

European Court of Justice (ECJ) decisions on Healthcare policy

I. Introduction

If the term “European Citizenship” is to have any real meaning, health policy has to be one of the essential considerations with regard to social rights and geographic mobility.

Still a decade ago, there was little discussion of the issue of patient mobility at a European level. The Treaty of Amsterdam made clear that health care systems were a matter for national governments. Furthermore, the number of people who moved across borders was still relatively few, and most of those who did were – as visitors - unlikely to need health care, or would – as working immigrants – be taken care of with the social security system of the member state in which they had taken residence.

This situation has changed, in many ways. The extent of mobility within Europe has increased markedly. In border areas, people have become accustomed to take advantage of differences of price, as well as quality, in goods and services on both part of the former frontier. A growing number of the elderly people decide to spend their retirement years in the warmer climates in the south. The growth of low cost airlines enables many people who might never have travelled to take several short breaks each year in a different part of Europe, and allows a growing number of people to change weekly between homes in one part of Europe and work in another. This new European generation, accustomed to crossing frontiers easily, is less likely to accept constraints on where it can obtain health care.

II. From closed national systems to a European health care market – a view to the “demand site”?

Do people, or, in a more economic manner of speaking, does the “demand side”, have a right to “shop across borders”, as far as health care in another Member State is concerned? And, if so, is this, from the point of view of European Community Law, also valid for the “supply side”, opening the door also for a mature market with health care providers free to offer their health services to residents in other member states, or even to enter the market in other members, respectively? In the following half hour, I shall tackle these two questions, informing you about the relevant rulings of the European Court of Justice on the freedom of movement, goods and services, as well as on the European competition and cartel law.

1. Legal Framework

Before we move on and take a look at the judgements, it is necessary to highlight the existing legal framework of European (or as shall formulate: “EU”) Law.

Until the late 1990’s, there have been no EU initiatives to develop specific legislation on health care delivery issues in the Community. According to the public health provision of the European Community (EC) treaty (**Article 152 EC**), the Community has only residual competencies in the field of health. Services such as the provision and financing of medical care fall within the exclusive jurisdiction of national governments. It is up to each Member State to determine the rules governing the rights or duties under their social security system, the cover of health care and the conditions under which benefits are granted.

Nonetheless, a system of co-ordination of national social security systems had been developed within the Community and was governed by **Regulations EC No. 1408/71¹ and 574/72²**. These regulations have their roots in the need to adopt social security measures necessary to facilitate freedom of movement for workers. The aim of those regulations is to guarantee that the application of the different national health care schemes does not negatively affect citizens exercising their right to free movement within the Union. It deals with the situation that citizens are staying temporarily in a Member State other than the State of affiliation of their social security system and that they happen to need medical services abroad. On the basis of this Regulation such treatment will be provided on the same basis as for persons insured in that country and the costs will be reimbursed according to the tariffs in force in the Member state where the care was received. The basic mechanism established by the said Regulation as for „mobile patients“ is that any person wishing to receive health care services in another member state has to obtain prior authorisation by the competent social security fund in his home state, except for emergencies.

As we will see shortly, the European Court of Justice (henceforth: “ECJ”) intervened in this system of co-ordination and created an alternative foundation for cover of cross-border care which is based directly on the treaty provisions of free movement of persons, of goods and services, as set out in articles 18, 30 and 49–50 of the EC Treaty.

¹ Council Regulation (EEC) No 1408/71 of 14 June 1971 on the application of social security schemes to employed persons, to self-employed persons and to members of their families moving within the community; last modification by Regulation (EC) 883/2004 of 29 April 2004.

² Council Regulation (EEC) No 574/72 of 21 March 1972 fixing the procedure for implementing Regulation (EEC) No 1408/71 on the application of social security schemes to employed persons and their families moving within the Community. The Regulation identifies the competent institutions in each Member State, the documents to be produced and the formalities to be completed in order to receive benefits. It sets out the procedures for administrative and medical checks and the reimbursement conditions for benefits provided by an institution in one Member State on behalf of an institution in another Member State.

2. The main cases

Before we turn to the main conclusions of the judgements, it will be useful to study which kind of cases we are dealing with. I am not going to bother you with the particular circumstances of each case, but shall distinguish two main categories of cases, that is the “ambulant” and the “hospital” version of what I shall call the “European patient”.

a) Ambulant treatment

The first category consists of patients who cross a border to receive ambulant health care or to buy health goods. This can happen because of alleged advantages related to quality, accessibility or price, and should be of particular interest for persons living in border areas, or who are ready to take advantage of a holiday for some fancy “health care shopping”.

b) Hospital Care

The second category consists of patients seeking for hospital care abroad. Most patients belonging to this category are either forced to do so to avoid long waiting lists in their home country or they seek for specific treatments due to their particular type of disease which are not available in the Member State of their residence. As a matter of fact, it might also be the case, that ever more specimes of this version of the European patient (and not only the very rich), nowadays not as fearful of language barriers as in former times, are simply looking for the best quality of health care available for them. Knowing that a hospital in Portugal does simple the best (e.g. safest) kidney transplantations, in Europe might one day bring me back to Oporto....

3. Main conclusions of the judgements

To the view of European Law, in the interpretation of the European Court of Justice (in the following addressed as “ECJ”), let us now answer my first question posed at the beginning about the right to free health care shopping in the European Market.

I could start to bother you with a long litany, decribing the facts and legal considerations of at least 8 to 10 ECJ rulings, starting 1998 with the so-called *Kohll* and *Decker* Cases, proceeding with such unpronounceable names as *Vanbraeckel*, *Geraets-Smits / Peerbooms*, *Müller-Fauré/ Van Riet*, *Leichtle* and finally coming to the most current decision on this matter, the *Watts*-ruling from 2006. As I understand, this is not a legal seminar. Therefore, I shall stick to the bottom-line of the mentioned sequence of judgements with respect to our two categories of the European patient. What is the message the ECJ has told us?

a) General considerations as for the applicability of EC-Law

First of all, Health services including hospital services **are services within the meaning of the Treaty** irrespective of the way Member States organise and finance their social security systems. In the words of the ECJ:

“It is settled case-law that medical activities fall within the scope of Article 60 (now 50) of the free provision of services, there being no need to distinguish in that regard between care provided in a hospital environment and care provided outside such an environment.”³

“A medical service does not cease to be a provision of services because it is paid for by a national health service or by a system providing benefits in kind. (...) there is no need, from the perspective of the freedom to provide services, to draw a distinction by reference to whether the patient pays the costs incurred and subsequently applies for reimbursement thereof or whatever the sickness fund or the national budget pays the provider directly.”⁴

Secondly the requirement of 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. The ECJ points out that

“(...) such rules deter insured persons from approaching providers of medical services established in another Member State and constitute, for them and their patients, a barrier to the freedom to provide services.”⁵

b) Implications for the described cases

What does this mean in effect to our cases?

The ECJ had made it clear that, in the light of the basic freedom of services, an **authorisation requirement may be justified only for hospital services but not for non-hospital services**. The Court indicated that in view of the necessary planning in order to ensure sufficient and permanent access to a balanced range of high quality hospital treatment as well to control costs:

“A requirement that the assumption of costs, under a national Social security system, of hospital treatment provided in a Member State other than that of affiliation must be subject to prior authorisation appears to be a measure which is both necessary and reasonable.”⁶

Therefore, member states have to remove such a requirement for non-hospital care. In the Müller-Fauré ruling of 2003, the ECJ indicated that such a requirement can not to be justified, since the reimbursement of costs for non-hospital care would not seriously affect the financial balance of social security systems:

³ Smits and Peerbooms, para 53.

⁴ Case Müller-Fauré/ van Riet (C-385/99), judgment of the court from 13 May 2003, para 103.

⁵ Kohll, para 34 and 35.

⁶ Smits and Peerbooms, para 76 to 80; Müller-Fauré/van Riet, para 76 to 92.

“As regards non-hospital medical services (...) no specific evidence has been produced to the Court (...) to support the assertion that, were insured persons at liberty to go without prior authorisation to Member States other than those in which their sickness funds are established in order to obtain those services from a non-contracted provider, that would be likely seriously to undermine the financial balance of the (...) social security system.”⁷

One has to be careful to take this as a general assertion. However, it applies to all funds, or insurance based system as the System in the Netherlands, which to ECJ ruled on.

From the view of the former tradition in some member states, for example Germany, this was a legal revolution, by the same token depriving the old system of authorization for ambulant services of its legitimating.

As for hospital care, the court still accepts if the law of a member states stipulates the necessity of an authorization for “health shopping” in another member state. However, an **authorisation** can no longer **be refused** when the **two** following **conditions** are met:

- (1) the treatment must be one which is normally provided in the Member State of affiliation, meaning the proposed treatment must be under the benefits for which the sickness insurance scheme is responsible
- (2) the treatment, which has to be equally effective, can not be given to the patient in the MS of residence (affiliation) within the time normally necessary for obtaining this particular kind of treatment, taking account of his current state of health and the probable course of the disease

Concerning the first condition the Court pointed out once more that it is for the legislation of each Member State to organise its national social security system and in particular to determine the conditions governing entitlement to benefits⁸. The Court has already held in former cases that it is not incompatible with community law for a member state to establish limitative lists excluding certain medical services or goods from reimbursement under its social security scheme⁹ as long as this list is drawn up in accordance with the provisions of Articles 28, 49 EC¹⁰. The term “normal in the professional circles concerned” must therefore be interpreted as what is tried and tested by international medical science¹¹ and not only what is common practice on a

⁷ Müller-Fauré/van Riet, para 93 to 98.

⁸ Smits and Peerbooms, para 44, 45, 85.

⁹ Smits and Peerbooms, para 86, 87 with reference to Duphar and Others, (C-238/82) judgement from 07 February 1984, para 17 concerning the Health-care scheme of the Netherlands and the compatibility with the Treaty of restrictions on access to certain medicinal preparations.

¹⁰ Smits and Peerbooms, para 89.

¹¹ Smits and Peerbooms, para 94.

level of national medical knowledge and expertise. Otherwise it is likely that national providers will be preferred in practise and this may lead again to a barrier to freedom of services. This does not indicate that the national social security scheme is forced to open its catalogue of benefits to all medical services and products which are acknowledged due to international medical science. The standard of international medical science is related only to provision of a treatment which is already among the benefits available by the responsible national scheme¹². Therefore the national legislator can determine autonomously, if and under which circumstances a benefit is to be provided in his healthcare scheme¹³. It is subject to the national legislator to exclude certain benefits due to economic or ethical reasons¹⁴ or to open its catalogue to benefits which are up to the latest medical science, but not yet approved on an international level. Otherwise we would soon face a problem of “healthcare shopping” in the dimension that patients may claim medical services abroad which they are not entitled to in the state of their affiliation.

According to the second criterion “necessity of the proposed treatment” the Court has indicated in *Smits and Peerbooms*¹⁵ and *Müller-Fauré/van Riet*¹⁶ and recently in *Watts*, that this condition should be interpreted exclusively on medical grounds and not economic ones. A strictly medical reason has to be applied in order to consider whether the treatment is available without undue delay in the country of affiliation of the patient or not. The court defined the term “undue delay” as a “medically acceptable period having regard to the patient’s condition and clinical needs”. It found that account should be taken not only of the patient’s medical condition, but also of his medical history.¹⁷ The court made very clear that economic considerations as such will not suffice to justify waiting periods longer than a period which, from a medical point of view, can be accepted as bearable.

c) The problem of distinguishing health care of “ambulant” and “hospital” kind

As we have seen, the distinction of our categories, that is of a European patient shopping for ambulant or for hospital treatment, makes a tremendous difference: Only if he or she seeks *hospital* treatment, authorization by the health insurer may to be justified. However, practises to delineate these to kinds of health services vary among the Member States and even within any single health system, it sometimes is difficult to tell if a particular patients treatment *in* a hospital was indeed one of the “hospital” kind, and not only *ambulant*. Think of a birth without complications with the women leaving after a short recovery time.

¹² see Bieback in NZS 11/2001 p.561 (568)

¹³ Smits and Peerbooms, para 45

¹⁴ e.g. due to Transplantation or Biogenetical medical science

¹⁵ Smits and Peerbooms, para 103 et 104.

¹⁶ Müller-Fauré/van Riet, para 90 to 92.

¹⁷ Müller-Fauré/ van Riet, para 90.

The Court in *Müller-Fauré/van Riet* faced this problem and admitted that the distinction between the two categories of care is not easy to draw¹⁸. It provided a guideline of two criteria to facilitate this: The clearest measure is that the healthcare concerned requires overnight accommodation. The second criterion is that the treatment cannot be provided outside a hospital environment. Accordingly it should be clear that a birth without complications is a difficult case: Although it might not necessarily imply an overnight stay, to the legitimate view of some member states looking at the typical cases, a birth can be treated as a hospital service for good reasons, as to cover risks of “medical escalations” like a caesarean section. In the light of the ECJ the member state of reference, that is the one determining the term of hospital treatment, is the state of affiliation of the patient. The ECJ made clear that only the general interest of keeping the financial balance of a social security system can justify the authorisation requirement. Therefore the Member States need to plan healthcare in the hospital sector in order to prevent logistical and financial wastage¹⁹. The Member State of affiliation is the one which bears all the responsibility of planning the hospital services on its territory. In consequence, an authorisation may be required for the assumption of costs of what is considered to be hospital care in this state, even though this treatment is considered to be ambulant care in the other state.

d) Relationship between Art.22 Regulation 1408/71 and Article 49 EC

One of the technical questions which have to be looked at to round off the summary of the main conclusions of the rulings is the mechanism between Article 22 Regulation 1408/71 and Articles 49 and 28 EC. It was a big surprise for many member states, who participated in the various proceedings supporting the concerned national service to defend authorisation of health care shopping in another member state that according to the ECJ the application of the fundamental principles of the Treaty is **not** excluded, although regulation 1408/71 applies.

The Court stated 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 Treaty²⁰. Regulation 1408/71 is part of the secondary legislation²¹. This regulation corresponds to an early and, hence, limited attempt to comply with the obligations under Article 42 EC. As is confirmed by the second subparagraph of Article 22 (2) of regulation No. 1408/71, the sole purpose of Art.22 (1) (c) (i) is to grant workers and pensioners the right to have access to “treatment” in another Member State on conditions for reimbursement as favourable as those enjoyed by the patients covered by that legislation²². The Court found that

¹⁸ Müller-Fauré/van Riet, para 75

¹⁹ Smits and Peerbooms, para 79.

²⁰ Decker para 27; Kohll para 25; Watts para 46, 47.

²¹ The provisions of the Regulation which are more specifically concerned with Healthcare services are Articles 22 for workers and Article 31 for pensioners.

²² see Vanbraekel para 32, Inizan para 21, Watts para 135.

Regulation No. 1408/71 falls short of achieving any substantial degree of harmonisation and that its ambit is limited to the coordination of basic national rules concerning social benefits²³. As a fundamental justification for its ruling the Court emphasized that the provisions of the Treaty can in no way be avoided by secondary legislation. In fact the Regulation has to be measured, as every national action, on the Treaty itself. By interpreting Regulation No. 1408/71, its Article 22 can only be understood as being applicable only for the reimbursement of the costs of medical treatments received with prior authorisation. In contrast the case of reimbursement of costs without prior authorisation is not regulated by Article 22 and not covered at all by the Regulation²⁴. Therefore Article 22 of Regulation No. 1408/71 guarantees only a minimum protection for the cases falling in the span of its application²⁵. Cases which go beyond this scope or are not comprised by the Regulation have still to be measured on the fundamental principles of the Treaty.

e) The level of the assumption of costs

Those thoughts lead to three other questions: First, the amount of benefits the patient can require from his home insurance institution after having received treatment abroad; Second, the question which system is applicable regarding the determination of the amount of costs – Home State or State of treatment - and finally the question how the reimbursement mechanism works in the case of a difference in price between state of treatment and Home state. Having talked about the two main groups of ambulant and hospital care, the answer to that question has to be: “it depends”:

(1) Hospital Treatment with prior authorisation

That situation falls within the regime of Art. 22 (1c) of the Regulation 1408/71, which states that **reimbursement** is made on the basis of the legislation of the **Member State where the treatment is obtained**²⁶. Article 22(1c)(i) is to be interpreted as meaning that, when an insured person has been authorised by the competent institution to go to another Member State for treatment, the institution of the place where the treatment is provided is required to grant him with benefits in kind in accordance with the rules on assumption of costs of health care which the latter administers, as if the persons concerned would be registered with it.²⁷ The manner and amount of the benefits as well as the costs follow therefore the regulations of the State where the medical service is provided. In practice in most of those cases the reimbursement is

²³ see Rossi (C 100/78) para 13 ...where the Court stated that the regulation did not set up a common scheme of social security, but allows different schemes to exist; the Regulation can therefore be qualified as an instrument of coordination rather than of as a means of harmonisation.

²⁴ Kohll para 27, Decker para 29, Inizan para 19.

²⁵ The personal scope is limited to workers (Art.22) and pensioners (Art.31) and the material scope covers all treatments (mostly hospital services) having received with prior authorisation.

²⁶ Vanbraekel para 32, Inizan para 20, Watts para 125.

²⁷ Vanbraekel para 53

winded up exclusively between the member states social security institutions leaving the patient himself uninvolved. The benefits in kind provided to the patient are fully refunded after Art. 36 (1) of the Regulation 1408/71 on behalf of the competent institution. Art. 36 (2), (3) provides different schemes of refund: the compensation is either to be carried out on production of proof of actual expenditure or on the basis of lump-sum payments or two or more states may even provide other methods of reimbursement or may waive all reimbursement between institutions under their jurisdiction. Only if it was not possible for the patient to fulfil the formalities, e.g. authorising his entitlement for treatment by giving evidence with his European health insurance card or the former E 112 form, his expenses shall be refunded in cash by the competent home institution in accordance with the refund rates administered by the institution of the place of treatment²⁸.

To summarize: An “export” of benefits in kind in the case of applicability of Art. 22 is not taking place rather the mechanism is to be understood as an integration of the patient in the foreign social security system, “as if the patient would be affiliated with it” and this on behalf of his home insurance institution. The applicable scope of benefits, supply and services follows the rules and regulations of the place of treatment exclusively and the process of refund is handled “over the head” of the European patient between the two national social security institutions. Only in exceptional cases the patient himself has to pay the expenses out his own pocket and claim afterwards for reimbursement of the actual costs occurred. The only difficulty which may come up is that the actual benefits in kind received may differ remarkably from those provided by the competent institution at home²⁹. But this is not to the disadvantage of the patient due to the fact that he had decided deliberately to ask for medical treatment outside of his state of affiliation.

(2) Hospital Treatment in case of unfounded refusal of authorisation

This case is not regulated by Article 22 (1c) of the Regulation 1408/71 due to the fact that this Article is only applicable if prior authorisation was granted before receiving the treatment. Where the request of an insured person for authorisation on the basis of Article 22 (1c) has been refused by the competent institution and the refusal was unfounded, the reimbursement of the expenses can't go along with the provisions of Article 22. The person concerned is then entitled to be reimbursed directly by the competent home institution by an amount which is equivalent to what would have been borne by the institution of the place of treatment if the authorisation had been properly granted in first place.³⁰

²⁸ see Council regulation No 574/72 of 21 March 1972 Article 34 (1)

²⁹ e.g.: France operates a system of benefits in cash including co-payments in various cases, meaning that the French patients have to pay the medical treatment out of their own pocket in advance and might get stuck with a part of the expenses when claiming for reimbursement later on

³⁰ Vanbraekel para 53

(3) Ambulant treatment without prior authorisation

In this case, Regulation 1408/71 is not applicable either³¹. The **reimbursement** of the costs is made **according to the provisions of the Member State of affiliation**. The applicable tariff and the limit of costs follow the tariff and the costs for an equal treatment provided in the Member state of affiliation of the patient³². That means the competent insurance institution treats the service concerning its reimbursement as it would have been received “at home”. As a consequence the treatment in question must be reimbursable after the conditions and within the limit of cover of the competent institution in the State of affiliation of the patient. The reasoning behind this decision favouring the “regulations at home” is that the reimbursement of the costs incurred abroad without any authorisation should not impose any significant burden on the social security budget of the Member State the patient is affiliated in. This, however, may prove difficult in practice e.g. for patients coming from a pure NHS system, where services are offered “for free” and bear no specific price. In this respect, Member States should be encouraged to establish tariffs – or at least determining factors – for all healthcare services under the insurance cover in their territory.

(4) Additional reimbursement

Furthermore the issue comes up how to sort out the reimbursement of additional costs. Additional costs occur as soon as there is a difference in price between the actual treatments received abroad compared with the price for an equal treatment in the state of affiliation, meaning that the expenses abroad are lower than the costs arising at home. The Court decided that Article 49 EC requests the Member State of affiliation to pay the patient an additional reimbursement covering the very difference between the amount of the patient’s entitlement at home and the actual costs incurred by the treatment³³. It seems from a critical point of view that the ECJ had stressed its reimbursement ruling to the maximum with that decision. This ruling provokes a truly “Forum shopping” due to the patients possibility to earn good money and even to get enriched by choosing his place of treatment carefully. This is surely not what the Court had wanted. The single patient should be protected from unfair additional costs, which deter him from approaching health care providers in another Member State and therefore constitute a barrier to freedom of services. The assumption of costs must consequently be limited to the costs actually incurred by the patient. One can only hope that the additional reimbursement comes only into play in cases where, as in Vanbraekel, the authorisation has been wrongfully refused by the com-

³¹ Kohll para 27

³² Kohll para 42, Müller-Fauré/ Van Riet para 98, 106.

³³ Vanbraekel, para 46, 51, 53.

petent institution³⁴. Alongside there can be no room for patients claiming an amount which is higher than the actual costs of the treatment.

4. Intermediate Summary as for the “demand” side

To put my paper up to now in a nutshell: If a patient is looking for **non-hospital care**, prior authorization of the competent national institution is no longer needed according to EU Law. Patients are thus free to visit a medical practitioner in another member state and have a right to be reimbursed up to the level of reimbursement of their own system³⁵. On the other side, patients have no European legal right to shop **hospital care** in other Member States without authorisation. However, the authorisation for this treatment can only be refused on the basis of the presented specifically defined objectives. It is therefore now made difficult for the Member States to justify refusing authorisation for hospital treatment abroad. According to the scope of application it can be outlined that Regulation 1408/71 is only applicable in cases where an authorisation is either necessary or asked for by the patient, the reimbursement in all other cases is specified by Art. 49 EC.

III. “Close up” of the national health care markets for private hospitals – a view to the supply side -

As we have seen above, due to the growth of patient’s mobility in the Member States at least on the demand side a European market for health services is about to mature. Is it an economic market as well from the demand side? Do potential suppliers have the same free, equal and transparent access to the market? If not, is the European competition or cartel law applicable to intervene? What follows in the rest of my presentation shall be a swift reflection on the complex relationship between the Community’s competition law and national health policy regimes.

1. Health care and market?

The internal market regulations of the European Community are generally aimed at freeing up markets to obtain the economic benefits associated with free competition and reduced barriers to trade. However, health care might not be a typical „marketable“ service. The importance of health to the individual, and the need for Member States to ensure equitable access to health care for their population as a whole,

³⁴ The court remained silent concerning the scope of application of the additional reimbursement in the Vanbraekel ruling.

³⁵ According to ambulant treatment the patient obtained a right to choose between the applicability of Article 49 EC or the Regulation 1408/71. Under the scope of Regulation 1408/71 patients can claim full refund according to the tariffs applicable in the host state and under Article 49 EC they can claim reimbursement up to the maximum tariff of the national law in the state of affiliation.

might give justification to a type of market which is not easily subject to the competitive model based on supply and demand. For example third party payment (through insurance funds or taxation) combined with the fact that historically patients have been dependent on the advice of medical experts to tell them what and how much health care they should „consume”, means that patients do not purchase services in a conventional sense. In addition it has to be taken into consideration that the „consumer” of health services in some member states is not the patient, but, as a matter of fact, the social insurance company or public social insurance body, respectively. Thus, e.g. in Germany we are talking about the social security triangle: the insurer provides health service to his client, sends him to the doctor or hospital, which he (the insurer) pays; the relation between the patient and the doctor is only „mediated” by the insurer). The insurance institutions are responsible for the decision who may or who may not participate in the market in general, and it's up to them to decide who of the suppliers is to be chosen to „sell” its particular health service. Therefore a market in the form where hospitals freely offer general medical services and compete to meet the demand of all potentially ill patients does not exist.

2. Freedom of establishment, Article 43 EC

Before we deal in detail with the provisions of the competition law regime, I would like to come back to the “four freedom regime” by determining if there is a remaining scope for the application of Article 43 EC to help the supply side to enter the national markets. The issue of interest is, if the freedom of establishment is affected by a preferential treatment of the public hospital sector to the disadvantage of private providers in the health care market. This chapter is hence reviewing the chances of foreign European operators of private hospitals to break into the national markets of health services with the help of Article 43 EC.

a) General considerations

The principle of freedom of establishment enables an economic operator (whether a person or a company) to carry on an economic activity in a stable and continuous way³⁶ in one or more Member States³⁷. The principle of the freedom to provide services is not concerned thinking of hospitals services because they are to be provided steadily in one spot and not only on a temporary basis. The provision of Article 43 EC has direct effect. This means, in practice, that Member States must modify national laws that restrict freedom of establishment and are therefore incompatible with these principles. This includes not only discriminatory national rules, but also any national rules which are indistinctly applicable to domestic and foreign operators but which

³⁶ Gebhard (C-55/94) judgement of the Court of 30 November 1995 para 25; Sodemare SA (C-70/95) judgement of the Court of 17 June 1997, para 24.

³⁷ Bröhmer in Callies/Ruffert „Kommentar zu EU und EG-Vertrag“ 1999, Article 43 para 8.

hinder or render less attractive the exercise of these "fundamental freedoms"³⁸, in particular if they result in delays or additional costs. In these cases, Member States may only maintain such restrictions in specific circumstances where these are justified by overriding reasons of general interest, for instance on grounds of public policy, public security or public health; and where they are proportionate.

b) Barriers to the freedom of establishment?

The member states retain full competence to regulate the range of providers who are entitled to supply medical services at the expense of the national health insurance scheme, provided they do not discriminate against nationals or goods of the other member states³⁹. The question in case is if a restriction of the permission for private hospitals to enter into contractual arrangements with social security funds constitutes a barrier to the freedom of establishment⁴⁰. Such a barrier in the form of an indirect discrimination of foreign providers may be seen in a substantially unequal treatment in the assortment process between private and public providers of hospital care to the disadvantage of private providers, if the majority of foreign providers wishing to gain access to the national market are those of private structure⁴¹. Article 43 EC precludes a Member State from allowing only national public hospital providers to participate in the running of its social welfare system by concluding contracts which entitle them to be reimbursed by the public authorities for the costs of providing services. The foreign private hospital provider 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. Condemning a foreign Hospital provider to "private practice" would directly affect his access to the market in the host member state in so far as patients will rather

³⁸ Gebhard (C-55/94), para 37; Overview of the development of the ruling from a prohibition of discrimination to a ban of confinement: see judgements Klopp (C-107/83), Vlassopoulou (C-340/89), Kraus (C-19/92), Gebhard (C-55/94), Inasti (C-53/95)

³⁹ see Geraets-Smits/Peerbooms para 83-99

⁴⁰ Such barriers may be seen in the German hospital-financing-system. This is affected by a „dual-system“, which distinguishes between costs for capital assets and running costs. The former are ruled by the German Hospital Financing Code (Krankenhausfinanzierungsgesetz- KHG), the Hospital Codes of the federal states (Krankenhausgesetze der Länder) and the hospital-plan. The latter relies on the Social Security Code V (Sozialgesetzbuch V – SGB V) in conjunction with the care-rates (Pfllegesätze) which are regulated by KHG and care-rate-agreements. It is necessary for a hospital to be part of this system; otherwise it cannot "survive" on the German hospital market. The question of being subsidised by this system depends on the accreditation as a „hospital“. This precondition exists for both kinds of the financing system. There are three types of hospitals – plan hospitals, university hospitals and hospitals which possess a utility supply contract with a public health insurance fund (§ 108 SGB V). One can allege that this accreditation-condition is a barrier for the freedom of establishment or even an indirect discrimination. The same can be supposed for the compensation of deficits for public hospitals. Although the compensation of deficits does not directly affect the accreditation as a hospital it is not ruled out yet that this administrative-custom is not factually limiting the freedom of establishment.

⁴¹ See opinion of the Advocate General N. Fennelly at the sitting on 06 February 1997 in Sodemare SA (C-70/95) para 34, 41

visit a hospital which is bound by a contract with the health insurance institution, because otherwise they must pay their bill up front out of their own pocket.

By all means, those regulatory mechanisms even if they might not appear discriminatory in each particular case still constitute a *hindrance* to the freedom of establishment in the sense of the *Gebhard*⁴² ruling. The effect of a mandatory accreditation process before gaining access to a certain market might very well be likely to hold back or render less attractive the provision of services to foreign providers. The court has stated in its famous ruling that national measures which are liable to hinder or make the exercise of fundamental freedoms guaranteed by the Treaty less attractive must fulfil four conditions: they must be applied in a non-discriminatory manner; they must be justified by imperative requirements in the general interest; they must be suitable for securing the attainment of the objective which they pursue; and they must not go beyond what is necessary in order to attain it⁴³.

With regards to *Geraets-Smits and Peerbooms*, as confirmed by *Müller-Fauré and Van Riet*, it can be inferred that Member States, even if they operate a selective contracting system, are liable of restricting the free provision of services if they fail to equate the rights of insured persons who applied to a foreign contracted provider with the rights of those who visited a domestic contracted provider. This principle can be transferred to the provision of the freedom of establishment. The imposition of national regulations on medical service providers which are not such as to define the boundaries of health care cover and which are therefore not closely connected to patient's entitlement to health care, is likely to restrict the freedom of establishment. These national regulations are then suitable for justification under Article 46 EC⁴⁴ or under the judicially created exceptions to the freedom of establishment. As we have seen in the first part of this paper, the ECJ has interpreted the scope of the public health exception, concerning the free provision of services, broadly so that it encompasses the objective of maintaining a high quality and balanced medical service open to all⁴⁵ as well as the objective of maintaining treatment capacity or medical competence on the national territory⁴⁶. The risk of seriously undermining the financial balance of the social security system constitutes, despite its economic undertone, an overriding reason of general interest⁴⁷ as well and the same appears to apply for the essential characteristics of the national insurance scheme⁴⁸.

⁴² *Gebhard* (C-55/94), judgment of the Court of 30 November 1995 - Reinhard Gebhard v Consiglio dell'Ordine degli Avvocati e Procuratori di Milano

⁴³ *Gebhard* (C-55/94), para 37

⁴⁴ „the protection of public health“.

⁴⁵ *Geraets-Smits/Peerbooms* para 73, *Müller-Fauré / Van Riet* para 66, *Kohl* para 50.

⁴⁶ *Geraets-Smits/Peerbooms* para 74, *Müller-Fauré / Van Riet* para 67, *Kohl* para 51.

⁴⁷ *Geraets-Smits/Peerbooms* para 72, *Müller-Fauré / Van Riet* para 71, *Kohl* para 41.

⁴⁸ *Müller-Fauré / Van Riet* para 99.

As seen above besides being justified by reasons of overriding interest, the national restrictive measures must be proportionate to the aim pursued. In particular, they must be suitable for securing the attainment of the essential general interest requirement they pursue and must not go beyond what is necessary in order to achieve it (proportionality test). In that context and with regards to the absence of a common standard of organisation of national social security schemes created by the European legislator, the national view must go beyond borders and compare ways of organising a social security system to determine if the regulation which has been chosen is really the less restrictive rule to achieve the aim. If there are member states which organise their social security scheme in a less restrictive way without risking the financial balance and the high level of their health protection then it is about the time to ask seriously if the national regulation can still be characterised as proportionate and therefore as in accordance with the four freedom regime. In order to be able to impose its own indistinctly applicable rules, in compliance with the principle of proportionality, the Host member state must then demonstrate the failure of the legislation of the other member state to safeguard the general interest justifying the national restriction⁴⁹. However, faced with national regulations pursuing objectives of public health or social policy, the court tends to employ a lighter-version of proportionality test and to grant the single member state a wider area of discretion⁵⁰.

As an example, the ECJ acknowledged in its former case-law (e.g. *Sodemare*⁵¹) that in assessing the compatibility of the national measure with the provisions of the Treaty "it must be born in mind that Community Law does not detract from the powers of the member state to organize their social security systems"⁵². Therefore the Court ruled in 1997 that "Article 43 EC does not preclude a Member State from allowing only non-profit –making private operators to participate in the running of a social welfare system by concluding contracts which entitle them to be reimbursed by the public authorities for the costs of providing social welfare services of a health care nature"⁵³. In its more recent rulings the ECJ amended this principle by stating that "when exercising that power Member States must comply with Community Law, in

⁴⁹ e.g. *Arblade* joined cases C-369/96 and C-376/96, para 34 consider also para 31 of this ruling, where the Court held that "...the 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".

⁵⁰ "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", O'Leary and Fernandez Martin in Andenas, M. and Roth, W.-H., (eds.), "Services and Free Movement in EU Law", Oxford, Oxford University Press, 2002, p.188.

⁵¹ *Sodemare SA (C-70/95)* judgement of the court of 17 June 1997.

⁵² *Duphar and others (C-238-82)* para 16; *Poucet and Pistre (C- 159/91, C-160/91)* para 6; *Sodemare SA (C-70/95)* para 27.

⁵³ *Sodemare SA* para 35.

particular with the provisions on the freedom to provide services”⁵⁴. For that reason it can be assumed that today the ECJ would not reiterate such a decision in the same way it did in *Sodemare* in 1997. One reason for the diverse review by the Court could be due to the different plaintiffs in the cases *Sodemare* and in the ongoing chain of cases *Smits/Peerbooms*, *Müller-Fauré* and lately *Watts*. Two different sides of the social security schemes have been viewed in those cases. In *Sodemare* the court had to deal with the financing of a social security scheme by which the interests of the supply side have been affected, whereas in the later cases the demand side represented by the European patients was concerned.

Besides those thoughts, in the subsequent health care cases, the Court has always stated that national measures hindering the Europeanisation process of the scope of social care providers constitute barriers to the free provision of services and the freedom of establishment and are consequently in need of justification. 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.

To summarize: The application of national rules to service providers from another Member State must be appropriate for securing the objectives such as proper functioning of the care insurance scheme and the stability of quality of care and must not go beyond what is objectively necessary in order to achieve these goals. To put it another way, it has always to be asked, are the national regulations into which one Member state wants to force the foreign provider suitable for achieving the legitimate general interest objectives? Can these objectives not be reached by less restrictive means? Article 43 EC helps the foreign health care providers to gain access to the national market, if those questions can be affirmed.

3. European rules on competition

After having dealt at length with the provisions of freedom of establishment and freedom to provide services it is necessary to outline if the supply side, representing providers of hospital care, can expect help from the European competition law regime. The question arises if the European competition law is applicable considering the hospital sector and if we do face perhaps an additional problem of cartel law when we think of the unfair use of a monopoly by the insurance companies to decide who has access to this market.

a) General considerations

Art. 82 EC prohibits any abuse of a dominant position within the Market or in a substantial part of it as being incompatible with the Common Market.

⁵⁴ *Geraets-Smits/Peerbooms* para 44-46; *Müller-Fauré / Van Riet* para 100; *Watts* para 92.

In its rulings, the ECJ clearly holds that

„according to settled case-law, an undertaking which has a legal monopoly in a substantial part of the Common Market may be regarded as occupying a dominant position within the meaning of Article 82 of the Treaty”⁵⁵.

While the articles of the „ban on cartels“ and the „abuse of a dominant market position“ refer to undertakings in general, **Art. 86 (1) EC** directly targets national governments. In case of public undertakings or undertakings to which Member States grant special or exclusive rights, governments are prohibited from enacting or maintaining in force any measure contrary to the Union’s competition regime.

Finally, Art. 87 (1) EC prohibits all kinds of direct or indirect financial support or allocation of funds by the state that distort or threaten to distort competition by favouring certain undertakings or the production of certain goods. **Articles 16 and 86 (2) EC** in contrast open up a ‘backdoor’ for political decisions and exemptions. These articles explicitly aim to exclude protecting areas or practices from the European competition law.

b) Health care sector and application of cartel law

The application of the ban on cartels and the abuse of a dominant market position cannot be judged on a general level but has to be investigated in each and every case. Since 1991 the Court, in a various number of decisions, has made first hesitant steps to decide that corporations in the social sector are considered to be undertakings in the sense of Art. 81, 82 EC.

The Court draws a fundamental distinction with regard to EU competition rules and the health care sector.

On the one hand, it recognises that all entities exercising an economic activity, irrespective of their legal status or the way in which they are financed or if the work on a profit or non-profit basis, are to be viewed as undertakings according to European competition Law⁵⁶. In this context every activity consisting in offering goods and services on a given market is an economic activity⁵⁷ and so must be the activity of providing medical services to patients.

On the other hand, however, the Court has ruled that if the activities of these undertakings represent the fulfilling of an obligation imposed by law, they are not acting in an economic way. The ECJ case-law provides clear lines of argument⁵⁸ suggesting

⁵⁵ C-219/97, (Maatschappij Drijvende Bokken BV) para 81; C-41/90 (Hoefner), 23 April 1999, para 29.

⁵⁶ C-41/90 (Hoefner).

⁵⁷ C-118/85 (Commission v. Italy), 16 June 1987.

⁵⁸ List of elements to distinct a non-profit organisation in the health care sector:

- ☞ delegation by law of a task of general interest
- ☞ the Member State legitimizing and financing the social scheme

that offering social protection via social insurance is basically to be not considered as an economic activity. National law which gives an exclusive and dominant position to organisations acting as suppliers of the specific public good ‘healthcare’ within a social security system are in accordance with EU law.

Referring to the Treaty, the Court stated that

“the concept of an undertaking [...] does not include organisations involved in the management of the public social security system, which fulfil an exclusively social function and perform an activity based on the principle of national solidarity which is entirely non-profit-making”⁵⁹.

In 1999, 2000 and 2004⁶⁰ the ECJ passed further important judgements on the relationship between EU competition/cartel law. The Court came to the conclusion that the restrictions on competition on account of a dominant position and exclusive rights granted by the state can be in accordance with EU competition law. It once again underlined the importance of Art. 86 (2) EC in the sense that undertakings entrusted with the operation of services of general interest are subject to the rules on competition

“only in so far as the application of such rules does not obstruct the performance, in law or in fact, of the particular task(s) assigned to them”⁶¹.

As a result, one can say that a social insurance institution does not act economically when it exclusively pursues social objectives and therefore the ban on cartels is not easily applicable on, of example, a system of contract hospital set up by such an insurer, sending patients only to hospitals accepted as contractors under a system of choosing such hospitals according to national law. From European Cartel law, private hospitals don’t have to expect much help if they want to “sue themselves in”, so to speak, in a closed national shop, set up by national law.

c) Provisions on state aid

If we refer those statements to the national hospital sector in particular, one cannot deny that at least in the case of private hospitals an economic activity exists and that

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- ☞ compulsory membership necessary to fulfil its social function
 - ☞ social protection for nearly all workers or citizens
 - ☞ benefits laid down by law and not dependent on the individual contributions

⁵⁹ C-159/91 and C-160/91 (Poucet).

⁶⁰ Joined cases C-264/01, C-306/01, C-354/01 and C-355/01 – (AOK Bundesverband a.o., sog. Festbetragsurteil), judgement of 16 March 2004; concerning the field of competition between German health insurance funds and pharmaceutical providers regarding the determination of fixed amounts for prices of medical products.

⁶¹ Maatschappij Drijvende Bokken BV (C-219/97) Judgement from 21 September 1999 (Compulsory affiliation to a sectoral pension scheme, Compatibility with competition rules, Classification of a sectoral pension fund as an undertaking).

there is a remarkable intention to make profits. On the other hand hospitals, no matter if public or private, have a public service responsibility. They are for example obliged to contract with every patient that asks for treatment. Moreover, the scope of services, provided to the patient, is fixed on the basis of national legislation.

As we have seen so far, **Art.86 (2) EC** applies to enterprises entrusted with services of general economic interest only forasmuch as the competition rules do not hinder the performance of the particular social task. Art. 86 (2) EC aims therefore to draw a clear distinction between true market competition and regulatory competition oriented on public interest. That means the EU competition law can only be successfully applied to hospitals and their owners, if a breakdown of the market of health provision is not to be feared by the opening of the regulated market. From an economic point of view this question has to be negated due to various reports of financial and economic experts⁶².

aa) New developments

Therefore the topic is open for discussion. As some of you might know, we – that is your German sister association, the Bundesverband der deutschen Privatkrankenanstalten (BDPK) represented by my law firm, are trying to bring a similar issue to come to a decision in Brussels. The provision of state aid to public hospitals in Germany can be named in the focus of the current discussion on the application of competition rules to the hospital sector. Private hospitals and their services are intertwined in a competitive relationship with public hospitals. Using public funds to grant selective compensation for deficits only for public hospitals can be viewed as a state aid which could significantly distort competition.

(1) Commission Decision of 28 November 2005 (2005/842/EC)

The commission has answered to that topic with a **decision from November 2005**⁶³ regarding the exemption from the notification requirement of Art.88 (3) EC for compensation payments, particularly to public hospitals.

The commission is of the opinion that those subsidies constitute state aid within the meaning of Articles 87 and 88 EC. This aid is being granted only to undertakings entrusted with the operation of services of general economic interest. The commission stated that hospitals therefore fall under Art. 86 (2) EC, and are thus exempt from the application of competition rules. In recognition of that fact, the commission has exempt hospitals from the notification requirement of Art. 88 (3) EC. This decision is to be viewed very carefully.

⁶² e.g.: Kuchinke/Schubert “Staatliche Zahlungen an Krankenhäuser: Eine juristische und ökonomische Einschätzung nach Altmark Trans und der Entscheidung der Kommission vom 13.7.2005”, August 2005, Technical University Ilmenau, Institut for economics

⁶³ Commission Decision of 28 Nov 2005 (2005/842/EC) „on the application of Article 86(2) of the EC Treaty to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest“.

(a) First of all, it can be critically asked if the commission had the competence to release such a decision. The commission itself is of the opinion that it is empowered by Art. 86 (3) EC to adopt the contested decision. The commission is stating that Article 86 (3) EC allows to specify the meaning and extent of the exception under Article 86 (2) EC, and to set out the rules intended to enable effective monitoring of the fulfilment of the criteria set out in Article 86 (2) EC, where necessary⁶⁴. It is true that Article 86(3) EC authorises the commission to address directives or decisions to the member states to ensure the application of the provisions of Art. 86 EC (1,2), but it has the power to address the latter only to aim at stopping fundamental breaches of the provisions of the said article by the member states in an ex post manner. What the commission did with the aforesaid decision was not the punishment of a breach of contract in a singular case but rather the release of an exemption from the notification requirement “en bloc” for certain subsidies and to claim that this “group” of subsidies is in accordance with the Treaty provisions on competition. The content of that decision as well as the manner of its appearance has strong traces of a regulation and is insofar incompatible with the enabling power of Article 86 (3) EC. It rather looks like the commission has truly adopted a group exempting regulation by claiming it to be a singular decision in the scope of Art. 86 (3) EC. By doing this, the commission committed a breach of the very principles which govern the community institutions. It is clear from the Treaty provisions that all original law making power is vested in the Council, whilst the commission has only powers of surveillance and implementation. That division of powers is confirmed by the specific enabling rules in the Treaty, virtually all of which reserve to the Council the power to adopt regulations and directives. The same division of responsibilities is to be found in the rules on competition, namely Art.86 (3) EC in conjunction with Art. 87 (3) lit. e and Art. 89 EC. Only the Council is authorised to expand the catalogue of Art. 87 (3) EC concerning licensable state aid. The formal procedure of Article 89 EC has to be kept in the way that the council may make any appropriate regulation for the application of Art. 87, 88 EC and in particular determine the categories of aid exempted from the procedures of Art. 88 (3) EC. The commission itself has those competences only insofar as the council has delegated them on behalf of Art. 89 EC.

To cut a long story short: Art. 86 (3) EC does not entitle the Commission to indemnify a certain group of state aid “en bloc” from the requirements of the competition rules. One can only hope that the Court gets the chance to show the commission its limits concerning the division of powers and responsibilities between the Community institutions.

⁶⁴ Commission Decision of 28 Nov 2005 (2005/842/EC) para 6

(b) Second, this exemption means the commission assumes that the compensation of deficits to public hospitals by German authorities indeed constitutes state aid under Art.87, 88 EC. However the commission linked this exemption from the notification duty to specific conditions coming from the important judgement of the ECJ in the case „**Altmark Trans**” decided in 2004.⁶⁵

In *Altmark*, the court laid down the conditions under which public service compensation does not constitute state aid within the meaning of Art. 87 (1) EC (*concerning the Operation of urban, suburban and regional scheduled transport services*) and accordingly is not subject to the notification requirement. This is the case if the compensation meets four conditions according to which

- (1) the Member State must have imposed clear public service obligations,
- (2) the parameters for the calculation of the aid must have been fixed previously,
- (3) the aid must not exceed the necessary costs,
- (4) and finally, either it must not exceed the costs of a “well-managed and well-run” undertaking or the provider must be chosen by way of a public procurement procedure.

Only a compensation that respects all four requirements will escape the state aid ban.

The *critical* factor is the fourth condition. According to the *Altmark*-Ruling, the amount of compensation granted must not exceed what is necessary to cover the costs incurred in following the public service obligations. As we have seen the level of compensation should be determined on the basis of an analysis of the costs which “a typical, well run undertaking” would have spent in following the national obligations. In other words the costs a well run hospital would cause under competitive conditions. The problem is that the current compensations paid by the German authorities are beyond this amount due to the fact that the majority of public hospitals cannot meet these criteria.

In its same decision from November 2005 the Commission stated that there is always a case of state aid in the meaning of Art. 87 (1) EC if the subsidised hospitals cannot meet the fourth criterion. Surprisingly it still left a “backdoor” open for justification of the aid on the basis of Art. 86 (2) EC if only a high level of transparency is to be guaranteed in the process of granting the aid. To simplify the context: as long as the beneficiary of the aid, namely the public hospital, is transparent enough concerning its cost structure and its parameters of calculation of the aid, the unlawful subsidising process can still be declared as compatible with the common market over the application of Art. 86 (2)EC. Whilst looking simply to

⁶⁵ C-280/00 (*Altmark-Trans*) judgement from 24 July 2003.

the compliance of transparency criteria and leaving the “private investor test” of the fourth *Altmark* condition behind, the commission is dealing insufficiently with “monitoring of malpractice” to find its distinction between unlawful state aid and rightful granted subsidies. This consequently gives rise to an evasion of the *Altmark* criteria on the level of justification and produces a remarkably inconsistency in the application and interaction of Art. 87 (1) and Art. 86 (2) EC.

In practice this leads to the effect that public hospitals have no incentive to operate as “a typical, well run undertaking” would act concerning efficiency and reduction of actual costs, because the state aid is granted as long as they simply follow the provisions of the transparency directive. Such an extensive application of the justification option is not required to avoid a “breakdown in the public hospital sector” and to evade an imbalance in the supply of hospital care. In fact the commissions practice leads to an undue preference of inefficient working public over private providers. Where Art.87 (1) and Art.86 (2) EC meet identical criteria they have in our view to be interpreted and applied equally. To come up with an “efficiency-test” to distinct between lawful granted aid and wrongful subsidies in the meaning of Art.87 (1) EC on the one hand and to overcome the given results immediately on the level of justification by saying “it doesn’t matter that the hospital provider does not operate under the premise of cost-saving” on the other hand leads to an immense discrepancy concerning payments for undertakings entrusted with the operation of services of general economic interest. Art.86 (2) EC is therefore to be treated as an exceptional rule and has to be interpreted restrictively. Notwithstanding the code of practice of the commission, Art. 86 (2) EC may no longer be used as justification for a payment which does not meet the fourth *Altmark* criterion.

bb) Objectives

It seems therefore, where hospitals are concerned; the commission is still struggling to find the borderline of what constitutes permissible subsidies for services of general interest.

As the history in the European course of justice has shown us until today, equal rights for participants of the common market are not enforced by themselves. Participants and competitors always had to fight for their right to access a particular piece of the market. In this spirit I am looking curiously forward to the next decisions concerning this matter on a European level.

d) Conclusion

However, the overall tendency is obvious: the more the social objectives and the redistributive dimension are controlled by the commercial and competitive aspects of ‘selection’ and ‘individualisation’, the more health insurance institutions will be treated as economic enterprises. The problem is to define the “relevant deficit of solidarity”

which makes a difference in terms of the applicability of the EU competition law. The basic message of the Court is that “the social aim of an insurance scheme is not in itself sufficient to preclude the activity (...) from being classified as an economic activity”⁶⁶. If public health insurance funds can be therefore judged as economic entities when they act as ‘service enterprises’ in the highly regulated market organizing health provision, many navigating instruments in the healthcare systems would have to be changed because they privilege specific actors, produce exclusive effects, explicitly limit or exclude competition, and restrict access to the healthcare market.

IV. Overall summary:

The increasing mobility in the health sector will have major effects on national systems, both on their way of financing health services and their capability to competitiveness. The impact of a potentially European-wide competition among providers, the free flow of goods and services and of the EU citizens’ right of access to healthcare irrespective of national borders will force this process additionally. Consequently the individual right of patients to quasi-unconditional access to healthcare abroad constitutes the new challenge to Member States’ systems. European citizens have carefully started to compare healthcare and healthcare systems and to demand equal and high quality treatment and protection everywhere. This will start a new course of harmonization and discussion. Furthermore the complex and often contradictory EU competition law might effectively put pressure on the institutional, regulatory and financial frameworks of health policy in Member States, especially in those cases of incompatibility with the liberal single market. Whilst there is undoubtedly no general pressure to liberalise or privatise institutional healthcare arrangements, governments basically have to respect the momentum of open competition across borders and – depending on the specific features and institutional configurations of each health system – probably have to adjust to a greater “market conformity” in certain sectors.

⁶⁶ C 123/83 (BNIC/Clair) 30 January 1985; C-41/90 (Hoefner) 23 April 1991; C-35/96 (Commission v. Italy) 18 June 1998.