offset less profitable sectors against profitable sectors. Hence, the paragraphs (1) and (2) of Article 86 EC were placed on an equal level for the first time. It was further elaborated in the 1994 Almelo³⁸⁴ judgment, where the Court held that in order to balance the task of general interest justification of Article 86(2) against the breach of competition rules, it was "necessary to take into consideration the economic conditions in which the undertaking operates, in particular the costs which it has to bear, and the legislation, particularly concerning the environment, to which it is subject". The "economic viability test" gave its last gasp in the Energy cases³⁸⁵ in the late 90s, as the Court declared that **"for the Treaty rules not to be applicable to an undertaking entrusted with a service of general economic interest under Article 90(2) [now Article 86(2)] of the Treaty, it is sufficient that the application of those rules obstruct the performance, in law or in fact, of the special obligations incumbent upon that undertaking. It is not necessary that the survival of the undertaking itself be threatened"**. The switch **"from economic measurement to value judgment"**³⁸⁶ could be considered as the development of a concept similar to rule of reason as it is known from the case law on the rules of the internal market.³⁸⁷ Indeed the overall circumstances are comparable. Where the Cassis jurisprudence in the free movement case law had a deep impact on the national regulation, this urged the need for a broader view on the justifications on the grounds of higher interests. Mutatis mutandis, one could argue that the increasing influence of competition rules on entrusted undertakings due to the introduction of market elements in sectors of general economic interest, calls for a broader base on which derogations can be justified in order to protect objectives recognised in Community law. Anyhow the present status of Article 86(2) and the more generous use that is made of it in the Court's case law supports the idea of the Article's potential to establish a valuable and useful counterweight for the influence of the Treaty rules on services of general economic interest.

This status is reinforced by Article 16 EC,³⁸⁸ positioned in the 1997 Amsterdam Treaty as a principle alongside more frequently mentioned Community values such as non-discrimination and equal treatment, resulting in a horizontal³⁸⁹ applicability of the common values underpinning services of general interest. Although the potential of this article should not be overestimated, the adoption of the new version of this article in the Draft Treaty establishing a Constitution for Europe indicates that something is moving regarding the status of services of general economic interest at the Community level, as a legal base for Community legislative action in the field of services of general economic interest is incorporated "in fine" in Article III-6.³⁹⁰ Article II-36 of the Draft Constitution, former Article 36 of the Charter of

Fundamental Rights of the Union, completes the picture as it declares **"the Union recognises and respects the access to services of general economic interest as provided for in national laws and practices, in accordance with the constitution, in order to promote the social and territorial cohesion of the Union"**. This constitutional and fundamental (social) rights aspect of services of general interest is reflected in the Community's approach, which tightly connects the subject of services of general interest with EU citizenship (Article 17 EC).³⁹¹⁾ In this vision services of general interest are seen as "something to which all citizens enjoy a right". "Social citizenship", just like political citizenship, can be defined as an equality of rights and obligations and **"as so defined social citizenship includes, without question, equal access to certain services (i.e. services of general economic interest as referred to in Article 90(2) [now Article 86(2)] of the Treaty) of appropriate quality"**.³⁹²⁾ Due to this bottom-up approach the discussion has been opened up to all services to which European citizens can have a right and the dividing lines between the different possible types of services of general interest (services of general economic interest, network industries, non-economic services, social services, ...) have blurred.

As far as the financing of services of general interest is concerned, one has to bear in mind that different services of general interest cannot be viably provided on the basis of market mechanisms alone. A specific characteristic of services of general interest is indeed that they need to be provided even where the market may not have sufficient incentives to do so. Consequently, specific arrangements are necessary in order to ensure the financial equilibrium of the provider. Member States can apply different mechanisms in order to guarantee the financial equilibrium of providers of services of general interest. The financing mechanisms applied by the Member States include direct financial support through the State budget (e.g. subsidies or other financial advantages such as tax reductions), special or exclusive rights (e.g. a legal monopoly), contributions by market participants (e.g. a universal service fund), tariff averaging (e.g. a uniform country-wide tariff in spite of considerable differences in the cost of provision of the service) or solidarity-based financing (e.g. social security contributions). Member States are free to choose which method they apply to finance their services of general interest. They only have to make sure that the mechanism chosen does not distort unduly the functioning of the internal market. In particular, Member States can grant public service compensations, which are necessary for the functioning of the service of general economic interest. But in case the Member State over-compensates, State Aid rules are applied, as can be derived from extensive case law and several Commission actions.³⁹³⁾

2) Health care as a social service of general interest

A. Social services of general interest

As can be derived from Article 16 EC, services of general economic interest all play an important role in the promotion of "social and territorial cohesion" in the Community. Thus the "social function" is inherent to this type of services. The term "of general interest" already suggests this relation as, just like the term "social", it refers to a higher interest in society that is taken into consideration. However, there is one category of services of general interest that intrinsically is related to a social objective and consequently labelled "social services of general interest". Like "services of general interest", it is very difficult to give a satisfactory and comprehensive definition of "social services (of general interest)". Social services of general interest cover a broad range of activities such as statutory social protection schemes, supplementary social protection schemes, health³⁹⁴⁾ and social care services,³⁹⁵⁾ employment services, child care, services to promote social integration, education and training, social housing.³⁹⁶⁾ Far from being exhaustive, this list already indicates that most social services are of a special nature as they are strongly connected to the "person" (birth, education, employment, sickness, age, etc.). This **"personal nature of many social and health services leads to requirements that are significantly different from those in the network industry"**,³⁹⁷⁾ as acknowledged and perhaps to some extent understated in the 2004 White Paper. Regarding the above-mentioned examples of social services, one could argue that they tightly correlate to the several "social risks" as they are known in the traditional systems of social security and social assistance and thus responding to difficulties that individuals encounter during their lifetime.³⁹⁸⁾ Being qualified as "social services" and considered to be related to "social risks", as known in social protection schemes, certainly does not mean this category of services constitutes only non-economic services, as could be erroneously concluded from the élan of the Court's jurisprudence to exclude solidarity-based services from the EC competition framework. As already discussed earlier, solidarity elements or underlying social objectives do not preclude qualifying certain services as economic activities.³⁹⁹⁾ However, it is also clear that some social services are definitely of general interest, but cannot be considered of general 'economic' interest, as they are not regarded as economic activities.

The classification as an economic or a non-economic service in Community law is of course important for the key question of the role of services of general interest as a counterweight against the influence of internal market and competition rules. Noneconomic services are not totally excluded from the scope of the EC Treaty, but the application of the latter is restricted to the rules on the free movement of persons, the prohibition of discrimination and the EC public procurement rules. The internal market rules on the right of establishment, the free provision of services and the competition rules on

cartels, abuse of a dominant position and state aid, only apply to "economic activities". In Community law, "economic activity" is defined as "an activity that consists in offering goods or services on a given market".⁴⁰⁰⁾ We already know that the same entity can provide both economic and non-economic services. Yet it is not possible to draw up a list of activities that would not a priori be economic, as this depends on constantly evolving political choices. What should be kept in mind is that non-economic services are excluded from the application of the internal market and competition rules of the EC Treaty. So there is no need for a counterbalance in the "non-economic services field". This will be further specified for the health care sector. We have already seen in part II that there are two exemptions to the principle of economic activities. The most clear-cut example of non-economic services is the category of activities, **"where the state, by definition, faces neither actual nor potential competition by private companies: the exercise of imperium"**.⁴⁰¹⁾ Further we have the exemption for solidarity-based services.

According to the European Economic and Social Committee, the distinction between economic and non-economic services is blurry and uncertain. However, the EESC stresses that this distinction cannot be the purpose, which should be to ensure the implementation of the principle of subsidiarity, as "the Union should recall the types of service to which common competition law does not apply (services of sovereign or national, regional or local interest, the compulsory education system, health care and social protection, or cultural, charitable, social, solidarity/donation-based activities, etc.)".⁴⁰²⁾ It also reiterates⁴⁰³⁾ the importance of a special treatment of organisations providing social services on a non-profit basis. The question of how to reconcile these views with the competition policy of the Commission and (the functional approach in) the Court's relevant case law remains. An important feature of the activities that can be categorised as "social services of general interest" is that they are indeed provided by a variety of providers, such as public entities, for-profit private "undertakings" or non-profit private providers, varying from Member State to Member State and making this a very heterogeneous sector, also within each Member State.⁴⁰⁴⁾ However, many of them are provided by non-profit welfare organisations, claiming a specific status according to their social tasks and objectives and their **"specific role in maintaining solidarity and encouraging active citizenship"**.⁴⁰⁵⁾ They are defined by the EESC as **"a category of private not-for-profit organisations, having different status in different countries (associations or foundations) that are active in the health and social spheres, though where necessary conducting economic activities that are subordinate to their primary social functions"**⁴⁰⁶⁾.

Although social services of general interest are, certainly in the opinion of stakeholders in the field of social services, still dealt with only superficially in the 2004 White Paper, the Commission has certainly made an effort to unravel a part of the often mysterious and complex tangle around this issue

at the European level. Their status as services of general interest is unquestionably acknowledged as they are, in their turn, recognised as an "integral part of the European model of society", to which is added that **"based on the principle of solidarity, social and health services of general interest are person-centred and ensure that citizens can effectively enjoy their fundamental rights and a high level of social protection, and they strengthen social and territorial cohesion"**.⁴⁰⁷⁾ Recognition of the distinction between missions and instruments for their delivery and financing on the one hand and the modernisation of these services on the other, seem to be priorities for the Commission. But the complete Commission's approach towards social and health services of general interest is postponed and will be revealed in a Communication on social services of general interest, including health services, to be adopted in 2005.

These social services are also the result of different historical, cultural and political evolutions in the Member States and thus difficult to reduce to one single identity. Nevertheless throughout this whole range of social services, several common points can be discerned. Applying above-mentioned characteristics, it is apparent that social services can easily be classified as services of general interest because they share common values, such as universality, high quality, affordability, continuity and user / consumer protection, with the other services of general interest. Their close relation to social rights⁴⁰⁸⁾ also gives them the specific fundamental rights aspect already mentioned in the context of services of general interest. But due to their specific nature and personal character, social services are characterised by additional common values and underlying principles. First of all, they pursue the concrete implementation of social rights and the creation of equal opportunities. They are based on particular principles like human dignity, solidarity, social justice, social cohesion, social capital, empowerment and users' participation. Also important is that they respond to societal weaknesses and social needs which are not sufficiently addressed by market mechanisms. Finally they are considered to be effective tools for the implementation of public policies in the areas of social protection, non-discrimination, solidarity and the fight against poverty and exclusion.⁴⁰⁹⁾ Taking these different elements into consideration, the place of the health care sector in this context is the final issue to be considered.

B. The concept of services of general interest in the health care sector

1. Health-related services of general interest

Having marked out the field of "services of general interest" and "social services of general interest", we can now go down one more level to explore the place occupied by the health care sector in this domain. This examination will divide the "health care sector" into three large subdivisions, i.e. "health

care provision" (the provision of preventive and curative care by health care professionals and institutions: patient-provider relation) and "health care insurance" (patient-purchaser relation), in particular statutory health insurance (the basic compulsory social security scheme covering the risk of sickness) and voluntary health insurance (substitutive, complementary and supplementary⁴¹⁰) social protection schemes). In fact, the application of the concept of services of general interest to these sectors is to a large extent experimental, considering that this concept is still very closely linked to the big network industries as services of general "economic" interest. Comparing "health care" with "electricity" seems an unfeasible task, but a closer look reveals that they have more in common than one would expect. In fact, notwithstanding many unresolved questions, health fits well in the present "services of general interest"-debate. This is unquestionably acknowledged in the 2004 White Paper under subsection "4.4 Recognising fully the general interest in social and health services". This makes clear that there can be no doubts on the classification of health services as "of general interest". We will explore later to what extent "economic interest" is involved. The White Paper furthermore clearly states that health services should be treated differently from the network industries in the traditional general "economic" interest sector. What is meant exactly by "health services" is not clear. It should be further specified whether this only concerns "health care provision" or if it covers also the "health care insurance" sector. In this paper, we have focused on the "health care sector" or what could be identified as "health-related services".

Recalling the above-mentioned "underlying principles" or "common values" of services of general interest, these are in fact all values frequently used in the health care context. The principle of universality or universal access for the whole territory is an actual concern of health authorities in all Member States, of which hospital or pharmacy planning are textbook examples. It is almost needless to mention that continuity and quality requirements are core topics in the health care sector. While continuity of care is certainly an essential element, quality of care must be one of the all-important matters in this area, considering the magnitude of regulation on quality in every Member State. This concerns the quality of input (infrastructure, staff), e.g. admission criteria or accreditation; quality of applied techniques and procedures, e.g. quality control in clinical biology or blood transfusions, and quality of output, e.g. programmes on hospital infections or bedsores, etc.⁴¹¹ The concept of affordability is a primary health care topic too, concretised e.g. in the fixing of maximum tariffs or the installation of a ceiling on health care expenses for vulnerable groups. Finally, the continuously reiterated importance of user and consumer rights is easy to "convert" to the health care sector as in the protection of patient rights, the installation of complaint procedures or the protection of personal health data. This very short overview of main principles and examples already indicates that almost all state intervention in the health

care sector can be linked to a particular "general interest" requirement as it is known in the field of services of general interest.

But as the specific nature of health care - that **"leads to requirements that are significantly different from those in the network industry"** - already suggests, there is obviously more to health care. The "additional underlying principles" or "extra values" make it presumable that health care can be qualified as a "social service of general interest", independent of the question whether the health care sector and its subdivisions are to be considered economic or non-economic. The person-centred character of health care is obvious, as it involves human life and well being. Also the above-mentioned relation to "social security matters" is self-evident, as "sickness" is one of the traditionally insured risks in social protection schemes. The status of social services of general interest as a tool for the implementation of fundamental social rights is fully applicable to health care. In the European Union **"everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities"** (Article II-35 Draft Treaty establishing a Constitution for Europe) and the Union **"recognises and respects the entitlement to social security benefits and social services providing protection in cases such as maternity [and] illness, [...], in accordance with the rules laid down by Union law and national laws and practices"** (Article II-34 Draft Treaty establishing a Constitution for Europe). These articles of the Draft Constitution for Europe - ominously preceding the Article on the access to services of general economic interest - are the emanation of the fundamental rights aspect in the health care sector, as also acknowledged in international treaties. To complete the picture, it suffices to repeat the "principles indicating the social character of the service", such as solidarity, social justice, social cohesion, social capital, non-discrimination, empowerment and users' participation, etc. These notions and the social services' inherent responsiveness to societal weaknesses and social needs which are not sufficiently addressed by market mechanisms presses arguments to qualify the health care sector in the category of social services of general interest.

2. Health-related services of general economic interest

There is no doubt therefore that the health care sector and its subdivisions are (social) services of general interest. But being more of a "declaration" at a "general principles-level" or "European common value-level", it leaves unanswered the question concerning the potential usefulness of Article 86(2) as a derogation in Community law from the applicability of fundamental EC rules in the health care sector. This article is only applicable to "services of general economic interest" and thus leads unavoidably to the question of the economic character of the services concerned. Here the division between

health care provision, statutory health insurance and voluntary protection schemes is essential for an overview. Following the Commission's subdivisions of services of general interest in the Green Paper, it is clear that these health-related services cannot be placed in the same category as "networking industries". The remaining categories of "other services of general economic interest" and "noneconomic services" do not satisfy either. It would be contrary to the special status of health care in the Member States to characterize this sector as purely economic, as there is considerable consensus in the European Union that health care has specific characteristics to which the market is unable to respond accurately.⁴¹²⁾ On the other hand, qualifying health care as a genuinely non-economic service does not match reality either, as e.g. the Court confirmed several times "health care provision" is an economic activity and in some countries (e.g. the United States) basic health care insurance is to a large extent left to private undertakings acting in a market environment.⁴¹³⁾

First, as far as the provision of health care (relation patient-provider) is concerned, the Court confirmed on several occasions that health care provision is a service according to the EC Treaty. The Court of Justice dealt with this topic in relatively early jurisprudence and came to the conclusion in the *Luisi and Carbone* case that **"persons receiving medical treatment are to be regarded as recipients of services"**.⁴¹⁴⁾ Also in later decisions the Court leaves no doubt that medical activities are services within the meaning of the EC Treaty.⁴¹⁵⁾ Of course these activities have a special nature as they are provided in the Member States under the national health care system in the framework of a social security scheme. However, according to the settled case law of the Court, the special nature of certain services does not remove them from the ambit of the EC Treaty and the fundamental freedoms therein.⁴¹⁶⁾ This means that activities in health care provision cannot be excluded from the range of action of the internal market. Moreover, also the providers of medical activities (general practitioners, medical specialists, pharmacists, hospitals, etc.) have been considered by the Court to be economic actors and thus undertakings according to the EC competition rules.⁴¹⁷⁾ The fact that health provision can be qualified as a service of general interest and is unmistakably of general economic interest too, means that there is certainly a potential for Article 86(2) to be applied in this domain. This was the case in *Ambulanz Glöckner*⁴¹⁸⁾ for providers of transport of sick persons, where Article 86(2) justified the exclusive right to provide both emergency and regular transport for sick and injured persons. This was necessary to prevent "cream skimming" by private companies (by providing transport in the more profitable non-emergency sector in urban areas), which would make the task of general economic interest (of providing all transport by ambulance) of the entrusted entities very difficult. Of course in the domain of health care provision, the requirement that competition law only applies

where the conduct in question is liable to affect trade between Member States should be kept in mind, e.g. in the case of general practitioners.

However, the situation is totally different in the case of "basic" or "statutory" health insurance as a part of the national social security schemes. Since the *Poucet-Pistre* case⁴¹⁹ the Court created a "new category" for social insurance services based on compulsory affiliation, such as statutory health insurance schemes. This category was exempted from the application of competition law because the activities concerned were based on the "principle of solidarity", providing for a transfer of wealth among members of a given risk group or among different groups. The fact that the activities are embedded in solidarity motives entails that the entities engaging in them are not to be considered as engaging in an economic activity and thus are not undertakings according to the EC Treaty. This line of thought was reiterated in the cases *Garcia*,⁴²⁰ *Cisa* ^[421] and *AOK Bundesverband*.⁴²² It entails that there is no scope for applying Article 86(2), as the entire field of solidarity-based activities in statutory health insurance are excluded from the range of action of the competition rules and need not to be countered by the legal derogation for services of general economic interest.

However we have already mentioned that health care is in principle an economic activity. Therefore we agree with different authors⁴²³ that the Court was wrong to prevent application of the competition rules on the entire field of statutory (health) insurance and that a better result could have been reached if the Court had acknowledged that these "insurance services" are in fact an economic activity (health as an insurable risk), but as they are services of general economic interest, Article 86(2) could be applied where their provision is threatened by the application of the Treaty rules. In this reasoning the solidarity element is used as an argument for demonstrating the "general economic interest" character of these activities. Consequently, Article 86(2) could affirm the necessity of special or exclusive rights such as compulsory affiliation to maintain solidarity in the system.⁴²⁴ This argument was also developed by Advocate General (AG) Jacobs in his Opinion on the *AOK Bundesverband* judgment.⁴²⁵ The Court did not follow its AG and simply applied the *Poucet-Pistre* interpretation of the "solidarity exemption", though it noted that **"the possibility remains that, besides their functions of an exclusively social nature within the framework of management of the German social security system, the sickness funds and the entities that represent them, namely the fund associations, engage in operations which have a purpose that is not social and is economic in nature. In that case the decisions which they would be led to adopt could perhaps be regarded as decisions of undertakings or of associations of undertakings"** and added an Article 86(2)-like reasoning. The Court seems to suggest that it will not consider entities like mutual health funds to be of a special nature and will not give them special protection when they clearly engage in economic activity according to its definition of undertaking. This

could be the case for entities managing the basic health insurance scheme, engaging in voluntary health insurance activities. There is another issue related to this. In his Opinion, AG Jacobs points to a potential future usefulness of Article 86(2) in the field of statutory health insurance too. Indeed, in the ongoing search for new cost-containing measures, several Member States have already introduced and will introduce more market incentives in their health care systems (cf. the Netherlands). The more market elements in the system, the higher the chance that the latter will be viewed as less based on solidarity, which makes the actual application of the competition rules presumable. The derogation of Article 86(2) could prove to be essential for preserving social objectives and solidarity elements in the national basic health insurance schemes, depending on the amount of market elements in the statutory health insurance scheme. This of course depends on political decisions in the Member States, responsible for the organisation of their social security system,⁴²⁶⁾ on how to set up the statutory health insurance scheme. If a Member State decides to introduce more competition elements in its system, it will have to take into consideration that EC competition rules will apply and vice versa. In this way the powers of the Member States can be respected.

This need for the "services of general economic interest derogation" will presumably be even more the case for voluntary health insurance schemes. If they are considered "economic activities" by analogy with the supplementary pension schemes that have already passed the scrutiny of the Court, it is obvious that Article 86(2) will play an important role in preserving the social objectives and general interest tasks of these voluntary social protection schemes. In the supplementary pension funds cases *FFSA*,⁴²⁷⁾ *Albany*,⁴²⁸⁾ *Brentjens*⁴²⁹⁾ and *Drijvende Bokken*,⁴³⁰⁾ the exclusive rights of the funds were challenged. In part II, we have already pointed out that the social objectives and the solidarity elements in the supplementary scheme could not prevent the qualification of their activities as economic, but were an essential element when the application of Article 86(2) was judged. The Court acknowledged that the pension funds were entrusted with a service of general economic interest according to Article 86(2), of which the operation could be threatened if the exclusive rights concerned were to be banned. Again "cream skimming" by competing private companies was acknowledged as a major risk for the pursuit of the social objectives in these cases. *Mutatis mutandis*, the concept of services of general economic interest could help in finding a balance between the competition rules and the inherent general interest requirements (open enrolment, lifetime cover, community rating, minimum benefits, etc.) in the field of voluntary health insurance. As in the supplementary pension cases, voluntary health insurance and the basic regime could be seen as forming a whole with the purpose of covering the same social risk.⁴³¹⁾ If the level of solidarity in the scheme is insufficient to enjoy the "solidarity exception", Article 86(2) can bring the necessary

counterweight. If certain voluntary health insurance services were to be opened to competition, bad risks could be refused by private for-profit-companies and entities with a social objective would have to cover these bad risks, which would make it difficult for those organizations to offer these services at an affordable price to the beneficiaries concerned. Of course the relevance of the supplementary pension jurisprudence for the voluntary health insurance sector is uncertain.

As health-related services are or have the potential to be considered as services of general economic interest, Article 86(2) also requires that the undertakings concerned are "entrusted" by the government with a task of general economic interest⁴³²⁾ and that the discharge of the latter would, in law or in fact, be obstructed by the application of the Treaty rules.⁴³³⁾ The "entrusting" of health-related service providers can presumably be found in "Sickness Insurance Acts" or national "Acts on the medical professions", "Hospital Acts", "Pharmacy Acts" for health care providers and for statutory health insurers in e.g. "Sickness Funds Acts" or also in general "Sickness Insurance Acts". For voluntary health insurance the entrustment with general interest tasks should be found in the regulation setting boundaries for the providers of this service, like an "Act on complementary health insurance". The entrustment could also be derived from a series of governmental actions and policy documents.⁴³⁴⁾ Of course the relevant government action will differ from country to country so this will be a case-by-case evaluation. The search for this "entrusting Act" will surely not always be unproblematic. However, in the cases *Albany*, *Brentjens* and *Drijvende Bokken*, the Court did not really "investigate" explicitly the entrustment with a task of general economic interest by governmental action when it ruled on the application of Article 86(2). The stringency of this requirement should therefore be put in perspective since both the Commission and the Court interpret it liberally.⁴³⁵⁾ The Court seems to draw this conclusion from the obvious and essential social function of the pension scheme. Furthermore, it has to be demonstrated that it would not be possible for the undertaking to perform the particular tasks entrusted to it or to perform the tasks of general economic interest which have been assigned to it under economically acceptable conditions,⁴³⁶⁾ but the entrusted entity must not prove that the financial balance or economic viability of the undertaking entrusted with the operation of a service of general economic interest is threatened. Nonetheless this means that as long as health care institutions can perform their task without infringing the Treaty, they are bound by it. The performance assessment of art. 86(2) with relation to health care institutions should therefore not only consider financial matters, but also quality and access to health care. Finally this obstruction of the normal functioning of EC law should not go further than is necessary for the preservation of the performance of the given tasks. This proportionality requirement holds that a balance must be found between the anticompetitive action and the entrusted task of general interest (i.e. health)

and could be the main cause of disagreement, as it constitutes a more subjective deliberation on whether the given public task is worth the breach of competition rules. Be that as it may, a Member State **"should not be required to prove that no other conceivable measure, which by definition would be hypothetical, could enable [those tasks] to be performed under the same conditions"**.⁴³⁷⁾ Of course the freedom that Member States enjoy to organise their own social security system in the present state of Community law, is also of undeniable importance when the health care sector is concerned. More in particular, according to Article 152(5) EC, Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care. This clause should shed a specific light on the Article 86(2) proportionality test in health care matters.⁴³⁸⁾

3) Concluding remarks

The topic of services of general interest has acquired an inerasable place on the political agenda of the European Union, the Member States and the stakeholders in the related activity sectors. This should not be underestimated, as the European Commission already acknowledged in its first and almost 10 year old Communication on services of general interest in the European Union that these services are a key element in the European model of society, a view recently confirmed in the 2004 White Paper. Nonetheless the notion and the debate on services of general interest have undergone an undeniable evolution, which has not yet ended and presumably never will, as the topic is strongly related to the constantly evolving economic, social, political and cultural changes in the Member States and the EU. The 1996 Communication already covered the issue of "services of general interest", but was to a large extent devoted to the big network industries of postal services, telecommunications, energy and broadcasting. Although this link has not disappeared in 2004, it has certainly made room for a broader approach of the issue, opening it up as a shared responsibility of the Union and the Member States, operating close to citizens, reiterating underlying common values, the importance of monitoring and evaluating performance, but maybe most important of all, respecting diversity of services and situations, integrating social and health services in the document and thus recognizing fully their general interest. The same evolution is noticeable in the jurisprudence of the European Court of Justice, which has moved away from a rather narrow-minded "competition obstruction approach" to what is called a "value approach" of services of general economic interest in the EC Treaty Article 86. This certainly points to future opportunities with regard to recourse to Article 86(2) as a counterweight for the normal application of Treaty rules before the Court of Justice.

And this was the issue at stake for the health care sector. To what extent can the concept of "(social) services of general (economic) interest" function as a

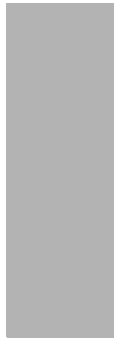
counterbalance for the "threat" of internal market and competition rules in the field health care and its subdivisions? It was easy to conclude that all the examined "health-related activities" are indeed services of general interest, which is not surprising as social security matters, like health care, are a sort of "archetype" or at least a "textbook example" of services of general interest. But whilst acknowledging the well-known specific status and specific characteristics of health care cannot be considered revolutionary or innovating, the practical legal usefulness of the concept "services of general economic interest", as it is found in Article 86(2) EC, in health care matters seems more interesting and challenging. An examination led to the conclusion that all activities in the health care sector (provision, statutory insurance and voluntary insurance) can have an actual or potential (future) virtuous effect on it. Activities in the health care sector already labelled as "economic services according to EU law" could be joined by the other "sheltered" subdivisions in health care, when, due to cost containment measures, more market elements are introduced in the health care systems and the level of solidarity elements is too low to stay out of the action range of European economic law. That is why it is impossible to draw up a list of "a priori noneconomic services": what is sheltered from internal market and competition rules today, can be an economic activity tomorrow, depending on changing views on the role of the state and political reorientations in the Member States. In this view the importance of Article 86(2) for justifying national measures aiming at solidarity or other social objectives could be major and this Article could become the key element in finding a balance between the application of EU competition rules and socially inspired activities, as a "third way" next to the "state prerogative" and "solidarity"-exemptions. The more benign approach of the Court towards the higher interests of balance within the EC Treaty rules, is of course crucial for the health care sector. Once an entity engaging in health care activities is considered an undertaking according to EC law, the qualification of a health care activity as a task of general interest will be quite trouble-free, but the requirements of "entrusted by an act of public authority", "obstructing in law or in fact" and of proportionality could be more delicate subjects.

Be that as it may, both the European Union and the Member States should take this key role seriously and this should in the first place be done by eliminating semantic problems and further exploring and elaborating the status of health care as a "service of general interest". Even where it is self-evident that this tag is justified, it will certainly be a more complicated task to evaluate the tangible consequences of this qualification. One concrete consequence could be an in-depth re-evaluation of the pending "Proposal for a Directive on services on the internal market", taking into account the importance of services of general interest and the specific status of health care as a service of general interest **"of which the personal nature leads to requirements that are significantly different from those in the network**

industries" and at the same time "**recognising fully the general interest in social and health services**". The latest version of the proposal for a services Directive covers the issue of services of general interest in a rather noncommittal way, as a new recital relating to the subject-matter of the Directive states that it is only applicable to services of general interest that correspond to an economic activity and proclaims a status quo as regards these services of general "economic" interest: "**The Directive does not affect the freedom of the Member States to define, in conformity with Community law, what they consider to be services of general economic interest, how those services should be organized and financed and what specific obligations they should be subject to**". The recital concludes that "**this Directive does not deal with the follow-up to the Commission White Paper on services of general interest**". Unmistakably having a prima facie reassuring effect, these considerations not only avoid a more thorough analysis of the relationship between the services Directive and the White paper on services of general interest, they also confirm - by means of a status quo - that nothing changes as far as services of general (economic) interest are concerned, which also means that no specific attention will be given to their specific status in the services field. The services Directive thus fully applies to services of general economic interest in the same way as it applies to other services. A good example of this special attention can however be found under Chapter II "Freedom of establishment for service providers", in a recital concerning mutual evaluation process for the evaluation of requirements, stating that this evaluation process "**has to take fully into account the specificity of services of general economic interest and of the particular tasks assigned to them**". It is acknowledged that "**these may justify certain restrictions to the freedom of establishment in particular where these pursue the protection of public health and social policy objectives**". This being merely a recital only relating to the establishment chapter of the Directive, it doesn't remedy the absence of a legally binding Article dedicated to the specific status of services of general economic interest. This lack of special consideration should at least be brought to attention and be re-evaluated, leaving, in the context of this paper, the precise tenor or content of an Amendment open for discussion.

The Commission Communication on social services of general interest, including health services, is a very important step and should be a very interesting document holding the Commission's views on the future of on health and (other) social services. It should bring more clarity and hopefully more legal certainty and transparency to the relation between health care systems and European economic law, often referred to as "the threat of the internal market and competition rules for the national health care systems". Establishing a common vision on health care as a (social) service of general (economic) interest among 25 countries will definitely be a very demanding exercise (in which the open method of coordination in health care matters

could be very valuable). But finding a common line of thought is what Europe is for and it's what Europe is good at, albeit from time to time the result of an exhausting crusade.



V. Overall conclusions

It is a fact that the competence of the European Union in the Health Care sector remains rather limited, implying that Member States are free to determine the characteristics and the structure of their national health systems. This cannot however hide the further interference of European law and in particular the rules on the internal market. This is not surprisingly in a time where national social security systems evolve in the direction of hybrid systems with a mix of public and private elements. The need is felt for a greater responsibility of the citizen, for increasing elements of competition leading to a bigger role of the private sector. This does not exclude that the State is pulling the strings, but rather now from another perspective. More and more the State sees its task to guarantee everybody a right to social security as a kind of end-responsibility allowing other actors to participate in the execution of the social security system.

This report wanted to see how far the internal market can affect access to health care.

In a first part the element of free movement was investigated.

As a general rule, regulation and free movement fit uneasily. Combining market access with enduring regulatory control is a difficult assignment, not least in a field as delicate and highly regulated as that of the provision of health care, a field which is moreover interrelated with territorially and solidarity-based social security. The current European legal framework in relation to the free movement of health care professionals is unremarkable for legal certainty. Leaving aside the issue of professional qualifications, one is confronted with a situation in which secondary legislation, in the form of the Doctor's Directive, prescribes the application of significant yet ill-defined parts of the legislation of the host Member State, whereas at the same time, the Court's services case law has gradually developed to embrace of a "qualified" country of origin principle, on the basis of which a conditional mutual recognition applies. Conditional indeed, as the host Member State is able to impose its non-discriminatory legislation in the event and to the extent that the legislation of the Member State of establishment of the service provider fails to safeguard a legitimate aim of public interest. In the matter under consideration, i.e. health care provision, this proportionality assessment, which is to be conducted on a case-by-case basis, might be applied with less rigour by the Court, an approach which is prompted by the delicate nature of the regulation at hand, pursuing health and social policy objectives. Whilst this flexibility helps safeguarding Member States' legitimate interests, it renders the legal position of health care professionals providing services in the host Member State utterly difficult to predict. Conversely, the proposed Directive on services in the internal market, though largely drawing from the Court's case law, envisages a virtually absolute and unconditional implementation of the home State model. Being conceptually

clear and, admittedly, predictable, the country of origin principle as laid down in the Commission's Proposal almost irrefutably presumes a European wide-equivalence in the protection of the public interest, an equivalence which in fact does not exist and which is neither instituted by the Proposal. In so doing, the Proposal disowns the legitimate interest of Member States to impose their own legislation on foreign health care professionals providing services within their territory, forcing them to nearly unconditionally recognize the legislation of the home Member State of the service provider. Health- and health-care related derogations are altogether scarce, unclear or their use is strictly framed.

The relationship of the Proposal with the future Directive on the recognition of professional qualifications leaves much to be desired. The scope of the former and the range of its coordinated field are such that it plainly encompasses the matters regulated by the latter. Although derogations are provided for to compensate for situations of manifest inconsistency, more attention should be paid to the coordination of the two instruments, so as, ideally, to come to an integrated legal framework within which the free movement of health care providers is to take place. Clarification is definitely needed as to the scope of the concept of "disciplinary rules of a professional or administrative nature which are directly linked to professional qualifications", to which the service provider, pursuant to the future Recognition Directive, is subject at any rate in the host Member State and in respect of which a derogation to the country of origin principle has been included in the Proposal. This vague notion, reintroduced by the Council in the Common Position on the Recognition Directive, will delineate to a significant extent the scope of the country of origin principle in respect of the cross-border pursuit of numerous professional activities, notably health-care related ones.

Furthermore, the Proposal for a Directive on services in the internal market adds nothing to the thorny issue of the connection between the intra-Community provision of health care services and the incidence of aspects of social security; the question as to whether, and if so, under which conditions, these services should give rise to a financial intervention by the national health insurance institution in the host Member State remains unanswered, although some provisions of the Proposal hint at an "activated" reading of the Court of Justice's cases on patient mobility under Article 49 ECT. Elaborating on these "activated" health care rulings as well as on the general services case law, we contend that a health care provider established in a Member State where he lawfully provides medical services, is entitled to provide those services on a temporary and occasional basis in the host Member State. If these services, had they been provided by a contracted provider established in the host Member State, would have been assumed by the national health insurance institution, the patient, recipient of the medical services provided by the foreign doctor, should in principle be entitled to reimbursement, the

amount of which may not be lower than the level of assumption of that care as provided by a domestic contracted provider. We further submit that it should not be possible for the foreign medical service provider to challenge the host Member State's legislation defining the boundaries of health care cover, that is the personal scope of their schemes of social protection in the area of health care, the range of treatments which are covered and the extent to which they are covered, and lastly, the conditions on which benefits are granted.

The Court's health care cases have paved the way for a second method of patient mobility, which comes on top of the procedure enshrined in the Community Regulations on the coordination of social security. Having described the manner in which the Court deals with the compatibility of the Regulation-based method of patient mobility – which subjects the assumption of the costs of treatments provided in another Member State, in accordance with its legislation, to prior authorisation by the competent institution of the Member State of affiliation – with the Treaty, we take a prescriptive approach and submit that, as regards the cross-border receipt of intramural care, the two methods are mutually complementary and their application should be merged as much as possible. The same reasoning, however, cannot be maintained in relation to the cross-border receipt of extramural care, in respect of which prior authorisations requirements constitute unjustified restrictions to the free movement of services. Proceeding from a prescriptive point of view, the application of the Regulation-based method as regards extramural care should be limited to those cases where it offers its beneficiary some added value, on pain of running counter to the Treaty. In that regard, it is to be regretted that the Council has not seized the opportunity, on adoption of the new coordination regulation, to at least implicitly refer to the Treaty-based method of patient mobility, instead making it appear as if Regulation (EC) No 883/2004 will be the one route for patients wishing to be treated in another Member State at the expense of the national health insurance institution. Without advocating an incorporation of the Court's case law into the Coordination Regulation, which, for various reasons, seems not desirable, we believe that the Community legislature ought to take account of the one method while regulating the other, as the Commission has satisfactorily done in Article 23 of its Proposal for a Directive on services in the internal market, intended to codify the Court's health care cases. It does so not without merit, even if it fails to remove uncertainty regarding some important concepts, most notably the distinction between intra- and extramural care.

In a second part attention was paid to the difficult relation between competition law and health care, leading to the fundamental issue whether social security institutions are performing economic activities or not. The Court has been clear on the qualification of health care provision as an economic service within the meaning of the Treaty and the same probably

holds true for voluntary health insurance, if the supplementary pensions case-law can be transposed to the health sector. But an entangled situation has been created by the Court of Justice as regards the question whether the management of statutory health insurance under the national social security schemes should be regarded as an economic activity or not. The Court has exempted the institutions governing these schemes from the notion of “undertaking exercising an economic activity” on the grounds that their operation is founded on the principle of solidarity. This raised the crucial question which criteria an insurance system has to meet to be considered as “a social security system” allowing it to escape from full application of the internal market rules. Here we are however confronted with the problem that the case law of the Court is far from clear. It is understandable that the European concept of social security differs from the national concept, however it is very remarkable that exactly an important aspect of what is social security, is answered differently by the Court, most of the time depending on the European instrument in question.

Under the third –non-life insurance directive e.g. the fact that the system is executed by private insurance companies acting at their own risk excludes the possibility to be considered as social security system. The fact however that a system is executed by companies not acting at their own risk, does not immediately imply that we are dealing with a social security system. What is the relevance of being considered as social security under Regulation 1408/71? Sometimes considered completely irrelevant while at other occasions used as an argument pointing in the direction of a social security system.

Moreover the Court has in a recent case, in which the examined basic insurance scheme displayed a considerable amount of market elements, made entirely clear that it is willing to go far with this solidarity-based immunity for basic social protection schemes. A crucial policy question is thus at what point of this “balance of solidarity” the degree of solidarity in a given scheme will not suffice to be exempted from European economic law. When will reforms towards a more market-oriented model in the different European models of health care systems lead to the application of competition law? Are certain types of solidarity (income solidarity, solidarity by scope, risk solidarity, intergenerational solidarity and solidarity between schemes) more decisive than others for the outcome of this weighing exercise and which? Intergenerational solidarity does e.g. not concern health insurance. All this is not in favour of much legal certainty.

How far can the Court go in this respect without compromising its own authority?

The different cases have however shown that social objectives can be introduced as a safeguard against full application of the competition rules and this not only in the public sector.

Where these first two chapters unambiguously demonstrate that national health care policy cannot be established with disregard of European economic law, the third Chapter examines a concept in Community law that could constitute a safeguard or counterbalance to this increasing influence of market-based rules, which are often deemed maladjusted in a sensitive and person-centred sector like health care. The practicability of this concept is to be viewed in the first place on a looser conceptual level under the denominator of “services of general interest”, which are tackled in a recent Commission White Paper. But on a strictly legal level it is only the sub-concept of “services of general economic interest” as it appears in the Treaty that can be used as a decisive derogation to the provisions of Community law indirectly aiming at the “organisation and delivery of health services and medical care in the Member States”. Putting the Babel-like confusion relating to the term and the historical connection of the concept to the network industries (electricity, telecommunication, postal services, ...) aside, one straightforwardly agrees that the concept of services of general interest, as services of which the provision to the citizens is deemed very important in a given society and therefore is submitted to a number of common values and specific demands, fits perfectly for health care. As a strongly person-oriented sector, health care is to be considered as a “social service of general interest” and therefore subject to additional requirements. In a nutshell, health care evidently is a part of this “pillar of the European model of society”.

But legally binding provisions on “services of general interest” are absent in Community law. Indeed the EC Treaty only knows the sub-concept of “services of general economic interest” of Art. 86(2) EC, which aims at “economic” services. As we have seen, in health matters, this is exactly a troublesome qualification, especially when it concerns basic health insurance schemes, lacking the necessary legal certainty. But should this issue continue to be dealt with on a case-by-case basis? If this would be the case, the challenge will be to find the answer to the question of which role Art. 86(2) EC could or should play after failure of the solidarity-argumentation and qualification as an economic service, and if this provision could be the basis for a new type of “rule of reason”, supported and reinforced by the special status given to services of general economic interest in Art. 16 EC and in the future Constitution. But is Art. 86(2) EC case-law considered to be the right path to mitigate potential undesired impact of European economic law on health care policy in the first place? Or should this once and for all be dealt with in future primary or secondary EC legislation, with the risk of introducing rigidity in a dynamic concept? Should the Treaty provide for a general derogation clause for social security and if so, how to define “social security”? Must the answer rather be found in secondary legislation? Could e.g. a consensus be reached on a European legislative framework on standards for health care as a service of general economic interest, in which common values are laid down and thus legal safeguards as to solidarity,

equality, accessibility, affordability, etc..., would become a part of Community law? Would that be conducive to the recognition of basic health insurance as a service of general economic interest and reduce the vagueness surrounding the regulatory environment of the institutions administering these schemes? Expressing this kind of considerations could be building castles in the air, but touching on emanations of the legal uncertainty regarding the relation between national health care policies and the EU internal market and competition policies, there is a strong case for these issues to be sorted out within the scope for policymaking of the Community. If not, the legislative powers of the Community probably condemn themselves to tail along after the case-to-case solutions of the judiciary.

Either way, whether the essential protective layer is found in art. 86(2) EC or in future legislative intervention, we argue that also basic health care insurance can be qualified as an economic activity, without being robbed of the elemental solidarity grounds it is based on. The final result probably will not differ much from the current situation, but the institutions managing health care schemes would then be put in a situation of more legal certainty, as their activities would be considered as an economic activity, to which competition law is applicable in principle, but for which clear safeguards (on the basis of Art. 86(2) EC, future primary or secondary legislation) can be provided in order to protect the fundamental principles most health protection schemes are based on. This would of course do much to the coherence of the Court's case-law concerning the scope of EC competition law too.

VI. References

- 1) *Art. 152 of the EU Treaty and II-94 and 95 of the Charter of Fundamental rights; see also article I-17 of the EU-Convention that states that the Union shall have competence to carry out "supporting co-ordinating or complementary actions" in the field of the protection and improvement of human health.*
- 2) *FERRERA, M., "European Integration and National Social Citizenship: Changing Boundaries, New Structuring?", Working Paper CIIP-3, June 1 2003; http://ies.berkeley.edu/pubs/workingpapers/CIIP-3-Changing_Boundaries_New_Structuring.pdf, see also JORENS, Y., "Towards a European Social Model in an enlarged Europe" in JORENS, Y. (ed.) , *European Social policy*, Bristol, Policy Press, to be published.*
- 3) *Conclusion Advocate General Tesouro under ECJ, Cases C-120/95, Decker ECR [1998] I-1831 and C- 158/96, Kohll, ECR [1998] I-1931, par. 22.*
- 4) *In a certain way, the concept of Common market is broader than the concept of internal market. While the internal market is dealing with the free movement of goods, persons, services and capital, common market can be described as "a market in which every participant within the Community is free to invest, produce, work, buy and sell, to supply or obtain services under conditions of competition which have not been artificially distorted wherever economic conditions are most favourable". (KAPTEYN, P.J.G. and VERLOREN VAN THEMAAT, P., "Introduction to the law of the European Communities: from Maastricht to Amsterdam", London, Kluwer law international, 1998). Common market is therefore also dealing with competition law.*
- 5) *Not all elements related to the Common market can be discussed here. The fact that pharmaceuticals and medical devices constitute goods for the purposes of Article 28 ECT and therefore are freely saleable throughout the Community, will not be treated here. This legislation is predominantly concerned with market access through harmonisation and centralised authorisation procedures [Directive 2001/83/EC and Regulation (EC) No 726/2004].*
- 6) *JORENS, Y., "The right to health care across borders", in McKEE, M. MOSSIALOS, E. and BAETEN, R., *The Impact of EU law on health care systems*, Bruxelles, Peter Lang, 2002, 120.*
- 7) *The directives relate to the mutual recognition of health care professionals' diplomas. As regards private health insurance, see Directive 1992/49/EEC on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance.*
- 8) *See COUCHEIR, M., "The legal framework in relation to patient mobility", paper prepared in the framework of the European 6th Framework Programme, Europe for patients.*
- 9) *VANDENBROUCKE, F., "Forword" in MOSSIALOS, E. and McKEE, M., *EU Law and the Social character of Health Care*, Bruxelles, Peter lang, 2002, 15.*

- 10) *KESSLER, F., "L'incidence du droit communautaire de la concurrence sur le fonctionnement des régimes de protection sociale : un bilan à partir du cas français", TSR/RDS, 1997, 250-251 ; see also JORENS, Y., "The rights of the European citizen, balancing equity with choice", "presented at 7th European Health care Forum, Gastein, Creating a Better Future for Health in Europe, Global Health Challenges, European approaches and responsibility, 6 to 9 October 2004.*
- 11) *Roughly, as the many formal and informal levels of decision-making with relation to health care matters make it very hard to assess the structure and relevance of various activities.*
- 12) *ECJ, Case C-158/96, Kohll [1998] E.C.R. I-1931; ECJ, Case C-120/95, Decker [1998] E.C.R. I-1831; ECJ, Case C-368/98, Vanbraekel [2001] ECR 5363; ECJ, Case C-157/99, Geraets-Smits / Peerbooms [2001] E.C.R. I-5473; ECJ, Case C-385/99, Müller-Fauré / Van Riet [2003] E.C.R. I-4509; ECJ, Case C-56/01, Inizan [2003] (not yet published) and ECJ, Case C-8/02, Leichtle [2004] (not yet published).*
- 13) *Recommendation 92/442/EEC of the Council of 27 July 1992 on the convergence of social protection objectives and policies, OJ L 245/49 of 26 August 1992.*
- 14) *Resolution on the Commission report to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions on "Social Protection in Europe 1997", A4-0099/99.*
- 15) *Presidency Conclusions - Lisbon European Council Meeting of 23 and 24 March 2000, see http://ue.eu.int/ueDocs/cms_Data/docs/pressData/en/ec/00100-r1.en0.htm*
- 16) *European Commission Broad Economic Policy Guidelines 1999, http://europa.eu.int/comm/economy_finance/publications/european_economy/1999/ee_gopeannex1999_en.pdf*
- 17) *Communication from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions, "The future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability", COM(2001) 723 final.*
- 18) *Presidency Conclusions - Barcelona European Council Meeting of 15 and 16 March 2002 see http://ue.eu.int/ueDocs/cms_Data/docs/pressData/en/ec/71025.pdf*
- 19) *See http://europa.eu.int/comm/employment_social/social_protection_committee/index_en.htm*
- 20) *Council Decision 2000/436/EC of 29 June 2000 setting up a Social Protection Committee OJ L 172/26 of 12 July 2000.*
- 21) *See http://europa.eu.int/comm/employment_social/employment_strategy/emco_en.htm*
- 22) *See http://europa.eu.int/comm/economy_finance/epc/epc_en.htm*
- 23) *Presidency Conclusions - Göteborg European Council Meeting of 15 and 16 June 2001 see http://ue.eu.int/ueDocs/cms_Data/docs/pressData/en/ec/00200-r1.en1.pdf*

- 24) *Communication from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions, "The future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability", COM(2001) 723 final.*
- 25) *Presidency Conclusions - Barcelona European Council Meeting of 15 and 16 March 2002 see http://ue.eu.int/ueDocs/cms_Data/docs/pressData/en/ec/71025.pdf*
- 26) *See http://europa.eu.int/comm/employment_social/social_protection/docs/questionnaire1_en.pdf*
- 27) *See http://www.cc.cec/sg_vista/cgi-bin/repository/getdoc.cgi?full_file_name=CONS_PDF_CS_2003_07166_1_EN.pdf*
- 28) *Presidency Conclusions - Brussels European Council Meeting of 20 and 21 March 2003 see http://ue.eu.int/ueDocs/cms_Data/docs/pressData/en/ec/75136.pdf*
- 29) *See <http://europa.eu.int/eur-lex/pri/en/oj/dat/2004/ce038/ce03820040212en02690277.pdf>*
- 30) *The High Level Group on Health Services and Medical Care is a Group instituted in the health area to facilitate cooperation among the Member States on health services and medical care, see Draft Commission Decision setting up a High Level Group on Health Services and Medical Care, C(2004) 1501 of 16/04/2004.*
- 31) *See <http://www.ose.be/health/default.htm>*
- 32) *See http://europa.eu.int/comm/health/ph_information/implement/wp/systems/docs/ev_20040325_rd01_en.pdf*
- 33) *Communication from the Commission - Follow up to the high level reflection process on patient mobility and health care developments in the European Union, Brussels, 20 April 2004, COM(2004) 301 final.*
- 34) *Communication from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions - e-Health - making healthcare better for European citizens: An action plan for a European e-Health area, Brussels, 30 April 2004, COM(2004) 356.*
- 35) *Proposal for a Directive of the Council and the European Parliament on services in the internal market, Brussels, 5 March 2004, COM(2004) 2.*
- 36) *Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems OJ L 166/1 of 30 April 2004.*
- 37) *See http://europa.eu.int/comm/health/ph_overview/health_forum/health_forum_en.htm*
- 38) *See http://europa.eu.int/comm/health/ph_overview/health_forum/open_forum_en.htm*

- 39) *The current wording of this provision results from a restrictive amendment adopted in the aftermath of the Pierik cases, in which the Court of Justice had granted patients a nearly unrestricted right to obtain health care in another Member State at the expense of their social security institution. See Case C-117/77 Pierik I [1978] ECR 825 and Case C-182/87 Pierik II [1979] ECR 1977.*
- 40) *Case C-158/96 Kohll [1998] ECR 1931.*
- 41) *ECJ, Case C-157/99 Geraets-Smits and Peerbooms [2001] ECR 5473; Case C-385/99 Müller-Fauré and Van Riet [2003] ECR 4509.*
- 42) *In this paper, the terms "hospital care", "intramural care" and "inpatient care" will be used as synonyms.*
- 43) *Consider the Court's divergent approach in examining the grounds for justification in respect of the two types of care. Concerning extramural care, the Court refers to concrete elements (linguistic and geographical barriers, the fact that outpatient care is generally provided near the place the patient resides) to minimize the financial impact of patient mobility. Although these arguments hold true also in relation to intramural care, they are not mentioned in the paragraphs concerning intramural care. There, the relationship between free movement of services and hospital care is treated in an abstract manner: hospital care is expensive and its financing could suffer if patients were to move freely abroad. The Court does not examine the likeliness of this "freely moving" actually occurring. According to VAN DE GRONDEN and MORTELMANS, an explanation for this different approach can be found in the word "risk", figuring in the rule of reason exemption "the risk of seriously undermining the financial balance of the social security system". In this regard, two different risks can be identified. There is the risk related to the functioning of the health care system in the event of large "health care movements" and there is the risk of large numbers of patients making use of the possibility to obtain health care in another Member State. The first risk is more abstract whilst the second is rather concrete. It is plausible that the ECJ, in the case of intramural care, appraises the abstract risk more seriously; problems stemming from a disruption of precious and vital hospital care may be far more difficult to resolve than problems in the provision of outpatient care. Because of these "abstract intramural problems", the Court did not proceed with its investigation. For extramural care, on the contrary, the Court did dare to go into the concrete consequences, but these were found not to justify the restrictive national rules at issue: see J. W. VAN DE GRONDEN and K.J.M. MORTELMANS, annotation Case C-385/99 Müller-Fauré and Van Riet [2003], Tijdschrift voor Europees en Economisch Recht 2003, 276.*
- 44) *These judgments will henceforth be referred to as "the health care cases".*
- 45) *ECJ, Case C-158/96, Kohll [1998] E.C.R. I-1931, par. 26.*
- 46) *ECJ, Case C-158/96, Kohll [1998] E.C.R. I-1931, par. 27.*
- 47) *ECJ, Case C-56/01, Inizan [2003] not yet published.*
- 48) *Opinion ECJ, Case C-56/01, Inizan [2003] (not yet published), par. 27-33.*

- 49) ECJ, Case C-56/01, *Inizan* [2003] (not yet published), par. 21-22. See also ECJ, Case C-368/98, *Vanbraekel* [2001] ECR 5363, par. 32.
- 50) ECJ, Case C-56/01, *Inizan* [2003] (not yet published), par. 23.
- 51) PALM, W., NICKLESS, J., LEWALLE, H., and COHEUR, A., "Implications of recent jurisprudence on the co-ordination of health care protection systems", *General Report produced for the Directorate-General for Employment and Social Affairs of the European Commission, Brussels, AIM, 2000, 137*; JORENS, Y., "Impact van de meest recente rechtspraak van het Europees Hof van Justitie inzake de invloed van de regelen inzake interne markt op de nationale gezondheidssystemen, met name de arresten die werden geveld na december 2001: de zaken Müller-Fauré-Van Riet, *Inizan* and *Leichtle*", *Belgisch Tijdschrift voor Sociale Zekerheid, 2004, 392*. Contra: V. HATZOPOULOS, "Killing national health and insurance systems but healing patients? The European market for health care services after the judgments in of the ECJ in *Vanbraekel* and *Peerbooms*", *Common Market Law Review, 2002, 703*, who contends that Article 22 of the Regulation is a *lex specialis* in relation to the Treaty rules and that it should be applied by preference when the relevant conditions are met.
- 52) Amply criticised in doctrine, see inter alia KESSLER, F., and LHERNOULD, J.-P., "L'impact sur le droit de la protection sociale de la jurisprudence de la CJCE relative à la libre prestation de services", *Droit Social 2002, 751*; CABRAL, P., "Cross-border medical care in the European Union - bringing down a first wall", *European Law Review, 1999, 393*.
- 53) Cf. CABRAL, P., "The internal market and the right to cross-border medical care", *European Law Review, 2004, 679*. See also FOUBERT, P., "Vrije medische dienstverlening in de rechtspraak van het Hof van Justitie", annotation ECJ, Case C-56/01, *Inizan* [2003], *Tijdschrift voor Europees en Economisch Recht, 2003, 394*.
- 54) CABRAL, P., "Cross-border medical care in the European Union - bringing down a first wall", *European Law Review, 1999, 393*.
- 55) PALM, W., NICKLESS, J., DEWALLE, H., and COHEUR, A., "Implications of recent jurisprudence on the co-ordination of health care protection systems", *General Report produced for the Directorate-General for Employment and Social Affairs of the European Commission, Brussels, AIM, 2000, 135*. See also DOUGAN, M. and SPAVENTA, E., who refer to what is happening as a consequence of the direct effect of Article 18 ECT, which has been interpreted as expanding rather than challenge the residency directives, and find a connection with the matter under discussion. The same *modus operandi* applies: Community secondary legislation is re-interpreted according to the demands of primary law: "Educating Rudy and the non-English Patient: a Double Bill on Residency Rights under Article 18 EC", *European Law Review, 2003, 704-705*.
- 56) ECJ, Case C-90/92, *Dr Tretter* [1993] ECR 3596, par. 11; ECJ, Case C-61/94, *Commission v. Germany* [1996] ECR 3989, par. 52.

- 57) VAN RAEPENBUSCH, S., "La libre choix par les citoyens européens des produits médicaux et des prestataires de soins, conséquence sociale du marché intérieur", annotation Cases C-120/95 Decker [1998] and C-158/96 Kohll [1998], *Cahiers de droit européen* 1998, 689-690. This author refers to ECJ, Case C-1/85 Miethé [1986] (ECR 1837), in which the Court construed Article 71 (1) (a) of Regulation 1408/71 imperatively, stating that "a wholly unemployed frontier worker who comes within the scope of that provision may claim benefits only from the Member State in which he resides even though he fulfils the conditions for entitlement to benefits laid down by the legislation of the Member State in which he was last employed" (operative part of the judgment, emphasis added) (see also par. 11).
- 58) ECJ, Case C-56/01, *Inizan* [2003] (not yet published), par. 21.
- 59) On the understanding that the competent institution, in that case, is never obliged to grant the authorisation.
- 60) DAVIES, G., "Health and Efficiency: Community Law and National Health Systems in the Light of Müller-Fauré", *Modern Law Review*, 2004, 101.
- 61) Opinion ECJ, Case C-56/01, *Inizan* [2003] (not yet published), par. 30 (present author's translation).
- 62) ECJ, Case C-368/98, *Vanbraekel* [2001] ECR 5363.
- 63) To be precise, authorisation had been initially refused but that refusal had later been reversed. However, the ECJ treated this judicial authorisation a posteriori as a proper authorisation within the meaning of Article 22 (1) (c) of Regulation 1408/71.
- 64) Case C-368/98, *Vanbraekel* [2001] ECR 5363, par. 37.
- 65) Case C-368/98, *Vanbraekel* [2001] ECR 5363, par. 38 e.s.
- 66) It is to be recalled that the requirement of prior authorisation for the reimbursement of the costs of extramural care incurred in another Member State, constitutes an unjustified restriction to the free provision of services.
- 67) By foreign providers, we mean providers established in another Member State than that of the patient's affiliation, irrespective of their (Community) nationality. The term "domestic providers" will be used to indicate providers established in the Member State of affiliation of the patient.
- 68) Cf. Case C-368/98, *Vanbraekel* [2001] ECR 5363, par. 45.
- 69) One could object that a well-informed patient wishing to obtain extramural care in another Member State will make use of the Regulation-based method, and thus apply for authorization, only when this procedure proves more beneficial to his situation. However, that is not the issue here. The fact of the matter is that if a Community citizen appeals to an imperative legal provision of secondary legislation, he may find the rights conferred upon him directly by the Treaty being infringed.
- 70) CORNELISSEN, R., "The principle of territoriality and the Community Regulations on social security (Regulations 1408/71 and 574/72)", *Common Market Law Review*, 1996, 464.

- 71) ECJ, Case C-56/01, *Inizan* [2003] (not yet published), par. 43 and 45. Cf. ECJ, Case C-157/99, *Geraets-Smits / Peerbooms* [2001] E.C.R. I-5473, par. 103 as well as Case C-385/99 *Müller-Fauré and Van Riet* [2003] ECR 4509, par. 89.
- 72) ECJ, Case C-56/01, *Inizan* [2003] (not yet published), par. 46. Cf. ECJ, Case C-157/99, *Geraets-Smits / Peerbooms* [2001] E.C.R. I-5473, par. 104 as well as Case C-385/99 *Müller-Fauré and Van Riet* [2003] ECR 4509, par. 90.
- 73) Official Journal L 166 of 30 April 2004. On this Regulation, see PIGEON, C., "Reforms in the coordination of social security systems for people who move within the European Union", Oslo, 21-23 April 2004, International Social Security Association, 12 p.
- 74) ECJ, Case C-56/01, *Inizan* [2003] (not yet published), par. 48. Cf. ECJ, Case C-157/99, *Geraets-Smits / Peerbooms* [2001] E.C.R. I-5473, par. 90 as well as Case C-385/99 *Müller-Fauré and Van Riet* [2003] ECR 4509, par. 85. See also ECJ, Case C-56/01, *Inizan* [2003] (not yet published) par. 49.
- 75) In actual fact, these requirements reflect "a general principle of Community law which underlies the constitutional traditions common to the Member States" and which has been "enshrined in Articles 6 and 13 of the European Convention for the Protection of Human Rights and Fundamental Freedoms": ECJ, Case C-222/86, *Heylens* [1987] ECR 4097, par. 14.
- 76) See footnote 78.
- 77) As mentioned *supra*, the Articles on the free provision of services cannot be relied upon to obtain treatment in another Member State at the expense of the institution of the Member State of affiliation where that treatment is not among the benefits covered by the legislation of that Member State.
- 78) Admittedly, the fusion between the two methods can never be perfect. For one thing under the former method, patients have a freer choice as to the foreign institution in which they wish to be treated.
- 79) It can be questioned whether the circumstance that the patient under the Regulation-based method does not have to prepay the treatment suffices to make up such value added. The same can be said in respect of more beneficial conditions for the granting of treatments.
- 80) Explanatory note from the Commission services, annexed to Document 11570/04 of the Council, Brussels, 16 July 2004, 2.
- 81) Explanatory note from the Commission services, annexed to Document No 11570/04 of the Council, Brussels, 16 July 2004.
- 82) Annexed to Document No 5161/05 of the Council, Brussels, 10 January 2005.
- 83) The initial Commission proposal provides that "Member States shall ensure that authorisation for assumption by their social security system of the cost of hospital care provided in another Member State is not refused where the treatment in question is among the benefits provided for by the legislation of the Member State of affiliation and where such

treatment cannot be given to the patient within a time frame which is medically acceptable in the light of the patient's current state of health and the probable course of the illness". This phrase largely corresponds to Article 20 of Regulation (EC) No 883/2004. The textual difference between the terms "medically acceptable" and "medically justifiable", figuring in the new Regulation, is most probably immaterial. Note however the peculiar disappearance, in both instruments, of the reference to the patient's medical history, to be found in the Court's case law. Instead, the legislative instruments contain a relegation to the "probable course" of the patient's illness. See PALM, W., "La Cour de Justice européenne et la mobilité des patients: un nouveau pas franchi", *Revue Médicale de l'Assurance Maladie*, 2003, 179.

- 84) Pursuant to the current text of the Draft services directive, the conditions on which benefits are granted will always be determined by the legislation of the Member State of treatment, even if application of the legislation of the Member State of affiliation would be more advantageous to the patient in this particular regard.
- 85) Accordingly, in the present author's view, it would be erroneous to say that the Commission has extended the Vanbraekel case law to extramural care, as some commentators do. See e.g. GEKIERE, W., "Towards a European Directive on Services in the Internal Market: Analysing the legal repercussions on the draft Services Directive and its impact on national services regulations", Research Report commissioned by A. VAN LANCKER (MEP), Leuven, 24 September 2004, 29.
- 86) Para. 107: "[...] nothing precludes a competent Member State with a benefits in kind system from fixing the amounts of reimbursement which patients who have received care in another Member State can claim, provided that those amounts are based on objective, non-discriminatory and transparent criteria.
- 87) GEKIERE, W., "Towards a European Directive on Services in the Internal Market: Analysing the legal repercussions on the draft Services Directive and its impact on national services regulations", Research Report commissioned by A. VAN LANCKER (MEP), Leuven, 24 September 2004, 29; Association Internationale de la Mutualité (AIM), Position Paper on the Proposal for a Directive on services in the internal market, Nice, 11 October 2004, 5.
- 88) GEKIERE, W., "Towards a European Directive on Services in the Internal Market: Analysing the legal repercussions on the draft Services Directive and its impact on national services regulations", Research Report commissioned by A. VAN LANCKER (MEP), Leuven, 24 September 2004, 29; Association Internationale de la Mutualité (AIM), Position Paper on the Proposal for a Directive on services in the internal market, Nice, 11 October 2004, 5.
- 89) Cf. the explanatory note from the Commission services, annexed to Document 11570/04 of the Council, Brussels, 16 July 2004, 9.
- 90) E.g. JORENS, Y., note under ECJ, Case C-56/01, *Inizan*, *Rev.dr.San.*, 2004, ... See also Umbrella Organisations representing the German Social Security System, "Joint Position Paper of the on the Proposal for a Directive on services in the internal market", Brussels, April 2004, 4.

- 91) *DRIJBER, B.J., "De bezems van Bolkestein", Nederlands Tijdschrift voor Europees Recht, 2004, 119.*
- 92) *Case C-385/99 Müller-Fauré and Van Riet [2003] ECR 4509, par. 75.*
- 93) *FLEAR, M., "annotation ECJ, Case C-385/99, Müller-Fauré and Van Riet [2003]", Common Market Law Review, 2004, 223 e.s.*
- 94) *Explanatory note from the Commission services, annexed to Document 11570/04 of the Council, Brussels, 16 July 2004, 5. See also the definition proposed by the Dutch Centrale Raad van Beroep, according to which a treatment can only be classed as intramural when, according to international medical standards, it comprises a stay in the hospital of at least one night: ECJ, Case 97/10642, ZFW Van Riet [2004]. Consider also the definition proposed by the Standing Committee of European Doctors (CPME) in its Position Paper on the Proposal for a Directive on services in the internal market (CPME 2004/148 Final, Göteborg, 12 November 2004): "medical care under the supervision and responsibility of medical doctor(s) and provided in specific facilities where medical surveillance is available 24h/day and which normally requires accommodation in the facility".*
- 95) *Explanatory note from the Commission services, annexed to Document 11570/04 of the Council, Brussels, 16 July 2004, 5.*
- 96) *FLEAR, M., "annotation ECJ, Case C-385/99, Müller-Fauré and Van Riet [2003]", Common Market Law Review, 2004, 224.*
- 97) *DAVIES, G., "Health and Efficiency: Community Law and National Health Systems in the Light of Müller-Fauré", Modern Law Review, 2004, 103.*
- 98) *Explanatory note from the Commission services, annexed to Document 11570/04 of the Council, Brussels, 16 July 2004, 5. See also VAN DER STEEN, I., "Vergoeding van extramurale zorg in een andere lidstaat: geen ziekenfondstoestemming vooraf?", Nederlands Tijdschrift voor Europees Recht 2003, 277; Umbrella Organisations representing the German Social Security System, Joint Position Paper of the on the Proposal for a Directive on services in the internal market, Brussels, April 2004, 3.*
- 99) *DAVIES, G., "Health and Efficiency: Community Law and National Health Systems in the Light of Müller-Fauré", Modern Law Review, 2004, 103.*
- 100) *College voor Zorgverzekeringen, Tweede aanvullende circulaire inzake arrest Müller-Fauré en Van Riet n.a.v. uitspraken Centrale Raad van Beroep d.d. 18 juni 2004, Circular No 04/45, Diemen, 1 September 2004.*
- 101) *Article 20 of Regulation (EC) No 883/2004.*
- 102) *Position of the European Parliament adopted at first reading on 3 September 2003 with a view to the adoption of European Parliament and Council Regulation (EC) No .../2003 on coordination of social security systems, Official Journal C 76 E of 25 March 2004, 190.*
- 103) *European Commission, Amended proposal for a Regulation of the European Parliament and of the Council on coordination of social security systems, Brussels, 9 October 2003, COM(2003) 596 final, 4.*

- 104) *Communication from the Commission to the European Parliament pursuant to the second subparagraph of Article 251(2) of the EC Treaty concerning the common position of the Council on the adoption of a Regulation of the European Parliament and the Council on the coordination of social security systems, COM(2004) 44 final, Brussels, 27 January 2004, 5.*
- 105) *Brussels, 14 January 2003, Document No 15577/03 ADD 1.*
- 106) *The Member State where the services are provided will be referred to as the host Member State. The term "home Member State" or "Member State of establishment" will be used to indicate the Member State in which the service provider is established.*
- 107) *BAETEN, R., "The proposal for a Directive on services in the Internal Market applied to Healthcare Services", Paper presented for the public hearing in the European Parliament, 11 November 2004, 2.*
- 108) *Official Journal L 165 of 7 July 1993.*
- 109) *In early 2002, the Commission published a Proposal for a Directive on the recognition of professional qualifications [COM(2002)119 final]. Following the first reading of the Proposal by the European Parliament, an amended Proposal was adopted by the Commission [COM(2004)317 final], on the basis of which a political agreement was reached by the Council on 18 May 2004. This political agreement has been incorporated in the Common Position. The European Parliament must complete the second reading three months - and at most four months - from the date of the common position (Article 251 ECT).*
- 110) *ECJ, Case C-294/00, Gräbner [2002] ECR 6515.*
- 111) *"[The service provider] shall provide services with the same rights and obligations as the nationals of the host Member State; in particular, he shall be subject to the rules of conduct [dispositions disciplinaires] of a professional or administrative nature which apply in that Member State".*
- 112) *Brussels, 21 December 2004, Doc No 13781/2/04 REV 2 ADD 1, 6.*
- 113) *"The guarantee conferred by this Directive on persons having acquired their professional qualifications in a Member State to have access to the same profession and pursue it in another Member State with the same rights as nationals is without prejudice to compliance by the migrant professional with any nondiscriminatory conditions of pursuit which might be laid down by the latter Member State, provided that these are objectively justified and proportionate" (emphasis added).*
- 114) *ECJ, Case C-232/99, Commission v. Spain [2002] ECR 4235, par. 52.*
- 115) *If the draft Directive on services in the internal market were to become law, it would become the frame of reference for the free provision of services - including medical services - as its coordinated field extends to "any requirement applicable to access to service activities or to the exercise thereof": Article 4, 9° of the Proposal (not revised).*
- 116) *SPAVENTA, E., "From Gebhard to Carpenter: Towards a (non-)economic European constitution", Common Market Law Review, 2004, 748.*

- 117) *The situation is entirely different for the beneficiaries of the free movement of workers and the right of establishment. Unlike service providers, these persons enter into a much closer relation with the host Member State and cease - for most purposes - to be regulated by their home Member State. Hence, if for providers of services, national treatment by the host Member State might entail duplications of conditions already fulfilled, for the migrant workers (employed or self-employed), it simply makes sure that they comply with the conditions of some State. See HATZOPOULOS, V., "annotation ECJ, Case C-250/95, Futura Participations [1997]", *Common Market Law Review*, 1998, 504.*
- 118) ECJ, Case C-279/80, Webb [1981] ECR 3305, par. 16.
- 119) ECJ, Case C-76/90, Säger [1991] ECR 4221. Amply confirmed in subsequent rulings, e.g. ECJ, Case C-390/99, Canal Satélite Digital [2002] ECR 607.
- 120) HATZOPOULOS, V., "Le principe communautaire d'équivalence et de reconnaissance mutuelle dans la libre prestation de services", Brussels, Bruylant, 1999, 192-193. Note however that some authors approach the imposition of double regulatory burdens on service providers as a matter of indirect discrimination.
- 121) ECJ, Case C-76/90, Säger [1991] ECR 4221, par. 13.
- 122) ECJ, Case C-76/90, Säger [1991] ECR 4221, par. 12.
- 123) DANIELE, L., "Non-discriminatory Restrictions to the Free Movement of Persons", *European Law Review*, 1997, 195-196.
- 124) HATZOPOULOS, V., "Le principe communautaire d'équivalence et de reconnaissance mutuelle dans la libre prestation de services", Brussels, Bruylant, 1999, 192-193.
- 125) DANIELE, L., "Non-discriminatory Restrictions to the Free Movement of Persons", *European Law Review*, 1997, 196.
- 126) HATZOPOULOS, V., "Le principe communautaire d'équivalence et de reconnaissance mutuelle dans la libre prestation de services", Brussels, Bruylant, 1999, 167, 197 and 315 e.s.
- 127) Hence, rather than being a creation of the Community legislature, the country of origin principle stems from the Court's interpretation of the fundamental freedoms contained in the ECT. However, it is not laid down by the Treaty, and the Community legislature can depart from it, cf. ECJ, Case C-233/94, Germany v. European Parliament and Council [1997] ECR 2405, par. 64.
- 128) ECJ, Cases C-286/82, Luisi and Carbone [1984] ECR 377.
- 129) ECJ, Case C-159/90, Grogan [1991] ECR 4685.
- 130) This relationship is a non-economic one. This can be inferred from a series of cases on the applicability of the competition rules to bodies governing statutory social security schemes. On these cases, see further part II of the present report.
- 131) ECJ, Case C-157/99, Geraets-Smits / Peerbooms [2001] E.C.R. I-5473, par. 58.

- 132) ECJ, Case C-157/99, *Geraets-Smits / Peerbooms* [2001] E.C.R. I-5473, par. 55 and ECJ, Case C-385/99, *Müller-Fauré / Van Riet* [2003] E.C.R. I-4509, par. 39.
- 133) Indeed, proving that the financial balance of the health care system is at risk of being seriously undermined will be a virtually insurmountable task, given the overall approach that must be adopted in relation to the consequences of the freedom to provide health-related services: *Müller-Fauré and Van Riet*, par. 74; A.P. VAN DER MEI, "Cross-border Access to Medical Care: Non-Hospital Care and Waiting Lists, *Legal Issues of Economic Integration* 2004, 66.
- 134) FLEAR, M., "annotation ECJ, Case C-385/99, *Müller-Fauré and Van Riet* [2003]", *Common Market Law Review*, 2004, 229-230.
- 135) FERRERA, M., "European Integration and National Social Citizenship: Changing Boundaries, New Structuring?" Working Paper CIIP-3, Institute of European Studies, Comparative Immigration and Integration Program, 2003, 19. See also *Müller-Fauré and Van Riet*, par. 94.
- 136) NICKLESS, J., "Smits/Peerbooms: Clarification of Kohll and Decker?", *Eurohealth* 2001 (Vol. 7 No 4), 7-10; PALM, W., NICKLESS, J., LEWALLE, H., and COHEUR, A., "Implications of recent jurisprudence on the co-ordination of health care protection systems", General Report produced for the Directorate-General for Employment and Social Affairs of the European Commission, Brussels, AIM, 2000, 126 e.s.; DE CORTAZAR, C.G., "Kohll and Decker, or That is Somebody Else's Problem. The Challenge facing Spain", *European Journal of Health Law*, 1999, 398-399. See also DAVIES, G., "Welfare as a service", *Legal Issues of Economic Integration* 2002, 35 e.s.; and SPAVENTA, E., "Public Services and European Law: Looking for Boundaries", in BELL, J., DASHWOOD, A., SPENCER, J. and WARD, A. (eds.), *The Cambridge Yearbook of European Legal Studies*. Volume 5, 2002-2003, Oxford - Portland, Hart Publishing, 2004, 284 e.s. SPAVENTA submits that, the relevant relationship being that between the patients and the funds, the patients were relying on the duties the funds bore towards them - duties which cannot be defined as arising from an economic relationship. She contends that it is only when national law recognises a right to be treated outside the pre-organised structure that Article 49 ECT should become of relevance. She acknowledges that this interpretation is not entirely consistent with the Court's rulings.
- 137) Indeed, *Geraets-Smits and Peerbooms* did not exclude the possibility that the authorisation requirement for non-hospital care could be justified when applied within the framework of contract systems such as the one existing in the Netherlands: PALM, W., , "La Cour de Justice européenne et la mobilité des patients: un nouveau pas franchi", *Revue Médicale de l'Assurance Maladie*, 2003, 178; VAN DE GRONDEN, W., and MORTELMANS, K.J.M., annotation Case C-385/99 *Müller-Fauré and Van Riet* [2003], *Tijdschrift voor Europees en Economisch Recht* 2003, 273. See in particular its par. 81. *Müller-Fauré and Van Riet* made abundantly clear that is the aspect of hospital planning which is decisive in this regard.

- 138) *Comp. KIEFFE, R R., "Quelques réflexions sur la nature des prestations hospitalières au Luxembourg et sur la justification de l'autorisation préalable pour les transferts à l'étranger", Bulletin luxembourgeois des questions sociales, 2001, 10 e.s.*
- 139) *ECJ, Case C-157/99, Geraets-Smits / Peerbooms [2001] E.C.R. I-5473, par. 66.*
- 140) *ECJ, Case C-157/99, Geraets-Smits / Peerbooms [2001] E.C.R. I-5473, par. 67. See also ECJ, Case C-385/99, Müller-Fauré / Van Riet [2003] E.C.R. I-4509, par. 43.*
- 141) *This holds true in particular for the Luxembourg system, under which authorisation to practice medicine cannot be detached from accession to the collective agreement with the Union des Caisses de Maladie (UCM).*
- 142) *The Austrian example is sometimes cited - mistakenly, in our view - as an example of a potentially Euro-compatible solution. Under that system, health care provided by non-contracted providers is reimbursed up to 80% of the rate applicable to contracted providers. For the reasons mentioned above, we do not believe that application of this level of cover to the services of foreign providers would be consistent with the Treaty. For one thing, what about Member States that do not cover health care provided by non-contracted providers, such as Luxembourg? To be sure, for not to annihilate patient mobility, these Member States ought to establish a tariff. But which one? Why would 80% be acceptable and 35%, for the sake of argument, not? What would refrain Member States from laying down reimbursement tariffs which are altogether negligible, such as the French tarif d'autorité?*
- 143) *Cf. PALM, W., NICKLESS, J., LEWALLE, H., and COHEUR, A., "Implications of recent jurisprudence on the co-ordination of health care protection systems", General Report produced for the Directorate-General for Employment and Social Affairs of the European Commission, Brussels, AIM, 2000, 125 e.s.*
- 144) *Discussions were held, at the end of which it was decided to maintain the compulsory contracting system but to comply with certain subsidiary demands of the medical and dentist profession, cf. the Act of 22 July 2003, Mém.A. 2003, 2257.*
- 145) *See the argument submitted by the Dutch government and sickness fund in ECJ, Case C-385/99, Müller-Fauré / Van Riet [2003] E.C.R. I-4509, par. 49.*
- 146) *Reverse discrimination is not a target of Community law. See in this regard HATZOPOULOS, V., who writes on the perspective of a non-discriminatory assessment of conditions relating to the pursuit of an economic activity under Articles 39 and 43 EC: "[...] s'il est de jurisprudence constante de la Cour que le droit communautaire ne vise pas les discriminations à rebours, il est aussi juridiquement intenable et politiquement impensable que de prétendre que des dispositions du traité aussi fondamentales que les Articles 39 ou 43 UE, incitent et même obligent les Etats à discriminer à l'encontre de leurs propres ressortissants: si la discrimination à rebours est tolérée en tant qu'effet indésirable de l'intégration des marchés, elle ne peut pas pour autant être érigée en moyen pour la réalisation de cette intégration": ("Le principe*

communautaire d'équivalence et de reconnaissance mutuelle dans la libre prestation de services", Brussels, Bruylant, 1999, 184.)

- 147) *Proving that the financial balance of the health care system is at risk of being seriously undermined will be a virtually insurmountable task, given the overall approach that must be adopted in relation to the consequences of the freedom to provide health-related services: ECJ, Case C-385/99, Müller-Fauré / Van Riet [2003] E.C.R. I-4509, par. 74; VAN DER MEI, A.P., "Cross-border Access to Medical Care: Non-Hospital Care and Waiting Lists, Legal Issues of Economic Integration, 2004, 66.*
- 148) *See also par. 91 of ECJ, Case C-496/01, Commission v. France [2004] not yet published, stating that French legislation prohibiting sickness funds from reimbursing the costs of bio-medical analyses carried out in another Member State "de facto precludes laboratories established in another Member State from being able to provide services to insured persons established in France".*
- 149) *We believe that this serves to illustrate the relativity of the distinction between conditions relating to the exercise of an economic activity and those relating to access thereto. Indeed, the former may very well bar market access. See V. HATZOPOULOS, "Le principe communautaire d'équivalence et de reconnaissance mutuelle dans la libre prestation de services", Brussels, Bruylant, 1999, 135 footnote 257, referring to ECJ, Case C-246/80, Broekmeulen [1981] 2311. See also ECJ, Case C-442/02, CaixaBank France [2004] not yet published.*
- 150) *This view is negated nor supported by the provisions of Article 18 of the Doctor's Directive and Article 6 (b) of the Proposal for a Directive on the recognition of professional qualifications, calling for an exemption of foreign medical service providers from registration with a public social security body for the purpose of settling accounts relating to medical services with an insurance body. As mentioned supra, the Court has held in respect of the former Article that it does not seek "to eliminate all obstacles that might exist in the Member States relating to the reimbursement of the cost of medical services by an insurance body to which the doctor established in another Member State does not belong" (ECJ, Case C-232/99, Commission v. Spain [2002] ECR 4235, par. 52). Nevertheless, it could be argued that, whereas the Community legislature has deemed the mere registration with a public social security body an unreasonable obstacle to the free provision of temporary services, this would apply a fortiori in respect of a requirement to enter into agreements with a health insurance institution. On the other hand, the aforementioned provisions differentiate between insurance bodies and public social security bodies; only with the latter can there be no requirement to register. This would mean a contrario that the Doctor's Directive does not preclude registration with an insurance body as a condition for reimbursement of the cost of treatment. See the Opinion of Advocate General STIX-HACKL in Commission v. Spain, par. 98 e.s.*

- 151) Indeed, Articles 49 e.s. ECT do not affect Member States' power to determine the range of providers "internally". For instance, the Treaty Articles on the free provision of services do not preclude Member States from not reimbursing the costs of services provided by domestic non-contracted providers or from reimbursing them at a lower level than those incurred with domestic contracted providers.
- 152) See ECJ, Case C-385/99, *Müller-Fauré / Van Riet* [2003] E.C.R. I-4509, par. 98, 100 and 106.
- 153) Cf. ECJ, Case C-157/99, *Geraets-Smits / Peerbooms* [2001] E.C.R. I-5473, par. 83-99.
- 154) See e.g. ECJ, Case C-96/85, *Commission v. France* [1986] ECR 1475, declaring incompatible with Article 49 ECT French legislation requiring doctors and dental practitioners established in another Member State to cancel their enrolment or registration in that other Member State in order to be able to practise their profession in France.
- 155) See however recital 8 on the Common Position relating to the envisaged Directive on the recognition of professional qualifications.
- 156) Some contend that an obligation to observe the host Member State's tariffs stems from Article 17 of the Doctor's Directive and Articles 5 (3) and (6) (a) of the Common Position relating to the envisaged Directive on the recognition of professional qualifications: See e.g. the working document on the Proposal for a Directive on services in the internal market ("defensive points") of the Luxembourg Ministère de l'Économie et du Commerce Extérieur, 28 and 42. In our view, it is highly questionable whether such an obligation can be inferred from "automatic temporary registration with" or "pro forma membership of a professional organisation or body", so as to facilitate the application of the host Member State's "disciplinary provisions of a professional or administrative nature which are directly linked to professional qualifications".
- 157) See e.g. ECJ, Case C-158/96, *Kohll* [1998] E.C.R. I-1931, par. 50-51.
- 158) See e.g. ECJ, Case C-157/99, *Geraets-Smits / Peerbooms* [2001] E.C.R. I-5473, par. 72.
- 159) ECJ, Case C-385/99, *Müller-Fauré / Van Riet* [2003] E.C.R. I-4509, par. 99 e.s.
- 160) E.g. *Joined Cases C-369/96 and C-376/96, Arblade* [1999] ECR 8453, par. 34. Consider also par. 31 of this ruling, where the Court held that "[t]he fact that national rules are categorised as public-order legislation does not mean that they are exempt from compliance with the provisions of the Treaty".
- 161) In practice, the examination of the subjective and concrete proportionality is nested in the abstract proportionality test of the restrictive rule, see V. HATZOPOULOS, "Le principe communautaire d'équivalence et de reconnaissance mutuelle dans la libre prestation de services", Brussels, Bruylant, 1999, 167, 197 and 315 e.s.

- 162) BARNARD, C., "Fitting the remaining pieces into the goods and persons jigsaw?", *European Law Review* 2001, 57; SPAVENTA, E., "From Gebhard to Carpenter: Towards a (Non-)Economic European Constitution", *Common Market Law Review*, 2004, 763-764. See also O'LEARY, S. and FERNANDEZMARTIN, J.M., stating that "where a service is of a sensitive nature and regulation of it involves moral, ethical or social policy considerations, the obligation of determining the proportionality of national restrictive measures has either been left to national courts with little or no guidance, or left to the Member States themselves": "Judicially-Created Exceptions to the Free Provision of Services", in ANDENAS, M., and ROTH, W.-H., (eds.), "Services and Free Movement in EU Law", Oxford, Oxford University Press, 2002, 188. G. DE BURCA lists a number of factors which can usefully be kept in mind when examining the extent to which the ECJ subjects a national measure to review, *inter alia*, whether the measure relates to a nationally sensitive or ideologically contentious matter; whether it involves a complex political objective; whether there is no European-wide or internationally agreed standard; or whether, if a measure were found disproportionate, it would impose a considerable financial burden on the Member State": "The Principle of Proportionality and its Application in EC Law", *Yearbook of European Law* 1993, 111, cited in O'LEARY, S. and FERNANDEZMARTIN, J.M., "Judicially-Created Exceptions to the Free Provision of Services", in ANDENAS, M., and ROTH, W.-H., (eds.), "Services and Free Movement in EU Law", Oxford, Oxford University Press, 2002, 190-191.
- 163) ECJ, Case C-294/00, *Gräbner* [2002] ECR 6515.
- 164) ECJ, Case C-61/89, *Bouchoucha* [1990] ECR 3551 and, post-*Gebhard*, ECJ, Case C-108/96, *Mac Quen* [2001] ECR 837.
- 165) ECJ, Case C-294/00, *Gräbner* [2002] ECR 6515, par. 43.
- 166) ECJ, Case C-294/00, *Gräbner* [2002] ECR 6515, par. 46-50.
- 167) In that regard, the status of the foreign medical service provider in the Member State of establishment may be relevant. Indeed, the host Member State may find it more difficult to impose its rules on foreign doctors who are contracted in the home Member State, as opposed to foreign doctors who are not. More generally, one can wonder whether Article 49 ECT can be relied upon by a private doctor, whose services do not give rise to a financial intervention of the health insurance scheme of the home Member State, to claim assumption by the health insurance scheme of the host Member State of the cost of the services he provides in that State. The health care cases do not seem to lend support for an answer in the negative.
- 168) Revised version.
- 169) Article 16 § 1.
- 170) Article 4, 9° and recital 21.
- 171) Article 16, § 2.
- 172) To foster trust in the country of origin principle, mutual assistance procedures between the Member States are provided for in the Draft services directive (Articles 35-37), in addition to provisions on the quality

of services (Articles 26-33) and accompanying measures to encourage self-regulation by the providers (Article 39).

173) This addition does not appear in the initial Commission Proposal.

174) Recital 47a does not occur in the initial Commission Proposal.

175) B.J. DRIJBER, "De bezems van Bolkestein", *Nederlands Tijdschrift voor Europees Recht*, 2004., 118.

176) See B.J. DRIJBER, "De bezems van Bolkestein", *Nederlands Tijdschrift voor Europees Recht*, 2004, 118", who states that Article 16 § 3, read in conjunction with Articles 19 jo. 37, may fall foul of the Treaty.

177) Cf. *supra* and § 35 of the Opinion of Advocate General Kokott in Case C-189/03 *Commission v. the Netherlands* [2004], not yet published.

178) B.J. DRIJBER, "De bezems van Bolkestein", *Nederlands Tijdschrift voor Europees Recht*, 2004.

179) Cf. K. ARMSTRONG, "Mutual Recognition", in C. BARNARD and J. SCOTT (eds.), *The Law of the Single European Market. Unpacking the Premises*, Oxford, Hart Publishing, 2002, 228-230, borrowing from P. MADURO's models of market integration.

180) *Ibid.*, 229-230.

181) One can wonder whether the temporary provision of cross-border medical services should at all be encouraged. Many health services indeed require an establishment in the Member State where the service is provided (cf. recital 47a of the revised Proposal) and the temporary and occasional nature of the health care provided seems at odds with the present trend towards integrated care and care programmes.

182) Cf. FEIDER, J.-M. et al., "L'assurance dépendance", *Bulletin luxembourgeois des questions sociales*, 1999, 126.

183) Assisting the dependent person in tasks of a domestic nature, in personal hygiene, nutrition, mobility etc.

184) Pursuant to Article 1 of the Act of 8 September 1998 (*loi du 8 septembre 1998, réglant les relations entre l'état et les organismes oeuvrant dans les domaines social, familial et thérapeutique*, *Mém.A.* 1998, 1600).

185) E.g. *règlement grand-ducal du 8 décembre 1999 concernant l'agrément à accorder aux gestionnaires de services pour personnes âgées*, *Mém.A.* 1999, 2622).

186) Article 393 of the Social Insurance Code (*Codes des Assurances Sociales*).

187) Using either a geographic, an age-based or a pathology-based criterion.

188) ECJ, Case C-70/95, *Sodemare* [1997] ECR 3395, par. 24 (implicitly).

189) ECJ, Case C-131/01, *Commission v. Italy* [2003] ECR 1659, par. 23.

190) ECJ, Case C-55/94, *Gebhard* [1995] ECR 4165, par. 25-27.

191) ECJ, Case C-215/01, *Schnitzer* [2003] not yet published, par. 30-31; ECJ, Case C-171/02, *Commission v. Portugal* [2004] not yet published, par. 26.

- 192) Cf. par. 33 of the Opinion of Advocate General Léger in ECJ, Case C-131/01, *Commission v. Italy* [2003] ECR 1659.
- 193) Cf. ECJ, Case C-33/74, *Van Binsbergen* [1974] ECR 1299; ECJ, Case C-205/84, *Commission v. Germany* [1986] ECR 3755. See also W.-H. ROTH, "The European Court of Justice's Case Law on Freedom to Provide Services: Is Keck Relevant?", in M. ANDENAS and W.-H. ROTH (eds.), *Services and Free Movement in EU Law*, Oxford, Oxford University Press, 2002, 20.
- 194) Cf. J. MOTA CAMPOS, cited in par. 22 of the Opinion of Advocate General Mischo in ECJ, Case C-215/01, *Schnitzer* [2003] not yet published.
- 195) Workforce shortages constitute indeed a problem with which aid and care networks are faced, see IGSS (*Inspection générale de la sécurité sociale*), *Rapport sur le système des soins de santé et des soins de longue durée*, 11 September 2002, 9-10, http://europa.eu.int/comm/employment_social/socprot/healthcare/lux_healthreply_fr.pdf
- 196) On the understanding that market access in casu implies that the dependent person should not be put at a disadvantage for the sole reason of having applied to the services of a foreign provider, in particular in respect of the level of coverage: see *supra* and ECJ, Case C-496/01, *Commission v. France* [2004] not yet published, par. 91.
- 197) ECJ, Case C-70/95, *Sodemare* [1997] ECR 3395, par. 28-29 and 33.
- 198) ECJ, Case C-70/95, *Sodemare* [1997] ECR 3395, par. 34.
- 199) V. HATZOPOULOS, "Killing national health and insurance systems but healing patients? The European market for health care services after the judgments in of the ECJ, in Vanbraekel and Peerbooms", *Common Market Law Review*, 2002, 721.
- 200) However, the national measure at issue may well have been indirectly discriminatory, as argued by Advocate General Fennelly. Moreover, it was clearly liable to act as a hindrance to market access.
- 201) In any case, a *prima facie* exception, based on social solidarity, to the application of the common market rules, such as the Court has implemented in cases where claimants challenged the exclusive rights granted to bodies governing statutory social security schemes, does not seem warranted in relation to the mobility of providers of social and health care. See COUCHEIR, M., "Gezondheidszorgverstrekking als economische activiteit in de zin van het EG-verdrag: over gevrijwaarde solidariteit en (semi-)territorialiteit", forthcoming in *Tijdschrift voor Sociaal Recht*, 2005.
- 202) *Ministère de la Sécurité Sociale, Aperçu sur la législation de la sécurité sociale*, Luxembourg, 2003.
- 203) IGSS, *Rapport sur le système des soins de santé et des soins de longue durée*, 11 September 2002, 18, http://europa.eu.int/comm/employment_social/soc-prot/healthcare/lux_healthreply_fr.pdf
- 204) E.g. ECJ, Case C-58/98, *Corsten* [2000] ECR 7919, par. 35.

- 205) V. HATZOPOULOS, "Le principe communautaire d'équivalence et de reconnaissance mutuelle dans la libre prestation de services", Brussels, Bruylant, 1999, 71. See also GAVIES, G., "Nationality Discrimination in the European Internal Market", The Hague, Kluwer Law International, 2003, 41 e.s., who writes that "[t]ypically, national rules have a purpose, but they do not express it directly, instead translating it into specific requirements [...] Obviously, in doing so they entrench one particular way of achieving the end they desire, at the expense of excluding others" (at 50).
- 206) ECJ, Case, C-496/01 *Commission v. France* [2004] not yet published, par. 70.
- 207) Cf. ECJ, Case, C-496/01 *Commission v. France* [2004] not yet published, par. 71.
- 208) Apparently, such an obligation does not ensue from Luxembourg legislation.
- 209) E.g. ECJ, Case C-439/99, *Commission v. Italy* [2002] ECR 305, par. 30.
- 210) Comp. ECJ, Case C-351/90, *Commission v. Luxembourg* [1992] ECR 3945, par. 20 e.s.
- 211) In any case, the foreign provider of home aid services will have be established near the Luxembourg borders.
- 212) Articles 354 e.s. of the Code des Assurances Sociales.
- 213) J.-M. FEIDER et al., "L'assurance dépendance", *Bulletin luxembourgeois des questions sociales*, 1999.
- 214) JORENS, Y., "Preface, Open Method of Co-ordination, objectives of European health care policy", Nomos Verlagsgesellschaft, Baden-Baden, 2003, p. 5.
- 215) See Abrahamson, P., Report written in the framework of "Special" (Social Protection in SS Europe. Convergence ? Integration, Accession and the free movement of Labour), financed under the European Fifth Framework Programme and co-ordinated by Ghent University (Belgium), in which academics out of 24 European countries were involved.
- 216) AIM, *Health Protection systems today*, Brussels, 2002, 21.
- 217) AIM, *Health Protection systems today*, Brussels, 2002, 28.
- 218) See MAARSE, H., and PAULUS, A., "Has solidarity survived ? A comparative analysis of the effect of social health insurance reform in former European countries", *Journal of Health Politics, Policy and Law*, Vol. 28, 4, 2003, 59.
- 219) See MAARSE, H., and PAULUS, A., "Has solidarity survived ? A comparative analysis of the effect of social health insurance reform in former European countries", *Journal of Health Politics, Policy and Law*, Vol. 28, 4, 2003, 596-597.
- 220) AIM, *Health Protection systems today*, Brussels, 2002, 30.
- 221) AIM, *Health Protection systems today*, Brussels, 2002, 12 and MOSSIALOS, E., and McKEE, M., *EU law and the social character of health care*, Brussels, Peter Lang, 2002, p. 27 and following.

- 222) *It is precisely the obligatory inclusion of wide categories of citizens that allows the institution to affirm itself as a powerful redistributive machine, capable of affecting the life chances of millions. Compulsory membership gives a solid institutional and financial foundation to national social policy as a key tool for redistribution. Obligatory inclusion means that risks could be shared across wide populations, with three big advantages: a less costly protection per insured, the possibility of charging 'contributions' (i.e. flat rate or proportional payments) rather than 'premiums' (i.e. payments differentiated on the basis of individual risk profiles, as in policies offered by private companies) and the possibility of granting special treatment (e.g. lower or credited contributions, or minimum benefits) to categories of disadvantaged members; see FERRERA, M., "European Integration and National Social Citizenship: Changing Boundaries, New Structuring?", Working Paper CIIP-3, June 1 2003; http://ies.berkeley.edu/pubs/workingpapers/CIIP-3-Changing_Boundaries_New_Structuring.pdf and JORENS, Y., "The rights of the European citizen, balancing equity with choice", "presented at 7th European Health care Forum, Gastein, Creating a Better Future for Health in Europe, Global Health Challenges, European approaches and responsibility, 6 to 9 October 2004.*
- 223) DUPEYROUX, J.J, "Brèves observations, en marge" *Droit Social* 1993, p 494.
- 224) *The expression public undertaking means any business over which a public authority may exercise, directly or indirectly, a dominant influence by virtue of its ownership thereof, a financial participation therein, or the articles or other rules that govern the business operations (see Directive nr. 2000/52/EC on the transparency of financial relations between member states and public undertakings, OJ, L 193/75).*
- 225) ECJ, Case 41/90, Höfner, [1991], ECR , I-1979, par. 21 and RITTER, L. and BRAUN, W.D., "European Competition Law: A Practitioner's Guide", The Hague, Kluwer Law International, 2004, 963.
- 226) CFI, Case T-305/94, T-306/94, T-307/94, T-313/94 to T-316/94, T-318/94, T-325/94, T-328/94, T-329/94 and T-335/94. Shell, [1992], ECR II-757, par. 311.
- 227) See in particular ECJ Case -41/90, Höfner, [1991], ECR , I-1979, par. 21, ECJ Joined Cases C-159/91 and C-160/91, Poucet and Pistre [1993] ECR I-637, par. 17, ECJ Case C-244/94 FFSA [1995] ECR I94 4013, par. 14 ; ECJ, Case 219/97 , Bokken, [1999], ECR, 6121, par. 67; ECJ, C-115/97 to 117/97, Brentjens, [1999], ECR, 6025, par. 77; ECJ, Case C-67/96, Albany, [1999], ECR, 5751, par. 77.
- 228) ECJ Case -41/90, Höfner, [1991], ECR , I-1979.
- 229) *Conclusions advocate general Jacobs under ECJ , Joined Cases C-264/01, C-306/01, C-354/01 and C-355/01, AOK.*
- 230) ECJ, Cases C-180/98 to 184/98 , Pavlov, [2000], ECR, 6451, par.66-67 and 82.
- 231) *As such pension funds may be undertakings, even if they are not profit making (ECJ, September 21, 1999, Albany, [1999], ECR I-5751, par. 77-87.*

- 232) WINTERSTEIN, A. "Nailing the Jellyfish" *Social Security and Competition Law*", ECLR, 1999, 3-7.
- 233) *Conclusions advocate general Mayras under ECJ, Case 2/74, Reyners, [1974], ECR, 631.*
- 234) "Taken as a whole, Eurocontrol's activities, by their nature, their aim and the rules to which they are subject, are connected with the exercise of powers relating to the control and supervision of air space which are typically those of a public authority. They are not of an economic nature justifying the application of the Treaty rules of competition" ECJ, case C-364/92, *Sat Eurocontrol*, [1994], ECR, 43, 30 see also ECJ, case 343/95, *Porto di Genova*, [1997], ECR 1547, 22.
- 235) WINTERSTEIN, A., "Nailing the Jellyfish: Social Security and Competition Law", ECLR, 1999, 326-327.
- 236) ECJ, Case 118/85, *Commission vs Italy*, [1987] ECR 2599, par. 7.
- 237) CFI, Case 82/01 P, *Aéroports de Paris*, Dec 2000, [2000], ECR II-3929, par. 112 ; A distinction must be drawn between, on the one hand, ADP's purely administrative activities, in particular supervisory activities, and, on the other hand, the management and operation of the Paris airports, which are remunerated by commercial fees which vary according to turnover.
- 238) ECJ, Case -41/90, *Höfner*, [1991], ECR, I-1979 and ECJ, case 258/98, *Carra*, [2000], ECR, 4217.
- 239) RITTER, L. and BRAUN, W.D., *European Competition Law: A Practitioner's Guide*, The Hague, Kluwer Law International, 2004, 953.
- 240) ECJ, Case *BNIC* Case (30 jan. 1985), ECR 391, ro 16 and 17.
- 241) ECJ, Case, 35/99, *Arduino*, [2002], ECR, I-1529, 39.
- 242) See e.g. ECJ, Cases 209-213/84, *Asjes*, [1986], ECR, 1425.
- 243) ECJ, *Joined cases 188 to 190/80, Transparency Directive I*, [1982], 2545, ECR, par. 21.
- 244) RITTER, L. and BRAUN, W.D., *European Competition Law: A Practitioner's Guide*, The Hague, Kluwer Law International, 2004, 961.
- 245) ECJ, Case 475/99, *Ambulanz Glöckner*, 2001, [ECR], 8089, par. 23.
- 246) ECJ, Case 320/91, *Corbeau*, [1993], ECR I-2533, par. 16-17.
- 247) VAN DE GRONDEN, J.W., *Zorg tussen lidstaat en interne markt: zorgverzekeringen, EG-recht en particulier initiatief*, Deventer, Kluwer, 2004, 38.
- 248) ECJ, Cases C-180/98 to 184/98, *Pavlov*, [2000], ECR, 6451, par. 118 and ECJ, Case C-218/00, *Cisal*, [2001], ECR, I-691, par. 37.
- 249) Solidarity can take the form of (1) an extension of the scope of a risk group; (2) risk solidarity; (3) income solidarity; (4) intergenerational solidarity and (5) inter-scheme solidarity. WINTERSTEIN, A., "Nailing the Jellyfish: Social Security and Competition Law", E.C.L.R. 1999, 328 and BOSCO, A., "Vers une remise en cause des systemes nationaux de protection sociale?", *Observations sur la jurisprudence récente de la*

Cour de Justice, page 6, See <http://www.notre-europe.asso.fr/IMG/pdf/Probl7-en.pdf>

- 250) ECJ, cases 159/91 and 160/91, *Poucet and Pistre*, [1993], ECR, I-637.
- 251) ECJ, cases 159/91 and 160/91, *Poucet and Pistre*, [1993], ECR, I-637, par. 9-12.
- 252) *Conclusions advocate general Jacobs under ECJ, Joined Cases C-264/01, C-306/01, C-354/01 and C-355/01*, AOK.
- 253) MOSSIALOS, E. and McKEE, M, "EU Law and the Social character of Health Care", Bruxelles, Peter Lang, 2002, 168.
- 254) CFI, Case T-319/99, *Fenin*, [2003], ECR, 357, 39.
- 255) ECJ, Case C-218/00, *Cisal*, [2001], ECR, I-691.
- 256) See already KESSLER, F., "L'incidence du droit communautaire de la concurrence sur le fonctionnement des regimes de protection sociale : un bilan à partir du cas français", TSR/RDS, 1997, 268.
- 257) CFI, case T-106/95, *FFSA*, [1997], ECR, II-229, par. 21.
- 258) ECJ, Case C-67/96, *Albany*, [1999], ECR, 5751, 86 95.
- 259) ECJ, Case 219/97, *Bokken*, [1999], ECR, 6121, par. 77; ECJ, C-115/97 to 117/97, *Brentjens*, [1999], ECR, 6025, par. 87; ECJ, cases C-180/98 to C-184/98, *Pavlov* 2000, [6541], par. 82 and CFI, case T-106/95, *FFSA*, [1997], ECR, II-229. *FFSA*, 20.
- 260) *Conclusions advocate general Jacobs under ECJ, Joined Cases C-264/01, C-306/01, C-354/01 and C-355/01*, AOK.
- 261) Not at least because the cases refer to the "pay as you go" element, example of an inter-generational solidarity, which by definition almost excludes the existence of an economic activity. This is however unknown in health care schemes.
- 262) ECJ, *Joined Cases C-264/01, C-306/01, C-354/01 and C-355/01*, AOK, 16 March 2004, par. 57.
- 263) SLOT, P.J., "Applying the competition rules in the health care sector", *E.C.L.R.*, 2003, 586.
- 264) BELHAJ, S. and VAN DE GRONDEN, J.W., "Some room for competition does not make a sickness fund an undertaking. Is EC competition law applicable to the health care sector ? (AOK-case)", *ECLR*, 2004, 11, 684.
- 265) ECJ, *Joined Cases C-264/01, C-306/01, C-354/01 and C-355/01*, AOK, 16 March 2004, par. 58.
- 266) See also LHERNOUD, J.PH., "La fixation du taux du remboursement des médicaments est-elle contraire aux règles du droit de la concurrence ?" note sous CJCE, 16 mars 2004, AOK, RJS, 2004, nr. 6, 441.
- 267) See also BELHAJ, S. and VAN DE GRONDEN, J.W., "Some room for competition does not make a sickness fund an undertaking. Is EC competition law applicable to the health care sector ? (AOK-case)", *ECLR*, 2004, 11, 686.
- 268) See further concluding remarks and chapter IV.

- 269) MOSSIALOS, E. and McKEE, M., *EU Law and the Social character of Health Care*, Bruxelles, Peter Lang, 2002, 170.
- 270) KARL, B., "Competition law and health care systems", in McKEE, M. MOSSIALOS, E. and BAETEN, R., *The Impact of EU law on health care systems*, Bruxelles, Peter Lang, 2002, 69.
- 271) See also ECJ, Case 155/73, *Sacchi*, [1974], ECR, 409, 14: *Nothing in the treaty prevents member states, for considerations of public interest, of a non-economic nature, from removing radio and television transmissions, including cable transmissions, from the field of competition by conferring on one or more establishments an exclusive right to conduct them. However, for the performance of their tasks these establishments remain subject to the prohibitions against discrimination and, to the extent that this performance comprises activities of an economic nature, fall under the provisions referred to in article 86 relating to public undertakings and undertakings to which member states grant special or exclusive rights.*
- 272) CFI, Case T-319/99, *Fenin*, [2003], ECR, 357, 36-37.
- 273) See also WINTERSTEIN, A., "Nailing the Jellyfish: Social Security and Competition Law", *ECLR*, 1999, 332.
- 274) VAN DE GRONDEN, W., and MORTELMANS, K.J.M., "Is de inkoper van medische hulpmiddelen een onderneming in de zin van het EG-mededingingsrecht?", *Ars Aequi*, 2003, p. 469.
- 275) RITTER, L., and BRAUN, W.D., "European Competition Law: A Practitioner's Guide", The Hague, Kluwer Law International, 2004, 997.
- 276) ECJ, *Joined cases 40 to 48, 50, 54 to 56, 111, 113 and 114-73, Suiker Unie*, [1975] ECR, 1663.
- 277) CFI, Case T-77/92, *Parker Pen*, [1994], ECR, II-549, par. 29-34.
- 278) ECJ, Case C-3/95 *Reisebüro Broede* [1996] ECR I-6511, par. 38.
- 279) ECJ, Case 309/99, *Wouters*, [2002], ECR, 1577, par. 97.
- 280) RITTER, L., and BRAUN, W.D., "European Competition Law: A Practitioner's Guide", The Hague, Kluwer Law International, 2004, 234.
- 281) VAN DE GRONDEN, J.W., "Zorg tussen lidstaat en interne markt: zorgverzekeringen, EG-recht en particulier initiatief", Deventer, Kluwer, 2004, 45.
- 282) RITTER, L., and BRAUN, W.D., "European Competition Law: A Practitioner's Guide", The Hague, Kluwer Law International, 2004, 384-385.
- 283) ECJ, Case 85/76, *Hoffmann La Roche*, [1979], ECR 461, par. 38-39.
- 284) CFI, case T-228/97, *Irish sugar*, [1999], ECR-II, 2969, 70. *In the Hoffmann la Roche case the Court accepted a very high market share of 75% or more as evidence of a dominant position without being further investigation necessary. Strong evidence of a dominant position is provided by market shares between 40 and 55 % but this must be confirmed by data on the relative market shares of competitors and other evidence of competitive conditions on the market and the firms own structure, resources and conduct. Market shares varying between 20 and 50% with a competitor accounting to 30% needs additional factors in*

order to be able to admit the existence of a dominant position. A firm with a market share below 25% is unlikely to have a dominant position, see recital no. 32 to regulation 139/2004 on merger control.

- 285) MOSSIALOS, E. and McKEE, M., "EU Law and the Social character of Health Care", Bruxelles, Peter Lang, 2002, 175.
- 286) MOSSIALOS, E. and McKEE, M., "EU Law and the Social character of Health Care", Bruxelles, Peter Lang, 2002, 179.
- 287) Decision 99/416, DC of 22 July 1999.
- 288) Court of Appeal Brussels, 25th of January 2005, AR N. 2003/MR/14: Elements of solidarity were the uniform amount of the benefits, independent from the contributions paid, the composition of the family as well as the personal risk for the insured. See also Belgian Court of Arbitration Case N. 23/92 (2 April 1992).
- 289) ECJ, Case C-280/00, Altmark, [2003] ECR, 7747, par. 75.
- 290) ECJ, Case C-280/00, Altmark, [2003] ECR, 7747, par. 84.
- 291) ECJ, Case 53/00, Ferring, [2003] ECR, I-9076.
- 292) CFI, Case , French Post Office, [1997], ECR II-229.
- 293) ECJ, Case C 301/87, France v. Commission, [1990], ECR, I-307.
- 294) ECJ, Case 39/94, La Poste, [1996], ECR-3547, par. 58.
- 295) MOSSIALOS, E. and McKEE, M., "EU Law and the Social character of Health Care", Bruxelles, Peter Lang, 2002, 185.
- 296) VAN VEEN, E.B. and HAMILTON, G.J., "De zorgverzekeringwet in Europees(rechtelijk) perspectief", Tijdschrift voor Gezondheidsrecht, 2005, 93.
- 297) ECJ, Case C-280/00, Altmark, [2003] ECR, 7747, par. 87.
- 298) ECJ, Case 492/99, French Republic, [2002], 4397, par. 70-71.
- 299) See CFI, Case T-106/95, FFSA, [1997] ECR II-229: A measure by which the public authorities grant to a public undertaking a tax concession which, although not involving a transfer of State resources, places the recipient in a more favourable financial situation than that of other taxpayers, constitutes State aid within the meaning of Article 92(1) of the Treaty.; CFI , case T-46/97 SIC, [2000] ECR-II-2125: The fact that a financial advantage is granted to an undertaking by the public authorities in order to offset the cost of public service obligations which that undertaking is claimed to have assumed has no bearing on the classification of that measure as aid within the meaning of Article 92(1) of the Treaty, although that aspect may be taken into account when considering whether the aid in question is compatible with the common market under Article 90(2) of the Treaty).
- 300) ECJ, Case 53/00, Ferring, [2003] ECR, I-9067, 33: "provided that the tax on direct sales imposed on pharmaceutical laboratories corresponds to the additional costs actually incurred by wholesale distributors in discharging their public service obligations, not assessing wholesale distributors to the tax may be regarded as compensation for the services

they provide and hence not State aid within the meaning of Article 92 of the Treaty.

- 301) ECJ, Case C-280/00, *Altmark*, [2003] ECR, 7747, 2003, C-280/00, par. 95.
- 302) RITTER, L., and BRAUN, W.D., "European Competition Law: A Practitioner's Guide", *The Hague, Kluwer Law International*, 2004, 1010; see also KARPENSCHIF, M., "Qu'est-ce qu'une compensation d'obligations de service public?" *Petites affiches*, 2004, n° 64, 4 -14)
- 303) PALM, W., "Voluntary Health Insurance and the EU Insurance Directives", in McKEE, M. MOSSIALOS, E. and BAETEN, R., *The Impact of EU law on health care systems*, Bruxelles, Peter Lang, 2002, pp 195 ff.
- 304) MOSSIALOS, E., and McKEE, M., "EU Law and the Social character of Health Care", Bruxelles, Peter lang, 2002, 147.
- 305) OJ L. 228, 11 August 1992, 1-23.
- 306) PALM, W., "Voluntary Health Insurance and the EU Insurance Directives", in McKEE, M. MOSSIALOS, E., and BAETEN, R., *The Impact of EU law on health care systems*, Bruxelles, Peter Lang, 2002, p. 209.
- 307) Article 2, §2 of the third non-life insurance directive, referring to Article 2, 1d, the first non-life insurance directive 73/239.
- 308) ECJ, Case C-238/94, *Garcia*, [1996], ECR I-1673.
- 309) ECJ, Case C-355/00, *Freskot*, [2003], ECR, I-5263.
- 310) PALM, W., "Voluntary Health Insurance and the EU Insurance Directives", in McKEE, M. MOSSIALOS, E. and BAETEN, R., *The Impact of EU law on health care systems*, Bruxelles, Peter Lang, 2002, pp. 211.
- 311) ECJ, Case C-206/99, *Commission vs Belgium*, [2000], ECR 2000, I-3509.
- 312) See also VAN DE GRONDEN, J.W., "Zorg tussen lidstaat en interne markt: zorgverzekeringen, EGrecht en particulier initiatief", Deventer, Kluwer, 2004, 21.
- 313) VAN DE GRONDEN, J.W., "Zorg tussen lidstaat en interne markt: zorgverzekeringen, EG-recht en particulier initiatief", Deventer, Kluwer, 2004, 22.
- 314) "Which is in breach of the principle of specialisation of insurance companies, requiring that the commercial and philanthropic activities pursued by mutual societies should not be managed by the same legal entity" ECJ, Case C-239/98, *Commission vs France*, [1999], ECR I-8935.
- 315) HOUDIJK, J.C.A., "Zorg en mededinging: meer marktwerking, meer mededingingsrecht", NTER, 2004, 188.
- 316) ECJ, Case- 59/01, *Commission vs Italy*, [2003], ECR, 1759. I-8935, par. 29.
- 317) ECJ, Case C-346/02, *Commission vs Luxembourg*, not yet published and ECJ, Case C-347/02, *Commission vs France*, not yet published.

- 318) VAN VEEN, E.B. and HAMILTON, G.J., "De zorgverzekeringswet in Europees(rechtelijk) perspectief", *Tijdschrift voor Gezondheidsrecht*, 2005, 91.
- 319) See EU-consideration 23 of this directive
- 320) See EU-consideration 24 of this directive.
- 321) VAN DE GRONDEN, J.W., "Zorg tussen lidstaat en interne markt: zorgverzekeringen, EG-recht en particulier initiatief", Deventer, Kluwer, 2004, 30-31 and Letter from EU Commissioner Bolkestein to Dutch Minister of Public Health Mr. Hoogervorst, 25 November 2003, CAB/PvB/D(03)0848.
- 322) European Commission, Interpretative Communication, "Freedom to Provide Services and the General Good in the Insurance Sector", C(1999)-5046, 2 February 2000.
- 323) ARROWSMITH, S., "An assessment of the new legislative package on public procurement", *C.M.L.R.*, 2004, 41, 1278.
- 324) The Public Procurement regime includes the Public Supplies Directive 93/36/EEC, OJ L 1999/8/1993 as amended by Directive 97/52/EC OJ L 328 28/11/1997; the Public Works Directive 93/37/EEC OJ L 199, 9/8/1993 as amended by Directive 97/52/EC OJ L 328 28/11/1997; the Utilities Directives 93/38/EEC OJ L 199 9/8/1993 as amended by Directive 98/4/EC OJ L 101 1/4/1998; the Public Services Directive 92/50/EEC, OJ L 209 24/7/1992 as last amended by Directive 97/52/EC OJ L 328, 28/11/1997; the Remedies Utilities Directive 92/13/EEC OJ L 076 23/03/1992; the Public Remedies Directive 89/665/EEC OJ L 395, 30/12/1989. The Public Procurement Directives have been recently amended by Directive 2004/18, OJ L 134 30/4/2004 on the coordination of procedures for the award of public works contracts, public supply contracts and public service contracts and Directive 2004/17, OJ L 134 30/4/2004 coordinating the procurement procedures of entities operating in the water, energy, transport, and postal services sectors.
- 325) BOVIS, C., "Financing services of general interest in the EU: how do public procurements and state aids interact to demarcate between market forces and protection?", *E.L.J.*, 2005, 11, 92.
- 326) Article 1 §2, Directive 92/50 and 93/37.
- 327) BOVIS, C., "Recent case law relating to public procurement: a beacon for the integration of public markets", *C.M.L.R.*, 2002, 39, 1038.
- 328) ECJ, Case 31/87, *Beentjes*, ECR [1988], 4635, par. 11.
- 329) In the case *Beentjes* the body concerned depended in particular on the authorities for the appointment of its members, its obligations and operations were subject of observants by the state and the measures and the financing of the public works contracts. In other cases (see e.g. ECJ, Case 306/97, *Teorante* ECR [1988], I-8565) the Court pointed out that even an indirect control by the state is sufficient. In particular, a minister had power to give instructions to the entity requiring to comply with state policy, as well as there was financial and management control, although there was no provisions expressly to the effect that state control is to extend specifically to the awarding of public supplied contracts.

- 330)BOVIS, C., "Financing services of general interest in the EU: how do public procurements and state aids interact to demarcate between market forces and protection?", *E.L.J.*, 2005, 11, 94.
- 331)BOVIS, C., "Financing services of general interest in the EU: how do public procurements and state aids interact to demarcate between market forces and protection?", *E.L.J.*, 2005, 11, 82 .
- 332)BOVIS, C., "Financing services of general interest in the EU: how do public procurements and state aids interact to demarcate between market forces and protection?", *E.L.J.*, 2005, 11, 82-83.
- 333)See eg. ECJ, Cases C-223/99 and C-260/99, *Agora*, [2001], ECR I-3605, par. 34.
- 334)BOVIS, C., "Recent case law relating to public procurement: a beacon for the integration of public markets", *C.M.L.R.*, 2002, 39, 1044.
- 335)ECJ, Case C-360/96, *BFI*, [1998], ECR I-6821, par. 47-49.
- 336)See eg. ECJ, Cases C-223/99 and C-260/99, *Agora*, [2001], ECR I-3605 par. 43.
- 337)ECJ, Case C-44/96, *Mannesmann*, [1998], ECR I-73, par. 25-26; see also ECJ, Case C-26/03, *Stadt Halle* 11 January 2005.
- 338)See MOSSIALOS, E., and McKEE, M., "EU law and the social character of health care", *Brussels, Peter Lang*, 2002, p. 188.
- 339)ECJ, Case C-76/97, *Tögel*, [1998], ECR I-5357; Recently a third reasoned opinion has been sent to Italy for infringement of the rules on the ward of public service contracts, on the occasion of the award by Tuscany of a contract for transport services (ambulant) services in connexion with health care on the regional territory, as the tendering procedures provided for in the community law on public procurement were not applied.
- 340)MOSSIALOS, E., and McKEE, M., *eEU law and the social character of health care*, *Brussels, Peter Lang*, 2002, p. 189.
- 341)ECJ, Case C-107/98, *Teckel*, [1999], ECR I-8121, par. 50-51, confirmed by ECJ, Case C-26/03, *Stadt Halle*, 11 January 2005.
- 342)BOVIS, C., "Recent case law relating to public procurement: a beacon for the integration of public markets", *C.M.L.R.*, 2002, 39, 1048.
- 343)This is particular the case in complex contracts as eg. public private projects, see Article 29 of these directives. These new directives came into force on 1 May 2004 and must be implemented by the 31 January 2006 by the member states.
- 344)ECJ, Case C-209/98, *FFSA-case*, [2000] ECR I-5743, 74.
- 345)ECJ, Case 219/97, *Bokken*, [1999], ECR, 6121; ECJ, C-115/97 to 117/97, *Brentjens*, [1999], ECR, 6025; ECJ, Case C-67/96, *Albany*, [1999], ECR, 5751.
- 346)Not at least because the pension funds could determine the amount of contributions and benefits.
- 347)"Undertakings entrusted with the operation of services of general economic interest or having the character of a revenue-producing

monopoly shall be subject to the rules contained in this Treaty, in particular to the rules on competition, in so far as the application of such rules does not obstruct the performance, in law or in fact, of the particular tasks assigned to them. The development of trade must not be affected to such an extent as would be contrary to the interests of the Community".

- 348) See COUCHEIR, M., "The legal framework in relation to patient mobility", paper prepared in the framework of the European 6th Framework Programme, Europe for patients.
- 349) See COUCHEIR, M., "The legal framework in relation to patient mobility", paper prepared in the framework of the European 6th Framework Programme, Europe for patients and HATZOPOULOS, V.G., "Killing national health and insurance systems but healing patients? The European market for health care services after the judgments of the ECJ in *Vanbraekel* and *Peerbooms*", *Common Market Law Review* 2002.
- 350) SAUTER, W., "Competition Law and Industrial Policy in the EU", Oxford, Clarendon Press, 1997, 143.
- 351) SCOTT, C., "Services of General Interest in EC Law: Matching Values to Regulatory Technique in the Public and Privatised Sectors", *E.L.J.* 2000, Vol. 6, 311.
- 352) Some supporters of the public service want to portray the Commission as a dangerous and ultra-liberal privatising machinery, while fervent market-believers are eager to give services of general interest the status of an outmoded concept of state intervention. The Commission tried to keep consumer interest as its guiding principle according to DUBOIS, J., "The European Commission's Approach to Liberalisation and Universal Service Obligations", in HAIBACH, G. (ed.), *Services of general interest in the EU: Reconciling Competition and Social Responsibility*, Maastricht, EAPI, 1999, 5-7.
- 353) More specifically attributed to the insertion in the Treaty of provisions on "Citizenship", "Consumer Protection", "Trans-European networks", "Economic and Social Cohesion", "Environment" and the "Protocol on Social Policy", annexed to the Treaty. See BAUBY, P., "Public Service: Forging a European Conception", in HAIBACH, G. (ed.), *Services of general interest in the EU: Reconciling Competition and Social Responsibility*, Maastricht, EAPI, 1999, 57.
- 354) For an overview of important documents, see http://europa.eu.int/comm/secretariat_general/services_general_interest/pages/documents_en.htm
- 355) Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, "White paper on services of general interest", Brussels, 12 May 2004, COM(2004) 374 final, 4.
- 356) MEULMAN, J., "Na het Groenboek over Diensten van Algemeen Belang: naar een horizontale aanpak van overheidsinterventie?", *SEW* 2004, Vol. 3, 98-107.
- 357) WILHELMSSON, T., during the Helsinki seminar on Services of General Interest in Europe (9 and 10 September 1999), cited in TRINCIA, G., *Services of general interest*, Issues paper for the Second European

Assembly of Consumer Associations, see http://europa.eu.int/comm/dgs/health_consumer/events/event17w1a_en.html

- 358) Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, "White paper on services of general interest", Brussels, 12 May 2004, COM(2004) 374 final, 22.
- 359) Consolidated version of the Treaty establishing the European Community OJ [2002] C 325/33.
- 360) Green paper on services of general interest, Brussels, 21 May 2003, COM(2003) 270 final, 10-12.
- 361) FLEISCHER, T., "Comments on services of general interest and territorial and social cohesion", Contribution in the international conference on "Services of general interest in an enlarged European Union", organised by the TEPSA members study group for European Policies (of Belgium), the Institute of World Economics (of Hungary) and the Initiative pour des services d'utilité publique en Europe with the support of the European Commission, Budapest, 21 and 22 October 2004.
- 362) DEVROE, W., "Universele dienstverlening als nieuwe manier van denken?", SEW 2000, Vol. 3, 82.
- 363) As the organisation of services of general interest is concerned, three models of organisation have been put forward by BEHRENS: provision by one or several providers offering their services on competitive markets with limited state interference; provision by one single provider or a small group of providers, to which the State grants exclusive or special rights after competitive tendering procedures; provision by one or a limited number of operators, to which the State grants exclusive or special rights without tender procedures and thus with elimination of all competition. See BEHRENS, P., "Public Services and the internal market - An analysis of the Commission's communication on services of general interest in Europe", in *Spontaneous Order. Organisation and the Law. Roads to a European Civil Society. Liber Amicorum Ernst-Joachim Mestmäcker*, Den Haag, Asser Press, 2003, 46-48.
- 364) Article 16 EC: "Without prejudice to articles 73, 86 and 87, and given the place occupied by services of general economic interest in the shared values of the Union as well as their role in promoting social and territorial cohesion, the Community and the Member States, each within their respective powers and within the scope of application of this Treaty, shall take care that such services operate on the basis of principles and conditions which enable them to fulfil their mission". On the significance of art. 16 EC for services of general economic interest, see ROSS, M., "Article 16 E.C. and services of general interest: from derogation to obligation?", *European Law Review* 2000, Vol. 25, 22-38. In the final Act annexed to the Amsterdam Treaty, Declaration No. 13 states that "The Provisions of Article 16 [Article 7d] ... on public services shall be implemented with full respect for the jurisprudence of the Court of Justice, inter alia as regards the principles of equal treatment, quality and continuity of such services".

- 365) Article 5 EC: "The Community shall act within the limits of the powers conferred upon it by this Treaty and of the objectives assigned to it therein. In areas which do not fall within its exclusive competence, the Community shall take action, in accordance with the principle of subsidiarity, only if and in so far as the objectives of the proposed action cannot be sufficiently achieved by the Member States and can therefore, by reason of the scale or effects of the proposed action, be better achieved by the Community. Any action by the Community shall not go beyond what is necessary to achieve the objectives of this Treaty".
- 366) Nonetheless these additional powers are already a fact, as Art. III-6 of the Draft Treaty establishing a Constitution for Europe provides an additional legal base for Community action in the field of services of general economic interest.
- 367) Opinion of the European Economic and Social Committee on the 'Green paper on Services of General Interest' OJ [2004] C 80/66.
- 368) ECJ, Case C-157/94, *Commission v. Netherlands* [1997] ECR I-5699.
- 369) More in particular the article applies to the competition rules (Articles 81, 82 and 87 EC), the adjustment of State monopolies (art. 31 EC), free movement of labour (art. 39 EC), the right of establishment (art. 43 EC) and the free provision of services (Article 49 EC). See GOYDER, D.G., *EC Competition Law - Fourth edition*, Oxford, Oxford University Press, 2003, 483.
- 370) SCOTT, C., "Services of General Interest in EC Law: Matching Values to Regulatory Technique in the Public and Privatised Sectors", *E.L.J.* 2000, Vol. 6, 312.
- 371) BEHRENS, P., "Public Services and the internal market - An analysis of the Commission's communication on services of general interest in Europe", in *Spontaneous Order. Organisation and the Law. Roads to a European Civil Society. Liber Amicorum Ernst-Joachim Mestmäcker*, Den Haag, Asser Press, 2003, 45.
- 372) Even this marginal scrutiny of the Court is contested, according to the view that the supervision of this definition task cannot be assigned to judicial bodies, which are not democratically elected. See MEULMAN, J., "Na het Groenboek over Diensten van Algemeen Belang: naar een horizontale aanpak van overheidsinterventie?", *SEW* 2004, Vol. 3, 101.
- 373) ECJ, Case C-66/85, *Ahmed Saeed Flugreisen* [1989] ECR 803.
- 374) ECJ, Case C-41/90, *Höfner and Elser* [1991] ECR I-1979.
- 375) ECJ, Case T-266/97, *Vlaamse Televisie Maatschappij* [1999] ECR II-2329.
- 376) Cf. ECJ, Case C-260/89, *ERT* [1991] ECR 2925; ECJ, Case C-179/90, *Merci Convenzionali Porto di Genova* [1991] ECR I-5889 and ECJ, Case C-266/93, *Corsica Ferries II* [1998] ECR I-3949.
- 377) Cf. ECJ, Case C-127/73, *BRT v. SABAM* [1974] ECR 313 and ECJ, Case C-7/82, *GVL* [1983] ECR 483.; The term "entrust" presupposes an express act of state, i.e. a delegation by a public authority in a general economic interest, see ECJ, and ECJ, Case, C-127/73 *BRT/SABAM*, [1974] ECR, 313; ECJ, ECJ, Case C-393/92, *Almelo*, 1994, ECR I-1477.

- 378) Cf. ECJ, Case C-18/88, RTT [1991] ECR I-5941 and ECJ, Case C-320/91, Corbeau [1993] ECR I-2523; *obstruct* signifies that the performance of the tasks assigned must be made impossible and not merely made more difficult, see ECJ, Case C-41/90, Höfner, [1991], ECR, I-1979, par. 24-25.
- 379) ECJ, Case C-260/89, ERT [1991] ECR 2925 and ECJ, Case C-260/89, ERT [1991] ECR 2925.
- 380) Commission Communication on Services of General and Economic Interest, 2001, OJ C 17/4, points 4039 and RITTER, L. and BRAUN, W.D., *European Competition Law: A Practitioner's Guide*, The Hague, Kluwer Law International, 2004, 976.
- 381) E.g. ECJ, Case C-155/73, Sacchi [1974] ECR 409; ECJ, Case C-41/90, Höfner and Elser [1991] ECR I-1979 and ECJ, Case C-41/83, Italy v. Commission ("British Telecom") [1985] ECR 873; ECJ, Case C-311/84, Télé-Marketing [1985] ECR 3261 and ECJ, Case C-41/90, Höfner and Elser [1991] ECR I-1979. GILLIAMS, H.M., "Diensten van algemeen belang als rechtvaardiging van mededingingsbeperkingen", SEW 1995, Vol. 7/8, 536.
- 382) ECJ, Case C-94/74, IGAV v. ENCC [1975] ECR 699.
- 383) ECJ, Case C-320/91, Corbeau [1993] ECR I-2523.
- 384) ECJ, Case C-393/92, Almelo [1994] ECR I-121.
- 385) ECJ, Case C-157/94, Commission v. Netherlands [1997] ECR I-5699; ECJ, Case C-158/94, Commission v. Italy [1997] ECR I-5789; ECJ, Case C-159/94, Commission v. France [1997] ECR I-5815 and ECJ, Case C-160/94, Commission v. Spain [1997] ECR I-5851.
- 386) ROSS, M., "Article 16 E.C. and services of general interest: from derogation to obligation?", *European Law Review* 2000, Vol. 25, 25.
- 387) *Ibidem*.
- 388) Cf. *Supra*, footnote 364.
- 389) The subject is unmistakably related to several policies of the European Union, more specific internal market and competition policy, but also consumer policy, agriculture, environment, transport, public health, research, external trade, development policy, etc.
- 390) Draft Treaty establishing a Constitution for Europe OJ [2003] C 169/1.
- 391) GUILLEN, A. and CLIFTON, J., *Services of general interest: Towards Europeanisation of Social Policy?*, ESPAnet 2004 Conference, Oxford, 9-11th September 2004, 12-13.
- 392) SUPIOT, A., "Employment, Citizenship, and Services of General Public Interest", in X., *Public Services and Citizenship in European Law*, Oxford, Clarendon Press, 1998, 160.
- 393) See Chapter III.
- 394) Health services: diagnostic, curative, primary and secondary medical care.
- 395) Social care services: long-term, rehabilitative, non-medical and palliative care.

- 396) Social Protection Committee, "Social Services of General Interest and Community Law - Background document legal framework", 23, see http://www.aim-mutual.org/docs/CEA/background_en.pdf
- 397) Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, "White paper on services of general interest", Brussels, 12 May 2004, COM(2004) 374 final, 10.
- 398) DUBOIS, L., *Presentation générale, Services sociaux et santé, in Services Publics dans la CE*, Paris, 409.
- 399) ECJ, Case C-67/97, Albany [1999] ECR I-5751; ECJ, Case C-115/97 - 117/97, Brentjens [1999] ECR I-6025 and ECJ, Case C-219/97, Drijvende Bokken [1999] ECR I-6121.
- 400) ECJ, Case C-70/95, Sodemare [1997] ECR I-3395 and ECJ, Case C-180/98 - 184/98, Pavlov [2000] ECR I-6451.; for a further evaluation of the concept economic activity, we refer to part II.
- 401) WINTERSTEIN, A., "Nailing the Jellyfish: Social Security and Competition Law", E.C.L.R. 1999, Vol. 6, 326.
- 402) Opinion of the European Economic and Social Committee on the 'Green Paper on Services of General Interest', COM(2003) 270 final.
- 403) As in its Opinion of the Economic and Social Committee on 'Private not-for-profit social services in the context of services of general interest in Europe' OJ [2001] C 311/08.
- 404) DUBOIS, L., *Presentation générale, Services sociaux et santé, in Services Publics dans la CE*, Paris, 409.
- 405) "Social Services of General Interest - Assessing their Specificities, Potential and Needs: Key issues to be taken into account and further explored", Conference on Social Services of General Interest in the European Union, Brussels, 28th and 29th June 2004. See http://www.socialplatform.org/module/FileLib/04-06_SocialServicesConf_KeyIssuesPaper.pdf
- 406) Opinion of the Economic and Social Committee on 'Private not-for-profit social services in the context of services of general interest in Europe' OJ [2001] C 311/08.
- 407) Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, "White paper on services of general interest", Brussels, 12 May 2004, COM(2004) 374 final, 16.
- 408) E.g. right to life, right to education, right to engage in work, rights of the elderly, integration of persons with disabilities, entitlement to social security benefits and social services, right to preventive health care and medical treatment, all mentioned in the Draft Treaty establishing a Constitution for Europe.

- 409) "Social Services of General Interest - Assessing their Specificities, Potential and Needs: Key issues to be taken into account and further explored", Conference on Social Services of General Interest in the European Union, Brussels, 28th and 29th June 2004. See http://www.socialplatform.org/module/FileLib/04-06_SocialServicesConf_KeyIssuesPaper.pdf
- 410) Substitutive Health Insurance substitutes for cover that would otherwise be available from the state; Complementary Health Insurance provides complementary cover for services excluded or not fully covered by the state, including cover for co-payments imposed by the statutory health care system; Supplementary Health Insurance provides cover for faster access and increased consumer choice. See MOSSIALOS, E. and THOMSON, S., *Voluntary Health Insurance in the European Union*, Report prepared for the Directorate General for Employment and Social Affairs of the European Commission, 27 February 2002, 2, http://europa.eu.int/comm/employment_social/soc-prot/social/vhi.pdf
- 411) CALLENS, S., and PEERS, J., "Organisatie van gezondheidszorg, Antwerpen, Intersentia, 2003, 360-381.
- 412) Frequently mentioned causes of market failure are the information asymmetry between patient and provider; the uncertainty with relation to time, nature, scope and effect of the provided care; the moral hazard as a result of sickness insurance; and finally the external effects of health care. See COUCHEIR, M., "Publieke gezondheidszorg als economische activiteit in de zin van het EG-verdrag: over gevrijwaarde solidariteit en (semi-)territorialiteit", TSR 2005, forthcoming, citing SCHUT, E., *De Zorg is toch geen markt? Laveren tussen marktfalen en overheidsfalen in de gezondheidszorg*, Rede uitgesproken bij de aanvaarding van het ambt van bijzonder hoogleraar gezondheidszorgbeleid en economie van de gezondheidszorg aan de Faculteit der Geneeskunde en Gezondheidszorgwetenschappen van de Erasmus Universiteit Rotterdam, 9 May 2003, <http://www.zorgaanzet.nl/materiaal/OratieSchut.pdf>
- 413) GILLIAMS, H.M., "Noot bij het arrest C-244/94 FFSA", SEW 1997, 445.
- 414) ECJ, Case C-286/82 and 26/83, *Luisi and Carbone* [1984] ECR I-377.
- 415) ECJ, Case C-159/90, *Society for the Protection of the Unborn Children* [1991], ECR I-4685; ECJ, Case C-158/96, *Kohll* [1998], ECR I-1931; ECJ, Case C-157/99, *Geraets-Smits / Peerbooms* [2001] ECR I- 5473; ECJ, Case C-475/99, *Ambulanz Glöckner* [2001] ECR I-8089; ECJ, Case C-203/99, *Henning Veedfald* [2001] ECR I-3569 and ECJ, Case C-385/99, *Müller-Fauré / Van Riet* [2003] ECR I-4509; ECJ, Case C-475/99, *Ambulanz Glöckner* [2001] ECR I-8089 and ECJ, Case C-203/99, *Henning Veedfald* [2001] ECR I-3569. For an overview of health care professionals as service providers in the EU, see VAN OVERMEIREN, F., "Kohll en Decker anders bekeken: de mobiliteit van gezondheidsmedewerkers in de Europese Unie", TSR 2005, to be published, but consultable on the web page http://www.europa.eu.int/comm/health/ph_overview/Documents/refl/ev20041015_co_180_en.pdf. For hospitals see also BELANGER, M., "Droit communautaire et service public hospitalier", in *Services Publics dans la CE*, Paris, 415.

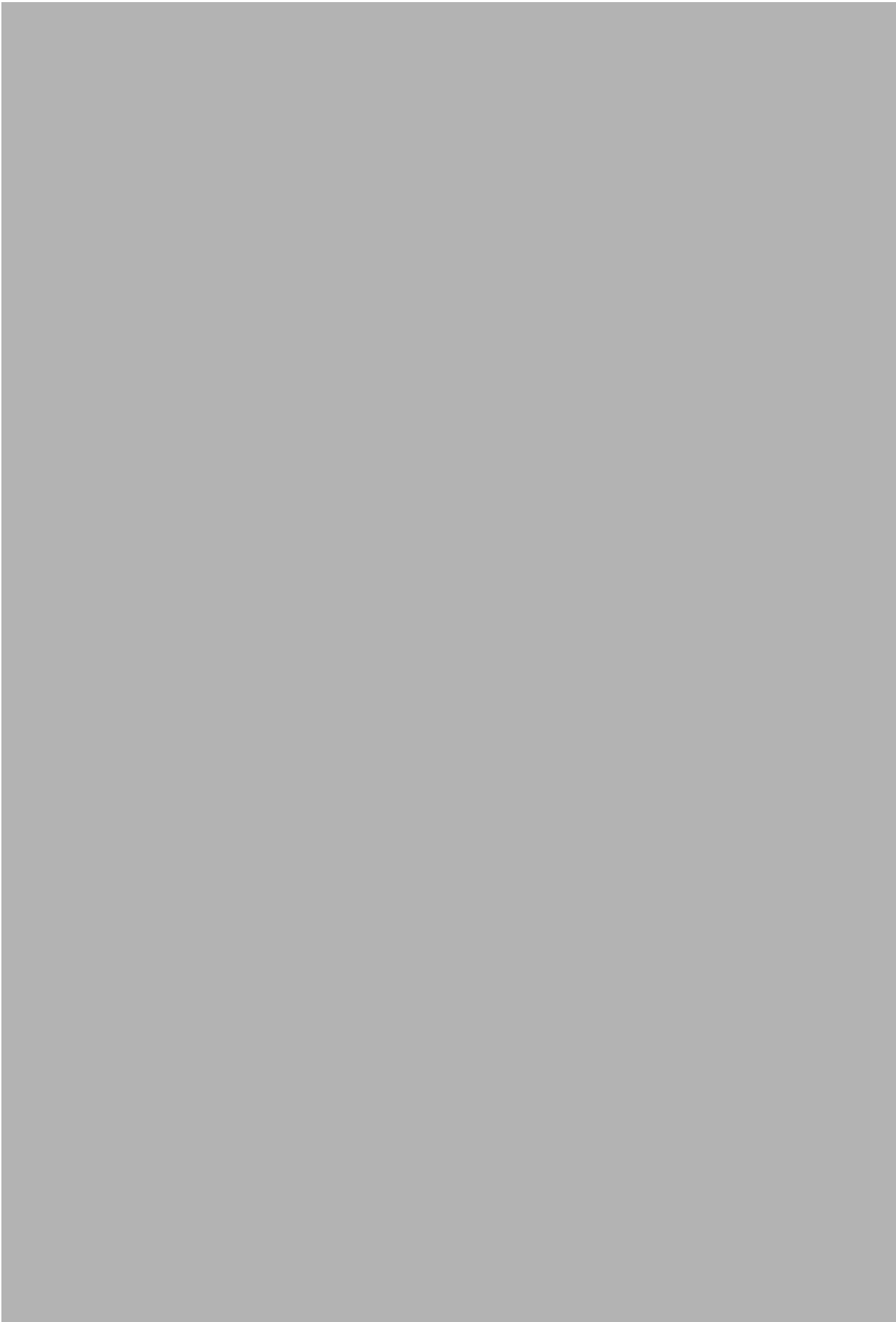
- 416) ECJ, Case C-279/80, Webb [1981] ECR I-3305; ECJ, Case C-158/96, Kohll [1998] ECR 1931 and ECJ, Case C-157/99, Geraets-Smits / Peerbooms [2001] ECR I-5473.
- 417) ECJ, Case C-180/98 - 184/98, Pavlov [2000] ECR I-6451. Cf. SLUYS, J.J.M., "Toepasselijkheid van het mededingingsrecht op sociaalrechtelijke vraagstukken", NTER 1999, 37-39; LOOZEN, E.M.H., "Pavlov en Van der Woude: meer dan een Pavlov-reactie?", NTER 2000, 303-304 and LHERNOULD, J.-P., "Nouvelles dérives libérales de la CJCE en matière de retraite complémentaire", Droit Social 2000, 1114-117.
- 418) ECJ, Case C-475/99, Ambulanz Glöckner [2001] ECR I-8089.
- 419) Joined Cases C-159/91 and 160/91, Poucet and Pistre [1993] ECR I-27.
- 420) ECJ, Case C-238/94, Garcia [1996] ECR I-1673.
- 421) ECJ, Case C-218/00, Cisa [2002] ECR I-691.
- 422) Joined Cases C-264/01, 306/01, 354/01 and 355/01, AOK Bundesverband [2004] ECR 000.
- 423) E.g. WINTERSTEIN, A., "Nailing the Jellyfish: Social Security and Competition Law", E.C.L.R. 1999, 324-333; SLOT, P.J., "Applying the Competition Rules in the Health Care Sector", E.C.L.R. 2003, 580-593; GYSELEN, L., "Comments on the Joined Cases Albany, Brentjens and Drijvende Bokken", CML Rev. 2000, 425-448.
- 424) The AG argued that the market elements in the German social health insurance scheme (competition between the mutual health funds on premium rates, on the different services they offer and open competition with private health insurers for the business of those employees who are not obliged to take out statutory health insurance) made that the activities of the entities managing this scheme (mutual health funds) should be qualified as undertakings engaging in an economic activity. But as "there is no doubt in my mind that German sickness funds are charged with such a service [service of general economic interest], namely in the provision of a solidarity-based system of statutory health insurance", according to AG Jacobs, Article 86(2) could be invoked as the application of the competition rules could hinder the social objectives of the health insurance scheme.
- 425) Joined Cases C-264/01, 306/01, 354/01 and 355/01, AOK Bundesverband [2004], ECR, O.
- 426) 425 ECJ, Case C-238/82, Duphar [1984] ECR I-523.
- 427) ECJ, Case C-244/94, FFSA [1995] ECR I-4013. Cf. VAN DER STEEN, I., "Sociale-zekerheidsorgaan als onderneming?", NTER 1996, 14-17 and GILLIAMS, H.M., "Noot bij het arrest C-244/94 FFSA", SEW 1997, 448-448 and LAIGRE, P., "L'intrusion du droit communautaire de la concurrence dans le champ de la protection sociale", Droit Social 1996, 82-88.
- 428) ECJ, Case C-67/97, Albany [1999] ECR I-5751. Cf. SLUYS, J.J.M., "Marktwerking in de bedrijfspensioensector", NTER 1997, 199-202.
- 429) ECJ, Case C-115/97 - 117/97, Brentjens [1999] ECR I-6025. Cf. SLUYS, J.J.M., "Marktwerking in de bedrijfspensioensector", NTER 1997, 199-202.

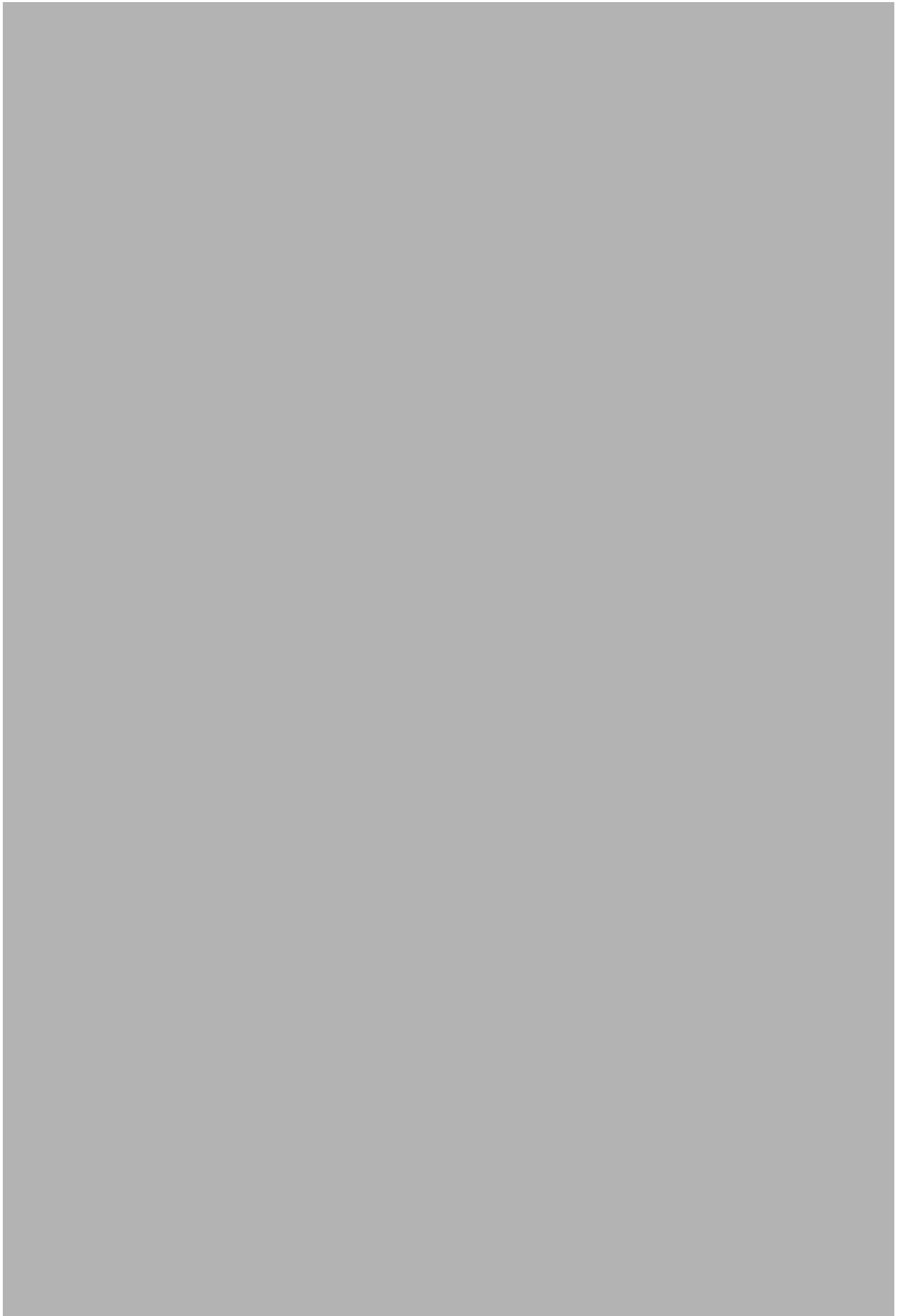
- 430) ECJ, Case C-219/97, *Drijvende Bokken* [1999] ECR I-6121. Cf. SLUYS, J.J.M., "Marktwerving in de bedrijfspensioensector", NTER 1997, 199-202.
- 431) BOSCO, A., "Vers une remise en cause des systèmes nationaux de protection sociale?", *Observations sur la jurisprudence récente de la Cour de Justice*, page 12, See <http://www.notreeurope.asso.fr/IMG/pdf/Probl7-en.pdf>
- 432) ECJ, Case C-7/82, *GVL v. Commission* [1983] ECR I-483.
- 433) ECJ, Case C-159/94, *Commission v. France* [1997] ECR I-5815.
- 434) HOUDIJK, J.C.A., "Zorg & Mededinging: meer marktwerving, meer mededingingsrecht", NTER, 2004, 188. With referral to ECJ, Case C-393/92 *Almelo* [1994] ECR I-121.
- 435) SLOT, P.J., "Applying the Competition Rules in the Health Care Sector", *E.C.L.R.* 2003, 593.
- 436) ECJ, Case C-320/91, *Corbeau* [1993] ECR I-2533, par. 14 to 16 and ECJ, Case C-157/94, *Commission v. Netherlands* [1997] ECR I-5699, par. 53.
- 437) Opinion of Mr Advocate General Jacobs delivered on 22 May 2003 in the *Joined Cases C-264/01, 306/01, 354/01 and 355/01 AOK Bundesverband* [2004] ECR 000 and KORAH, V., *An Introductory Guide to EC Competition Law and Practice*, Oxford, Hart Publishing, 2004, 195-196.
- 438) HOUDIJK, J.C.A., "Zorg & Mededinging: meer marktwerving, meer mededingingsrecht", NTER 2004, 185 and VAN DE GRONDEN, J.W., "Purchasing Care: Economic Activity or Service of General (Economic) Interest?", *E.C.L.R.* 2004, 88.

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LUXEMBURG, SCENE OF THE INTERNATIONAL CONFERENCE





OPENING ADDRESS



MR MARS DI BARTOLOMEO, MINISTER OF HEALTH AND SOCIAL SECURITY



MR FERNAND SAUER, EUROPEAN COMMISSION

PRESENTATION OF THE BASIC REPORT



PROFESSOR YVES JORENS, UNIVERSITY GHENT, BELGIUM



MRS ANNE VAN LANCKER, MEMBER OF THE EUROPEAN PARLIAMENT



**CLOSING SPEECH
MR RON HENDRIKS (AIM)**

THE ORGANISERS



**PHILIPPE SWENNEN, CRISTINA VALLINA, WILLY PALM, RITA KESSLER (AIM)
(FROM LEFT TO RIGHT)**



**FERNAND LEPAGE (aloss) CLAUDE EWEN (MSS) MICHEL SCHMITZ (CSML)
(FROM LEFT TO RIGHT)**

PRESS REVIEW

Quotidien

samedi 9 et dimanche 10 avril 2009

Une législation pour les soins

Lors d'une conférence, la notion de solidarité des soins dans une Europe unie était au centre des discussions. Une législation pour chaque pays est inévitable.



Théâtre en anglais au LG



Fort, Dignité, une pièce écrite en langue anglaise abordant les problèmes d'immigration et de l'emploi, sera présentée dans le cadre du projet d'établissement "Tous Liés" à la suite des fêtes de l'école de gare de Luxembourg les 15 et 16 avril à partir de 20 h. La pièce est destinée à être jouée spécialement pour 21 élèves qui l'interprètent. La pièce a été développée dans une optique pédagogique et est destinée à être jouée dans une étape d'intégration importante pour chaque élève. Justine Goebler m'a invité pour le 9 mai à venir travailler au LG, avec qui nous avons de nos côtés d'élèves. Je ne me doutais pas en apprenant, au début de mon travail, que le pro

Seite 16 Tageblatt

Politik

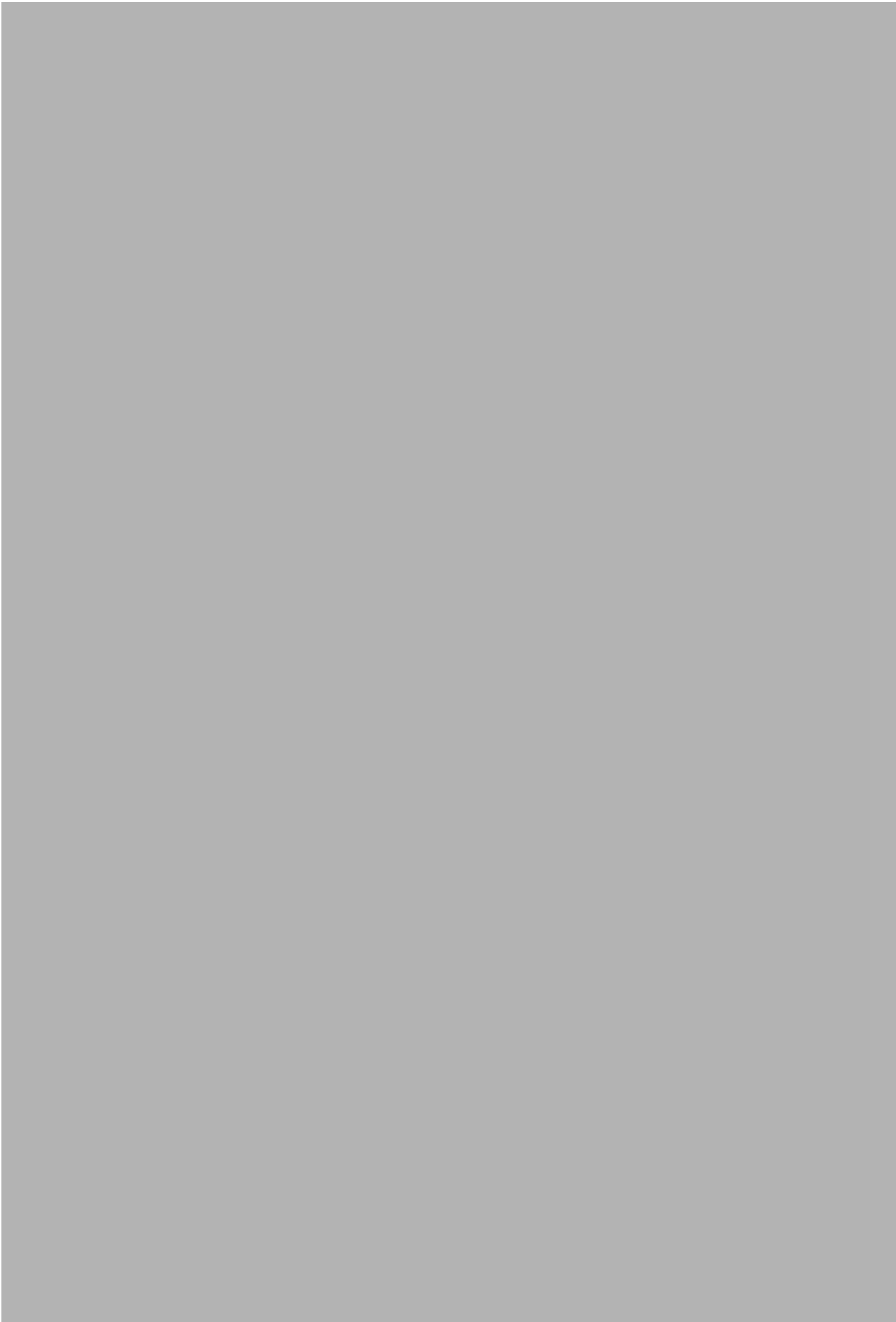
Gesundheitsleistungen und gemeinsamer Markt Zeit, zu reagieren



PART II

INTERNATIONAL CONFERENCE

Luxembourg, April 8th 2005



OPENING ADDRESS



Mars DI BARTOLOMEO

*MINISTER OF HEALTH AND SOCIAL SECURITY
LUXEMBOURG*

Mesdames, Messieurs,

Tout d'abord, je vous souhaite la bienvenue à Luxembourg et je tiens à vous remercier de votre participation à notre conférence. Bienvenue aux représentants du Parlement européen, aux délégations gouvernementales des différents États membres, aux représentants des institutions européennes, aux personnes du milieu académique ainsi qu'aux acteurs du secteur sanitaire et social.

Je tiens aussi à féliciter les organisateurs de la conférence, à savoir l'AIM, l'Association internationale de la mutualité, l'aloss, l'Association luxembourgeoise des organismes de sécurité sociale et le Conseil supérieur de la mutualité luxembourgeoise.

Merci de participer à cette conférence qui retient tout mon engagement et qui traite du thème très important de l'accès aux soins de santé dans un marché unique et de l'impact sur les systèmes légaux et complémentaires.

Les soins de santé dans une Europe unie doivent continuer à obéir aux critères et aux objectifs mis en place par des générations entières, c'est-à-dire correspondre à un système performant, assurant des soins de qualité et garantissant un libre accès aux concernés, sans distinction de leur situation sociale, et fondé sur le principe de la solidarité entre les différents acteurs.

L'avenir de ce système doit nous préoccuper. Quand le thème a été retenu, la directive Bolkestein était en pleine discussion. Elle le reste d'ailleurs mais nous avons constaté une certaine évolution en la matière. A l'heure actuelle il est très fortement envisagé que le secteur de la santé ne sera pas inclus dans le champ d'application de la directive, dont le texte devra être remodelé. Cependant ne soyons pas dupes, le sujet reste d'actualité même si les premiers dangers ont été écartés.

Avant la conférence, je viens de parler avec la rapportrice du Parlement européen sur la directive Bolkestein. Nous nous devons de suivre la discussion non pas seulement en matière de services de santé, mais aussi dans le domaine des services d'intérêt général. L'évolution sur le plan européen a une très forte influence sur nos systèmes nationaux qui ont été construits à grands efforts et à grands frais et que nous devons sauvegarder et développer dans le bon sens.

Nous sommes très contents d'avoir aujourd'hui la possibilité d'échanger nos vues avec celles d'un expert reconnu qui est le professeur Yves Jorens de l'Université de Gand. A notre demande, le professeur Jorens a rédigé un

rapport d'une qualité exceptionnelle qui va constituer la base de nos discussions dans les tables rondes respectives.

Fort d'une expérience ministérielle de seulement huit mois, j'ai appris beaucoup de choses dans cette période. J'ai appris que si la politique ne s'occupe pas de sujets prioritaires, ceux-ci continuent à évoluer et à se développer. Pour ma part, j'ai tiré la conclusion qu'on a intérêt à se préparer et à s'engager dans la discussion. Il ne suffit pas de laisser le terrain à des fonctionnaires, aussi bien intentionnés et motivés qu'ils soient. Il faut engager la politique dès les premiers pas.

Conscient que la politique ne peut pas tout résoudre, j'estime quand même qu'elle peut jouer le rôle d'arbitre en recherchant l'équilibre entre les différents intérêts. Concernant le sujet qui nous préoccupe aujourd'hui, il y a des intérêts qu'on doit garder en point de mire: à côté de la libre circulation des services et du libre échange, il y a la qualité des services et le libre accès aux soins de santé.

Parfois on a tendance à dire que les soins de santé sont des services. Certes, ce sont des services, mais ce ne sont pas des services comme tous les autres. Ce ne sont pas des services marchands qui obéissent à la seule idée de la concurrence. Nous ne sommes pas seulement en présence de deux partenaires, l'un qui fait l'offre et l'autre qui fait la demande, mais il y a un troisième partenaire, celui qui garantit le financement. C'est la collectivité qui, par voie de conséquence, doit garder le droit d'intervenir et de déterminer le cadre général.

Je ne veux certainement pas monopoliser la discussion, mais j'ai voulu insister sur un certain nombre de points qui me sont chers et qui, j'espère, seront présents dans nos débats d'aujourd'hui. Certainement nous n'allons pas trancher toutes les questions mais je suis sûr que les conclusions de nos discussions nous armeront pour les débats futurs.

Retenu par des obligations ministérielles pendant la matinée en participant respectivement à la réunion du Conseil du Gouvernement luxembourgeois et à une réunion informelle du Conseil des ministres du Travail et de l'Emploi de l'Union européenne, j'aurai le plaisir de vous rejoindre pour les discussions de cet après-midi.

Finalement, je vous souhaite une conférence intéressante et surtout fructueuse.

Je vous remercie.

Fernand SAUER

*DIRECTOR
DG HEALTH AND CONSUMER PROTECTION
EUROPEAN COMMISSION*

Minister, Honourable Member of Parliament,

Ladies and Gentlemen,

I am very pleased to be able to participate in this International Conference on access to health care in an internal market co-organised by the "Association Internationale de la Mutualité", under the auspices of the Luxembourg Presidency of the European Union.

Let me thank on this occasion Ron Hendriks and Willy Palm, from AIM, for their invaluable contribution to the Commission's reflection work on patient mobility as well as a strong partner in our EU Health Forum.

Recognition of the European dimension of healthcare

- Healthcare issues are primarily national in nature. The fundamental responsibility for ensuring universal access to high-quality care, funded through solidarity, lies with the Member States.
- But there are a variety of trends creating a European dimension to these issues.
- Jurisprudence from the European Court of Justice on the rights of patients to seek healthcare in other countries and be reimbursed is one major aspect.
- Also common challenges for all health systems of coping with the need to adapt to constant developments in medical technologies and techniques; the ageing of the European population changing overall health needs; and rising public expectations, as discussed by Health ministers under the Dutch Presidency.

First elements of a European strategy now in place

- An important report on Health and the Internal Market was finalised in 2001 for my directorate by a group of governmental experts chaired by Hans Stein. This report and other contributions were the subject of a major conference in Minorca under Spanish Presidency in June 2002.
- The Commission brought together health ministers together with representatives of patients, professionals, providers and purchasers of healthcare and the European Parliament in a high-level reflection process on patient mobility which agreed a wide-ranging report in December 2003.

- Three Commissioners, responsible respectively for health employment and internal market, were involved in this process, leading to a close cooperation between their services.
- The key result of this patient mobility reflection process was the recognition of the importance of the European dimension for national health systems, and the potential value that European cooperation can bring in helping Member States to achieve their objectives.
- The Commission set out proposals for developing a European response to these challenges in April 2004:
 - establishing a High Level Group on health services and medical care to take forward the recommendations of the reflection process;
 - and extending the open method of coordination to healthcare and long-term care.

Practical collaboration through the High Level Group will help improve health service across Europe

Work is being taken forward in seven main areas.

- on **cross-border healthcare purchasing and provision**, looking at issues such as the financial impact and sustainability of cross-border healthcare; developing a purchasing framework; and patients' rights and responsibilities;
- on **health professionals**, looking at issues beyond recognition of qualifications to subjects to such as continuing professional development and the impact of health professional migration within the Union;
- on **centres of reference**, developing principles for a European system of centres of reference that could pool resources on tackling very rare diseases, for example, and where we hope to see pilot projects in 2006;
- on **health technology assessment**, where the High Level Group has developed orientations for a network which the public health programme could help finance this year;
- on **information and e-health**, and looking at the key elements of information strategies for health services;
- developing **impact assessment** methodologies to take account of the impact of proposals on health services;
- and developing collaboration on **patient safety**, as described at the conference also supported by the Presidency here in Luxembourg earlier this week.

The future Health & Consumer Protection programme will better support to health system cooperation

- My directorate and the health research directorate have already been able to support some activities on healthcare cooperation under the current public health programme, but in a limited way.
- However, on Wednesday the Commission adopted a proposal for a new Health and Consumer Protection Programme to run from 2007 to 2013 within the so-called “financial perspectives package”. This programme will be expanded both in scope and in size.
- In terms of size, the new programme would have a total budget of over 1.2 billion Euros – a major increase on our current resources.
- And we also propose adding a specific new strand of action to support cooperation between Member States on health services.
- Of course, health expenditure will still be undertaken within the Member States, not through this programme. So this very much respects subsidiarity.
- Nevertheless, this new programme will allow us to turn the many ideas for areas where European collaboration can add value into practical initiatives.
- The start of the European Centre for Disease Prevention and Control (ECDC) next month in Stockholm adds another dimension to what the EU will be able to do for the health of its citizens.

Nevertheless, questions about the impact of European rules on health systems remain

- One of the main recommendations of the patient mobility reflection process was that legal certainty about the application of European rules needed to be improved.
- This need for greater clarity remains and my colleagues dealing with internal market aspects will address this today.
- There has been a great deal of discussion about these questions, in particular with regard to the proposed directive on services in the internal market (the “Bolkestein” directive proposal). That debate will be lively today!
- I would simply like to underline that we must always bear in mind the patients’ perspective in the middle of these discussions.
- Whatever mechanism we choose, we must be sure that it provides sufficient certainty and clarity for patients to be clear about what their rights under European law. Providers and policy-makers also need to know what the situation is in order to plan and manage services.

This conference is therefore very timely in providing an opportunity to discuss these issues

- I therefore congratulate the *Association Internationale de la Mutualité* for organising this event, and the Luxembourg minister for lending his support to today's conference.
- Speakers and participants will address the various issues relating to legal certainty throughout this day.
- Other colleagues from the Commission are contributing in each of the sessions that will take place today:
 - Geraldine Fages in the session on health services and the internal market.
 - Anne Houtman in the session on health insurance and internal market
 - Jérôme Vignon in the session on social services of general interest.
- I think that the range of Commission participants indicates the seriousness that our Institution attaches to these issues.
- The preparatory work undertaken by Professor Jorens is also provides a valuable overview of the complex nature of the issues to be addressed.

Conclusion

- Health and healthcare now become priority issues for citizens across the European Union.
- Whilst respecting subsidiarity, enabling patients to have healthcare in other Member States is of significant value to European citizens.
- It has a great potential to demonstrate the benefits of European integration in a very tangible way to citizens, and to help improve the effectiveness and efficiency of European health systems overall.
- This needs a proper cooperation framework and accompanying measures to be put in place, which we are working to develop.
- It also requires clarity and certainty about how European rules apply to the health sector, in a way that enables professionals and policy-makers to plan and manage systems and patients to get access to the high-quality care they seek in a way that ensures that systems are financially sustainable.
- This conference is a valuable opportunity to address these issues and prepare solutions to these complex issues.

I look forward to the results of our discussions today.

PRESENTATION OF THE BASIC REPORT



Yves JORENS

*PROFESSOR OF SOCIAL SECURITY
LAW AND EUROPEAN SOCIAL LAW
GHENT UNIVERSITY
BELGIUM*

General introduction

Welfare states are national states. The organisation of health care systems are therefore a matter for the Member States, notwithstanding the gradual, but limited expansion of the competences of the European Union in the field of social policy and public health.

But far more important than the increase in competences attributed in the European Treaty to the European Union, has been and is the influence of the internal market rules. It cannot be denied that health care is an economic market where goods and services are delivered and that in principle could be supplied by private actors operating in a purely commercial market. On the other hand, health care is not a normal market as there is information asymmetry: Suppliers still determine demand, rather than the well-informed consumers. In addition, health care is a fundamental right.

The health care market, therefore, cannot be left completely open to free competition and all Member States have therefore also a widely developed system of collective responsibility and solidarity.

The combination of these two elements of solidarity on the one hand and more economic oriented elements from the free market on the other hand, requires legal fine-tuning. This fine-tuning is an ongoing process, where the European Court of Justice plays the most important role.

Here we would like to discuss a few issues.

I. Access to Health Care in an Internal Market: Impact for Statutory and Complementary Systems

1) Free movement of patients: the relation between the Treaty-based and the Regulation-based Method of Patient Mobility

A. Two methods of mobility

Up until 1998, Community nationals seeking medical treatment in another Member State at the expense of their national health insurance institution had no choice other than to rely on Article 22 § 1 (c) of Regulation (EC) No 1408/71.

The 1998 Kohll judgment of the Court of Justice paved the way for a second method of planned health care abroad, stemming directly from the Treaty. Two different procedures, the one having no primacy over the other – govern

therefore now the assumption of health care costs incurred in another Member State. The Court's reasoning is centred around the advantages the Regulation offers its beneficiaries being that they are entitled to treatment in the other Member States "on conditions as favourable as those enjoyed by insured persons covered by the legislation of those other States".

Admittedly, these are advantages which the Treaty-based procedure does not offer, cannot offer, for lack of a restriction to the free provision of services. Indeed, the mere fact that the national health institution or sickness fund refuses to pay for health care expenses incurred abroad is not sufficient to hold it liable for restricting the free movement of services.

The Court, reiterating its "facultative" interpretation of Article 22, stated in *Vanbraekel* that this provision "does not have the effect of preventing extra reimbursement, additional to that resulting from the application of the system of the Member State [of] treatment [], when the system [of the Member State of affiliation] is more beneficial"

B. Partial incompatibility in respect of extramural care

Vanbraekel was concerned with intramural care for which, even under the Treaty-based procedure, prior authorisation must be obtained. Let us consider now a hypothetical case, which is identical in terms of facts with *Vanbraekel*, except that the cross-border receipt of extramural care is at stake. If the system of cover which is in place in the Member State of treatment is more beneficial to the patient than that in force in the Member State of affiliation, it can be argued that the added value of the Regulation-based procedure makes up for the prior authorisation requirement associated with that procedure. By contrast, if the amount of reimbursement provided by the system of the Member State of treatment is less than the amount which application of the legislation in force in the Member State of affiliation would afford to the patient concerned, Article 22 (1) (c) of the Regulation falls foul of the Treaty provisions in relation to services. Indeed, not only would the patient have a lower level of cover when he received outpatient care abroad than when he underwent the same treatment in the Member State of affiliation – which may deter or even prevent him from applying to foreign health care providers – but in addition, he would not have been required to request prior authorisation. Therefore, in such a case, the Regulation would be incompatible with the free provision of services, and this incompatibility could not just be offset by the granting of an additional reimbursement within the meaning of *Vanbraekel*.

During the revision process of Regulation 1408/71, the issue was raised as to whether the Court's health care rulings should be incorporated into the new coordination regulation. In that regard, it is however to be regretted that the Council has not seized the opportunity, on adoption of the new coordination regulation, to at least implicitly refer to the Treaty-based method of patient

mobility, instead making it appear as if Regulation (EC) No 883/2004 will be the one route for patients wishing to be treated in another Member State at the expense of the national health insurance institution. We believe that the Community legislature ought to take account of the one method while regulating the other, as the Commission has satisfactorily done in Article 23 of its Proposal for a Directive on services in the internal market, intended to codify the Court's health care cases.

2) The active provision of services by foreign medical service providers

However, the case law of the Court raised also questions concerning the active provision of services by foreign medical service providers. Service provision in the health care sector is complicated by aspects of social security.

A. The minor contribution of the recognition instruments

The mobility of medical doctors has been the subject of Community secondary legislation, in the form of a doctors Directive 93/16/EEC according to which the service provider "shall be subject to the disciplinary provisions of a professional or administrative nature which are directly linked to professional qualifications, such as the definition of the profession, the use of titles and serious professional malpractice which is directly and specifically linked to consumer protection and safety, which are applicable in the host Member State to professionals who pursue the same profession in that Member State".

The scope of this article is less than crystal-clear and far from legal certainty lending itself to divergent national interpretations. However at the same time, the Court's services case law has gradually developed to embrace of a "qualified" country of origin principle, on the basis of which a conditional mutual recognition applies. The lawful pursuit of similar activities in the Member State of establishment constitutes minimum, yet sufficient proof of the provider's aptitude as well as of the quality of his services. Conditional, as the host Member State is able to impose its non-discriminatory legislation in the event and to the extent that the legislation of the Member State of establishment of the service provider fails to safeguard a legitimate aim of public interest. If on the other hand the Draft services "Bolkestein" directive were to be adopted, it would become the frame of reference within which the free provision of medical services is to take place. The showpiece of the Draft's chapter on the free movement of services is the country of origin principle, pursuant to which Member States shall ensure that providers are subject only to the national provisions of their Member State of origin which fall within the coordinated field. To a large extent, the Draft services directive draws the consequences of the case law of the Court of Justice. In view of that, the mere exclusion from the Draft's scope of the provision of health-

care-related services, would not place the provision of health care outside the ambit of the internal market. However, the draft services directive goes significantly beyond that under the Treaty provisions. It applies to the entire field of service regulation, which is only declared coordinated, without prior harmonisation of the general interest. Whereas under the Treaty provisions, the host Member State may impose its legislation if and to the extent that the general good is not sufficiently protected by the rules to which the foreign provider is subject in the home Member State, and room is left for a wider margin of appreciation in the presence of sensitive matters and/or diverse standards, the Draft services directive, without instituting it, almost irrefutably presumes a European-wide equivalence in the protection of the general interest envisaging a virtually absolute and unconditional implementation of the home State model. Furthermore, the Proposal for a Directive on services in the internal market adds nothing to the thorny issue of the connection between the intra-Community provision of health care services and the incidence of aspects of social security; the question as to whether, and if so, under which conditions, these services should give rise to a financial intervention by the national health insurance institution in the host Member State remains unanswered.

B. The “Activation” of the health care cases

The requirement of prior authorisation for the assumption of health care costs incurred abroad constitutes a barrier to the freedom to provide services, not only for insured persons, but also for service providers, the nature of the domestic health care system being irrelevant.

In general, Member States will be held liable of restricting the free provision of services whenever they deter patients from seeking medical treatment from a health care provider established in another Member State. This leads to an Europeanisation of the range of providers whom the patient is entitled to visit.

1. Europeanisation of the range of providers: about contracted and non-contracted providers and its reimbursement

This Europeanisation should not be construed by reference to the nature of the national health care system. Which would imply that where Member States operating a reimbursement system, should henceforth cover the medical services provided by any doctor established in the European Union, Member States with a benefits-in-kind system, would have smaller repercussions. It would merely mean that the sickness funds cannot discriminate between domestic providers and providers established in another Member State. We do not think that this Eurospeak argument is well-founded.

Member States operating exclusive contracting systems cannot veil the restrictive effect of the prior authorisation requirement by putting forward that it applies to (domestic and foreign) non-contracted health care providers. In other words, even if foreign health care providers have an equal opportunity to conclude agreements with the national health insurance institution, the prior authorisation requirement for non-contracted care will still work to the detriment of foreign health care providers. The same line of reasoning should apply with respect to the level of assumption of the medical services supplied by foreign health care providers. Member States cannot evade the prohibition contained in Article 49 ECT by reimbursing the costs incurred abroad to the (lower) level of cover they happen to use in respect of care provided by domestic non-contracted providers

C. The temporary provision of extramural care by medical doctors in the host member state

Accordingly, a health care provider established in a Member State where he lawfully provides medical services, is entitled to provide those services on a temporary and occasional basis in the host Member State. As an intrinsic corollary of the qualification of health care professionals as service providers, the Articles 49 and 50 ECT, as construed in the health care cases, have detracted from the powers of the Member States to define, in the presence of an intra-Community situation, the range of providers who are entitled to supply medical services at the expense of the national health insurance schemes. The services of foreign health care professionals who lawfully provide health care in their Member State of establishment are eligible for coverage under the national health insurance scheme of the Member State of affiliation of the patient, irrespective of whether the insured person travels to the Member State of establishment of the health care professional to receive these services or whether the latter provides these services temporarily in the territory of the host Member State, in which the patient is insured. On the other hand, they appear to leave intact Member States' power to define the personal scope of these schemes, their power to determine the treatments which are covered and the extent to which they are covered, and lastly, their power to lay down the conditions on which benefits are granted.

II. Health Insurance and the Internal Market

1) Competition in health care systems

EU law of course does not force the Member States to introduce competition rules in their health care systems. Introducing elements of competition, in an attempt to increase efficiency and cost-reduction, makes them however vulnerable for application of competition rules.

The whole problem of the application of competition law to social security regimes deals with one fundamental issue: is the state or are other organisations authorised to set up any form of solidarity between the members of a certain collective group confronted with certain risks?

2) Competition Law

A. Are social security institutions undertakings?

Are health institutions undertakings? The basic test is whether the activity, at least in principle, could be carried on by a private undertaking in order to make profits and it faces actual or potential competition by a private company. As health care providers perform economic activities, it cannot be ignored that they have to be qualified as undertakings. The Court of Justice has however developed various exclusions in order to limit to a certain extent the spectrum of competition law.

B. Exemptions

1. Imperium

Activities resulting from the exercise of sovereign powers are not economic activities, as there is no actual or potential competition by private companies. Could it e.g. be said of the German Health Care Institutions that they are not subject to the anti-competition rules as they have a statutory duty to provide benefits in kind? But a sovereign exemption does not apply even when a body is exercising official authority, if it trades products or services alongside private undertakings that seek to make a profit. So it is not because certain health institutions- as in Germany- act under public law and form part of the administration that they would not fall under the anti-competition rules. This exception will be difficult to use.

In many health care systems, associations of medical health care providers play an important role and are granted specific powers as being the main and only responsible organisation to license and register practitioners or the remuneration/fees of the health care providers are negotiated between their professional associations and the state. Its decision may sometimes be adopted by law or made binding upon the whole profession. In this respect the questions raises if a high degree of state intervention leads to the conclusion that such associations lack the necessary autonomy to be engaged in economic activities or rather carry out their tasks as executor of the state? The issue here at stake however is not that these activities would not be economic activities, but who is responsible for the distortion of competition: the state under Article 86 or undertakings under Articles 81 and 82?

2. Social activities

A second group of activities exempted from the application of the competition rules are purely social activities. This concept is an invention from the Court of Justice. When judging if an economic activity takes place, one should examine how much space the legislator has left for a free market system when designing the system and to what extent the solidarity principle has been developed. However, balancing on the very thin line between the economic and the social character of an institution is not an easy task and the cases of the Court of Justice show how difficult it is to draw the line between social and economic activities. In addition there is the growing difficulty in defining the concept of social security. What are the typical social security components?

Elements such as contributions related to income, no relation between contributions and benefits, compulsory affiliation and no real possibility to influence the level of contributions, seem to point in the direction that one could not speak about undertakings. This last element however has become questionable following the ECJ's AOK case on German sickness funds. It seems logical that when sickness insurance funds can differentiate (part of) their level of contributions, irrespective of income, they will be considered as undertakings. Are contributions not to a certain extent also the financial compensation for delivering services? For the Court, however this one element of competition is not sufficient, deviating in that respect from the famous Poucet and Pistre case. The Court however pointed out that the funds might engage in operations that were not social, but economic in nature. Organisations therefore can partly be an undertaking and partly not.

Notwithstanding the clear elements of competition between the German sickness insurance funds, the Court did not want to consider them as undertakings. Perhaps the Court herewith wanted to make clear that one should not only look at the internal organisation, but rather at the ultimate aim (solidarity and redistribution) of the system.

The problem remains however that the line between entities being undertakings and entities that are not undertakings is very unclear and impossible to draw in general. Therefore no general statement can be made with respect to the application of competition rules in the health care sector

C. Health care institutions as purchaser of products

Health organisers act not only as suppliers of benefits, but as purchasers of health care products by contracting out or demanding certain health care services or purchasing medical equipment or pharmaceuticals. Does the non-application of the competition rules also apply to these activities? Is an activity on an upstream market (purchasing goods or services) not subject to competition law if there is no downstream activity (reselling to the citizens). The Court held that it would be incorrect, when determining the nature of that

subsequent activity, to dissociate the activity of purchasing goods from the subsequent use to which they are put. The activities on the supply side determine the character of these activities on the purchaser's side. An explanation could probably be found in the fact that as the insurance activities of these entities are strongly influenced by the solidarity principle, the entities concerned have no commercial interest when buying care on the market. The conclusion could however be different when the care they buy is not used for their patients/insured persons, but is sold to health care providers in other Member States.

The fact that these activities do not fall under the anti-competition rules, however, does not exclude the applicability of EU law, in particular the public procurement directives.

D. Prohibited conduct :cartel prohibition and abuse of dominant position

Competition rules forbid several conducts, as e.g. cartel prohibition. This could be the case if

health care providers agree amongst each other –not to contract under certain tariffs when negotiating collaboration agreements with the health insurance institutions. Or health insurance institutions that purchase together health care from health care providers could form a forbidden cartel as this could in certain circumstances lead to forbidden joint purchasing agreements. But could we e.g. also speak about abuse of dominant position in cases where a health insurance institution with a dominant position refuses to conclude a contract with a health care provider? Imagine the situation where a health insurance fund that occupies a certain region has a dominant position and refuses to offer contracts to certain medical providers. This is as such not really forbidden. Anti-competition law does not forbid a dominant position, but only if one abuses this position. This could e.g. be the case when a health insurance institution concludes that demand for a certain service has not increased with respect to last year and as a result will not allow it to sign a contract with new health providers.

But what to be said about e.g. the French complementary CMU (Couverture Maladies Universelles) system where beneficiaries are free to choose between either the statutory sickness fund and traditional complementary insurance, as mutual benefit societies, provident institutions and commercial insurance companies. Does this participation of the French public sickness funds in administering free complementary health insurance not lead to a dominant position and unfair competition? This could be believed. The same doubts could also be expressed with respect to the Flemish long-term insurance care, where commercial insurers compete with mutual health funds, responsible for the public health systems. Or what to be said about the fact that under Belgian law, insured people are obliged to accept the

complementary services offered by the mutual health funds -responsible for the public health system- they are insured with?

E. State aid

In the health care sector, the state gives many times certain financial advantages to health insurance funds, like subsidies, or forms of tax relief, credit facilities. Is this state aid? Or what if e.g. the state were to cover the deficit of certain hospitals? Or what about the compensation paid out of a risk-equalisation fund? The answer to this question remained unclear not least as a result of the fact that the case law of the Court of Justice and the Court of First Instance differed. It has to be said that the Court of Justice's approach in the Altmark case is more balanced, thereby examining more closely the operation of public service obligations and the services supplied in connection with a discharge of the public service obligation, which will not be recognised whenever the undertaking's activities have no connection with the provision of public service obligations. It remains to be seen however whether the approach is satisfactory or still too theoretical for relying on a typical undertaking well-run and adequately provided, except in cases of public procurement, where it is presumed that market conditions prevail.

3) The internal market and voluntary health insurance

A The possible application of the non-life assurances directives

Notwithstanding the dominance of solidarity-based statutory health care systems in the European Union, it cannot be neglected that voluntary health insurance plays a more and more important role in health protection. However, any Member State will, even when introducing private insurance companies for the execution of their health care system, prescribe certain statutory guarantees, such as the obligation to accept insurers or the prohibition of risks selection, exactly in order to protect the consumer/insured person. To what extent is the introduction of such guarantees contrary to the principles of the non-life insurance directives? Can social objectives therefore only be guaranteed through a statutory system of social security?

1. Field of application

The question if voluntary statutory health insurance falls under the field of application of the third non-life insurance directives is far from clear. Substitutive health insurance, providing private cover for persons excluded or exempted from statutory protection, seems to be included in the scope of application of EU insurance law. There is one certainty. For the applicability of the Directives, it is important according to the Court that insurances are offered at their own risk. But how should this concept be interpreted? Is the concept of "own risk" limited to the "insurance risk", i.e. the financial risk as a consequence of an uncertainty element characteristic for every insurance

relation or does it refer to any company-business risk? Is there convergence between the concept of economic activity under the competition rules and the activities which fall under the field of application of the third non-life insurance directive? Can we therefore say that the third non-life insurance directive does not apply when the insurers are performing a purely social activity?

2. The content of the third non-life insurance directive

Application of the non-life insurance directives, Member States shall not adopt provisions requiring the prior approval or systematic notification of general and special policy conditions or scales of premiums. A full harmonisation in the field of non-life insurance rates was clearly not the intention of the Community legislator. The question remains however whether other national regulations, not dealing with the business of insurance, are also forbidden by this article? This would imply that regulations other than those concerning financial supervision (such as e.g. obligation of acceptance, a minimum package of benefits to be provided), would not be possible either.

3. Limits of Article 54: general good exception

But even when certain measures are not in conformity with Article 29, an exception and justification may be sought under the general good exception.

It remains unclear however how broad this exception might be interpreted and in particular, whether this article also applies when private insurance companies substitute entirely the statutory system of social protection? Under a narrow interpretation the directive would only apply to private insurances that exist apart from the public statutory system and fulfils for a part of the population the function that the statutory public system fulfils for the rest of the population. There are however arguments in favour of a broad interpretation.

4) Procurement directives

Even when social security institutions do not fall under competition law because they are not undertakings, they are not exempt from EU law. In particular, discriminatory public procurement is considered to create significant barriers to trade. But do health care institutions fall under the field of application of the procurement directives? Therefore institutions do not have to be a formal part of the state, but could be said to be active in name of the state. In the public market it is not the commercial characteristics of private entrepreneurship that prevail in as much as the aim of the public sector is not the maximisation of profits, but the serving of public interest. Consequently, whenever bodies or entities, like health care institutions, perform activities not with a commercial intention and to maximize profits, but to provide goods and services for the public and thus in the general interest,

these institutions are active on the public market and therefore the public procurement laws will be applicable. However procurement rules will apply, irrespective of the fact whether it pursues a general interest needs or just commercial interests. Health care institutions purchasing for their own purposes equipment and buildings, will therefore have to apply the public procurement directives. In the case of health care institutions that provide benefits in kind, the public procurement directives apply to relations between the health care institutions and the performers of services.

During the last years the private sector is also becoming increasingly involved in delivering public services. In this public private cooperation the state no longer delivers the services. If contracting authorities award their public contracts via private undertakings under their control, these entities cannot be classified as contracting authorities within the meaning of the directives. In a certain way the Court of Justice found a response to this by stating in cases where a contracting authority has established an undertaking in order to enter into contracts for the sole purpose of avoiding the requirements specified in public procurement law, then the relevant directives should apply.

Concluding remarks

The whole problem of the application of competition rules is dealing with the question which criteria an insurance system has to meet to be considered as “a social security system” allowing it to escape from full application of the internal market rules. It is remarkable that exactly an important aspect of what is social security, is answered differently by the Court, most of the time depending on the European instrument in question. A crucial policy question is thus at what point of this “balance of solidarity” the degree of solidarity in a given scheme will not suffice to be exempted from European economic law. Are certain types of solidarity (income solidarity, solidarity by scope, risk solidarity, intergenerational solidarity and solidarity between schemes) more decisive than others for the outcome of this weighing exercise and which? How far can the Court go in this respect without compromising its own authority? The different cases have however shown that social objectives can be introduced as a safeguard against full application of the competition rules and this not only in the public sector. Article 86 (2) could thus be successfully invoked in order to set aside the application of the competition rules, in particular when the activity does not fulfil the conditions in order to qualify as a “core” solidarity activity but, still, displays enough solidarity aspects, including compulsory affiliation. A balance is herewith found between competition law and social law. This tendency is important in a time where social security is more and more shifting from a public to a mixed private-public system. Even when private elements are introduced in social security systems, it doesn't seem that the free market will apply without mercy.

III. The Notion of “Social Services of General Interest” as counterweight to the internal market rules

1) Services of general interest

The last part of our report examined a concept in Community law that could constitute a safeguard or counterbalance to this increasing influence of market-based rules. The practicability of this concept is to be viewed in the first place on a looser conceptual level under the denominator of “services of general interest”, which are tackled in a recent Commission White Paper. The topic of services of general interest has acquired an inerasable place on the political agenda of the European Union.

To this very day, at the level of the European Union, the services of general interest debate is still very closely linked to the “services of general economic interest” concept in Article 86(2). This is not surprising, as the Treaty itself concentrates mainly on economic activities. The term “services of general interest” is only used where it is not necessary to specify the specific nature of the services concerned or where the text also refers to non-economic activities. This could lead to new Babylonian misunderstandings, as the term “services of general interest”, conceived to function as a general term, thus becomes (maybe too) strongly related to non-economic services, with the risk of ending up as a synonym of “non-economic services”. On a strictly legal level however it is only the sub-concept of “services of general economic interest” as it appears in the Treaty that can be used as a decisive derogation to the provisions of Community law.

Article 86 has been described as the “Article reconciling Community objectives with the fulfilment of the mission of general economic interest entrusted by public authorities”.

The interpretation of this article has produced a long list of complex and from time to time puzzling case law from the Court of Justice, however showing an obvious change in approach of the Court of Justice to its interpretation, from economic measurement to value judgement. This certainly points to future opportunities with regard to recourse to Article 86(2) as a counterweight for the normal application of Treaty rules before the Court of Justice. This status is reinforced by Article 16 EC.

2) Health care as a social service of general interest

Putting the Babel-like confusion relating to the term and the historical connection of the concept to the network industries aside, one straightforwardly agrees that the concept of services of general interest, as services of which the provision to the citizens is deemed very important in a given society and therefore is submitted to a number of common values and principles (like human dignity, solidarity, social justice, social cohesion...), fits

perfectly for health care. As a strongly person-oriented sector, health care is to be considered as a “social service of general interest”, -independent of the question whether the health care sector and its subdivisions are to be considered economic or non-economic- and therefore subject to additional requirements. In a nutshell, health care evidently is a part of this “pillar of the European model of society”.

But legally binding provisions on “services of general interest” are as we have seen absent in Community law. We have only article 86 §2, which aims at “economic” services, which as we have also seen is exactly a troublesome qualification. It is impossible to draw up a list of “a priori non-economic services”: what is sheltered from internal market and competition rules today, can be an economic activity tomorrow, depending on changing views on the role of the state and political reorientations in the Member States. In this view the importance of Article 86(2) for justifying national measures aiming at solidarity or other social objectives could be major and this Article could become the key element in finding a balance between the application of EU competition rules and socially inspired activities, as a “third way” next to the “state prerogative” and “solidarity”-exemptions.

But should this issue continue to be dealt with on a case-by-case basis? Is Art. 86(2) EC case-law considered to be the right path to mitigate potential undesired impact of European economic law on health care policy? Should the Treaty provide for a general derogation clause for social security and if so, how to define “social security”? Must the answer rather be found in secondary legislation? Could e.g. a consensus be reached on a European legislative framework on standards for health care as a service of general economic interest, in which common values are laid down and thus legal safeguards as to solidarity, equality, accessibility, affordability, etc..., would become a part of Community law? Expressing this kind of considerations could be building castles in the air, but touching on emanations of the legal uncertainty regarding the relation between national health care policies and the EU internal market and competition policies, there is a strong case for these issues to be sorted out within the scope for policymaking of the Community. If not, the legislative powers of the Community probably condemn themselves, as they are still doing, to tail along after the case-to-case solutions of the Court .

Either way, it could be argued that also basic health care insurance can be qualified as an economic activity, without being robbed of the elemental solidarity grounds it is based on. The final result probably will not differ much from the current situation, but the institutions managing health care schemes would then be put in a situation of more legal certainty, as their activities would be considered as an economic activity, to which competition law is applicable in principle, but for which clear safeguards (on the basis of Art. 86(2) EC, future primary or secondary legislation) can be provided in order to

protect the fundamental principles most health protection schemes are based on.



Anne VAN LANCKER

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I would like to thank the Luxembourg Presidency of the European Council for organising this important conference on access to health care at a crucial moment in the European agenda and to give me the opportunity of speaking on behalf of the European Parliament.

Health care is a booming source of economic activity. Therefore, it's an important issue in the framework of the Lisbon agenda. Whilst recognizing that the creation of an internal market for services can stimulate economic growth and create jobs, it is equally important to stress that this should be done in a balanced way, especially in the case

Access to good quality health care is one of the major preoccupations of the European citizens. Health care systems in the Member states have developed over time for the well-being of people. Access to health care nowadays is considered as a fundamental right in Europe and the principles the systems are based upon- solidarity, inclusion, quality, access for all, - are core values for the European social model. For this reason, health care should never be considered as just an internal market issue. It should also be a common social challenge in the framework of the European social agenda.

However, as clearly demonstrated by professor Jorens, the competence of the EU in the field of health care remains rather limited. This limited competence of the EU makes the EU interventions, in the form of a positive integration, still rare. Given the very sensible character of national health care and social protection issues, a certain reticence is even understandable.

However, there are many reasons why the EU should get more involved in a positive way with health care.

- Firstly, although member states have different systems of organising and financing health care, the systems are facing many common challenges: the ageing of the population and the changing care needs of the elderly, the development of medical science and techniques, the need for more prevention care, the lack of sufficient qualified care providers, f.e.
- Secondly, citizens in Europe use their right to free movement more frequently. They live or reside in another member state and have access to care
- Thirdly, health care is not excluded from the application of the internal market rules. The European Court of Justice has repeatedly recognised health care as a service within the meaning of the Treaty and confirmed

that patients, as recipients of services, must be able to enjoy the free movement of services that the Treaty guarantees.

The process of positively coordinating health care at the EU level has been very modest and slow up till now.

Already in 1992 the Council stated in a recommendation that the "Member States should maintain and develop high quality health care systems". And although in 1999 the Council recommended health care as one of the four areas of social protection, where reinforced cooperation is necessary, there still is no real strategy at EU-level. After delivering its joint report in March 2003, Council did not show overwhelming enthusiasm to the work more ambitiously on health care at EU level.

Last week the European Parliaments' Committee on employment voted its report on the European Commissions' Communication on "Modernising social protection for the development of high quality, accessible and sustainable health care and long-term care". We warmly welcomed the fact that the European Commission wants to assist Member States in de modernisation and reform of their health care systems through the "open method coordination". We also strongly supported the 3 basic objectives of universal access for all to health care, high quality of care and long-term sustainability.

Parliament considers this Communication as a useful supplement to the Commissions Communication on the 'High level process on patients mobility and the development of health care in the EU", because together they could constitute at last a more comprehensive strategy to develop common views for European health care systems and social protections systems. It surely is high time to deliver!

Despite of this (still rare) initiatives of positive integration of European initiatives in the field of health services, we observe however a growing impact of the European internal market rules (by negative integration). The qualification of health services as a service in the sense of the Treaty makes the competition rules, the free provision of services, the state aid rules and the procurement directives apply. The full application of these kind of rules (especially the competition law and state aid rules) to our national health systems, could, as underlined by Jorens, put the accessibility to our systems under huge pressure. Therefore, it's absolutely necessary that a fair balance should be found between social issues (accessibility, high quality of health ...) and internal market topics.

An analysis of recent rulings of the Court of Justice makes me more hopeful in this regard. It seems to me that efforts are made to find such a balance: the Court does not apply in a blind way its competition rules to health systems, but tries to take all aspects and characteristics of the national health system at stake in consideration.

Despite of this 'good' rulings of the Court of Justice in the field of the health services, being member of the EP, I am, of course, not fully happy with the evolution that a 'European policy in the health sector' is developed by the judges of the ECJ. Indeed, doing nothing on the political side is not a good option. Health care policies should be directed by politicians, not only by judges.

But although the EU health Ministers already acknowledged this in 2002, progress is limited. There was no real enthusiasm to start a real Open Method of Coordination with clear objectives, action plans and indicators. And in the outcome of the modernisation process of the regulation 1408/71, the problems of reimbursing costs of health care, were not properly addressed.

On the other hand, I miss such a fair balance between social topics and internal market rules in the proposal for a directive concerning services in the internal market of January 2004. This directive will have an enormous impact on health care. Indeed, it does not only deal with reimbursement of costs, but also deals with the health care sector as it does with any other service sector.

For the majority of the European Parliament this is unacceptable. Health care services do not belong in an internal market directive that does not consider the specific features and requirements of this sector. Let me give three reasons for this.

1. As I said before, in EU access to high quality health care is a fundamental right. European health care systems are therefore based on solidarity and universal coverage and embedded in social protection systems. Provision of high quality care, equally accessible to all citizens is considered a core task of public authorities, that invest large amounts of public money in this sector.
2. Health care providers form part of complex system of interactions between many players and there are many built-in checks and balances. Not only customers and suppliers are involved, but also a third party that pays the major part of the bill. Price mechanisms based on the supply and demand do not work here. Therefore healthcare financiers make agreements with care providers on price, content and volume of care.
3. Patients are not ordinary consumers of care. They are vulnerable and dependent. Health care is increasingly complex and patients do not have access all necessary information. Information asymmetry between patients and health care providers is a specific feature of the health care sector.

The services directive does not respect these specific features at all.

The chapter on freedom of establishment obliges member states to simplify and remove a large number of authorisations and licensing procedures and to limit the number of documents required for access and exercise of a service. It also obliges member states to set up a major screening exercise to

identify and assess procedures and conditions that service providers have to comply with. If these are not non-discriminatory, necessary and proportional, they should be abolished.

However, authorisations and licensing procedures in health care aim to guarantee the quality of care providers and equal access to care and the conditions that should be screened include national legislation on planning, price fixing mechanisms, the not-for-profit character of health care, staff requirements in health care institutions and referral systems. But these are basic instruments of health care authorities to ensure quality, accessibility and sustainability of health care!

The chapter on free movement of services introduces the principle of the country of origin. According to this principle, health care providers wishing to provide care on a temporary basis abroad would only be subject to the provisions of the member states of their establishment. These provisions include requirements governing the behaviour of the care provider, the quality or content of care, advertising, contracts and the care providers' liability.

Although some of the general and specific exceptions to the country of origin principle may be helpful to avoid the worst-case scenarios for health care systems, it is obvious that, given the enormous diversity in the organisations of health care between the 25 member states of Union and without any previous harmonisation, the principle of the country of origin can simply not be applied to health care. It would open a door for competition between health care conditions and legal requirements. And provide a spiral of deregulation. Such a scenario could only be detrimental for patients and the quality of care.

Therefore I am convinced as rapporteur the European Parliament will follow my advice to exclude health care services completely from the scope of the services directive.

Having said that, this does not mean that health care will be safeguarded from the application of internal rules. Indeed, the European Court of Justice will continue to jurisdiction on these issues and the European Commission started several infringement procedures.

Furthermore, the application of internal market rules is not limited to cases where patients move abroad for health care reasons, but also applies to cases where care providers move.

Finally, there is a need for positive impulses for development of national health care systems and cross border cooperation.

Therefore, the EU should speed up its legislative and coordinating action in this field.

(1) Firstly, the legal uncertainty for patients getting their care abroad without prior authorisation in unwilling member states, that do not comply with the ruling of the European Court of Justice should be stopped by law.

The report of the high level process on patient mobility recommended that secondary legislation could include further provisions updating the regulation on the coordination of social security systems (Reg 1408/171), or general provisions on free movement of patients or specific clarifications on the application of community law to health services.

It is a missed opportunity that Council did not solve part of this problem whilst dealing with the modernisation regulation 883/2004.

I think that - whilst exempting health care services from the services directive - Council should at the same time reach a political agreement on the issue of reimbursement of health care costs.

(2) Secondly, health care services must be safeguarded in a positive way through a framework directive on services of general interest. In its white paper on SGI, the commission fully recognised the general interest of social and health services. The Commission argued for a systematic approach to identify the specific characteristics of social and health services and to clarify the framework in which they can operate and can be modernised. Therefore, the Parliament is happy with the initiative taken by the European Commission to publish a communication on social services of general interest, taking into consideration the particularities of the health care sector. This could be an important step towards a proposal for a special legislative instrument dealing exclusively with the social and health services.

I know that this is not an easy thing to do, given the differences in health care systems between member states and the sensitiveness of the issue. But a clear definition recognising the specificity of social and health care services of general interest could provide the building blocks for a legal provision that would stop internal market rules from being blindly applied to these services.

Recently, a majority in parliament supported the idea of a framework directive on services of general interest. The future constitution provides for a new legal basis for such a framework directive. (art. 86§2) But the commission should not wait for ratification of the constitution to start working on such a framework directive.

(3) Thirdly, the open method of coordination on health care and long term care must be launched as soon as possible. The 3 basic objectives (quality, accessibility and sustainability) need to be worked out more in detail in order to identify common principles for the definition of health care as a service of general interest.

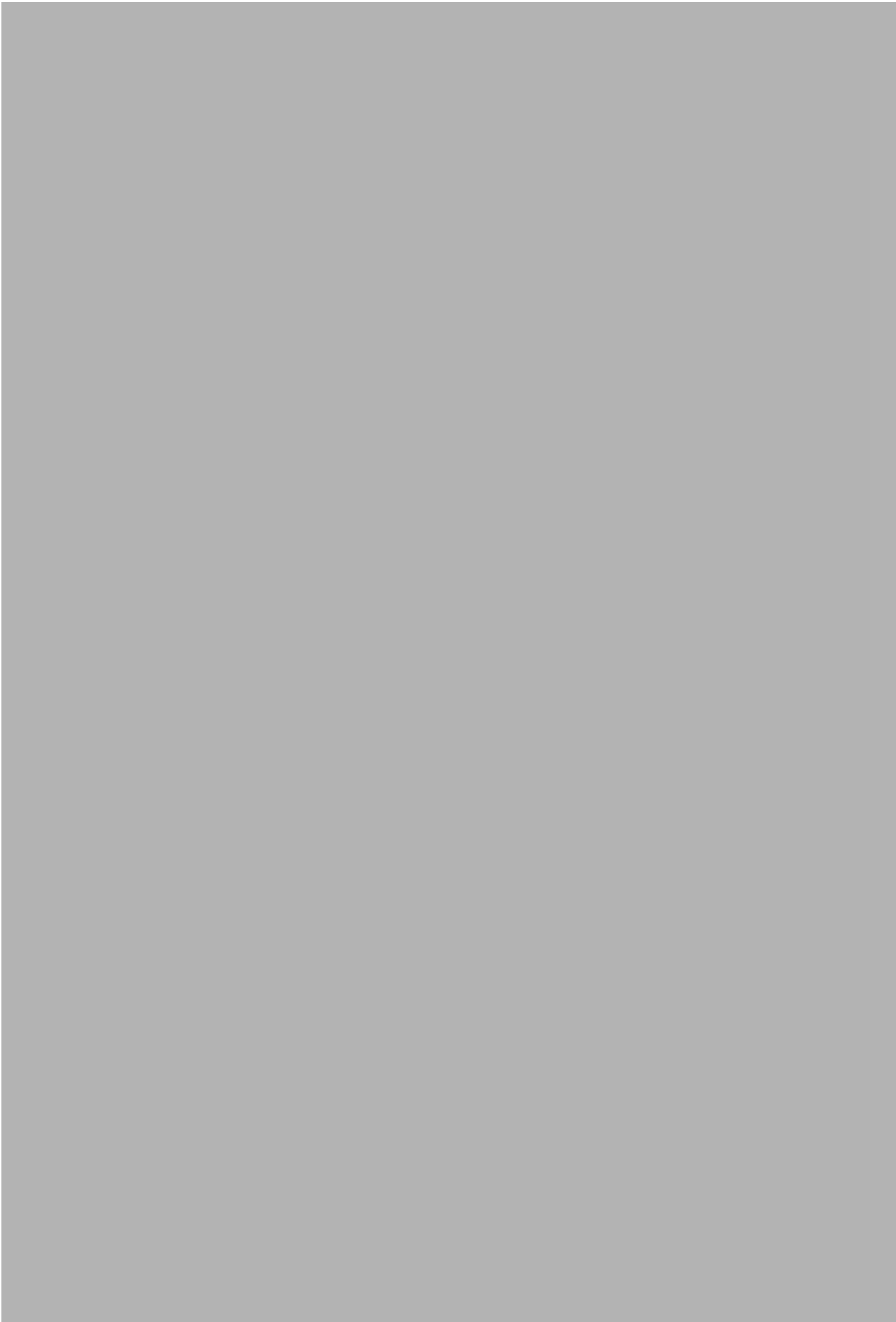
If the open method of coordination is taken seriously, it will also contribute to a process of mutual learning and exchange of best practices and thus to improvement of health care systems of the member states.

I sincerely hope that this high level conference will convince European politicians of the need for action and bring them some fresh ideas to build out a coherent strategy on health care in Europe.



SESSION 1

**HEALTH SERVICES IN THE
INTERNAL MARKET**



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1) Introduction

Dans la première partie de son rapport sur l'accès aux soins de santé dans un marché unique, le professeur Jorens nous a dressé un état des lieux extrêmement détaillé quant à la coexistence des deux procédures d'accès aux soins transfrontaliers. Il s'agit, d'une part, de la procédure traditionnelle prévue à l'article 22 du règlement 1408/71 avec l'exigence d'une autorisation préalable. Il s'agit, d'autre part, de la procédure nouvelle résultant directement du traité instituant la Communauté européenne (articles 49 et 50) qui se fonde sur le principe de la libre prestation des services à l'intérieur de la Communauté.

En outre, il a mis en évidence les difficultés pour les systèmes nationaux de santé qui résultent de la nature particulière des soins de santé en tant que services. En effet, la prestation de ces services se déroule dans un cadre triangulaire ou intervient à côté du médecin et du patient également l'organisme de financement. Elle nécessite donc un certain conventionnement entre les prestataires et l'organisme de financement.

N'étant pas un expert en droit communautaire, mais un gestionnaire de l'assurance maladie, je voudrais vous présenter mes réflexions concernant les conséquences pratiques de cette jurisprudence sur la gestion des systèmes de soins de santé.

Je vais vous présenter ces conséquences de la perspective d'un petit pays, qui, à l'opposé de la plupart des pays européens, subit les répercussions de cette jurisprudence avec un impact amplifié. En effet, le Grand-Duché de Luxembourg avec sa population résidente de 450.000 habitants présente certaines particularités qui le distinguent des autres pays.

En premier lieu, la taille réduite de la population entraîne nécessairement que l'offre de soins de santé ne peut pas couvrir tous les domaines spécialisés de la médecine à l'intérieur de son territoire et que le Luxembourg est obligé de recourir aux soins de santé offerts par les autres pays européens. Ainsi, le nombre de transferts à l'étranger sur autorisation préalable concerne plus de 2% de la population résidente.

Ensuite, l'exiguïté du territoire fait que chaque résident du pays se trouve à moins de 30 kilomètres d'une frontière, de sorte que la distance aux prestataires étrangers ne constitue guère de barrière pour l'accès aux soins.

De même, la pratique répandue des langues française et allemande supprime toute barrière linguistique vis-à-vis des pays avoisinants que sont l'Allemagne, la Belgique et la France.

Le problème de l'accès aux soins à l'étranger se pose donc du point de vue quantitatif d'une manière beaucoup plus aiguë que tel ne semble être le cas dans les autres pays européens.

2) Le problème du conventionnement des prestataires de soins

Dans ce contexte, je voudrais focaliser mon attention sur une caractéristique essentielle des systèmes de soins nationaux, caractéristique qui me semble totalement mise en cause au niveau européen par les libertés fondamentales incluses dans le traité.

2.1 La situation au niveau national

La caractéristique particulière des systèmes de soins de santé est précisément celle que les prestataires de soins de santé ne peuvent pas fournir librement leurs services à l'intérieur d'un pays, lorsque ces services sont financés par la collectivité sur la base du principe de solidarité.

Dans tous les Etats membres, on constate que le développement de la sécurité sociale sous quelque forme que ce soit en matière de soins de santé, a conduit historiquement à des formes de régulation extrêmement poussées du marché des soins de santé. Que cette régulation ait lieu dans le cadre de services nationaux de santé, centralisés ou décentralisés ou qu'elle ait lieu dans le cadre de systèmes d'assurance sociale, type remboursement, type prestation en nature ou type mixte (comme au Luxembourg), cette régulation a en définitive comme objectif de contrôler l'offre de soins de santé.

La finalité de ce contrôle consiste évidemment dans la limitation de la croissance des dépenses de santé en vue d'assurer l'équilibre financier. En effet, dans la mesure où ces soins de santé sont pris en charge totalement ou partiellement par un tiers, à savoir la collectivité publique, les mécanismes économiques classiques de l'offre, de la demande et de la fixation des prix ne fonctionnent plus normalement. Il s'agit justement de maîtriser la demande induite par l'offre des prestataires et de restreindre le hasard moral résultant du fait que les patients n'ont plus à supporter le coût intégral des services.

Ce contrôle a également pour objectif de garantir la qualité des soins et d'agir sur l'asymétrie d'information entre le patient et le prestataire.

Que cette régulation ne soit pas un simple accessoire de la politique sociale, mais constitue un pilier fondamental de cette politique, peut être documenté par le fait que, dans la législation sur l'assurance maladie au Luxembourg, le chapitre relatif aux relations conventionnelles avec les prestataires occupe un quart des articles de la loi sur l'assurance maladie.

Quelles que soient les formes que cette régulation du marché des soins de santé ait prises au niveau national, cette régulation s'inscrit depuis toujours dans le cadre de la compétence des Etats membres pour aménager leurs systèmes de sécurité sociale, compétence qui ne devrait pas être mise en cause par le droit communautaire.

2.2 La situation au niveau européen

Que se passe-t-il maintenant, si l'on passe du niveau national au niveau européen. Que le principe de la régulation du marché des soins de santé par des relations conventionnelles avec les prestataires ait une raison d'être est documenté par le fait que chaque Etat membre la pratique avec des degrés de contrainte plus ou moins forts. Il faudrait donc conclure que le principe de la régulation du marché des soins de santé a également une validité au niveau européen puisqu'il est pratiqué dans tous les Etats membres qui composent l'Union européenne et qu'il constitue une caractéristique fondamentale du système de soins de chaque Etat membre.

Mais tel n'est pas le cas.

La Cour de justice européenne a jugé que malgré la nature particulière de certains services – et dans le cas présent des soins de santé – cette nature particulière ne saurait faire échapper ces activités au principe fondamental de la libre circulation. Il s'ensuit que toute tentative par une législation nationale de restreindre la prise en charge de prestations transfrontalières – soit par le déremboursement, soit par un remboursement réduit, soit par une autorisation préalable – au motif que le prestataire étranger ne soit pas soumis aux relations conventionnelles, est considérée comme une entrave à la libre prestation de services. A remarquer que ces restrictions restent parfaitement valables à l'intérieur de chaque Etat membre.

On constate donc qu'en passant du niveau national au niveau européen, on est en présence d'une rupture dans la logique de la prise en charge des prestations. Les prestations d'un médecin non conventionné doivent être prises en charge différemment selon que le médecin réside de ce côté de la frontière ou de l'autre côté de la frontière. Il s'ensuit que la régulation prévue au niveau national ne fonctionne plus pour les prestations transfrontalières.

Il est évident que cette situation affecte davantage un petit pays où la demande transfrontalière de soins de santé est importante en comparaison avec les grands pays où cette demande est nettement plus réduite, en raison de l'offre plus complète de soins à l'intérieur de leur territoire. Pour un petit pays, comme le Luxembourg, la question de la possibilité d'un contrôle de l'offre de soins se pose donc concrètement. En outre, la proximité de l'offre transfrontalière qui n'est plus soumise aux contraintes de la régulation du marché luxembourgeois, provoque un fort sentiment de discrimination à rebours des prestataires luxembourgeois, ce qui rend extrêmement difficile les négociations avec le corps médical.

Ce qui est paradoxal, c'est le fait que la grande majorité des soins de santé en Europe soient délivrés dans le cadre de prestataires de soins conventionnés sous une forme ou une autre avec leur système de santé. Ce n'est qu'une minorité de soins qui sont prestés en dehors d'un tel système (notamment les patients privés et les personnes ne disposent pas de couverture sociale). Et ce sont les caractéristiques commerciales de cette minorité de soins de santé qui devraient maintenant s'appliquer à tous les soins transfrontaliers.

3) Quelles conséquences au niveau politique ?

Il faut se demander si ce défaut de continuité dans le traitement des prestations transfrontalières correspond à une véritable volonté politique au niveau européen ou s'il résulte d'une application mécanique d'une certaine hiérarchie des principes, à savoir que la libre prestation de services transfrontalière prime le droit des Etats membres d'aménager leur système de sécurité sociale.

La première hypothèse d'une volonté politique explicite au niveau européen de ne plus restreindre la libre prestation de services devrait logiquement aboutir au niveau national dans la suppression de toutes les limitations quant à la prise en charge de prestations fournies par des prestataires non conventionnés. Face aux difficultés croissantes du maintien de l'équilibre financier des systèmes de soins de santé nationaux, une telle volonté n'est manifestement pas décelable dans les différents Etats membres.

La deuxième hypothèse d'une résultante mécanique de l'application d'une certaine hiérarchie des normes me semble davantage plausible.

Aussi se pose-t-il la question de savoir s'il est possible de maintenir au niveau européen cette caractéristique fondamentale des systèmes de santé nationaux, à savoir le principe du conventionnement des prestataires en dépit du principe de la libre circulation des services.

Comme le principe de la libre prestation de service figure directement dans le traité, il ne suffira pas d'exclure de la Directive relative aux services dans le marché intérieur les services de santé et les services d'intérêt général financés par des fonds publics.

En effet, il faut se demander s'il est justifié de qualifier indistinctement tous les soins de santé comme services au sens de l'article 50 du traité. En raison de la relation triangulaire particulière entre le patient, le prestataire et l'organisme de financement et de la nécessaire régulation existant dans cette relation, il faudrait distinguer entre les soins de santé financés par la solidarité et les soins de santé ne tombant pas sous un tel financement solidaire.

A mon avis personnel, il sera nécessaire de créer au niveau du traité une dérogation à la libre circulation des services pour les services de santé qui sont financés par la solidarité, quitte à prévoir qu'un règlement ou une

directive spécifique fixe les règles applicables aux soins transfrontaliers financés par la solidarité.

Par exemple, pour un pays comme le Luxembourg avec un niveau élevé des coûts des soins de santé, il serait parfaitement possible d'accepter la prise en charge des soins transfrontaliers sans autorisation préalable aux tarifs sociaux du pays d'accueil, à la condition que ces soins de santé soient prestés par des prestataires conventionnés dans le pays d'accueil et selon les règles applicables dans ce pays d'accueil.

Un tel type de solution pour les soins transfrontaliers qui se réfère aux principes de la coordination contenue au règlement 1408/71, respecterait cette caractéristique essentielle des systèmes de soins de santé.

D'ailleurs, il fournirait une solution pour des cas problématiques qui subsistent actuellement au Luxembourg. Pour des traitements indispensables qui ne peuvent pas être réalisés au Luxembourg, il n'existe aucun tarif au Luxembourg puisqu'il n'est pas possible d'en déterminer le coût de revient. Quel montant rembourser à un patient qui s'est fait traiter à l'étranger chez un médecin ou dans un hôpital non-conventionné et qui présente des factures établies pour un patient privé ? Le fait de s'adresser à un médecin ou un hôpital conventionné produirait au moins des factures selon les tarifs sociaux du pays d'accueil.

Toutefois il est évident que cette solution ne serait pas, pour le moment, économiquement supportable pour les pays où le niveau des coûts des soins de santé est nettement inférieur à celui du pays d'accueil du patient.



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Les services de santé sont des services: il y a toujours une offre et une demande, celui qui offre et celui qui demande-reçoit. Mais ils sont des services spéciaux.

Dans le système sanitaire public espagnol, il y a quelques nuances à la conception classique de service. Celui qui offre c'est celui qui paie et celui qui reçoit ne paie pas, au moins directement (avec l'exception des médicaments)

Les services sanitaires publics sont gérés par les régions. Les professionnels de la santé qui travaillent dans les centres de santé ou les hôpitaux sont des fonctionnaires. Ils doivent passer un concours, ils reçoivent un salaire et il y a toute une procédure pour changer de poste de travail. Ils ne sont pas des professionnels indépendants qui offrent ses services et qui sont payés par acte médical.

C'est l'Administration, de l'État et régionale, qui planifie, organise, finance, offre et fournit les services et soins de santé. C'est pour cela que pour l'Espagne les services de santé sont des services, mais spéciaux.

Le système de santé privé est parallèle, un système séparé.

Jusqu'à récemment, les patients n'avaient pas beaucoup de choix. Chaque personne, chaque citoyen était attribué un médecin généraliste, en fonction du domicile. Et selon le médecin généraliste, sont attribués le médecin spécialiste et l'hôpital de référence. Mais, cela permet avec pas beaucoup d'argent, plus ou moins 1000 Euro par personne et par année, d'avoir un état de santé pas mauvais, le septième dans la classification de l'OMS et avoir une espérance de vie qui est entre les meilleures du monde, surtout pour les femmes. Et tout ça avec une protection sociale dans d'autres domaines qui est loin de celle d'autres pays (il n'y a pas d'allocations familiales directes, on commence seulement maintenant à discuter la couverture de la dépendance, les soins pour les personnes âgées ne sont pas grandement publics, etc).

Notre système de santé n'est pas un système de sécurité sociale. C'est très difficile à faire comprendre cela. La Sécurité Sociales est une chose et la Santé une chose différente. Ce sont des Ministères différents, ce sont des services différents, ce sont des budgets différents et ce sont des objectifs différents. Les soins de santé sont payés par les impôts. Les paiements pour la sécurité sociale (une partie du salaire du travailleur et une partie payée par l'employeur) sont destinés à la pension de retraite, le chômage, les paiements du salaire en cas de maladie, maternité ou invalidité, entre autres.

La carte sanitaire européenne est une carte de sécurité sociale pas une carte de santé. Non seulement parce qu'elle n'a pas des données de santé, mais parce que il y a des personnes qui ont droit à des soins de santé (tous les résidents en Espagne ont droit aux soins de santé), mais ils n'ont pas de couverture de sécurité sociale. La carte sanitaire espagnole est octroyée à toutes les personnes ayant le droit aux soins du système national de santé (dans les différentes régions ou régimes). Mais la carte «sanitaire» européenne est seulement pour les personnes qui ont la sécurité sociale. Cela laisse à l'écart au moins 2 millions de personnes, par exemple les fonctionnaires. Le droit à la sécurité sociale, c'est un droit pour les travailleurs/pensionnés, de protection sociale, mais les droits à la santé sont liés à la résidence en Espagne et parfois à la citoyenneté.

Le règlement 1408/71 n'est pas la panacée. Il y a aussi des situations à côté: les accords transfrontaliers, avec le Portugal ou la France, les citoyens européens qui se déplacent «sans papiers» pour obtenir traitement, les fonctionnaires, les personnes qui vivent entre deux pays, etc.

L'Espagne est un pays avec des caractéristiques spéciales, on a le soleil, les gens aiment bien y venir en vacances et même s'y installer pendant la retraite. Je voulais vous montrer une figure avec la réalité en Espagne. La première colonne, ce sont les résidents de l'Espace Économique Européen (l'Islande et le Lichtenstein non compris) qui résident légalement –avec carte de résidence– en Espagne, par région. La deuxième colonne montre les ressortissants des mêmes pays (sauf la Suisse) qui sont inscrits à la Commune.

414.610 ressortissants de l'Espace Economique Européen avec une carte légale de résident en Espagne, mais 598.990 qui sont inscrits dans la commune, c'est-à-dire qui habitent en Espagne. C'est-à-dire, qu'il y a 180 000 personnes plus qui réellement habitent que celles qui sont censées habiter. Ce sont des ressortissants européens, ils n'ont pas de problèmes pour avoir une carte de résidence légale, mais, pour une raison ou l'autre ils préfèrent avoir une double résidence, une effective dans leur pays d'origine et une en Espagne.

Cela rend la planification sanitaire très difficile. Le fait que vous êtes inscrit à la commune donne le droit à la carte sanitaire, aux soins de santé. Mais, au même temps, vous n'êtes pas un résident légal et le service régional de santé ne reçoit pas d'argent pour vous.

Cette population «flottante» provoque des problèmes de planification sanitaire (on sait qu'ils sont là, mais pas d'une façon régulière). Au même temps, provoque des problèmes de soins, parce que parfois ils reçoivent les soins de santé en Espagne et parfois dans leurs pays d'origine.

Les ressortissants étrangers qui font recours aux soins de santé peuvent se classer en 4 domaines:

- les personnes à la retraite qui habitent en Espagne
- les personnes à la retraite qui passent des séjours assez longs (6 mois) mais qui gardent ses droits de pension dans le pays d'origine
- les touristes
- les touristes sanitaires (ils profitent du tourisme pour se faire soigner; la reproduction artificielle est bien connue dans ce domaine, et les prothèses de hanche; ou bien le recours aux urgences hospitalières comme une façon de rentrer sans payer et sans liste d'attente, il en est de même pour les médicaments pour les personnes à la retraite qui ne sont pas payants).

Il y a deux sujets différents qu'on veut signaler et délimiter clairement: l'argent et les patients, le remboursement des soins donnés et le traitement adéquat. Le règlement 1408/71 garantit le droit aux soins et le remboursement, mais ne s'occupe pas du traitement, des problèmes d'information, de suivie, etc. Les Ministères de la Santé s'occupent des patients; cela veut dire faire le suivi, les personnes arrivent avec une histoire de santé ou non et elles repartent avec une histoire de santé ou non, mais le suivi du dossier médical, les données du patient est une affaire non réglé. Il faut se mettre d'accord avec les médecins traitants dans le pays d'origine et dans le pays de destination. Il y a des sujets cliniques, des sujets personnels (les personnes très malades parfois veulent retourner dans son pays d'origine pour être avec leurs proches, la langue, la méconnaissance du système, etc.). Les problèmes du déplacement de patients en Europe n'est pas seulement un problème de reconnaissance du droit et de remboursement, est beaucoup plus large.

	Legally residents EEE (falta Islandia y Liechstein)	Inscriptions at the Commune EEE (falta Suiza, Islandia y Liechstein)
TOTAL	414.610	598.990
ANDALUCÍA	81.032	109.018
ARAGÓN	4.031	3.941
ASTURIAS (PRINCIPADO DE)	3.778	3.965
BALEARS (ILLES)	37.263	56.856
CANARIAS	54.694	81.873
CANTABRIA	1.774	1.885
CASTILLA Y LEÓN	8.907	10.599
CASTILLA-LA MANCHA	2.790	3.406
CATALUÑA	64.464	76.219
COMUNIDAD VALENCIANA	73.541	157.913
EXTREMADURA	3.114	3.155
GALICIA	13.033	16.344
MADRID (COMUNIDAD DE)	45.717	47.121
MURCIA (REGIÓN DE)	7.682	9.880
NAVARRA (COMUN. FORAL DE)	2.448	4.015
PAÍS VASCO	8.560	10.481
RIOJA (LA)	1.245	1.854
Ceuta y Melilla	433	465



Eva LUKACS

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Ladies and Gentlemen, it is a pleasure for me to be here, and let me address some questions which are relevant from the Hungarian point of view. As it has been outlined by the previous speakers, we have three main reference points here regarding health services and the internal market: the Treaty of Rome, especially its provisions on the freedom of establishment and the freedom to provide services; Regulation 1408/71/EEC concerning the coordination of social security connected to the free movement of persons and, as third, the new Services Directive proposal. Regarding the Treaty of Rome, Hungary tries to deal with the principles of freedom of establishment and freedom to provide services along the same lines: stress is put on the persons who render and receive services.

As regards service provision, we believe that in order to maintain a high-quality service, the person actually providing the service must be taken as a reference point. The Hungarian regulation is the same for persons rendering health care services as self-employed or employees of a company, established either in Hungary or in another Member State. The basis for health care service provision is the possession of an appropriate (Hungarian or foreign) degree, the recognition of EC diplomas gains grounds in the directives on the mutual recognition of diplomas. In Hungary, there is an independent authority, designed for dealing with applications, and since our accession in May 2004, we have received and approved 1,240 applications, out of which 70% were doctors, and then 10-10% dentists and nurses. These health care professionals are welcome in Hungary, they are offered the opportunity to provide services on the same footing as their Hungarian colleagues, being active privately or in a contracted form, for a longer period or only incidentally. This framework for service provision is very useful in Community Law and there are numerous possibilities to pursue cross-border activity to persons as well as to companies.

However, in our opinion the Treaty itself has its limits. In respect of health care, the Treaty lays down that "Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health-services and medical-care". In our opinion this provision enjoys priority over the general rules laid down for free movement of services, and certain Member State competencies shall be preserved. In our view, Community action, thus, cannot intervene into national competencies in the way envisaged by the Services Directive proposal, hence the country of origin principle and the planned elimination of

certain authorisations, territorial restrictions, tariff setting and so on, would definitely be an interference with both national sovereignty and national competencies. Based on this, Hungary at present is not able to support the inclusion of health-care services into the Services Directive proposal, aimed at conserving the right of Member States to fully effectuate their regulatory and controlling powers.

However, it is only one side of the coin. As regards service provision, since the famous judgment of the ECJ in *Luisi and Carbone*, it is clear that the freedom to provide services also encompasses the right of service recipients to receive services. In this regard, the Hungarian position is completely different from our position concerning the Services Directive proposal. This way of thinking already brings us closer to the framework of Regulation 1408/71/EEC on the coordination of social security schemes and to Article 23 of the Services Directive proposal. In order to highlight the Hungarian position, it is necessary to mention, that since the EU accession, based on Regulation 1408/71/EEC, Hungary issued 200,000 E111 forms - the European Health Insurance Card is going to be issued as from the 1st of January, 2006 - and out of these 200,000 E111 forms, up to now, only 175 pieces have been invoiced by other Member States. This is a very small number, even if invoicing sometimes happens years after the actual medical treatment was provided. Similarly, we issued a small number of E112 forms, namely 122, meaning that prior approval was given to foreign medical care in only 122 cases. In both cases, the National Health Insurance Fund (NHIF) is required to bear the total cost of the treatment, which, taking into account the potential tariff differences, might be rather unpredictable. Clearly, the *Kohll and Decker* case and the subsequent case-law have brought a new element into the system of patients' rights. Now it is common sense, following these judgments, that Member States are obliged to reimburse the costs of non-hospital services even if prior approval has not been given. In these cases no E form is used, and the level of reimbursement is equivalent to the tariffs used in inland financing. Theoretically, hence the actual costs do not exceed Hungarian tariffs, this case law might not really affect finances, and is not so much unpredictable as is Regulation 1408/71/EEC. Let us take a couple of remarks regarding the legal situation and the actual practice connected to the Regulation and the case law.

In 1998, when Hungary first faced the challenging *Kohll and Decker* judgment, it has been quite undisputed that it is not going to have any concerns to Hungary. There has been a consensus that benefit-in-kind systems – such as the Hungarian one –, in which the service provider possesses an authorisation to operate, on the basis of which it is contracted and subsequently reimbursed by the NHIF, and patients are given free of charge health care services, does not fall within the ambit of this judgement. However, with the passage of time and the announcement of new cases (*Vanbraekel* etc.) it became clear that the decisions had far reaching legal

consequences also for the Hungarian system and new procedures has to be invented for its implementation. Being in the course of the accession negotiations and the legal approximation process, we tried to establish connecting points between Regulation 1408/71/EEC and the Kohll and Decker case law and finalise the legal amendments accordingly. As a result, as from the 1st of May 2004, the Hungarian Act LXXXIII of 1997 on Compulsory Health Insurance and its implementing government decree contain express provisions both on the application of Regulation 1408/71/EEC and on the application of the Kohll and Decker case-law. According to Article 27 of the Act, insured persons are entitled to obtain non-hospital medical care without prior approval in other Member States, and they have entitlement to reimbursement according to the Hungarian tariffs not exceeding the actual cost of the treatment. The Act expressly defines “non-hospital care”. It includes services of a general practitioners’ practice, dental treatments and in certain cases, after due consultation with a general practitioner, it can be extended to other medical services as well. From a legal point of view, the Hungarian law contains already what has been put forward by the judgements of the ECJ and what is planned to be accomplished by Article 23 of the Services Directive proposal. This is the reason, why Hungary has not expressed serious concerns regarding Article 23 of the Services Directive proposal. Indeed, support has been emphasised throughout the consultation process with a stress to place this implementing provision into Regulation 1408/71/EEC due to transparency and legal certainty reasons.

It should be noted, however, that in the last one year, we have received not a single application based on the provision implementing the Kohll and Decker case law (Article 27 of the Act). It means, that there was not one Hungarian insured person who wanted to avail himself of this provision. On the contrary, as it has been mentioned already, we issued 200,000 E111 forms among which 300 forms have been required after the treatment has been obtained. Though on a very small scale, practice has shown that persons who had obtained medical treatment in a Member State without an E111 form rather applied for it after the treatment instead of referring to the Kohll and Decker opportunity. It is quite understandable as the reimbursement tariffs are very different. Regulation 1408/71/EEC provides for total reimbursement (in terms of the hosting states’ norms) while the Kohll and Decker case law only provides for Hungarian tariffs. It is noteworthy to emphasise, that a country with low(er) health care tariffs, like Hungary, is much more challenged by Regulation 1408/71/EEC (speaking also of Regulation 631/2004/EC) than by the Kohll and Decker case law in financial terms.

In sum, Hungary applies both the Regulation and the relevant case-law, however, in our view, further elaborations might be necessary regarding the additional payment principle appearing in the Vanbraekel case. The additional payment principle in the Vanbraekel case, even if seems logical from a legal

point of view, might be very difficult to apply in practice, and abuses might not be excluded. We would put it forward for further discussion.

I would lastly reiterate our position regarding the Services Directive proposal. Hungary does not have any problems with Article 23 of the proposal, hence we already apply its Hungarian implementation (at least the legal basis has been invented). It would be, however, an appropriate step to insert this article or an article of similar wording into Regulation 1408/71/EEC. In our view, it is misleading to apply two different sets of rules for the same groups and reason, only because there are different reimbursement mechanisms.

And last but not least, based on our experiences with EC law, it seems to us that the provision of services in the field of health-care is most delicate in cross-border areas, especially between Hungary and Slovakia or Hungary and Austria. That is why we have frontier co-operations with Slovakia, outside the scope of Regulation 1408/71/EEC or partially inside, and we firmly believe that this sort of co-operations are going to result in very fruitful sorting out of the issues of patient mobility.

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As everybody knows the legal basis for discussions of last few years are judgements of ECJ providing repeatedly, that health care has to be considered as a service in the sense of free movement of services.

Jurisdiction of ECJ comes at the same time, when many European systems feel the necessity of reforms in order to reach higher effectiveness, taking into account future common European challenges like ageing of population and introducing of a new high costly methods of health treatment.

Surely it is not just a game of chance that these breaking judgements and reforming effort of particular states met at the same time, time which can be described as an epoch of new technologies, time of even easier access of patients to informations, time of even higher privat sector influence to public services, time where borders are losing their sense, time when processes running in one place are directly influencing happenings in other part of the planet, time which is usually defined as a globalisation,.

In this situation issue of cross border providing health care in a framework of EU can be seen from two perspectives. As more or less unnecessary further financial burden of already embarrassed public health insurance schemes, or we can see it positively, as an accelerant of necessary changes in national law on public health.

Anyway, discussions about health care as a service are all the more complicated due to the fact, that there are a very different systems among particular EU countries and that is why their approach to particular decisions of ECJ has also to be different. In that situation it 's hard to find uniform view which would be in compliance with free movements of services on one side and all the interests of member states on other side. State by state also differs possible financial, legal and organisational impact of ECJ judgements and following EU commision proposals introduction to the practice.

Approach of particular states differs, but one aspect of public discussion is the same probably for most of them. It is the fact, that everything what is connected with access to public services, financing of system and costs of health care is considered as one of the most important and sharpest political issues. Due to this fact discussions and consideration on possibilities of free european market of health services are not probably everywhere and always based only on objective analysis and assessments, but very often also on fear of changes.

Summarising very briefly the Czech approach to the problemacy it's necessary to state, that we consider jurisdiction of ECJ and it's interpretation of Treaty, binding on us and on the practise of our institutions. Of course this approach concerns situations, where decision of ECJ is clear and where are no doubts about the right way of its interpretation. Unfortunately there are still many questions staying and further jurisdiction of ECJ is impatiently expected.

Current situation, when decisions of ECJ, concerning entitlements of insurees are not transposed to any other EU legal act we consider undesirable and bringing legal uncertainty not only to insurees, but also to institution which should apply national, but also EU law in practice.

From our point of view the best solution would be to add results of ECJ jurisdiction to directly applicable Regulation 1408/71 (resp. 883/2004), dealing beside others with issues concering reimbursement of health care provided to insurees of one state in the territory of other state. The advantage of this solution is coverage of all issues connected with insurees entitlements in one legal act. Anyway, the results of ECJ jurisdiction should be as soon as possible transposed to EU legal act, either to the Regulation or to the Directive.

Talking about movement of patients, which is the most important part of issue, we know already first figures concerning 2004. During first year of our membership, Czech health insurance funds authorised treatment abroad in 23 cases. Seven applications were refused. On the other hand 210 foreign insurees were treated in the Czech Republic on E112 basis.

Unfortunately we have no exact figures about number of reimbursements on the basis of free movement of services principles. We know only that number of reimbursements according Czech tarrifs is not too high. The fundamental barrier for more often use of this freedom by Czech insurees is low level of reimbursements tarrifs according Czech law in comparison with costs of treatment provided in countries, which are potentialy interesting for our insurees.

According known figures and further assessments we can generally see, that Czech Republics' system is more provider of health care to foreign citizens and insurees than a consumer of health care abroad.

Talking about free movement of providers we suppose that the way of facilitation of services providing has to be more discussed and that the principle of state of origin cannot be fully applied in this sector. Especially without strenghten of trust and cooperation between particular countries we can hardly move on.

As it was mentioned before, there are stil many questions not explicitly responded by ECJ. One of these questions concerns providing of services by foreign provider in the territory of the state of insurance. Especially for the

systems based on contracting the providers, where insurees are not entitled to any reimbursement if they were treated by not contracted doctor, it seems to be very interesting and important to find out, whether current or future ECJ judgements can constitute legal basis for patient's reimbursement. Positive answer could probably lead to concrete changes not only in our national law.

Finally we can say, that development in the field of EU law is actually pushing to liberalisation of health sector and partially weakens regulatory power of member states. On the other hand this move of EU law can be seen also positively as an accelerant and as a part of necessary changes in our national legislations and as a pressure to improving of services providing in the framework of our public schemes.

In other words possible problems of our national health systems are not and are not going to be caused by application of EU freedoms, but more by objective challenges of today's world and lack of political courage on national level to respond to them and to make a necessary changes in time.





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DG INTERNAL MARKET AND SERVICES
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Je suis contente de prendre la suite de Monsieur Švec qui nous a donné une vision si positive du futur. Ma présentation portera sur la proposition de directive relative aux services dans le Marché Intérieur¹⁾. D'autres en ont parlé avant moi.

Je souhaiterais vous expliquer pourquoi la précédente Commission européenne a adopté cette proposition de Directive et pourquoi elle a décidé d'inclure les services de santé dans cette proposition.

1. Pourquoi une Directive services ?

Cette proposition de Directive, puisqu'il s'agit d'une proposition, trouve son origine dans le processus de Lisbonne. Elle vise à établir un véritable marché intérieur pour les services afin d'exploiter le potentiel en terme de création d'emplois et de croissance qui réside dans le secteur des services.

Cette Directive vise à faciliter l'exercice de la liberté d'établissement des prestataires de services et la prestation de services à l'intérieur de l'Union européenne.

Cette proposition trouve aussi son origine dans un rapport de juillet 2002²⁾ sur le fonctionnement du marché intérieur des services. Rapport qui a été très mal intitulé puisqu'en fait on aurait du l'appeler « rapport sur le non-fonctionnement du marché intérieur des services » ! Ce rapport est un véritable constat d'échec de mise en œuvre de ces libertés fondamentales. La réponse de la Commission à ce défi que représente la création d'un véritable marché intérieur des services dans l'Union européenne s'inscrit dans cette constatation que jusqu'à présent l'application directe des libertés garanties par le Traité n'a pas fonctionné.

2. Pourquoi une approche horizontale ?

L'approche suivie par la Commission est une approche horizontale. Elle choque dans le domaine des services. Tous les orateurs l'ont dit : les services de santé ne sont pas des services comme les autres. Pourquoi donc avoir suivie cette approche ?

Parce qu'en fait, lorsqu'on se détache de la nature du service: service de santé, de tourisme, de sécurité privée, on se rend compte que d'un point de vue juridique, les prestataires de services dans l'exercice de leurs libertés se

1) COM (2004) 2 final du 13.01.04.

2) COM (2002) 441 final du 30.07.02.

heurtent aux mêmes obstacles. Ce n'est pas avec cet objectif en tête que nous avons mis tous les services dans le même panier. Nous avons cherché à établir une nomenclature des obstacles auxquels se heurtent les prestataires de services et à y remédier.

De plus, je dois souligner que la proposition « Services » prend en compte la spécificité des services de santé. De nombreuses références sont faites dans les articles de la Proposition à la nécessité de protéger la santé publique. La Commission ne l'avait peut-être pas assez fait et la Présidence luxembourgeoise a bien amélioré le texte de ce point de vue. La Présidence luxembourgeoise a publié un nouveau texte qui se trouve sur le site Internet sur lequel les modifications apportées par le groupe de travail du Conseil sont clairement indiquées. Vous constaterez, si vous le lisez, que la plupart des ajouts concernent les questions de santé.

3. Pourquoi la précédente Commission a-t-elle décidé d'inclure les services de santé dans la Directive services ?

La responsabilité initiale en incombe à la Cour de Justice. Tout le monde a évoqué ici les arrêts Kohll, Decker et suivants³⁾. La Cour a confirmé, réitéré que les services de santé sont des services au sens du Traité. A partir de là, la Cour a développé une jurisprudence sur le remboursement des soins de santé. C'est cette question de la mobilité des patients qui, si je peux m'exprimer ainsi, encombre le rôle de la Cour et les armoires de la Commission.

Certains qui se sont exprimés avant moi, ont attiré l'attention sur les questions suscitées par la proposition de directive, dans sa partie concernant la liberté d'établissement. Oui, il y a des problèmes en matière de liberté d'établissement et nous avons reçu des plaintes de la part de professionnels qui font face à des difficultés dans l'exercice de cette liberté. Oui, il y a quelques plaintes en matière d'application du principe du pays d'origine au domaine des services de santé. Mais, ce n'est rien à côté des plaintes que nous recevons de patients qui se heurtent à des refus d'autorisation pour se rendre dans un autre Etat Membre afin d'y être soignés ou à des refus de remboursement de la part de leur organisme de sécurité sociale.

L'article 23 relatif à la prise en charge des soins de santé est la raison pour laquelle la Commission a décidé d'inclure les services de santé dans le champ d'application de la Directive. En effet, les patients ne comprendraient pas que cette Directive services qui est l'instrument historique de mise en oeuvre de la libre prestation de services ne traite pas de cette question qu'ils considèrent comme cruciale. On l'a dit, la santé publique est une des préoccupations essentielles du citoyen européen et le citoyen européen ne

3) Arrêt Kohll, affaire C-155/96 du 28.04.98, arrêt Decker, affaire C-120/95 du 28.04.98, arrêt Smits et Peerbooms, affaire C-157/99 du 12.07.01, arrêt Vanbraekel, affaire C-368/98 du 12.07.01, arrêt Müller-Fauré et Van Riet, affaire C-385/99 du 13 mai 2003, arrêt Inizan affaire C-56/01 du 23.10.03, arrêt Leichtle, affaire C-8/02 du 18 mars 2004.

comprendrait pas que finalement cette Directive « Services » soit une Directive business et pas une Directive citoyenne.

4. La prise en charge des soins de santé – L'article 23 de la proposition

Toute une section de la proposition de Directive est consacrée aux droits des destinataires de services. L'article 23 en est une composante essentielle. Cet article 23 constitue la transposition pure et simple des jugements de la Cour. Nous ne sommes pas allés plus loin en ce qui concerne les éléments essentiels.

L'article 23 stipule que les Etats membres doivent rembourser les soins non hospitaliers même en l'absence d'autorisation préalable. En ce qui concerne les soins hospitaliers, une autorisation peut toujours être exigée. En ce qui concerne les conditions de fond d'octroi de cette autorisation, la proposition renvoie aux conditions établies par le Règlement 1408/71 sur la coordination des systèmes de sécurité sociale. Elle impose aussi le respect de conditions de transparence destinées à encadrer le pouvoir discrétionnaire des Etats membres.

En ce qui concerne la question des tarifs de remboursement, l'article 23 précise que les soins doivent être remboursés aux tarifs applicables dans l'Etat membre d'origine du patient. L'article 23 précise dorénavant à la demande de certains Etats membres que le patient ne peut pas tirer profit de la libre circulation. En aucun cas, il ne pourra lui être remboursé plus que ce qu'il a dépensé.

Cet article 23 a pour objectif de garantir les droits des patients tels qu'ils ont été reconnus par la Cour de Justice. Certains diront pourquoi la jurisprudence ne suffit-elle pas ? Parce qu'à l'évidence, elle ne suffit pas, elle n'apporte pas la sécurité juridique nécessaire pour que les patients puissent en toute sérénité d'esprit franchir une frontière pour aller voir un médecin. Certains l'ont dit avant moi, la grande majorité des Etats Membres n'ont pas transposé la jurisprudence. Les services de la Commission ont rédigé un rapport sur la base des contributions des Etats Membres dont il ressort que la plupart des Etats Membres n'ont pas pris de mesures de mise en application de la jurisprudence⁴⁾.

Ainsi, à l'heure actuelle, au sein de l'Europe il y a des patients qui peuvent circuler parce que leurs Etats Membres se sont mis en conformité et d'autres qui ne circulent pas parce que leurs Etats Membres ne se sont pas mis en conformité. Et tout ça finit devant la Cour de Justice.

Sept arrêts ont été rendus par la Cour de Justice. Nous avons quatre questions préjudicielles devant la Cour. Nous n'en avons plus que deux, puisque la Cour d'un Etat membre a estimé que compte tenu de ses développements, la jurisprudence de la Cour était assez claire et lui

4) SEC(2003) 900 du 28.07.03.

permettait de rendre ses propres jugements. Nous avons cependant deux nouveaux cas devant la Cour et nous continuerons à avoir des recours préjudiciels de la part des Cours nationales qui seront de plus en plus souvent saisies et nous aurons des arrêts rendus sans recours préjudiciels par les Cours nationales si nous ne prenons pas la peine de clarifier dans un texte communautaire les droits des patients en matière de remboursement. Les objectifs de la directive Services sont de garantir les droits des patients et d'améliorer la sécurité juridique. Ce dernier point répond à une demande explicite du High Level Reflection Group on patient mobility and healthcare development, qui réunissait les Etats Membres, ceux-là mêmes qui aujourd'hui hésitent à franchir le pas. Un troisième élément est aussi très important, plusieurs orateurs l'ont souligné: il ne faut pas laisser s'établir une « République des Juges ». Il appartient maintenant au législateur communautaire de se saisir de cette question. Tout le monde dit que c'est une question importante et que le législateur communautaire doit s'en préoccuper. Je ne crois pas que la meilleure façon de s'en préoccuper soit de renvoyer cette question à plus tard. De toute façon et tout le monde l'a dit, les règles du marché intérieur continueront à s'appliquer avec ou sans Directive «services» et dans ce cas, nous aurons de la jurisprudence.

Une attention particulière doit être portée à la définition des soins de santé qui figure dans la proposition. Sur ce point, nous allons plus loin que la jurisprudence. Il s'agit d'une question importante puisqu'elle permet de rendre opérationnelle la distinction entre soins hospitaliers et non hospitaliers et donc de déterminer le champ d'application de l'obligation de disposer d'une autorisation. Le législateur communautaire doit trancher cette question.

5. Autres dispositions particulièrement pertinentes pour les services de santé

Mis à part l'article 23, d'autres dispositions de la proposition de la Directive doivent être évoquées en relation avec les services de santé. Elles concernent la liberté d'établissement et l'application du principe du pays d'origine.

Je traiterai de ces sujets très brièvement compte tenu du temps qui m'est imparti.

En ce qui concerne la liberté d'établissement, l'article 15 de la proposition a été souvent évoqué en relation avec les services de santé. Cet article établit une liste des exigences souvent imposées par les Etats membres aux prestataires de services. Ces exigences produisent des effets restrictifs importants pour la liberté d'établissement. Cependant, elles peuvent être justifiées selon les circonstances et compte tenu des objectifs poursuivis par les Etats membres en les imposant. Il s'agit donc d'une différence fondamentale avec l'article 14 qui identifie des exigences interdites c'est à

dire des exigences qui ont été déclarées incompatibles avec la liberté d'établissement par la Cour. Par exemple, l'article 15 fait figurer parmi les exigences à évaluer, « les exigences qui imposent un nombre minimum d'employés » (article 15 f)). Imposer un nombre minimum de personnel médical par lits d'hôpitaux apparaît justifié par des raisons de santé publique. En revanche dans un autre secteur, cette exigence pourra ne pas être justifiée.

En ce qui concerne les exigences à évaluer, l'alternative est la suivante : soit nous procédons à cette évaluation en commun selon la procédure prévue par la Directive soit nous laissons la Cour décider. A nouveau, il est dans l'intérêt de tous de procéder à cette évaluation mutuelle. Outre qu'elle permet d'écartier les aléas du contentieux, elle permet aussi un échange d'expérience et de bonnes pratiques qui ne peut être que profitable à toutes les parties intéressées.

Le principe du pays d'origine, l'article 16 de la proposition n'a jamais été envisagé de manière absolue par la Commission. Il est assorti d'un grand nombre de dérogation et d'exceptions. Dans le domaine de la santé, son application sera limitée dans la mesure où déjà, en pratique, ces services exigent souvent un établissement. Dans ce cas, il n'y a pas d'application du principe du pays d'origine et le prestataire de services relève de la législation de l'Etat membre dans lequel il est établi.

Dans les cas de prestation de services transfrontalières, par exemple, un docteur ou une sage-femme qui se rendent chez des patients, dans un autre Etat membre, pour des consultations, il est important de noter que la directive prévoit une dérogation au principe du pays d'origine pour les matières couvertes par la directive sur la reconnaissance des qualifications professionnelles. Ceci signifie que l'Etat membre de prestation pourra vérifier les qualifications professionnelles du prestataire (dans la mesure où elles ne sont pas harmonisées au niveau communautaire) comme il le ferait pour un prestataire établi sur son territoire. Les Etats membres pourront exiger une déclaration préalable à la prestation de services ou un enregistrement temporaire pro-forma à l'ordre professionnel. Ils pourront également imposer leurs règles disciplinaires directement liées aux qualifications professionnelles. Outre cette dérogation, la directive comprend d'autres dérogations qui permettent d'empêcher par exemple, la prestation de certains services pour des questions de santé publique – ce qui permet d'interdire la prestation de certains traitements ou service médicaux.

6. Conclusion

En conclusion, je voudrai rappeler les déclarations du Commissaire McCreevy au Parlement européen, au Conseil et à la presse. Il a clairement indiqué que la balle était dans le camp du Parlement. C'est maintenant au Parlement à prendre ses responsabilités et à amender, comme il le souhaite, la proposition de Directive. Le Commissaire McCreevy a indiqué que si des amendements dans le sens d'une exclusion des services de santé étaient proposés, il pourrait les considérer favorablement.

SESSION 2

HEALTH INSURANCE AND THE INTERNAL MARKET



Geert Jan HAMILTON

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It is a great pleasure to be back in this illustrious hall, where in 1998 so many people convened to discuss the effects of the famous Decker and Kohll rulings. These rulings shocked quite a few people because, for the first time, the European Court of Justice had set aside national social health insurance legislation which had been in place for ages and which everyone considered so solid. Certain governments were very shocked; they were even afraid that their national systems would fall apart. Well, seven years later we know that no system has fallen apart, but we have become very much aware how much European internal market regulations influence our national health systems and in fact, any change that you would consider, has to be examined under European law. Sometimes the confrontation of plans with European law threatens to stifle things too much. We sometimes are even afraid to bring about changes, because someone may say: "It is contrary to European law".

I want to illustrate this on the basis of recent experience in the Netherlands where we are bringing about a new universal health insurance system as from January 1st 2006, if our Senate approves because they are at stake at the moment.

This morning we heard a lot about a draft for a services directive. We all know that we have in place since about 15 years three directives for non-life insurances. Insurance is a very complicated product. It has to do with confidence, with trust. People pay for something unexpected that they do not want to happen, but that might happen in the future. Every European Union Country had a whole set of national rules to cover this area. To complete the internal market in direct insurances it was considered absolutely necessary to have these directives, because we wanted more freedom for companies to provide insurance services all through the European Union.

Two interesting features of these directives are:

- one single authorisation is valid for an insurer to become active throughout the Community;
- supervision, particularly the prudential control, is done by the home Member State.

Perhaps you notice certain parallels with the services directive that we discussed this morning. Of course all the rules of the insurance directives are there to make sure that the consumer gets what he expects. If a Danish man wants to buy insurance from a Portuguese firm, he has to be just as certain that he gets what he pays for, as when he goes to a firm of his own country.

Now these directives do not apply to insurances forming part of a statutory system of social security. And here you see the dichotomy that we seem to have under European law: we have statutory systems of social security where Member States have a great deal of autonomy to set their own rules on the one hand, and on the other hand we have free insurances where European law applies. Now, as Professor Jorens stated in his report, it is unfortunately not always very clear, where a social security system starts or ends, and where private insurance begins. There is an area of uncertainty in between.

Of course we all have a feeling of what social security and social health insurance means – everybody having access to a certain benefits package, reasonable premiums etc – but there is no clear definition of social security.

There is one certainty that we have, and, as is often the case when there first was uncertainty, it has been the European Court of Justice that provided it. The European Court of Justice in a famous case, *Commission versus Belgium*¹⁾, ruled that insurance undertakings covering the risk of accidents at work remain within the scope of the insurance directives, even when they act in the context of a statutory scheme of social security, if those undertakings operate at their own risk with a view to profit. So what shows us this ruling? That at the same time, you can be a private insurance company, and part of a statutory social security scheme. If a country leaves the execution of a social security scheme to private companies, with a profit orientation and running a certain insurance risk, then they have to meet the conditions of the insurance directives.

Now in the Netherlands for many years there have been efforts to create a new health insurance system. We have a long-standing desire in our country to bring about more competition among insurers in health care and among providers of care. We wanted a system that responds better to demands, desires, needs of patients and insurers. We want a social system that offers some choice to the citizens. You have to realize at the moment we have “duality” in our system. We have a statutory system for about 60% of the population and we have private insurance for about 40% of the population. And with this history of a split system you can imagine that there has always been a big debate, whether a new system for all should be a public health insurance model with more competition among the insurance agencies, or if it should be a private health insurance regime with a certain degree of necessary regulation applying to all insurance agencies. That was the choice: public or private.

1) *European Court of Justice, Commission/Belgium, case C-206/98, ECR 2000, I-3509.*

From the beginning a shroud of legal doubts has surrounded any proposal. In particular it was unclear if, in a private system, public preconditions the government wanted to impose on insurers were in accordance with EU competition law and the European insurance directives. And it was also unclear if you can materialize a public system, based on competition among insurance agencies. In fact, it was a lawyer's paradise and, as I am a lawyer, I enjoyed myself a great deal in the last few years. There were many different opinions, one saying "this cannot be done", and another saying "that cannot be done". There were interesting paradoxes, because from our private insurance side there were appeals to the government to make the system private and, when the government expressed doubts if it could impose rules on private insurers, these insurers would say "Oh yes, you can, European law leaves a lot of room for you to impose certain rules on us which are necessary for the public good".

But a clear framework to examine reform plans was lacking and this of course forced the government to be very careful. It led to the dilemma that I alluded to: change is so risky from a European law perspective that you do not change at all.

Under the last cabinets politically speaking there was a preference with the government to install a system of just ordinary private insurance, where every citizen would be privately insured against the health-care risk, but with certain preconditions:

- an obligation for citizens to have themselves insured against the risk of health care costs for a basic package;
- any insurer wanting to be in the system should have to accept any citizen that wanted to have health insurance with that company;
- insurers should be free to set their nominal premiums, but they should not differentiate in their rates on the basis of age, sex, social background and health condition of the insured people;
- to make that possible, a system of risk structure compensation should be installed.

These elements were considered vital in the public interest. Now as things turned out, we made a law exactly containing these elements. The law (Health Insurance Act) has been accepted by the second Chamber of Parliament and is now pending with the Senate²⁾. We succeeded in finishing for the time being our debate on the European law aspect of the new legislation. As there were so many different opinions the new Minister who came into office in 2003, decided to start serious consultations with the European Commission on this issue. There were talks with DG internal market, DG employment and social affairs and DG public health. And the debate ended with, what some of

2) The Senate accepted the law on 14 June 2005; *Zorgverzekeringswet*, *Staatsblad*, 2005, 358.

you may have heard of as, the *Bolkestein* letter³⁾ which is another *Bolkestein* product than the services directive discussed this morning, but in fact, the content of that letter was enough for the Dutch government to see it as the green light to proceed as they wanted. Of course, the Commission did not commit itself entirely, but came up with a rather strong opinion giving an answer to the question whether the legislation that we wanted to develop, could be considered compatible with the insurance directives. Here article 54 of the Third non-life insurance directive plays a role, because it contains a possible exemption for Member States to regulate insurances in a specific manner. This Article reads “Notwithstanding any provision to the contrary, a Member State in which contracts covering health risks may serve as a partial or complete alternative to health cover provided by the statutory social security system, may require that those contracts comply with specific legal provisions adopted by the Member State to protect the general good”.

There had been a lot of discussion on the extent to which you could use this exemption. The *Bolkestein* letter says in this respect that “this proviso also covers the situation where a Member State decides to entirely assign the cover of statutory social security health insurance to private insurance undertakings which must conduct such an activity at their own risk, following insurance techniques and on the basis of contractual relationships governed by private law”. In short the letter says there is ground to impose certain rules on private insurers, when an insurance scheme fulfils the function of a social insurance. Although the letter does not give legal guarantees, these parts of the letter are very important. The Commission says: the objective of the Dutch government is to guarantee health-care as a basic social right. This means that all residents in the Netherlands should have access to health insurance guaranteeing a basic package of essential care in return for acceptable premium. To ensure that goal the Dutch government wishes to require that the proposed health insurance regime is based on a few principles:

- open enrolment;
- a basic minimum cover defined by the government and which must be provided by any health insurer;
- the right of insurers to set their own premium rates as long as there is no discrimination on the basis of age, sex, health status and other circumstances;
- an equalisation fund to compensate insurers' losses because of the risk profile of their portfolio.

3) Letter of Commissioner F. Bolkestein on the Dutch Health Insurance System, 25 November 2003, CAB/PvB/D(03)0848.

And then a crucial quote: “I believe that these principles could be justified under Article 54 of the Third non-life insurance directive, as they appear necessary to ensure the legitimate objectives pursued by the Dutch government”.

This statement which, of course, did not take away that the Dutch government fully has to take its own responsibility for the framework of law that they are staging, is an important opinion of the European Commission. I think it reflects a trend which we have also seen in the EC-CoJ jurisprudence that social objectives have a mitigating influence on free market principles. And this trend, on its turn, can be seen as a recognition of the fact that governments of Member States must be able to aim for social objectives also outside the strictly public domain. We do not have the situation in Europe that, what is in the public interest, should fully and only be a State responsibility, and that the alternative is only the free market. That is not the choice of the European social model. There are in-between areas where you have to recognize, that certain social values have to be balanced with the internal market principles. I want to emphasize that this is an important trend in European legal development.

When we look back at the last seven years, since our Decker and Kohll conference, we see much more clarity now on the importance of public service within an internal market context, and the possibilities to find social solutions in a market environment. On what has happened in law and jurisprudence Professor Jorens has written his magnificent report showing all the new answers which bring about more legal certainty, although the ultimate level of legal certainty of course has not yet been obtained.

But we are making progress in certain fields. I want to finish by referring to another part of the *Bolkestein* letter. And that is where the commissioner writes: “I do not think that it would be proportionate to apply the requirements to any complementary insurance cover offered by private insurance which goes beyond the basic social security package of cover laid down in the social security framework”. So, governments do not have much room to regulate complementary health insurance in the public interest. I would like to remind you that already in the year 2000 the European Parliament, so eloquently represented here this morning, passed a resolution on supplementary health insurance⁴⁾. In it the European Parliament expressed the notion that supplementary insurance will play increasingly important roles in covering various health risks. The Commission was called upon to present a green paper and there was a call for a proposal for a directive where elements like no-discriminatory use of medical data, no medical examinations, life-long insurance could be part of rules that may be necessary also for complementary insurance.

4) Resolution of the European Parliament of 2000 (2000/2009 INI).

The position of the Dutch Ministry of Health is that it would be very interesting to revitalise the discussion on this resolution, because it did not have a proper follow-up yet. What was called for is not yet there. Nevertheless the relationship between basic coverage and complementary coverage is a very important one, in for instance France, in Germany, in many different countries. So I would like to hear what the feelings are among this audience. Do not you think that particularly the situation for complementary insurances requires a new discussion on the inclusion of social elements in insurance regulations in Europe?

Thank you very much.



Dermot SMYTH

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I wear three hats: I look after the budget of the Irish health system, I also have a role as head of International unit and I am also responsible for the regulation of private health insurance.

Let me start by giving a brief account of the Irish system because I do regard it actually as unique.

- We combine public and private health care.
- In private health insurance, we have an open market following on from the single market provisions. Three private health insurers are competing: one quite recently, one is an international organisation (BUPA), and one is a semi-state company which is on the road to deregulation.
- We have quite an extraordinary situation where half our population have private health insurance and yet the entire population has general eligibility for hospital services in public hospitals. For GP services, only 30% are eligible.
- A further complication is that half of the total private beds in our country are delivered in public hospitals.

This very Irish patch work actually works. As confirmed by OECD, it does deliver quality care, with choice both in terms of accessibility to public or private beds as well as what must be one of the cheapest private health insurance regimes in the world, albeit subsidised to a certain degree by the State. Also the majority of our hospital consultants have public contracts but they are allowed to engage in public and private practice outside public hospitals. We have tax relief available on health insurance premiums and we have private hospital developments encouraged through generous capital tax allowances. So the background is really a combination of systematic encouragement by the government towards generating extra capacity on the private side while at the same time ensuring sufficiently large public capacity delivered.

Let me briefly describe the derogatory framework for private health insurance we have in our country.

- Community rating: the same premium for a specific level of benefit irrespective of health status,
- Open enrolment: insurers are obliged to accept all candidates that are on the waiting list for some firm irrespective of the beneficial cover and pre-existing conditions,

- Life-time cover: an insurer cannot refuse to renew an insured person's health insurance cover irrespective of age or changes in health status,
- A basic minimum level of benefit: in fact it is the lowest level of benefit of private care available in the public hospital system. It covers about 10% of the plans that are actually covered by health insurance in Ireland.
- We also operate a risk-equalisation scheme although it has not actually started yet because the conditions under which it would start have not yet commenced. But that may change at any point depending on how the market is going. And that would involve compensating for natural transfers between insurers, or to members with profiles differing beyond specified levels, which I think has some elements we have different from the Dutch system. I must say that it is interesting for our teams to relate more to actual pathology of experience according to the report by Professor Jorens.
- We will be looking at life-time community rating in the future for this will allow persons of all ages to take out health insurance or provide that those who do not do so until older will be subject to late entry loadings. Up to now we have extended community rate for open enrolment up to people under 65.

So what is the perception by people in the country about it? According to recent research by an independent health insurance authority, people prefer if community rating were really straight. An overwhelming majority consider the type of medical cover to be much more important than the type of combination offered. So people are interested more in access to care immediately than in a choice of French wines. 94% of those with health insurance agree that insurance is a necessity and not a luxury, and is seen as a vehicle that provides fast access to services. The public system has not delivered access to people quickly enough and has waiting lists which we are trying to address.

As to the internal market issues, we are very acutely aware that developments in our market must take account of the EU regulatory framework. We have had a lot of dealings with the European Commission when introducing our system, which came into effect after legislation in 1994. The Commission has recognised on a number of occasions that private health insurance in Ireland can be regarded as alternative to the statutory social regime and confirmed our right to benefit from the rules referred to in Article 54 of the non-life insurance Directive.

They also recognised the need for risk-equalisation, and rejected a notion that involves State aids. However while the Commission has accepted our right to have these legal provisions it has noted that anything we do must be proportionate. The EU principles of necessity and proportionality obviously come into effect which we fully recognise.

At the moment the regulatory framework we have is challenged before the Court of First Instance. We are confident that what we do is consistent with European legislation. I would like to quote the OECD in this context: *“Adequate regulatory and informational tools are required to steer insurers towards efficiency-based competition, especially when equity considerations are paramount. As for when private health insurance represents a primary form of cover for certain sections of the population it only covers essential services. Regular safeguards are needed to enhance competition in the private health insurance market because of market imperfections such as information asymmetry, and insurance incentives to encourage enrolment and retention of lower risk persons”*.

Obviously the extent to which community rules should extend to individual Member States is open to debate. But given the role private health insurance has played in the provision of care to the Irish population, it is essential in our view that this continues to be recognised by the Community. And I think there are lessons to be learned from the Irish experience. There is not one necessary system to be into effect in any one country, but maybe a combination of systems which can help to address what is a fundamental problem of resourcing.

As a deviation from the script, let me just say that it is not an easy position for politicians to address the issues discussed today, also given the complexity of health care. Anything which damages their system or maybe filters proper control is a problem, exposing them to criticism at home. However, the fact is that ECJ have intervened because there isn't anything in place. The Commission has worked very hard over recent years in different fora to produce a framework which meets a problem, a case-law problem which exists now and is not going to go away. I was very interested to hear an official from the Veneto region talk about contracts before regulation. I understand that point of view - in fact as a pragmatist I have a lot of sympathy for it - but I also think we should continue to work in the context of the high level process. That is where the influence on the political system at Council level can be felt best and most directly. That is the highest level of decision-making, these people are accountable. It is through the work of the high level group on for instance exchange of information - that may sound anaemic, believe me it is not, exchange of information is crucial for having a proper market - that we may get an answer to the problem.

And we must get an answer and we do not have much time. I must remind people that we have a case coming up next year, the Watts case, where the undue delay issue on inpatient care, is up for judgement. If that decision goes against the UK government position and if undue delay is more easily defined, everything is up for grabs then. A solution must come through the governments, the civil servants, influenced by fora like this. How to do it? I think it is through a proper assessment of where the real problems are. I was surprised to hear from the Czech delegate that so little use is made of the

Kohll and Decker judgments for non-hospital care. We have the same experience in Ireland. We have a public treatment purchase fund for people traveling abroad directly. We see very little take-up of it. It makes one think.

Thanks very much.



Daniel LENOIR

*GENERAL DIRECTOR
FRENCH MUTUALITY
FRANCE*

Merci. Je dois dire que c'est un peu une surprise pour moi d'intervenir cet après-midi puisque je n'avais pas prévu de le faire. Mais c'est volontiers, puisque les responsables de l'AIM me l'ont demandé. Je demande un peu d'indulgence puisque j'ai improvisé cette intervention dans la matinée. Ce n'est pas celle d'un représentant du Gouvernement français, puisqu'il n'est pas là, mais l'intervention d'un point de vue personnel de quelqu'un qui est attaché aux valeurs de solidarité et mutualistes, des réflexions issues de mon engagement en France depuis plus de 10 ans dans la gestion de l'assurance-maladie obligatoire et complémentaire. Je voudrais féliciter au passage Yves Jorens pour son rapport qui a le mérite de présenter un état complet de la question. Je voudrais revenir sur le contexte auquel nos systèmes nationaux de protection sociale, en général et d'assurance-maladie, en particulier, sont confrontés.

Ces faits de la jurisprudence, en réalité, même si les critères ne sont pas toujours très précis, ont conduit, de facto, à séparer ce qui relève de la sécurité sociale, un régime public obligatoire de ce qui relève de la protection sociale complémentaire. C'est parti d'une distinction essentielle entre l'activité et le statut de l'organisme, et la jurisprudence européenne a considéré dans de multiples arrêts -la France a été à l'origine d'un certain nombre d'entre eux- que c'était l'activité qui primait sur la nature de l'organisme, et ce depuis 1993, l'arrêt Poucet-Pistre. Chacun s'en souvient et en particulier je m'en souviens puisque quelque temps après j'ai pris la direction de la Mutualité Sociale Agricole. L'arrêt COREVA disait l'inverse, c'est-à-dire que la MSA, organisme chargé d'un régime public, dès lors qu'il s'agissait d'un régime facultatif, était considérée comme une entreprise. Et récemment cette jurisprudence a été confirmée par un arrêt de 2004.

En conséquence, les régimes obligatoires ont été considérés comme étant en dehors du champ de la concurrence relevant de la compétence des Etats. Il a été dit par les principaux intervenants que les régimes complémentaires facultatifs, étaient dans le champ de l'article 85 du Traité. C'est bien le résultat de la jurisprudence et c'est bien la Cour de Justice qui a eu un effet réglementaire bien plus que les Directives assurances elles-mêmes. Il faut bien voir les conséquences que cela a eu sur les systèmes de type bismarckien, comme le système français car historiquement, il y avait dans ces systèmes une porosité entre les dispositifs obligatoires et facultatifs. C'est le cas en France où la protection sociale s'est étendue à partir de 1945 par la généralisation de dispositifs facultatifs progressivement généralisés et

rendus obligatoires. Cela a été le cas, par exemple, des retraites complémentaires qui ne sont pas considérées comme étant dans le champ de la concurrence. Il en fut de même plus récemment pour l'assurance-maladie avec la mise en place d'une généralisation puisqu'elle date de la loi CMU de 1999, ou l'extension de la couverture générale aux indépendants qui est également récente. Je m'honore d'avoir contribué à cette extension pour les accidents du travail dans l'agriculture.

Il ne faut pas oublier que cette distinction plus stricte, cela a été aussi rappelé tout à l'heure, s'est faite dans un contexte où la volonté des pouvoirs publics a été de maîtriser les forces sociales et, pour dire les choses plus brutalement, plus schématiquement, de plafonner le niveau de prélèvement obligatoire dans notre société. Je voudrais dire un mot sur les difficultés de maîtrise de ces dépenses.

Aujourd'hui, on assiste à une augmentation sans croissance apparente des dépenses publiques de protection sociale pour les deux principaux segments que sont l'assurance-maladie ou la retraite. La retraite, par l'effet du vieillissement, n'a plus de croissance apparente puisqu'on a abandonné l'idée d'abaisser l'âge de la retraite, mais chacun sait que l'espérance de vie continue à augmenter. C'est vrai aussi de l'assurance-maladie puisque chacun sait que les coûts de couverture de l'assurance-maladie - à niveau de couverture équivalente - ont augmenté du fait de l'évolution des techniques médicales.

Ces effets de croissance spontanée ont été accentués par la difficulté de gérer le risque, notamment, en maladie et d'optimiser la dépense de santé, le rapport entre la dépense et la réponse en termes d'offres de santé. Cela a des conséquences qui ne sont pas récentes sur les restrictions de la prise en charge d'un certain nombre de domaines tels que le handicap, mais on peut penser à un sujet qui est devant nous, celui de la dépendance. Il existe également une tendance à un désengagement ou à un moindre engagement par rapport aux besoins en matière de maladie ou de retraite.

Je crois que l'on peut analyser les différentes réformes et, notamment la réforme de l'assurance-maladie du 13 août 2004 en France, comme étant la mise en place d'une responsabilité plus importante des régimes complémentaires d'assurance-maladie. Je termine sur ces éléments de contexte de la situation française, mais je pense qu'elle est vraie au niveau européen, cette responsabilité croissante des régimes d'assurance, sociaux, mais facultatifs, fait face à une aspiration à la couverture des risques et, notamment des risques aux personnes, en étant peut-être le signe d'une société qui vieillit. Les risques, même s'ils ne sont plus pris en charge totalement ou bien dont on voit qu'ils ne pourront plus l'être totalement par des régimes obligatoires, restent par nature des risques sociaux. Je parle évidemment de la maladie ou l'on peut parler, comme je l'ai dit tout à l'heure, de la retraite ou de la dépendance. Des risques sociaux par la généralité de

l'aspiration à la couverture. Tout le monde aspire à être couvert en maladie par extension, à l'ensemble de la population sans le risque que ferait courir la société une non-couverture d'une partie de la population quelle qu'elle soit. Je rappelle –j'ai parlé de la loi sur la couverture maladie universelle– que la mise en place d'une couverture complémentaire au titre de la CMU était le résultat du fait que la part complémentaire avait augmenté et qu'une partie des citoyens français n'avaient plus accès à une complémentaire par leurs propres moyens. Cela a conduit à un effort public.

Face à cette situation, je crois qu'un des enjeux dans l'Europe de demain, c'est de développer une approche solidaire et facultative. Solidaire et facultative, cela veut dire à la fois qui n'est pas dans le monopole public mais qui ne relève pas pour autant des seules règles de l'article 85, des règles de la concurrence qui s'appliquent au marché unique. Je vais développer dans les deux minutes et demie qui me restent principalement le premier point qui est l'expérience française.

Nous avons eu à faire face à une situation contentieuse, introduite par la Fédération Française des Sociétés d'Assurance, sur les contrats d'assurance mutualiste et qui était lié à l'existence d'une exonération sur la taxe des contrats d'assurance –qui était très ancienne, puisqu'elle datait de 1944– exonération liée au caractère solidaire et non lucratif de la prise en charge du contrat d'assurance-maladie. Bien sûr, la France et la Mutualité ont défendu les principes sur lesquels s'appuyaient cette exonération, notamment le caractère non lucratif de la couverture, le caractère solidaire, prévu dans le code de la mutualité. Il n'en ressort pas moins que finalement l'idée qui est au centre de la jurisprudence européenne s'est imposée: ce n'est pas la nature de l'organisme qui a conduit à l'exonération, mais bien la nature de l'opération. Cela a conduit les pouvoirs publics français à mettre en place une exonération liée à, ce qu'on appelle, les «contrats solidaires», c'est-à-dire les contrats qui ne prévoient aucune sélection médicale ni de tarification en fonction de l'état de santé des personnes qui sont couvertes.

Cette idée de règles relatives au contrat se développe aujourd'hui par la réforme française, puisque les contrats complémentaires sont appelés à devenir également des «contrats responsables», c'est-à-dire des contrats qui évitent l'inflation inutile des dépenses et respectent le cadre d'organisation des soins prévu par la réforme. C'est d'ailleurs le point de vue de la Mutualité Française et c'est l'idée qu'elle avait évoquée et à laquelle nous tenons, de généraliser ce type de dispositif au travers d'un crédit d'impôt qui, certes, a pour objectif de favoriser l'accès à une complémentaire pour l'ensemble de la population, mais aussi de respecter les critères de responsabilité et de solidarité. On voit bien que derrière cela – et ça rejoint l'atelier suivant sur les services sociaux d'intérêt général – on introduit l'idée que les aides publiques en France sont des aides sociales et fiscales, liées à l'activité et non au statut. J'ajoute que cela conduira nécessairement les Etats à clarifier les critères d'intérêt général.

Mais cela pose aussi d'autres questions. Il me semble que nous tenons à cette solution, mais que probablement, nous devons aller plus loin. La première question: est-ce que nous pourrions (cela fait allusion à la situation aux Pays-Bas) nous limiter ou accepter que sur les risques sociaux, des critères de solidarité et de responsabilité ne soient respectés qu'à travers des mesures incitatives? Est-ce que ces domaines qui servent de relais du marché, de la libre adhésion, ne doivent pas faire l'objet, compte tenu de leur importance, d'une réglementation propre? Je pense notamment à l'assurance-maladie, et l'on voit aujourd'hui à travers la croissance de la dépense en fonction de l'âge, la nécessité de garantir le caractère viager pour tous de l'assurance-maladie. Est-ce qu'il ne faudra pas aussi, même si le critère d'activité s'est imposé face au critère d'entreprise, que ce type d'activité ne soit pas prioritairement exercé par des organismes dont c'est la vocation, c'est-à-dire qui maintiennent des principes chers à l'AIM: la gestion par les adhérents et le caractère non lucratif?

Est-ce qu'il ne faudra pas enfin, dès lors qu'on a réussi à concilier le caractère solidaire et le libre jeu, sinon de la concurrence du moins de la libre adhésion dans le marché intérieur de demain, développer notre capacité d'acheteur avisé? Certes, et j'y suis particulièrement sensible, l'ouverture du marché des services de santé doit respecter, cela a été dit ce matin, des critères de sécurité et de qualité, mais il doit aussi être l'occasion de peser sur l'offre sur ces coûts et sur son organisation. Je finirai par un dernier point. Je crois que la question qui se posera dans les organismes internationaux est la suivante: quels sont les outils de mesure que nous avons? Car il me semble qu'aujourd'hui l'outil de mesure est assez fruste, comme l'étaient les PIB d'hier, ne prend que le taux de prélèvement obligatoire. Je crois qu'il faudra que les organismes internationaux s'attachent au niveau de prélèvement social selon les différentes formes qu'ils peuvent prendre.

Je vous remercie de votre attention.

Susanne WEBER-MOSDORF

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Ich nehme das Wort auf Deutsch, herzlichen Dank.

Sehr geehrte Damen und Herren,

ich werde nicht versuchen, Ihnen das deutsche Sozialversicherungssystem oder auch nur die Krankenversicherung zu erklären, das ist so komplex mit seiner Selbstverwaltung und unserem föderalen System, das könnten andere hier im Saal, die von der deutschen Krankenversicherung kommen, auch besser. Ich möchte nur darauf eingehen, wie wir in Deutschland die Rechtsprechung des Europäischen Gerichtshofes anwenden und ich möchte noch ein paar allgemeine gesundheitspolitische Bemerkungen zu der Rechtsprechung des EUGH machen.

Herzlichen Dank zunächst noch einmal an die Veranstalter. Ich finde, es ist wichtig und nützlich, einmal die Gesamtschau der europäischen Rechtsprechung herzustellen und diese in Bezug zur nationalen Gesundheitsvorsorge zu setzen. Meine Einschätzung ist, dass der Bericht, der uns vorgelegt worden ist, ein sehr nützlicher und umfangreicher Bericht ist. Ich glaube, es ist die erste umfassenden Gesamtschau überhaupt. Also herzlichen Dank dafür.

Wenn wir jetzt in dieser Konferenz über Urteile des Europäischen Gerichtshofes sprechen, dann sprechen wir über hochpolitische Fragen, nämlich über die Frage der Balance der Binnenmarktregeln mit den Regeln der nationalen Gesundheitsversorgung. Wenn man jetzt die Urteile des Europäischen Gerichtshofes nimmt und wie Fähnchen auf ein Puzzle setzt, dann wird die Landschaft der Patientenfreizügigkeit immer weiter abgesteckt. Es kommt dann ein Gesamtbild heraus, das manche von den Mitgliedstaaten erst gar nicht sehen und erkennen wollten. Vereinfacht gesagt, sieht dieses Gesamtbild so aus, dass wir erstens zur Kenntnis nehmen müssen, dass die nationalen Gesundheitssysteme nicht gegen den Binnenmarkt abgeschottet werden können - der Watts-Fall wird das - auch für die staatlich organisierten Gesundheitssysteme - sehr deutlich machen. Zweitens, dass es die Freizügigkeit von Patienten ist, die die nationalen Regelungsgrenzen überschreitet. Wenn wir dieses sehen und wissen, dann müssen die national Verantwortlichen im Gesundheitswesen für sich beanspruchen, dass sie selbst als national Verantwortliche die Balance und die Grenzen der Binnenmarktfreiheiten auch abstecken - nicht, indem sie fragen: Was ist juristisch machbar, was ist juristisch mit dem Binnenmarkt vereinbar?, sondern: Was wollen wir politisch und was ist politisch notwendig? Die deutsche Bundesregierung hat diese Entscheidung für sich so getroffen,

dass die Binnenmarktfreiheiten für die Bürger umgesetzt werden. In einem Land mitten in Europa mit so vielen Grenzen wie Deutschland sie hat, ist es selbstverständlich, dass die Bürger über die Grenzen gehen, um die nächstgelegenen Gesundheitsdienstleistungen – Ärzte, auch Krankenhäuser – in Anspruch zu nehmen. Die Krankenversicherungen haben sich darauf eingestellt und haben sehr pragmatisch hier auch Lösungen gefunden. Die deutsche Regierung hat die europäische Rechtsprechung deshalb auch im Gesundheitsmodernisierungsgesetz umgesetzt. Die Bürger, die in anderen Ländern ihre Gesundheitsdienstleistungen in Anspruch nehmen, können danach die Kostenerstattung in Deutschland geltend machen. Das ist neu in einem System der Sachleistungen. Und es wurde zweitens folgendes geregelt: Die Krankenversicherungen können auch mit Dienstleistern in anderen Ländern Verträge abschließen. Der ungarische Kollege hat heute Morgen darauf hingewiesen, dass mehr Deutsche nach Ungarn kommen als umgekehrt. Das ist so, wir haben dieses ermöglicht. Wir haben dieses auch vor allem im Sinne der Patienten so ermöglicht. Gleichzeitig hat die Bundesregierung im Gesundheitsmodernisierungsgesetz auch dafür gesorgt, dass national der Wettbewerb verstärkt wurde, der Wettbewerb zwischen den Anbietern, der Wettbewerb zwischen den Krankenkassen, weil wir die Effizienzmöglichkeiten des Wettbewerbs auch nutzen wollen. Insofern, denke ich, können wir durchaus mit den Grundaussagen der europäischen Rechtsprechung leben. Wir wollen mehr Wettbewerb, aber Wettbewerb um Qualität, um bessere Qualität, und keinen Wettbewerb um die geringsten Kosten. Deshalb müssen wir immer im Auge haben, dass die Dienstleistungen nicht nur einfache Dienstleistungen im Sinne des Gütermarktes sind, wie es heute Morgen gesagt wurde, sondern Dienstleistungen im Gesundheitswesen sind etwas ganz Besonderes. In Deutschland haben wir seit der Einführung der sozialen Marktwirtschaft nach dem Zweiten Weltkrieg im Konsens darüber festgehalten, dass es für die Gesundheitspolitik und die Marktwirtschaft insgesamt einen stabilen ordnungspolitischen Rahmen geben muss – ganz besonders im Gesundheitswesen, wo es um die Sicherheit und Gesundheit der Menschen geht. Dieser bewährte Konsens sollte in einem sozialen Europa genauso gelten. Ich denke, die Politik muss sicherstellen, dass dieser Konsens auf der europäischen Ebene auch hergestellt und überhaupt erst einmal diskutiert wird. Frau van Lancker hat heute Morgen darauf hingewiesen, dass sich die Gesundheitsminister zu wenig darum kümmern, wie der Binnenmarkt auch auf die nationale Gesundheitssysteme wirke. Ich denke, sie müssten dieses tun, sie müssten selbst diesen Konsens auf europäischer Ebene herstellen. Es ist nämlich eine politische Frage und keine reine Binnenmarktfrage, wer, wenn er krank ist, Zugang zu welchem Gesundheitssystem und zu welchen Konditionen hat. Wir haben in Europa auch unter den Gesundheitsministern den Konsens, dass unabhängig vom Gesundheitszustand und unabhängig von der jeweiligen finanziellen Situation der einzelne an allen Orten Europas eine notwendige Behandlung erhalten

soll. Dieser Konsens hat Eingang gefunden in die Regelungen zur Koordinierung der sozialen Sicherung. Das Krankheitsrisiko darf nicht ein existentielles Lebensrisiko werden, und die Erhaltung der Gesundheit und die Versorgung bei Krankheit kann nicht den Kräften des freien Marktes von Angebot und Nachfrage überlassen werden. Dies gilt ganz besonders auch für das System der Risikoversorge und die Frage, in welcher Weise die Risikoversorge finanziert wird, nämlich über eine solidarische Versicherung oder eine private Versicherung. Die deutschen Bürger sind zu 90 % in gesetzlichen Versicherungen versichert und zu 10 % in privaten. Vor dem Hintergrund waren wir auch sehr froh über die Rechtsprechung des europäischen Gerichtshofes zum Festbetragsurteil. Er hat entsprechend eine solidarische Versicherung oder eine gesetzliche Versicherung, wie sie in Deutschland vorherrsche, mit obligatorischen Beiträgen und gleichen Leistungen unabhängig vom Beitrag, kein Unternehmen sei und deshalb nicht dem Wettbewerb ausgesetzt werden darf. Ich glaube aber, dass dieses Urteil uns nur eine kurze Atempause gibt. Welche Auffassung wird der EuGH vertreten, wenn die gesetzliche Versicherung durch private Elemente ergänzt würde. Verschiedene Vorstellungen sind hier im politischen Raum, und möglicherweise kommt dann der Europäische Gerichtshof zu einer anderen Auffassung. Und dies ist ein Beispiel dafür, dass die Politik die Prärogative hat, zu bestimmen, was dem Binnenmarkt überlassen werden soll und was nicht. Es sind die national verantwortlichen Gesundheitsminister, die sagen müssen, wie die Balance zwischen Freizügigkeit einerseits und Qualitätsstandard für den Patienten, den Bürger andererseits herzustellen ist, auch die Balance zwischen dem Wettbewerb der Anbieter und der Versorgungssicherheit, sowie die Balance zwischen Versorgungsverantwortung einerseits und Wahlfreiheit andererseits wie auch der Nachhaltigkeit der Finanzierung. Vielleicht brauchen wir so etwas wie eine Gesundheitscharta der Gesundheitsminister für die europäische Ebene, einen Kompass als Rahmen für die Binnenmarktinitiative, die derzeit in den unterschiedlichen Bereichen der EU unternommen werden. Gerade die Diskussion um die Dienstleistungsrichtlinie hat dazu geführt, dass sich die Gesundheitsminister sehr darüber bewusst werden, dass andere Kommissionen ihre nationale Gesundheitspolitik mitbestimmen. Ich denke, insofern sind sie auch inzwischen bereit, eine gemeinsame Haltung zu bilden zu all den Initiativen, die derzeit zu entscheiden sind, so die gesamte Fragestellung um die Daseinsvorsorge. Die Gesundheitsminister haben sich bei der Dienstleistungsrichtlinie schon darauf geeinigt, dass der Gesundheitsbereich gar nicht zum Anwendungsbereich gehören sollte und dass die Frage der Kostenerstattung für die Inanspruchnahme grenzüberschreitender Gesundheitsdienstleistungen nicht dort verankert werden sollte, sondern in der 1408, der Verordnung zur Koordinierung der sozialen Sicherheit. Diese müsse angepasst werden an neue Bedürfnisse, neue Anforderungen. Die Gesundheitsminister müssen weiter eine Haltung gewinnen zum Monti-Paket, zur Daseinsvorsorge insgesamt: Nämlich welche

Spezifikation sie hat und welche Freiräume zur Gestaltung der Daseinsvorsorge auf nationaler Ebene gesichert werden sollen. Vor allem müssen sich die Gesundheitsminister auch darüber im klaren werden, auf welche Weise, mit welchen Instrumenten Rechtssicherheit zu schaffen sein wird für die Bürger, die die Freizügigkeit zur Nutzung der grenzüberschreitenden Möglichkeiten in Anspruch nehmen wollen. Insofern war die Gesamtschau an Rechtsprechung, die wir heute bekommen haben eine wichtige Grundlage, aus deren Analyse die politischen Entscheidungen zu treffen sind.

Ich danke Ihnen.



Anne HOUTMAN

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Bonjour à tous. Je voudrais remercier les organisateurs et tout particulièrement le Professeur Jorens, qui a pu rassembler dans son rapport une expertise sur un domaine extrêmement complexe qui est la santé et l'impact de la législation communautaire.

Je me limiterai à rappeler la logique et les principes généraux de l'approche de la Commission européenne plutôt que de présenter des règles détaillées.

D'abord, il faut remarquer, qu'il n'y a pas en droit communautaire, de droit secondaire spécifique à l'assurance-maladie. On applique certaines Directives et en particulier la Directive sur l'assurance non-vie de 1992. D'autres textes horizontaux s'appliquent également, notamment les Directives en matière de marchés publics ainsi que les règles en matière de concurrence, qui couvrent à la fois les règles anti-trust et les règles en matière d'aides d'Etat.

Dans cette approche, on s'appuie, en réalité, sur le Traité. C'est aussi ce que fait la Cour de Justice qui a déjà rendu un certain nombre d'arrêts qui concernent le secteur de l'assurance maladie. Il faut savoir qu'il s'agit surtout des questions préjudicielles. Il n'y a que de très rares arrêts où la Commission a apporté des cas d'infraction devant la Cour.

Alors quelle est la logique du Traité? Le Traité permet une coexistence de plusieurs objectifs et de valeurs:

des règles en matière de concurrence, d'anti-trust, qui interdisent les aides d'Etat et les accords entre entreprises;

des articles qui concernent spécifiquement le marché intérieur notamment le principe de la libre prestation des services et le principe de liberté d'établissement;

des articles qui fixent des objectifs en matière de santé publique, de cohésion sociale, de politique sociale;

l'article 16 qui précise que les services d'intérêt général faisant partie du modèle social européen permettant une meilleure cohésion sociale et territoriale.

Le Traité fixe aussi les compétences et des responsabilités partagées entre le niveau communautaire et celui des Etats membres, pour assurer que les opérateurs puissent remplir leurs missions de service public dans des conditions acceptables.

La question d'aujourd'hui est de trouver en fait un équilibre entre ces différents objectifs pour l'assurance maladie. L'article du Traité qui permet de comprendre la philosophie de cette recherche d'équilibre est l'article 86. L'article 86 dit, d'une part, que les règles du marché intérieur et les règles de concurrence s'appliquent à toutes les activités économiques, peu importe la forme juridique (publique ou privé) de l'opérateur.

Mais cet article porte une nuance qui est très importante quand il s'agit des missions d'intérêt économique général et des obligations de service public. Il dit essentiellement que ces règles du marché intérieur et de la concurrence s'arrêtent de s'appliquer au moment où elles empêcheraient l'opérateur chargé d'une mission de service public de remplir sa mission dans des conditions normales. Il faut donc trouver un équilibre entre ces deux groupes d'objectifs sur base des principes de nécessité et de proportionnalité. Et c'est là évidemment que se trouve toute la difficulté.

Un autre équilibre difficile à trouver concerne les compétences. Le Traité et la Cour reconnaissent la compétence des Etats membres pour déterminer le type de système de santé qu'ils souhaitent. Il appartient également aux Etats membres de déterminer leurs objectifs en matière de politique de santé. Toutefois, dans l'exercice de ce droit de choisir le type de système et d'organisation, ils doivent respecter certaines règles communautaires. C'est un peu comme si on disait, vous pouvez aller n'importe où dans le monde, vous pouvez choisir aussi le mode de transport, mais à partir du moment où vous choisissez de prendre une voiture, vous êtes tenus de respecter le code de la route.

Les Etats membres décident du choix de leur système, qui ils veulent couvrir par leur système de sécurité sociale, et des risques qu'ils souhaitent couvrir. Le droit communautaire intervient pour déterminer, en fonction de ces choix, quelles sont les règles à appliquer. Pour être plus spécifique, je vais illustrer ce point par l'application de la Directive sur l'assurance non vie à l'assurance santé. Tout d'abord, il faut rappeler qu'elle ne s'applique pas aux systèmes de sécurité sociale obligatoires publics de base. La Cour a indiqué à plusieurs reprises que la gestion de ce système ne constitue pas une activité économique. Et il est bien clair que les règles du marché intérieur ne s'appliquent que là où il y a un marché. Le critère principal pour la Cour pour déterminer s'il y a un marché ou pas se reflète dans la rencontre entre l'offre, la demande et un prix qui constitue une rémunération pour un service. Est-ce qu'il y a vraiment un échange d'un service pour un certain prix? La Cour considère que les cotisations sociales qui dépendent, en fait, du salaire de l'individu et qui n'ont aucun rapport avec le risque couvert ne constituent pas un prix, et on n'est donc pas en face d'un marché. Pour la Cour un tel système est purement basé sur un système de solidarité; on n'est donc pas dans une économie de marché.

Mais, la Directive s'applique à tous les autres systèmes d'assurance complémentaires et supplémentaires. La Directive s'applique également à partir du moment où l'Etat décide que son système de sécurité sociale de base va être géré par des entreprises privées. S'il fait ce choix là, il fait un choix qui le soumet à la Directive sur l'assurance non-vie.

Toutefois, cette Directive prévoit que, pour un système de sécurité sociale de base, l'Etat membre peut imposer des obligations et des restrictions au libre marché pour autant que ces restrictions et obligations sont nécessaires pour atteindre l'objectif que s'est fixé l'Etat. Par ailleurs, les mesures prises doivent être proportionnelles par rapport à cet objectif et ne doivent pas aller au-delà de ce qui est nécessaire pour atteindre cet objectif. Enfin, il faut également appliquer le principe de transparence. Les restrictions possibles sont énumérées dans un considérant de la 3ème directive assurance non-vie. L'Etat peut, par exemple, imposer à l'assureur privé l'absence de restriction d'adhésion. Il peut imposer aussi la couverture à vie. Il peut imposer une interdiction de segmentation des risques, par l'imposition d'une tarification uniforme par type de contrat. Il peut aussi imposer des conditions types de couverture qui doivent être respectées par les assureurs au nom de l'intérêt général.

Enfin, les Etats membres peuvent prévoir un système de compensation des risques entre les opérateurs prenant en charge la couverture de base des citoyens. La question s'est posée si ce type de système serait aussi accepté pour les assurances-maladie complémentaires. La position qui a été prise par la Commission en attendant que la Cour se prononce est que, a priori, pour les systèmes complémentaires, ces conditions iraient probablement au-delà de ce qui est nécessaire. Dans le dossier irlandais la Commission s'est bien rendu compte que la frontière entre le système de base et le système complémentaire devenait floue et était, en fait, assez difficile à déterminer. La Commission a accepté dans ce dossier un système de compensation de risques qui, en réalité, va probablement au-delà de ce qu'on appellerait strictement l'assurance de base. Le dossier a été attaqué devant la Cour par un concurrent.

A mon avis, la Cour, jusqu'à présent, a été d'une énorme sagesse dans ses arrêts. Je pense que la série d'arrêts qui ont été rendus, aussi bien sur le droit des patients que sur la notion d'activité économique que sur l'application des règles en matière de marché public, sont d'un grand équilibre. Ils permettent aussi d'utiliser les règles du marché intérieur et de la concurrence comme instruments pour améliorer la qualité et l'efficacité du système de santé publique, ce qui va, à mon avis, dans le sens recherché par les Etats membres tout en maintenant leur budget en équilibre.

Je vous remercie.



SESSION 3

THE NOTION OF “SOCIAL SERVICES OF GENERAL INTEREST” AS COUNTERWEIGHT TO THE INTERNAL MARKET RULES



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Einleitung

Mein Beitrag ist zweigeteilt: Einerseits werde ich über meine Erfahrungen als Vorsitzender der Freiwilligengruppe des Ausschusses für Sozialschutz (SPC) für die sozialen Dienstleistungen von allgemeinem Interesse berichten und andererseits auch auf die österreichischen Überlegungen zu diesen Fragen näher eingehen. Die nur sehr knapp bemessene Zeit für den Vortrag erlaubt natürlich keine Detailüberlegungen, sondern nur kurze Hinweise auf die wesentlichen Themen.

1. Arbeiten der informellen Arbeitsgruppe des SPC

Im Rahmen des SPC wurden die Arbeiten an den Fragen der sozialen Dienstleistungen von allgemeinem Interesse¹⁾ in unmittelbarer Folge des Grünbuchs über Dienstleistungen von allgemeinem Interesse²⁾ aufgenommen. Dazu wurde eine Freiwilligengruppe³⁾ eingesetzt, mit deren Vorsitz ich betraut wurde. Ziel der Arbeiten dieser Gruppe ist es, dem SPC die in diesen sehr technischen und oftmals auch sehr formaljuristischen Fragen erforderliche Unterstützung zu geben. Als erster Schritt wurde ein Bericht an das SPC erstellt, der zum einen auf die verschiedenen Aspekte der Einflüsse des EG-Rechts auf die sozialen Dienstleistungen verwies und zum anderen auch das große Bedürfnis nach mehr Klarheit betonte.

Diese Vorarbeiten wurden im Weißbuch der Kommission insofern berücksichtigt, als die Sonderstellung der Sozial- und Gesundheitsdienstleistungen anerkannt und eine Sondermitteilung über diese Dienstleistungen für 2005 angekündigt wurde⁴⁾. Das SPC sowie die „Hochrangige Gruppe“ wurden beauftragt, an der Vorbereitung dieser Sondermitteilung mitzuwirken. Zur Unterstützung dieser Arbeiten legte die Freiwilligengruppe des SPC den Mitgliedstaaten einen Fragebogen und ein Hintergrundpapier vor. Der Fragebogen sollte abklären, welche Elemente für die Definition der

1) *Ich wähle bewusst diesen im Einklang mit dem EG-Vertrag stehenden Ausdruck um allfällige Unschärfen bei der Verwendung des Ausdruckes „Daseinsvorsorge“ zu vermeiden.*

2) *KOM (2003) 270 endg. vom 21.5.2003.*

3) *Dieser Gruppe gehörten die folgenden Staaten an: Belgien, Dänemark, Deutschland, Finnland, Frankreich, Griechenland, Niederlande, Österreich, Portugal, Polen, Spanien und das Vereinigte Königreich.*

4) *KOM (2004) 374 endg. vom 12.5.2004 – Abschnitt 4.4.*

wesentlichen Kriterien der sozialen Dienstleistungen von allgemeinem Interesse herangezogen werden können, welche nationalen Erfahrungen mit den verschiedenen Aspekten des EG-Rechts bereits gemacht wurden, was für Bereiche näher vertieft werden könnten und schließlich, welche Strategie die Union hinsichtlich der sozialen Dienstleistungen von allgemeinem Interesse weiterverfolgen sollte. Das Hintergrundpapier enthält eine kurze Zusammenfassung der wesentlichsten Aspekte des EG-Rechts.

Einen wichtigen Input lieferte auch die Brüsseler Konferenz am 28. und 29.6.2004⁵⁾, deren Schlussfolgerungen bereits den Versuch einer Definition der wesentlichen Kriterien der sozialen Dienstleistungen auf europäischer Ebene enthalten.

Die nationalen Antworten aller 25 Mitgliedstaaten, aber auch jene verschiedenster sonstiger Akteure (insbesondere jene verschiedener NGOs) liegen nunmehr vor. Ein Studium dieser Berichte gibt einen guten Überblick über die Position der Mitgliedstaaten zu diesem Thema. Die Kommission stellte diese Fragebögen-Beantwortungen bei einem Seminar am 1.4.2005 in Brüssel vor. Bei dieser Gelegenheit hatten auch die Vertreter der NGOs auf europäischer Ebene die Möglichkeit, sich vor einem größeren Forum zu äußern.

1.1. *Untersuchte Bereiche*

Der Fragebogen an die Mitgliedstaaten hatte zum Ziel, einen möglichst weitreichenden Bereich abzudecken. Als „sozialen Dienste“ konnten insbesondere die Systeme der sozialen Sicherheit, die Gesundheitssysteme, die sonstigen Sozialschutzsysteme (z. B. Fürsorge, Pflegedienste, Altenbetreuung usw.), soziales Wohnen aber auch die Systeme der Beschäftigungspolitik und die Bildungssysteme dargestellt werden. Ziel war auch die Herausarbeitung europäischer Gemeinsamkeiten und der Versuch einer Definition. Hinsichtlich des EG-Rechts, das Auswirkungen auf diese sozialen Dienste haben kann, standen die Binnenmarktvorschriften (Waren- und Dienstleistungsverkehr), die Wettbewerbsregeln (einschließlich der Beihilfenvorschriften), die Vergaberegeln aber auch die Außenhandelsbeziehungen (z. B. das GATS) zur Diskussion. Die Mitgliedstaaten hatten große Wahlfreiheiten, welche Punkte jeweils näher behandelt werden sollten.

5) Konferenz „Soziale Dienste von allgemeinem Interesse in der Europäischen Union – ihre besonderen Charakteristika, ihre Leistungsfähigkeit und Rahmenbedingungen der Dienstleistungserbringung“.

1.2. Ergebnisse der Antworten auf den Fragebogen

Die Gesundheitsdienstleistungen waren einer der wichtigsten Punkte der einzelnen Reaktionen. Die eingereichten Antworten lassen in diesem Bereich bereits einige Schlüsse zu: Hauptsorge für den Gesundheitsbereich dürfte die Dienstleistungsrichtlinie sein, und zwar insbesondere das im Kommissionsentwurf uneingeschränkt vorgesehene Herkunftslandprinzip aber auch die Regelung betreffend die Patientenmobilität⁶⁾. Die Grundsätze des Wettbewerbsrechts dürften im Unterschied dazu keine all zu großen Schwierigkeiten für die Gesundheitsdienstleistungen bereiten. Unter Berufung auf die Urteile des EuGH in den Rechtssachen *Pucet* und *Pistre*⁷⁾ sowie *AOK*⁸⁾ sind die meisten Mitgliedstaaten der Auffassung, dass die Einrichtungen ihrer Gesundheitssysteme keine Unternehmen im Sinne des EG-Wettbewerbsrechts seien. Daher würden auch die Grundsätze des Art. 81 EG („Kartellverbot“), Art. 82 EG (missbräuchliche Ausnutzung einer beherrschenden Stellung) und Art. 87 EG (Beihilfenverbot) für die Gesundheitssysteme keine Probleme bedeuten.

Man kann sich natürlich die Frage stellen, warum nur diese Priorität der Dienstleistungsrichtlinie gesehen wird. Zieht man auch die Antworten in den anderen Bereichen der sozialen Dienste heran, so drängt sich die Vermutung auf, dass immer jene Bereiche als prioritär eingestuft werden, in denen gerade die Kommission Initiativen in Richtung einer gemeinschaftlichen Regelung gesetzt hat⁹⁾. Aus diesem Blickwinkel verwundert daher nicht, dass das Wettbewerbsrecht bei den Gesundheitsleistungen derzeit kein Thema ist (weil diesbezüglich eben derzeit keine Kommissionsvorschläge auf dem Tisch liegen).

Auf der anderen Seite haben aber die Fragebogenbeantwortungen ein weites Feld aufgezeigt, in dem Gesundheitsleistungen durch das EG-Recht beeinflusst und beeinträchtigt werden können. Ein gutes Beispiel ist der Hinweis eines Mitgliedsstaats auf die Richtlinie 93/104/EG betreffend die Arbeitszeit, die ja aufgrund des *SIMAP*-Urteils¹⁰⁾ im Spitalsbereich tiefgehende Auswirkungen haben kann, wenn nämlich die Bereitschaftsdienstzeiten der Ärzte auf deren Arbeitszeit anzurechnen sind¹¹⁾.

Als Ergebnis der Fragebogenbeantwortungen kann daher gesagt werden, dass die Mitgliedstaaten sehr wohl die mannigfaltigen Auswirkungen des EG-

6) Art. 23 des Kommissionsentwurfs. Viele Mitgliedstaaten verlangen eine Regelung sämtlicher Aspekte der Patientenmobilität in der Verordnung (EWG) Nr. 1408/71 über die soziale Sicherheit der Wanderarbeitnehmer.

7) Urteil vom 16.2.1993, Rs C-159/91 und C-160/91.

8) Urteil vom 16.3.2004, Rs C-264/01 u.a..

9) So wurde z. B. bei den sozialen Wohnraummaßnahmen das Schwergewicht auf die Beihilfenproblematik gelegt, wo ja im Rahmen des „Monti-Pakets“ gerade dieser Bereich ausdrücklich angesprochen wird.

10) Urteil vom 3.10.2000, Rs C-303/98.

11) Dieses Urteil hat somit ganz wesentliche finanzielle Auswirkungen und die Mitgliedstaaten müssen das gesamte Personalwesen in den Spitälern überdenken.

Rechts im Gesundheitsbereich erkannt haben. Der angelaufene Prozess ist somit ein erster Schritt, um voneinander zu lernen, Erfahrungen auszutauschen und nach guten Vorbildern bei bestimmten Fragestellungen zu suchen¹²⁾. Wichtig ist dabei auch, dass die verschiedenen Experten in den Mitgliedstaaten, aber auch in der Kommission, voneinander lernen. Bisher war nämlich wenig Verständnis vorhanden, wenn Wettbewerbsexperten mit Sozial- oder Gesundheitsexperten zusammentrafen. Nunmehr ist aber klar, dass diese beiden Bereiche immer mehr verschränkt sind und daher eine enge Zusammenarbeit unbedingt notwendig ist.

2. Österreichische Überlegungen zu den Gesundheitsdienstleistungen von allgemeinem Interesse

Nach der Zusammenfassung der bisherigen Arbeiten im SPC sollen auch noch einige speziell auf die österreichische Situation abgestellte Überlegungen angefügt werden.

2.1. Position Österreichs

Wegen der starken Ähnlichkeit der österreichischen Krankenkassen zu den deutschen Kassen ist auch Österreich durch das AOK-Urteil beruhigt worden. Wir gehen daher in Österreich davon aus, dass unsere Krankenkassen keine „Unternehmen“ im Sinne des EG-Wettbewerbsrechts sind¹³⁾. Allerdings ist die Gewissheit natürlich nicht absolut! Hat doch der EuGH selbst darauf hingewiesen, dass die Ausnahme vom EG-Wettbewerbsrecht nur die Festsetzung von Festpreisen für Arzneimittel nach den deutschen Rechtsvorschriften betraf, dass aber auch die deutschen Kassen bei anderen Aufgaben möglicherweise als Unternehmen anzusehen sind. Es bleibt also die bange Frage, ob und allenfalls in welchen anderen Bereichen die österreichischen Kassen als Unternehmen anzusehen sind.

Natürlich wird oft darauf hingewiesen, dass selbst bei Klassifizierung einer Krankenkasse als Unternehmen das EG-Wettbewerbsrecht nicht uneingeschränkt zur Anwendung gelangen muss. Nach Art. 86 Abs. 2 des EG-Vertrags ist nämlich ein Schutz dieser Dienstleistungen zur Erfüllung der übertragenen Aufgaben von allgemeinem Interesse vorgesehen. Allerdings befindet man sich bei Anwendung dieser Regelung bereits auf der Rechtfertigungsebene. Aus der Sicht eines Mitgliedstaates ist es also viel sicherer, wenn die Einrichtungen der Gesundheitsdienste gar keine Unternehmen im Sinne des EG-Wettbewerbsrechts sind, als wenn im

12) Ohne es so zu benennen, hat somit hinsichtlich der sozialen Dienstleistungen bereits eine „Methode der offenen Koordinierung“ begonnen.

13) Als wesentliches Unterscheidungskriterium ist bei den österreichischen Krankenkassen noch darauf hinzuweisen, dass in Österreich – anders als in Deutschland – keine freie Kassenwahl besteht, sondern dass durch eine nahezu absolut wirkende Pflichtversicherung die versicherten Personen jeweils einer Kasse gesetzlich zugeordnet werden. Damit liegen in Österreich wohl noch mehr Elemente, die gegen eine Qualifikation als „Unternehmen“ sprechen, vor als in Deutschland.

Einzelfall versucht werden muss, Beschränkungen des Wettbewerbs nach Art. 86 Abs. 2 zu rechtfertigen.

Um die Gefahren deutlicher zu machen ist zunächst davon auszugehen, dass gerade der Gesundheitsbereich kein einheitlicher Markt ist, sondern dass viele verschiedene Märkte nebeneinander bestehen (z. B. Allgemeinmedizin, Zahnmedizin, Krankentransport usw.). Daher ist auch ein Querausgleich der Risiken in einem Marktsegment durch die Vorteile eines anderen Marktes nur sehr eingeschränkt möglich¹⁴⁾. Vor allem wird es dann bedenklich, wenn ein solches Unternehmen nicht (mehr) in der Lage ist, die an sich durch den Staat übertragenen Maßnahmen zufriedenstellend zu erfüllen¹⁵⁾. Wenn wir ein Beispiel herausgreifen wollen, könnten wir die Regelungen im Bereich der Zahnmedizin wählen. Viele Mitgliedstaaten führen gerade in diesem Bereich mehr oder weniger strenge Sparmaßnahmen verbunden mit Leistungsreduktionen ein. Wenn die gesetzliche Krankenversicherung ein Unternehmen ist, wird dann nicht möglicherweise irgendwann der Rubicon überschritten, ab dem Privatversicherungen viel effektivere Behandlungen anbieten können und das System der Pflichtversicherung das Monopol der gesetzlichen Krankenversicherung missbraucht? Wegen der getrennten Märkte ist es schwer zu argumentieren, dass ein Ausgleich zwischen allen Risikobereichen der Krankenversicherung erforderlich ist.

Daher ist aus meiner Sicht auch zur Garantie der einheitlichen Regelung aller verschiedenen Risiken (Solidarprinzip), die von den Gesundheitssystemen der Mitgliedstaaten üblicherweise abgedeckt werden, ganz wichtig, dass die Einrichtungen der österreichischen Krankenversicherung nicht als „Unternehmen“ im Sinne des EG-Wettbewerbsrechts betrachtet werden. Anderenfalls sehe ich persönlich die Gefahr, dass die Marktmechanismen das Gesundheitssystem auf ein System der Mindestversorgung (Notfälle, Großrisiko) beschränken und die anderen (lukrativen) Bereiche der Privatwirtschaft überlassen werden. Sozial- und gesundheitspolitisch kann eine solche Entwicklung wohl von keinem Mitgliedstaat begrüßt werden.

2.2. Österreichische Erfahrungen mit dem EG-Recht

Nach diesen eher allgemeinen Überlegungen möchte ich auf die konkreten Erfahrungen eingehen, die Österreich bereits mit dem Spannungsverhältnis zwischen den politischen Anforderungen an das Gesundheitssystem und dem EG-Recht gemacht hat:

- Vergabewesen: In Österreich wurde beschlossen, die moderne nationale Krankenversicherungskarte nicht direkt durch die Sozialversicherung produzieren zu lassen, sondern durch privatwirtschaftliche Unternehmen.

14) Hinsichtlich der getrennten Märkte des Krankentransports und des Notfallstransports siehe z. B. EuGH in seinem Urteil vom 25.10.2001, Rs C-475/99, Ambulanz Glöckner.

15) Hinsichtlich der Unfähigkeit des Arbeitsvermittlungsmonopols zur Vermittlung von Spitzenarbeitskräften und der sich daraus ergebenden EG-Widrigkeit des Monopols siehe EuGH, Urteil vom 23.4.1991, Rs C-41/90, Höfner und Elser.

Die Betrauung eines Unternehmens erfolgte zwar im Wege eine Vergabeverfahrens; die komplexen Verfahrensschritte aber auch die sich in der Folge ändernden politischen Vorgaben¹⁶⁾ führten dazu, dass bereits zwei Verfahren hinsichtlich des EG-Vergaberechts beim EuGH anhängig wurden¹⁷⁾. Diese Verfahren weisen auf die Probleme hin, die die öffentliche Hand haben kann, wenn Beschaffungsvorgänge ausgeschrieben werden müssen (z. B. Bestbieter muss nicht unbedingt der wirtschaftlich leistungsfähigste sein, mangelnde Flexibilität bei sich ändernden politischen Zielvorgaben).

Aber noch ein weiteres österreichisches Vergabeverfahren soll erwähnt werden. In der Rechtssache *Tögl*¹⁸⁾ entschied der EuGH, dass auch für die Verträge einer Krankenkasse mit Krankentransportunternehmen des EG-Vergaberecht anzuwenden ist. Nach meiner Kenntnis war es das erste Urteil des EuGH, das dies für den Gesundheitsbereich dermaßen klar zum Ausdruck brachte.

- Hinsichtlich der Dienstleistungsfreiheit hat der EuGH in der Rechtssache *Gräbner*¹⁹⁾ entschieden, dass das österreichische Verbot der Tätigkeit als Heilpraktiker durch Personen, die nicht Inhaber eines Arztdiploms sind, nicht den EG-Grundfreiheiten widerspricht. Aus meiner Sicht handelt es sich bei diesem Urteil um einen ganz wichtigen Grundsatz, der auch durch die geplante Dienstleistungsrichtlinie nicht in Frage gestellt werden darf.
- Im Urteil in der Rechtssache *Jauch*²⁰⁾ wurde entschieden, dass das österreichische Pflegegeld eine nach der Verordnung (EWG) Nr. 1408/71 zu exportierende Geldleistung bei Krankheit sei. Dabei handelt es sich somit nicht um den Kernbereich der untersuchten Bereiche des EG-Rechts. Allerdings hatte dieses Urteil, das in manchen Fällen zu ungewollten Kumulationen von Pflegesach- und Pflegegeldleistungen führte, dennoch die nationale österreichische Systematik des Pflegegeldes in Frage gestellt. Somit kann auch das EG-Recht betreffend den freien Personenverkehr unmittelbare und tiefgehende Auswirkungen auf das nationale System der sozialen Dienstleistungen von allgemeinem Interesse (wie auf das österreichischen Pflegegeldsystem) haben.
- Diese potentiell weitreichenden Auswirkungen des EG-Rechts auf das nationale Gesundheitssystem beziehen sich nach den österreichischen Erfahrungen auch noch auf einen anderen Bereich. Durch das Urteil des EuGH in der Rechtssache *Unterpertinger*²¹⁾ wurde entschieden, dass

16) So wurde erst in der Folge verlangt, dass die Krankenversicherungskarte (e-card) nicht nur zur Dokumentation der Anspruchsnachweise, sondern auch als Bürgerkarte zum Einsatz kommen sollte.

17) Urteil vom 18.3.2004, Rs C-314/01, Siemens AG Österreich, und Rs C-229/02, Debis, noch nicht entschieden.

18) Urteil vom 24.9.1998, Rs C-76/97.

19) Urteil vom 11.7.2002, Rs C-294/00.

20) Urteil vom 8.3.2001, Rs C-215/99.

21) Urteil vom 20.11.2003, Rs C-212/01.

ärztliche Untersuchungen z. B. zur Feststellung der Invalidität im Rahmen eines Pensionsverfahrens nicht unter die Steuerbefreiung nach der sechsten Mehrwertsteuer-Richtlinie 77/388/EWG fallen. Auch eine solche Steuerpflicht der ärztlichen Berufe kann zu großen finanziellen Rückwirkungen auf die Gesundheitssysteme führen und damit die Funktion als Dienstleistung von allgemeinem Interesse beeinflussen.

- Ein weiterer Bereich, in dem das österreichische Gesundheitssystem bereits mit dem EG-Recht Erfahrungen sammeln musste, ist die Verschreibung von Arzneimitteln durch die Krankenversicherung. Österreich war der erste Mitgliedstaat, bei dem festgestellt wurde, dass er die Transparenzrichtlinie 89/105/EWG nicht korrekt umgesetzt hat²²⁾. Dabei wurde erstmals entschieden, was unter einer „Positivliste“ im Sinne dieser Richtlinie zu verstehen ist. In der Folge mussten die österreichischen Verfahren zur Verschreibung von Arzneimitteln durch die Krankenversicherung zur Gänze überarbeitet werden, was bei dem großen wirtschaftlichen Interesse der Pharmaindustrie nicht gerade leicht war.

2.3. Fragen aus österreichischer Sicht

Gerade aus dem Blickwinkel des österreichischen Gesundheitssystems sind aber noch immer wesentliche Fragen der (möglichen) Auswirkungen des EG-Rechts auf Dienstleistungen von allgemeinem Interesse ungeklärt.

So wurde in letzter Zeit möglicherweise zu viel Gewicht auf die Dienstleistungsfreiheit gelegt; der freie Warenverkehr wurde sträflich vernachlässigt. Dabei ist gerade der „Einkauf“ von Leistungen durch die Gesundheitssysteme ein Bereich, in dem noch viel umgewälzt werden könnte. Sicherlich ein wichtiges Urteil in diesem Zusammenhang ist die Entscheidung in der Rechtssache FENIN²³⁾. Darin hat der EuGH ja ganz klar entschieden, dass nationale Gesundheitssysteme nicht als „Unternehmen“ gelten (Solidarprinzip) und daher diese Eigenschaft auch fortwirkt, wenn zur Erfüllung dieser Aufgaben Waren eingekauft werden²⁴⁾. Auf der anderen Seite hat der EuGH in einer Entscheidung Kommission gegen Belgien²⁵⁾ aber entschieden, dass Belgien dadurch gegen den freien Warenverkehr verstoßen hat, in dem für die Kostenerstattung der Krankenversicherung für bestimmte Heilbehelfe und Hilfsmittel (z. B. Rollstühle) zusätzliche Voraussetzungen vorgesehen wurden (Kriterien z. B. hinsichtlich der Radgröße bei Rollstühlen). Wie passt das zusammen? Immerhin werden ja

22) Urteil vom 27.11.2001, Rs C-424/99, *Kommission gegen Österreich*. Hinsichtlich der in dieser Rechtssache noch nicht entschiedenen Fragen ist bereits ein weiteres Verfahren gerichtsanhängig (Rs C-54/03, *Austroplant*, das allerdings noch nicht entschieden ist).

23) Urteil vom 4.3.2003, Rs T-319/99.

24) *Kein Missbrauch einer beherrschenden Stellung, wenn die Schulden gegenüber den Mitgliedern des Systems viel später als gegenüber anderen Wirtschaftsteilnehmern gezahlt werden*.

25) Urteil vom 13.1.2005, Rs C-38/03.

auch die Rollstühle eingekauft um sie dann - außerhalb einer wirtschaftlichen Tätigkeit - den Leistungsberechtigten der sozialen Sicherheit zuzuführen (nach FENIN müsste doch auch dieser Einkauf damit seine wirtschaftliche Bedeutung verlieren). Ich gehe davon aus, dass die meisten Mitgliedstaaten solche Zusatzkriterien vorsehen, wenn die Erstattungsfähigkeit durch die Sozialversicherung festgelegt wird.

Mir ist schon bewusst, dass das FENIN-Urteil zum Wettbewerbsrecht, das Urteil gegen Belgien zu den Binnenmarktvorschriften ergangen ist. Aus diesen beiden Urteilen wird aber das Dilemma sämtlicher sozialen Dienste im Spannungsfeld mit dem EG-Recht deutlich. Einem politischen Entscheidungsträger kann man diese Unterschiede nicht mehr erklären. Dadurch ist bei der politischen Diskussion der sozialen Dienstleistungen von allgemeinem Interesse zwar immer eine latente Angst vor den möglichen Einflüssen des EG-Rechts vorhanden; eine Bekämpfung dieser Ängste durch allgemeinverständliche Informationen ist aber nahezu ausgeschlossen.

Als Erklärungsversuch dieses scheinbar völlig unerklärlichen Nebeneinanders verschiedenere Urteile könnte man das Heil im *Freskot*-Urteil²⁶⁾ suchen, das eigentlich viele erhellende Aussagen enthält. Das untersuchte griechische Pflichtversicherungssystem entfaltet keine wirtschaftliche Tätigkeit (damit ist automatisch auch das gesamte EG-Wettbewerbsrecht nicht anwendbar, da die Einrichtungen nicht als „Unternehmen“ zu betrachten sind). Auch handelt es sich bei der Versicherung um keine Dienstleistung nach Art. 49 EG. Allerdings könnten durch die Pflichtversicherung Dienstleistungserbringer (Versicherungsunternehmen) aus anderen Mitgliedstaaten an der Ausübung ihrer Dienstleistungsfreiheit behindert werden. Da können dann die sozialpolitischen Zielvorgaben als Rechtfertigungsgrund herangezogen werden. Aus diesem Blickwinkel könnte (wohlgemerkt: für die Gruppe der eingeschworenen Experten) dieser aus erster Sicht zwischen dem FENIN- und dem Belgien-Urteil vermutete Widerspruch beseitigt werden. Deutlich wird hier aber jedenfalls, dass in der politisch hochbrisanten Frage, wie ein Gesundheitssystem EG-konform gemacht werden muss und wann die Grundsätze des EG-Rechts bereits verletzt sind, selbst Experten Probleme haben, sich zurechtzufinden. Mehr Rechtsklarheit - aus meiner Sicht selbst wenn das gemeinschaftsrechtliche Regelungen erfordert - ist daher unbedingt notwendig.

Eine konsequente Weiterverfolgung des *Freskot*-Urteils könnte aus meiner Sicht auch etwas Licht in das Dunkel bringen, das sich nach den *Kohll*- & *Decker*-Urteilen über die Mitgliedstaaten gebreitet hat. Wäre es nicht viel leichter verständlich, wenn der EuGH gesagt hätte, die nationalen Krankenversicherungssysteme selbst sind keine wirtschaftlichen Dienstleistungen; allerdings wird die Inanspruchnahme von Dienstleistungs-

26) Urteil vom 22.5.2003, Rs C-355/00.

erbringern in anderen Mitgliedstaaten behindert, wenn dafür keine Kostenerstattung geleistet wird. Dann wären nämlich die derzeit noch gerichtsanhängigen Fragen, ob reine Volksgesundheitssysteme wie das britische NHS auch von *Kohll & Decker* betroffen sind²⁷⁾, bereits geklärt. Aber leider hat der EuGH bei dieser Frage der Patientenmobilität für die Gesundheitssysteme keine Klarheit geschaffen, so dass wir auf weitere Urteile angewiesen sind.

2.4. Patientenmobilität aus österreichischer Sicht

Die vorangehenden Überlegungen leiten über zur Frage, welche Haltung Österreich überhaupt zur Patientenmobilität (*Kohll- & Decker-Prinzip*) einnimmt. Gerade dabei handelt es sich nämlich um einen wesentlichen Aspekt der Gesundheitsleistungen in ihrer Rolle als Dienstleistungen von allgemeinem Interesse. Nach der österreichischen Rechtslage können Versicherte, die nicht die Vertragseinrichtungen der Krankenkassen aufsuchen, immer und ohne vorherige Genehmigung eine Kostenerstattung nach österreichischem Recht beantragen. In der Folge werden die für die Behandlung durch einen vergleichbaren Vertragspartner der zuständigen österreichischen Krankenkasse vereinbarten Tarife erstattet, wobei allerdings z. B. bei Behandlung durch einen Nichtvertragsarzt 20% des Tarifs aufgrund der höheren Verwaltungskosten der Kasse abgezogen werden. Diese Rechtslage hat Österreich immer schon bei Behandlung durch österreichische Nichtvertragseinrichtungen aber auch weltweit für die Behandlung durch ausländische Leistungserbringer angewendet. Daher ist Österreich der Auffassung, dass wir bisher keine Umsetzungsprobleme bei der *Kohll & Decker*-Judikatur haben.

Umso schmerzlicher ist, dass in der nunmehr vorliegenden Studie der Universität Gent diese österreichische Rechtslage wegen der 20%-igen Reduktion ebenfalls als Behinderung der Dienstleistungsfreiheit gebrandmarkt wird²⁸⁾. Sollte diese Frage tatsächlich einmal vor dem EuGH landen, könnte das ein spannendes Verfahren werden. Wie bereits gesagt, handelt es sich bei dieser 20%-igen Reduktion nämlich um die erhöhten Kosten, die bei der Inanspruchnahme von Nichtvertragspartnern automatisch erwachsen. Nicht vergessen darf dabei werden, dass diese Reduktion auch bei der Inanspruchnahme österreichischer Nichtvertragspartner eintritt. Außerdem wurde auch der österreichische Verfassungsgerichtshof bereits mit dieser Frage befasst. Er kam zum Schluss, dass die Reduktion sachlich wegen der erwiesenermaßen (!) höheren Bearbeitungszeiten gerechtfertigt sind und damit keine Beeinträchtigung des Grundsatzes der freien Arztwahl

27) *Rs C-372/04, Watts, noch nicht entschieden.*

28) *Siehe Fußnote 142 des Berichts.*

vorliegt²⁹⁾. Könnte der EuGH dann überhaupt zu einem anderen Schluss kommen? – Wir sind davon überzeugt, dass das nicht der Fall sein kann!

Allerdings blieb Österreich bisher durch die Patientenmobilität nicht völlig unberührt. Das EG-Recht kann nämlich auch durch ausländische Systeme bewusst in Anspruch genommen werden. So ist es denkbar, dass sich ein Mitgliedstaat entscheidet, bei bestimmten sehr teuren Behandlungen³⁰⁾ nicht selbst die erforderliche medizinische Infrastruktur aufzubauen, sondern seine Versicherten gezielt mit einem E 112 in jene Mitgliedstaaten zu schicken, die bereits diese Leistungen für ihre Versicherten anbieten. Das kann wirtschaftlich gesehen durchaus rentabel sein. Für die solchermaßen „überschwemmten“ Mitgliedstaaten können sich echte Probleme ergeben. Im Extremfall können sich nämlich dann für die eigenen Versicherten Wartelisten aufbauen, was sozialpolitisch ganz schlimm wäre („Europa verschlechtert den Zugang der Inländer zu den Gesundheitsleistungen!“).

Aber besteht eine rechtliche Möglichkeit, gegen eine solche Entwicklung Maßnahmen zu ergreifen? Immerhin besteht ja auch die Verpflichtung, die Dienstleistungsempfänger nicht zu diskriminieren. Natürlich kann der betroffene Mitgliedstaat immer als letzte Notbremse Gründe der öffentlichen Gesundheit als Rechtfertigung einer Diskriminierung ins Spiel bringen³¹⁾. Ob damit aber generell die Hintanreihung der ausländischen Patienten erlaubt ist, kann angezweifelt werden. Bei den bestehenden Engpässen in manchen nationalen Gesundheitssystemen und den unterschiedlichen Entwicklungsstufen in den verschiedenen Mitgliedstaaten könnten sich aus dieser Rechtslage durchaus noch für einige Mitgliedstaaten erhebliche Probleme ergeben, die einer Lösung auf europäischer Ebene bedürfen. Diese Fragen wurden z. B. im Rahmen der laufenden Arbeiten an der Dienstleistungsrichtlinie bisher überhaupt noch nie näher behandelt. Bei dieser Richtlinie stehen nämlich bisher ausschließlich die Leistungserbringer als „behandlungswillige“ Dienstleistungserbringer, die Patienten oder die Sozialversicherungssysteme der Staaten, in denen die Krankenversicherung besteht, im Mittelpunkt der Überlegungen. Natürlich macht es Sinn, über solche *Centres of reference* oder *Centres of excellence* nachzudenken. Das sollte aber auf europäischer Ebene geschehen, wobei sämtliche Aspekte wie z. B. Planung, Forschung oder Finanzierung offen angesprochen werden können. Von einer solchen europäischen Lösung sind wir aber noch weit entfernt.

29) VfGH, Urteil vom 18.3.2000, G 24/98, V 38/98.

30) Z. B. Organtransplantationen, die nur bei einem hohen technischen, wissenschaftlichen aber auch Erfahrungsstandard durchgeführt werden können.

31) Mögliche Beschränkungen des freien Dienstleistungsverkehrs nach Art. 55 iVm Art. 46 EG.

Zusammenfassung

Die Gesundheitssysteme der Mitgliedstaaten sind derzeit auch auf europäischer Ebene wohl einer der am heftigsten diskutierten Bereiche. Dabei muss immer im Vordergrund stehen, dass jede Änderung die Funktion dieser Systeme als Dienstleistungen von allgemeinem Interesse empfindlich stören kann. Deswegen muss auf europäischer Ebene gerade bei den Gesundheitsdienstleistungen mit großer Vorsicht vorgegangen werden. Allerdings darf man nicht versuchen, sich vor jeglicher Diskussion auf europäischer Ebene gänzlich zu verschließen. Es darf nämlich nie vergessen werden, dass bereits derzeit viele Grundsätze des EG-Vertrages automatisch auch für die Gesundheitssysteme gelten. Daher wäre aus meiner Sicht eine offensive Strategie in Europa der beste Weg um den notwendigen Stellenwert der Gesundheitssysteme als Dienstleistungen von allgemeinem Interesse abzusichern, sei es auch durch gemeinschaftsrechtliche Maßnahmen. Ein „Tot Stellen“ indem nur z. B. eine Herausnahme der Gesundheitssysteme aus der Dienstleistungsrichtlinie gefordert wird, ist jedenfalls zu wenig. Auch darf die Stellung der Gesundheitssysteme in den anderen Bereichen des EG-Rechts (z. B. Wettbewerbsrecht) nicht vergessen werden. Ein Nachdenken über gemeinschaftsrechtliche Maßnahmen (z. B. im Rahmen des Art. 86 Abs. 3 EG) darf daher nicht tabuisiert werden. Die nächsten Jahre werden zeigen, wie erfolgreich unsere Bemühungen zur Aufrechterhaltung des Standards unserer Gesundheitssysteme waren.





Jonathan MOGFORD

*HEAD OF EUROPEAN AFFAIRS
DEPARTMENT OF HEALTH
UNITED KINGDOM*

Thank you for your invitation to speak this afternoon: can I also thank AIM for an extremely well prepared conference with some very thought-provoking literature which I think will really help take this debate forward.

I will speak mainly from the perspective of the UK NHS, which is a tax-funded, system integrating the financing, commissioning and provision of health services. However, within that legally integrated environment, substantial reforms are taking place, particularly about increasing the role of the independent sector and devolving responsibility to the front line. Some will recognise the challenge of asking the UK for a view on possible secondary legislation when we continue to argue - notably in the Watts case - that tax-funded systems like the NHS are not subject to the Treaty.

As far as Europe is concerned, we have very substantial support to patient mobility. I am responsible for an annual budget of nearly eighty million Euros, which supports healthcare for UK citizens moving around Europe.

As other people have already indicated, there are some very real tensions within the Treaty between the health interests and the single market interests. Slightly simplistically summarised, on the one hand Member States are saying that it is important that they are responsible for the management and organisation of their health systems and on the other hand the European institutions are saying that this is true for as long as it is compatible with the single market. We are still working out what that means.

So, do we think that the social services of general interests are somehow a counterweight to the internal market? This is certainly worth exploring in more detail. Certainly the UK does not underestimate how big a political issue this question actually is in terms of the implications that lie behind it.

The concept of social services of general interest is perhaps best seen as one of a range of options on how to find the balance between the health interests and the single market interests. But there still seems to be a considerable amount of uncertainty about the difference between the different concepts of services of general economic interest, services of general interest and social services of general interest. This needs to be further explored. We do need to look very carefully at what are the implications of going down this route.

Another option might be to accept that there will be an element of ad hoc development in this area, asking ourselves the question how big a problem this is. Some might think, however, that the questions raised by the Services



Directive are perhaps indicating that time is running out on this particular option.

A number of speakers have also mentioned revising Regulation 1408. I think this highlights one of my main points, which is that we need to be careful about what is the problem that we are trying to solve here. Is it a problem about patient mobility? Is it a problem about health and the single market? Or is it a much wider problem about economic and social aspects of health-care? The answer to that question probably defines which sort of options you are actually looking at: co-operation, guidelines, legislation.

Underlying all of this, is the need for a more sophisticated dialogue between the economic and social sectors.

To sum up, this is a debate that is only just starting. I think today's conference will be a very useful step forward in building a better understanding of the problem and the real implications of some of the options available to us. What is certain is that there are some very real tensions between the economic and the social objectives in this area and that Member States are concerned to discharge their responsibilities for managing and organising health systems. In that context, the prospect of a Commission's Communication on Social Services of General Interest is welcome. It can build on the outcomes of events like this one. It can help focus discussions during the forthcoming UK presidency.

Thank you very much.



Kari VÄLIMÄKI

*GENERAL DIRECTOR
MINISTRY OF SOCIAL AFFAIRS AND HEALTH
FINLAND*

I would like to thank the organisers for organising this conference. There was really a big need to discuss these very complicated issues. However I try to be very brief and simplify these questions because I think Mr Mogford made a really good question - what is the problem we are solving?

I do not think that it is very easy to answer this question. But I would like to say that one of the key problems is the fact that we have been trying to balance the two approaches – on the one hand we try to create internal markets and on the other we have addressed the principle of subsidiarity in social protection.

I think it is absolutely necessary to have more functioning markets in the European Union in order to meet, for example the goals which we have with the employment. And that is why we also need free markets for the services and we welcome the Directive on Services. However, the problem is that it is quite difficult - I would say - almost impossible to claim that social and health services would be fully independent from the free markets.

Health and social services include always economic aspects. Moreover, the four freedoms the EU stresses have to be taken into account also in organising of social and health services at the national level. In practice these two facts mean that we have already gone over the border that separates purely national health and social services and other services of economic interest.

Another problem is that the EU stresses competition and free markets. In social protection we stress solidarity and human rights and hence social protection has been mainly organised by the State and not by free markets. It is very challenging to combine these two approaches in the handlings of the Directive of Services.

As to the Finnish case I would like to say that the municipalities are responsible for providing social and welfare services. If they produce these services by themselves like in the most cases they do, we do not have any problems with the internal market rules. But if they want to purchase these services from the private or third sector, we are at once dealing with the market principles. And then we have to take into account the competition rules.

The Draft Directive of Services concerns the situations where the municipalities are buying these services from the private sector or from the NGOs. The main idea of the draft Directive is that we guarantee for the foreign enterprises the same opportunities and rights to enter Finland and offer these services to the municipalities. The idea of the draft directive is absolutely OK for us. Al-



ready today it is possible for the foreign companies to offer health and social services. We welcome foreign companies. The only thing, we expect them to follow, are Finnish rules in social and health sector that are equal for both domestic and foreign companies.

Health and social services are naturally in the interest of the public. However, until today Finland and most of the other European Member States have been able to live without defining the concept of services of general interest. It is very difficult to define whether the services are of general interest or just services of general economic interest. For example when we speak about child protection, in my opinion we could think that it is a kind of service of general interest. In Finnish case, it is possible to produce these child protection services in the private sector or in the public sector. So despite of the fact that we could regard child protection as a service of general interest, we have to apply the competition rules in child protection when the municipalities buy these services from the private sector. Thus health and social services cannot be automatically regarded as services of general interest in order to be able avoid the application of internal market and competition rules. The application of the competition rules depends on how the production of these services is organised.

Competition rules have caused some problems for the Finnish municipalities but these problems have nothing to do with the Draft Services Directive or the services of general interest. And that is why we are a little bit worried about the approach where we say that health services and social welfare services should be fully excluded from the Services Directive. As I mentioned before we have not needed the concept of service of general interest at all. That is why we think that at this stage, it would be wise to put all the efforts to amend the draft Directive on Services. The major amendment should concern the application of the country of origin principle. If the Services Directive would cover social welfare and health services but the country of origin principle would not be applied to these services, we would not meet major problems with the directive. Naturally there are some other smaller problems with the definitions because at the European Union level we do not have the concept of social services.

We hope that we could first solve the problems concerning the Draft Directive on Services and then come back to question do we need at all the concept of services of general interest.

Jérôme VIGNON

*DIRECTOR
DG EMPLOYMENT, SOCIAL AFFAIRS AND EQUAL OPPORTUNITIES
EUROPEAN COMMISSION*

Je vais m'en tenir au thème de cet après-midi: la notion de services sociaux d'intérêt général comme contrepoids du marché intérieur. Je m'exprimerai donc en relation étroite avec le rapport du Prof. Jorens puisque ça vient de son rapport. J'aimerais dire qu'il offre un concept global qui, pour l'avenir et les difficultés abordées ce matin, apporte beaucoup, mais que la Commission ne pourra pas complètement partager et je dirai en quoi.

Néanmoins, en utilisant ce concept - et en particulier la référence très précieuse à l'article 86.2 par lequel les services d'intérêt général économique rentrent de plein droit dans la vie communautaire - il rejoint les besoins de clarification auxquels veut répondre la Communication prochaine sur les services sociaux et de santé d'intérêt général. A travers le concept global de contrepoids entre l'intérêt général et le marché intérieur, mise en évidence par le Prof. Jorens, ouvre en germe une perspective structurante qui englobe les thèmes dont nous nous sommes saisis dans les sessions précédentes. En effet, cette notion de contrepoids est une autre manière de parler de conciliation entre, d'une part, la liberté d'accès aux soins - fondamentale dimension du Traité - et, d'autre part, l'universalité de cet accès - fondamentale responsabilité nationale encore soulignée par l'article 52. Il y a donc là une tension et parler de contrepoids, c'est recourir de manière large à une perspective de réconciliation.

Le rapport du Prof. Jorens montre la nécessité de ce contrepoids. Certains se disent, mais est-ce qu'il y a un problème? Oui, il y a un problème et M. Jorens le montre, dans la mesure où les services de santé, de soins, d'assurance-maladie se rattachent clairement à des services d'intérêt général sociaux, donc à une responsabilité directe des Etats et où, en même temps, ils sont de plus en plus considérés comme services économiques, même si, bien entendu, il y a des exceptions comme le cas britannique. Il est donc clair que la réconciliation de ce double aspect pose question.

Le rapport prône aussi une perspective, une forme de réponse, même encore que très générale. La nature de ce contrepoids réside dans l'article 86.2 dans la mesure où justement cet article est capable, dans son principe, de définir les conditions de cette reconnaissance sur la base d'un des principes les plus démocratiques, celui de la proportionnalité. Le Prof. Jorens nous dit qu'il faut habiter, installer en quelque sorte les meubles de la santé, des services de santé dans la perspective où, étant économiques (ce qu'ils ne sont pas toujours), ils appartiennent au grand monde de la Communauté, de la libre circulation, du marché intérieur, de l'ouverture des marchés économiques.

La Commission se reconnaît, dans cette approche, ne serait-ce parce qu'avec le concours de la plate-forme sociale, des Etats membres, des partenaires sociaux, elle a mis sur les fonts baptismaux cette notion de services sociaux d'intérêt général. Elle est apparue pour la première fois dans le Livre Blanc de mai 2004, qui est un point d'orgue dans une attitude nouvelle proactive et co-responsable de la part de la Commission européenne face à ces services économiques d'intérêt général particuliers que peuvent être les services sociaux. Aujourd'hui, grâce au Comité de protection sociale, au questionnaire qu'a évoqué M. Spiegel, aux réactions très intenses de la plate-forme sociale, des partenaires sociaux, du forum de la santé, nous avons énormément avancés dans la perspective d'un langage commun sur, à la fois, ce qu'il y a de spécifiquement commun au-delà des diversités nationales à ces services sociaux et de santé d'intérêt général, mais en même temps sur l'identification de ce qui doit être clarifié, de ce qui est obscur ou incertain pour les opérateurs et les Etats membres dans la rencontre inévitable entre cette spécificité et le grand bain du marché intérieur.

Mais pourtant, la Commission ne peut pas tout suivre. La notion de contreponds risque, en effet, d'être défensive dans une vue dynamique. Il y a même lieu de s'en distancier dans la mesure où contreponds peut suggérer une sorte d'antagonisme entre le marché intérieur qui serait systématiquement dissolvant, négateur de l'intérêt général et la responsabilité des Etats et des acteurs de veiller eux à cet intérêt général qu'ils devraient seuls préserver.

Notre perspective n'est pas manichéiste. La perspective de tous les services de santé, de soins de longue durée, d'assurance-maladie complémentaire ne peut être uniquement enfermé dans une conservation en l'état. Elle est aussi celle de leur développement. Or, ce développement passe aujourd'hui par une diversification des acteurs, par de nouvelles sources de financement, par de nouvelles garanties de qualité et donc aussi par une perspective d'entrée proactive dans la dynamique européenne, celle des échanges qui - d'ores et déjà d'ailleurs - pour ce qui est des soins de santé est organisés par les Etats membres.

Dans le but même d'éviter la polarisation, une médecine à deux vitesses, il faut entrer dans cette modernisation, dans cette diversification qui est, en même temps, une entrée dans l'Europe. Il n'y a pas de contradiction entre la perspective du marché intérieur et celle du développement futur des services de santé.

Les questions à traiter pour le futur ne sont pas seulement de maintenir des droits exclusifs, mais aussi de se placer dans une évolution qui se dessine la capacité régulatrice du marché intérieur. Comment les services de santé actuels, en particulier ceux qui se réclament de statuts spécifiques - notamment associatifs, mutualistes - vont-ils participer au futur

développement dans les champs proprement économiques des services d'intérêt sociaux général? Comment les marchés régulés, les partenariats publics-privés, la fonction régulatrice des nouveaux Etats providence resteront-ils compatibles avec les principes fondamentaux du Traité? C'est à cela qu'il faut que nous répondions. Nous ne devons pas rentrer à reculons dans la perspective du marché intérieur, mais nous pouvons adosser sur la proportionnalité de l'article 86.2, dans une perspective créatrice, respectueuse d'une diversité et promotrice d'un développement indispensable.

Cette perspective dynamique me conduit, en revanche, à souligner la convergence entre, d'une part, les questions à clarifier, qui seront l'objet de la Communication et, d'autre part, le bon usage de l'article 86.2, le *modus operandi* de cet article lorsqu'il s'applique à la situation particulière de ces services économiques d'intérêt général, que seront, de plus en plus, les services de santé, même si, bien entendu, tous ne le sont pas. La preuve du Prof. Jorens déplace la question de la zone grise entre économique et non-économique. Nous sommes invités à abandonner une perspective illusoire de délimitation énumérative en revanche de la garantie d'un traitement équitable au travers de cet article 86.2. Si clarification il y a, elle touche la prise de conscience par les usagers et les opérateurs sociaux que cette frontière accordera une place croissante à la perspective économique.

La seconde chose à clarifier est la notion d'acte légal au moyen duquel l'opérateur de santé, de soins, d'assurance reçoit la mission d'intérêt général social. Là encore, le Prof. Jorens énumère une variété de circonstances, mais qui n'existent pas partout. La balle est dans le camp des Etats membres de quelle façon établissent-ils le rattachement à l'intérêt général des services sociaux et de santé et de tous ce qui contribuent à leur système de santé?

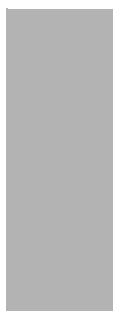
La troisième chose à clarifier concerne l'incertitude dans laquelle se trouvent aujourd'hui les opérateurs, les prestataires, en particulier ceux qui jouissent d'un statut spécifique et notamment non lucratif. Ce statut des droits exclusifs sont-ils bien justifiés au regard de leur mission particulière? Ici M. Jorens nous renvoie utilement à l'acquis de la jurisprudence qui considère désormais une vue large de ces missions, de leurs contraintes, des obligations de service public, pas seulement au nom de leur viabilité économique, mais de l'ensemble de la valeur du service qu'ils rendent.

Enfin, la question de la clarification porte sur la responsabilité systémique des Etats membres, leur responsabilité d'organiser les systèmes de santé, mais pas seulement celle d'accorder, au cas par cas, une autorisation, elle concerne l'ensemble d'un système de soin qui a sa logique et qu'ils leur arrivent parfois de transformer ou de modifier globalement, comme ce fut le cas récemment aux Pays-Bas. Ici, l'article 86.2 pointe sur un test global de proportionnalité qui permet de fonder, au regard du marché intérieur, les

caractéristiques du nouveau système qui se présente souvent comme une ouverture, une diversification.

J'ai conscience de ne pas avoir répondu clairement à la question de la clarification, de ne pas avoir annoncé la réponse à Mme Van Lancker, qui nous a présenté une vue forte et décisive qui va au-delà de la clarification et de la sécurité juridique. Ma collègue, Mme Fages, ce matin s'est référée aux paroles d'ouverture du Commissaire McGreevy et du Président de la Commission Barroso. Elle a indiqué deux choses importantes. La Commission actuellement s'attache au débat politique et parlementaire qui se développe, ainsi qu'au débat citoyen de manière à mettre en perspective l'ensemble des réponses qu'elle apportera de façon cohérente sur tous les outils législatifs, y compris la Directive services mais aussi le paquet concurrence, et qui touchent la spécificité des services sociaux de santé appelés à être, un jour, d'une façon ou d'une autre, économiques.

Cette cohérence, je ne pourrai vous la délivrer aujourd'hui. Mais je crois qu'au-delà de notre impatience pour l'obtenir, et notamment pour que cette communication consacrée aux services sociaux et de santé touche son but, il est important que nous soyons d'accord sur le fait qu'au-delà des diversités, le niveau européen doit lui-même dire quelque chose de commun et d'important au sujet de la dimension de droit fondamental, d'enracinement social dans le modèle social européen de ces services sociaux et de santé, et dire en quoi ceci est profondément respecté et respectable dans le cadre du marché intérieur. Il nous faut à la fois avoir conscience de nos racines et de nous donner des ailes. Je pense que la perspective ouverte par le rapport Jorens nous y aide.



Jozef NIEMIEC

*CONFEDERAL SECRETARY
EUROPEAN TRADE UNION CONFEDERATION (ETUC)*

Au nom de la Confédération européenne des syndicats, je voudrais féliciter les organisateurs de cette conférence et l'auteur de l'excellent rapport qui sert de base à nos débats sur « les services sociaux d'intérêt général comme contrepoids aux règles du marché intérieur » qui offrent une opportunité de contribuer ainsi à la recherche de solutions adéquates dans ce domaine au niveau communautaire.

Le séminaire organisé récemment par la Commission a témoigné qu'il y a un large consensus quant à la reconnaissance des spécificités des services sociaux et de santé, mais en même temps a confirmé – comme le fait aussi ce débat – les divergences de points de vue par rapport à leur prise en compte au niveau européen. Il n'est pourtant pas acceptable que l'incertitude demeure quant au lien qui sera fait avec d'autres initiatives communautaires dans le cadre du marché intérieur. La CES est d'avis que le projet de directive sur les services dans le marché intérieur, les propositions de régulation d'aides d'Etat (paquet Altmank) et le livre vert sur les partenariats publics-privés sont susceptibles d'influencer profondément aussi bien la définition que la mise en œuvre des services sociaux, avec un risque que la nature économique de l'activité en constitue un facteur déterminant.

Pour la CES, il n'est pas question de laisser uniquement au marché de résoudre des problèmes sociaux, parce que c'est exactement ses défaillances qui ont obligé les autorités publiques à réagir pour assurer à l'ensemble de la société la réalisation des droits fondamentaux et pour répondre à la demande sociale, en particulier de la part des personnes les plus vulnérables ou exclues. Ces services répondent en fait à des besoins sociaux collectifs et individuels, et pour lesquels il est nécessaire que les pouvoirs publics interviennent comme régulateurs du marché ainsi que comme tiers subsidiant pour élargir l'accès des bénéficiaires aux prestations et assurer certaines normes de qualité.

Avant l'instauration du Marché unique c'étaient les Etats membres (EM) seuls qui assuraient les conditions pour permettre la réalisation de la mission publique par certains services, répondant aux attentes de ses citoyens. Il s'agit maintenant de retrouver au niveau européen cet équilibre qui existait, même s'il pouvait être parfois fragile et en évolution constante, dans le cadre national. Dans ce sens, les SSIG sont perçus par la CES bien plus que comme des contrepoids aux règles du marché intérieur. Si on arrive à trouver des régulations européennes appropriées, elles permettront à l'UE de mettre sur un pied d'égalité deux objectifs inscrits dans les traités: la réalisation des

valeurs telles que la solidarité et la cohésion sociale avec les libertés du marché.

La CES, tout en reconnaissant le principe de subsidiarité et les compétences des Etats membres en matière d'organisation et de financement de services sociaux, reste convaincue qu'il est nécessaire d'introduire un (des) instrument(s) communautaire(s).

D'un côté, les changements sociétaux et les politiques choisies pour faire face aux défis multiples qui sont aujourd'hui posés, conduisent souvent à l'externalisation des tâches réalisées jusqu'à maintenant par le secteur public. Ceci conduit à une concurrence croissante des opérateurs différents (les Etats se réservant, dans ce contexte, le rôle de régulateurs), mais ils se voient soumis de plus en plus aux règles européennes de marché qui réduisent leur champ de manœuvre.

De l'autre côté, la jurisprudence de la Cour européenne de justice intervient dans ce domaine, en l'absence des règles plus claires et précises décidées par les politiques, pour résoudre des conflits entre les obligations de mission publique et les libertés du marché unique. Cette situation n'est pas soutenable, au moins pour deux raisons. La jurisprudence est susceptible d'évolution, et en plus, elle est appliquée à des cas concrets, donc s'il n'y a pas de transposition dans la législation nationale, l'insécurité juridique persiste.

Face à ces défis, le recours à la subsidiarité ne constitue pas du tout une réponse adéquate. La Commission européenne avec le Comité de protection sociale ont donc raison de poser la question, à savoir quel mécanisme ou instrument communautaire servirait le mieux la cause. Pour la CES, le processus lancé par le livre vert et repris par le livre blanc devrait aboutir à l'adoption d'un (d')instrument(s) qui compléterai(en)t l'ensemble des dispositifs réglementaires communautaires afin de permettre aux services sociaux d'intérêt général de se développer et de poursuivre leurs finalités au bénéfice de la société. Il est nécessaire qu'il(s) prenne(nt) en compte la finalité sociale des services sociaux d'intérêt général et la contribution essentielle de ces services à la réalisation des objectifs de l'UE en termes d'emploi et de cohésion sociale. En effet, il ne faut pas perdre de vue que l'objectif de cohésion sociale est et doit être recherché au niveau national mais également au niveau européen.

Les mécanismes communautaires devraient être mis en œuvre à cet effet. Concrètement, cela peut signifier, par exemple, l'échange de bonnes pratiques entre les Etats membres sur l'apport de ces services en termes de cohésion sociale. Pour que ce mécanisme soit vraiment utile, il doit impliquer l'introduction et la définition d'objectifs communs, accompagnés d'indicateurs qui rendraient possible une évaluation réaliste de la situation et des progrès réalisés par le Conseil, autrement dit la mise en œuvre d'une Méthode ouverte de coordination « complète ». Cette MOC pourrait s'inscrire

dans les procédures existant déjà, telle la MOC inclusion pour les services sociaux, ou récemment lancées – telle la MOC santé.

L'idée de créer un observatoire européen sur la qualité des services est intéressante. La CES l'a déjà demandé en 2000. Un tel observatoire, fonctionnant d'une façon transparente, avec la participation des représentants des partenaires sociaux et d'autres acteurs, faciliterait l'analyse indépendante et objective des réalités.

Toutefois, pour la CES, le recours à la seule méthode ouverte de coordination est insuffisant car les EM et les opérateurs de SSIG ont besoin de sécurité juridique pour fournir des prestations de qualité sans être sous le coup d'une jurisprudence fluctuante.

La CES rappelle ses préoccupations (exprimées à plusieurs reprises, et dernièrement dans sa résolution du mois de mars 2004 ayant trait à la proposition de directive relative aux services dans le marché intérieur), à savoir que les initiatives prises dans le cadre de la libéralisation du marché des services ne doivent pas venir mettre en danger d'autres initiatives qui seraient prises pour les SIG. En particulier, il serait erroné

- de réduire les systèmes de réglementation là où cette réglementation est un élément-clef de maîtrise des dépenses et l'assurance de la qualité et de la continuité des services,
- ou bien d'introduire le principe du pays d'origine qui va à l'encontre des compétences des EM d'imposer leur propre législation aux prestataires des services transfrontaliers.

De plus, en ce qui concerne les services médicaux, un conflit potentiel entre deux instruments juridiques européens (règlement 1408/71 et directive sur les services) serait difficile à éviter.

En conclusion, pour la CES, il faut donc en premier lieu exclure tous les SIG, et notamment les SSIG, du champ d'application de la directive services, ce qui est une condition indispensable pour supprimer les contradictions entre le plan de travail découlant du Livre blanc sur les SIG et la proposition de directive sur les services dans le marché intérieur. Et pour la CES, les régulations quant aux soins de santé pourraient facilement être incluses dans le Règlement 1408/71.

Il est nécessaire aussi de donner la priorité dans le programme de travail de la Commission à l'adoption d'un cadre législatif approprié.

C'est pourquoi la CES propose à nouveau de construire au niveau européen des principes communs en matière de SIG qui devraient faire l'objet d'une directive cadre ou de loi(s) cadre(s) sur la base de l'article III-122 du projet de Traité constitutionnel, dont la Commission pourrait anticiper la mise en œuvre. Dans ce cadre, pourraient être définies des normes communes aux SSIG, quant à leurs spécificités, leurs missions, leurs finalités et leur qualité.



Laurent GHÉKIERE

*VICE-CHAIRMAN OF THE PERMANENT COMMITTEE ENTERPRISES,
MARKET AND COMPETITION
EUROPEAN CENTRE OF ENTERPRISES WITH PUBLIC PARTICIPATION
AND OF ENTERPRISES OF GENERAL ECONOMIC INTEREST (CEEP)*

Permettez-moi de vous apporter quelques points de commentaires par rapport à ce que j'ai entendu aujourd'hui et notamment de la part des orateurs précédents.

J'aurai quatre observations à faire.

La première, c'est que la Communication de la Commission sur les services sociaux d'intérêt général portera sur l'ensemble des services sociaux, y compris le handicap, le vieillissement, l'éducation, le logement et la formation. Jusqu'à présent, le droit communautaire portant sur les services d'intérêt général s'était concentré sur les réseaux (le transport, l'énergie, les télécommunications) et pas du tout sur des services qui relèvent de la mise en œuvre de droits sociaux fondamentaux définis par les Etats membres et que l'on retrouve dans la Charte des droits fondamentaux de l'Union européenne.

Quelle est la particularité de ces services sociaux d'intérêt général ? Ce sont des services très sensibles et fondamentaux, ils relèvent de la compétence des Etats membres et se traduisent par une régulation nationale très forte qui, à un certain moment, peut entrer en tension avec le droit communautaire, la libre concurrence et les libertés fondamentales du marché intérieur.

Les membres du CEEP, qui sont prestataires de ces services sociaux, ont un peu de mal à admettre qu'ils ont à appliquer des règles du marché intérieur, alors que ces services sont développés parce que le marché ne permet pas de les fournir de façon adéquate face aux obligations d'universalité et d'accès universel à ces services.

Aujourd'hui, les Etats membres campent dans une position de subsidiarité, qui est de dire qu'il relève de la compétence des Etats membres de définir ces services et de mettre en œuvre les politiques y afférentes. Toutefois, cela n'exonère pas les Etats membres d'appliquer les règles du Traité quant aux modalités concrètes de mise en œuvre de ces politiques. Et c'est là où apparaissent des zones de tension importantes.

On voit également dans ces services l'importance de la qualité. On est face à des prestataires qui sont en situation de supériorité par rapport aux usagers, qui sont généralement des usagers captifs et vulnérables, qui ont besoin de ces services, qui n'ont pas d'autres modalités pour y avoir accès. La notion de contrôle du prestataire, de l'opérateur, est très importante pour s'assurer que la qualité soit au rendez-vous final dans ce rapport de force inégal entre le prestataire et le bénéficiaire.



Enfin, le financement de ces services est très important. Nous sommes sur des financements de nature solidaire, relevant des budgets publics - d'où le problème des aides d'Etat - et de déconnection du coût réel de production du service par rapport au prix facturé à l'utilisateur final, dans une logique d'accessibilité.

Donc, premier élément d'observation : une très forte spécificité qui, au-delà des particularités des différents services couverts, est commun à tous ces services sociaux d'intérêt général.

Deuxième point de l'observation : l'article 86.2 du Traité. C'est effectivement le point clef de cette Communication. Comment assurer pour ces services l'équilibre tout à fait subtil mais très important entre, d'un côté, le respect des règles de concurrence et du marché intérieur et, de l'autre côté, le maintien de la capacité des États membres à pouvoir mettre en œuvre ses missions d'intérêt général, qu'ils aient un caractère économique, social ou non-économique ?

Cet équilibre est tout à fait fragile. Il est à construire au quotidien. Il relève, en général, d'un arbitrage final de la Cour de Justice basé sur les principes fondamentaux des Traités, et notamment le principe de proportionnalité. Cela est non seulement peu démocratique et n'apporte pas la sécurité juridique nécessaire. Alors comment concilier cet intérêt communautaire, défini par les Traités, à l'intérêt général des États membres qui est tout aussi important et légitime en terme de mise en œuvre de politique sociale ? C'est la grande question à laquelle la Commission doit faire face à travers sa communication. Il nous faut en quelque sorte un mode d'emploi. Comment utiliser cet article 86.2 ? Comment en tirer toute la subtilité et le sens de l'équilibre, mais également sa potentialité ? D'un côté, nous avons des secteurs fortement régulés par la puissance publique, de l'autre, nous avons des principes de concurrence qui voient toute régulation comme quelque chose étant potentiellement une distorsion de la concurrence et une entrave aux libertés fondamentales du marché intérieur. Nous avons des systèmes très intégrés où l'on voit très bien le lien entre le prestataire, le client et l'autorité publique. On l'a vu avec le système finlandais. Le droit communautaire nous oblige à segmenter, à séparer le prestataire de l'autorité publique et au final, à nuire à la capacité de l'autorité publique à mettre en œuvre clairement leurs missions sociales d'intérêt général.

Dans les zones grises où le droit ne dit rien, où on ne connaît pas vraiment la potentialité de l'application du droit communautaire et il nous faut clarifier ce maquis.

Pour la troisième observation, je remercie M. Bolkestein. Avec sa proposition de Directive sur les services il a permis de poser le problème de cette rupture d'équilibre de l'article 86.2 en proposant une Directive générale, une Directive cadre, qui couvre tous les services avec les mêmes règles d'application, y compris les services sociaux d'intérêt général. Ainsi, cette Directive

interfère avec la compétence des Etats membres à réguler ce champ des services d'intérêt général. Et si aujourd'hui, il y a un vrai débat au sein du Parlement, au sein de la société civile et à l'intérieur même de la Commission européenne, on le doit à cette proposition de Directive qui a le mérite d'avoir mis cartes sur table.. Bien évidemment, nous comptons sur le Parlement européen pour l'amender en profondeur. Je me limiterai ici à citer simplement deux exemples.

En encadrant, voire en interdisant, des régimes d'autorisation particuliers, on ôte toute capacité des Etats membres à contrôler, à priori, le prestataire de services avant de lui confier une mission d'intérêt général, alors que cette possibilité est reconnue par la Cour de Justice (arrêt Analir).

En appliquant le principe du pays d'origine à tous les services d'intérêt général, y compris les services sociaux d'intérêt général, on prive les Etats membres de définir par un acte légal d'application interne ce qu'il entend par ce service, son contenu, sa qualité qui, en cas d'application de ce principe, sera défini par le pays d'origine du prestataire qui va assurer en libre prestation le service d'intérêt général. A travers ce principe, on risque de remettre en cause cet équilibre précaire mais subtil entre, d'une part, le marché intérieur et, d'autre part, la compétence des Etats membres à définir et à mettre en œuvre leur politique sociale. Dernier point : le rôle de cette Communication sur les services sociaux d'intérêt général est très importante et nous comptons beaucoup sur la Commission pour y mettre du contenu, mais également sur les Etats membres pour ne plus avoir une politique de l'autruche. A ce sujet, le CEEP a quelques revendications à exprimer en direction de la Commission.

Nous voulons à travers cette communication un mode d'emploi pour l'usage de l'article 86.2, qui indique comment mieux concilier les impératifs de l'intérêt communautaire avec les impératifs de l'intérêt général définis par les Etats membres.

Nous souhaitons obtenir un relevé complet de la jurisprudence communautaire, pour que nous sachions pour l'ensemble de ces services quel est l'état du droit communautaire, quel est l'état de la jurisprudence. Le rapport sur la Santé qui a été présenté aujourd'hui est tout à fait intéressant de ce point de vue, car il démontre que ce travail est faisable. Nous souhaitons qu'il soit élargi à l'ensemble du champ d'application de cette Communication.

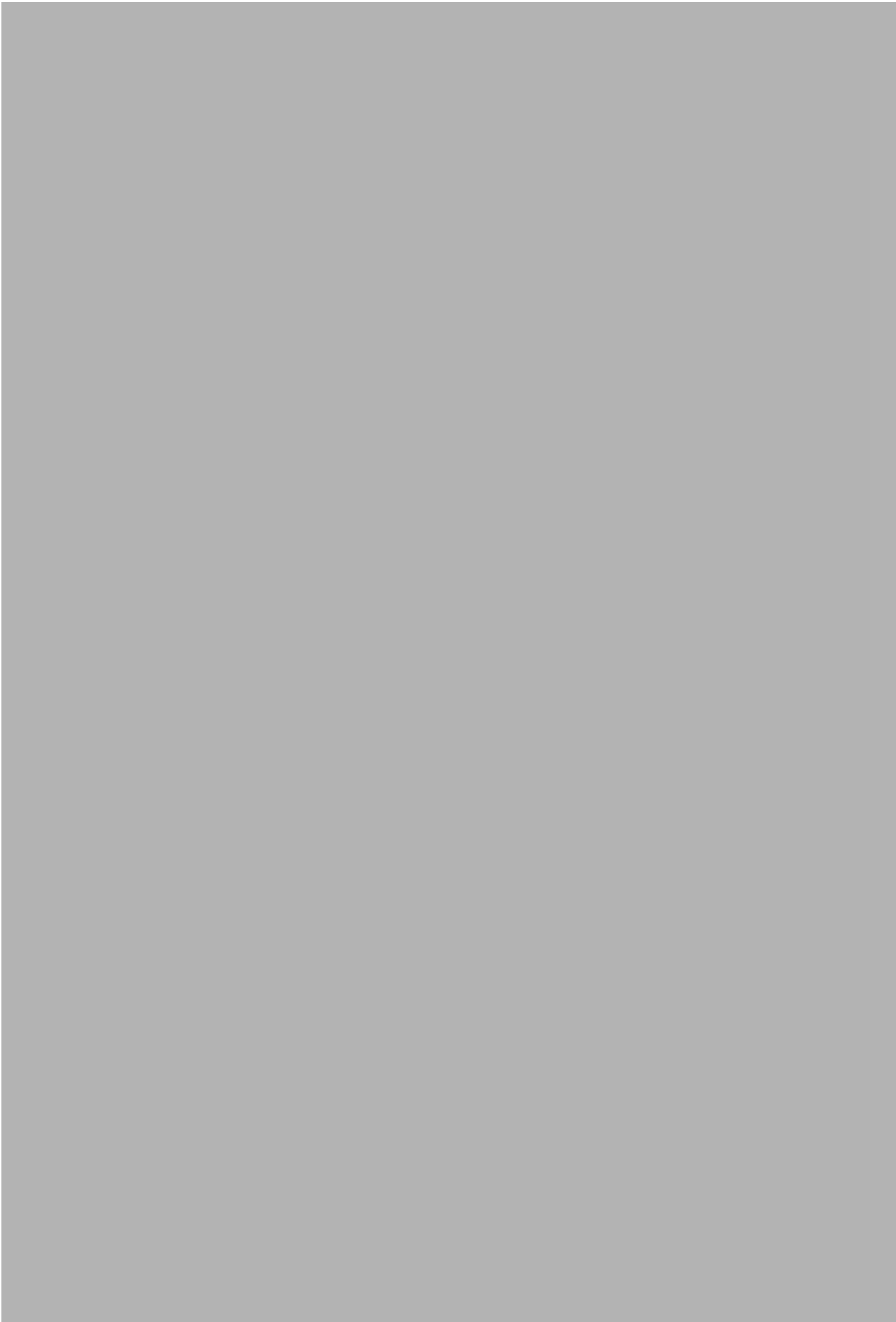
Nous souhaitons également que cette Communication identifie de façon la plus transparente possible, les zones de tension. Je crois qu'il faut développer une attitude proactive. Nous connaissons clairement, en tant que prestataires, les zones de tension qu'il y a entre la capacité de nos membres à réaliser leurs missions d'intérêt général et les contraintes du droit communautaire. Il faudrait que ces zones soient clairement définies et que la Communication - certes elle ne pourra difficilement proposer un instrument juridique unique pour les résoudre - au moins émette des pistes d'action par rapport à

ces zones de tension en terme de recherche d'équilibre et de conciliation entre l'intérêt communautaire et l'intérêt générale des États membres.

Je vous remercie.



CLOSING SPEECH



Ron HENDRIKS

*PRESIDENT OF THE INTERNATIONAL ASSOCIATION OF
MUTUAL BENEFIT SOCIETIES (AIM)*

Well, ladies and gentlemen I will try to keep my speech as short as possible. It is already late and we still have a lot of things to do tonight I understood. We have had a very good conference today, with a lot of good speakers, and good discussions. I would like to thank all who contribute to these discussions. The closing of this conference gives me the opportunity to say a few words concerning the point of view of the internationalisation of mutualities. I would like to change the title of this conference in "Access to health-care for all in an internal market". This Ladies and gentlemen is not as obvious as it seems, despite of what everybody is saying. Looking at the development of costs in health-care we can see that the problem is caused by the development of medical technology, and also by the ageing of the population. This means, looking at the costs that the sustainability of our health-care systems is in danger. What means solidarity looking at the future? Do we have to find an new balance in solidarity? There is also another danger however and that danger is the internal market, especially the competition rules. I do not think I have to explain to you that health-care is an economic activity. Looking at technology we want to have a competitive pharmaceutical industry in Europe. We all need a salary and nurses eating bread also. The biggest danger in my opinion if health-care has to comply to the competition rules lies in the health-care insurance. Insurance by definition means risk-selection. And the question is: do we want that? My answer is no. There are a lot, a lot of questions we have to find an answer for. How much pressure will the stability pact put on the statutory systems in the different countries? Can we expect that the European rules of co-ordination will quickly set the standards to which all health systems in the EU have to respond? Will the announced communication on health and social services of general interest provide the automatic answer on how economic and social policy objectives are to be balanced in the fields of social and health protections?

I can go on like this but you have already heard a lot of questions this afternoon. The point is, we are going to say it clearly: health-care is also an economic activity. We have competition rules and we have social systems. The question is what are we going to do with them? Does health-care have to follow the competition rules? Do the health-care insurances have to follow the competition rules? If the answer is yes, then risk-selection is unavoidable. And that could be a problem.

Ok ladies and gentlemen, a lot to think about in the future for the AIM, we are very pleased that we have the opportunity to combine our meetings with this conference. I would like to thank the Luxembourg organisers and especially



Michel Schmitz who made this possible. We should also thank our moderator. Where is he? Alex, you did a wonderful job. Thank you very much for that. And last but not the least, ladies and gentlemen, what do you think about the interpreters? Give them a big hand. Thank you. Have a nice evening.



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