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14.1 Introduction

Although health care policies are formally the competence of the member states, and although policy reforms within health care have historically been driven through domestic reforms, the internal market principles of the EU increasingly impact and challenge the national organization of health care. Particularly since the late 1990s, the principles of the internal market have reached within the formerly secluded area of national health policy. In addition, the health care systems of the Nordic member states are increasingly affected by the free movement logics of the encapsulating polity. In incremental and rather uncoordinated ways, the Nordic member states have started to adapt; meanwhile new challenges are emerging.

This chapter is structured into four main sections. Section 14.2 discusses the theoretical perspectives on EU social policy and their likely effect on national policies. Section 14.3 then analyses specific decisions of the activist European Court of Justice (ECJ) and how these have gradually formed the contours of supranational health care regulation in terms of patient mobility. Section 14.4 sets out the characteristics of the Nordic health care model in a European context in general and then Section 14.5 focuses on the implementation or adaptation carried out by the Swedish and Danish health care systems, with brief comparisons to Finland and Norway.¹

14.2 Theoretical perspectives on European social policy

The rapid progress of European integration in the area of social policy after the 1980s surprised many. Previously, it was generally believed that the welfare states of western Europe, with their different historical trajectories, would never subject themselves to regulation from a supranational body or take to the idea of convergence towards a common 'European' model. Today, direct regulation of issues clearly within the realm of social policy are not uncommon within the EU, for instance in the areas of public health, work and safety and access to health care. In addition, far-reaching efforts have been undertaken on a voluntary basis by the member states to coordinate policies within core welfare areas such as pensions, health services provision, poverty reduction and elderly care. These developments, which were thought unlikely only a few years ago, suggest that national welfare states are not quite as 'immobile' as earlier believed (e.g. Pierson 2001). They also raise the possibility of real convergence between them, even though this might come about in a slow and uneven manner. Maurizio Ferrera (2005) argues that we see today the emergence of a new type of social politics in Europe, characterized by a diminished importance of geographical borders and nationally confined arenas of policy-making. Increasingly, European citizens can choose to which type of welfare community (i.e. a community insuring them against social risk) they want to belong, as such communities need no longer be defined by territorial borders. By the same token, policy-making processes are moving from the nation states towards the European networks and decision-making bodies.

There are, however, many questions still to be answered about the dynamics of integration in European social policy and its effects on policy-making processes within national welfare states. What are the main driving forces behind integration in this area and how do integration efforts affect policy power balances at the domestic level? Who gains and who loses when the focus of policy-making shifts towards the supranational level? And what role do domestic political institutions play in shaping final policy outcomes as EU regulations and initiatives are implemented at the member state level?

One of the driving forces behind integration in the social policy field in recent years is undoubtedly what might be called spill-over effects from the creation of the single European market in the early 1990s. As the market came into force, observers pointed to its potential threat to the social protection systems of the member states and demanded that it be amended by measures to safeguard the systems. As a result, the project 'Social Europe' was born; a discursive platform where pro-welfare forces including politicians both to the left and right, EU civil servants, unions, lobby groups and policy experts could gather to formulate an agenda oriented towards protecting existing welfare systems in the region and to identify common goals for these. Such efforts were, however, hampered by the fact that the member states remained unwilling to delegate authority to the EU in the area of social policy. For this reason, the goals formulated under the banner of Social Europe remained vague and non-committal and few concrete measures were taken to create social regulation that could balance the pro-market orientation of the EU Treaty. Exceptions include work and safety standards in the labour market, which have been regulated through a string of binding directives during the 1980s and 1990s, and precautions taken in the wake of the bovine spongiform encephalopathy (mad cow disease) outbreak to ensure the safe transport of blood and donor organs (Blomqvist 2004).
14.2.1 European legalism as a driving force

In the late 1990s, social policy formation within the EU entered a new phase. The activities of the ECJ drew more political attention as the court started to deliver decisions that seemed to infringe on the autonomy of the member states in this highly sensitive political area. This was true particularly in health care but rulings with the same orientation were also handed down in other welfare areas such as social insurance. The most controversial aspect of the rulings which typically went further than existing regulations in ensuring the right of access to national welfare systems on the part of EU nationals from other member states, was that the ECJ based its decisions not on the social regulations themselves but recent articles in the EU Treaty safeguarding the four freedoms that underpinned the single market. The ECJ argued that, in order to move around freely in the region to seek work, all European citizens must have access to national social security systems on the same conditions as the inhabitants. This meant, in effect, that long-standing principles of social rights as linked to national citizenship and territorial borders were cast aside (Liebfried and Pierson 2000; Erhag 2004; Ferrera 2005). The recently proposed Directive on Patient Mobility from the European Commission has confirmed that the reasoning by the ECJ concerning the rights of EU nationals in the area of health will indeed be part of a common European policy in this area.

The heightened activity of the ECJ and its far-reaching implications for nation sovereignty can be seen as a sign of the increased legalism within European politics. According to scholars studying international organization, legalism became generally more important as a means to govern international relations during the 1990s. Examples include the setting-up of the North American Free Trade Agreement, the World Trade Organization, international criminal tribunals, and various quasi-legal agreements such as the United Nations' Kyoto Protocol (Goldstein et al. 1998). Among such phenomena, the ECJ stands out, however, as the extreme case of creating 'hard' (e.g. binding) legal regulations in order to govern a community of sovereign states. As observed by Garrett and co-workers (1998, p. 149), 'the accretion of power by the European Court of Justice (ECJ) is arguably the clearest manifestation of the transfer of sovereignty from nation-states to a supranational institution, not only in the European Union (EU) but also in modern international politics more generally'.

Interpretations of the increased legalism of EU integration and its implications for the member states vary. To some, the increasingly important role of the ECJ in driving the integration process forward signalled that the member states had lost control over it and that they had failed to see, in setting up the ECJ as a constitutional court and arming it with the Single European Act of 1986, what the consequences would be for their sovereignty. This so-called neo-functionalist interpretation stresses, moreover, that the activities of the ECJ have undermined the role of the nation states as political actors in the region in that its existence makes it possible for other social actors to appeal to it, thereby shifting political battles from the national political arena, with its vested power structures, to an arena outside the reach of national policy-makers (Alter 1998, 2000; Mattli and Slaughter 1998). In contrast, the intergovernmentalist perspective sees the ECJ more as an agent of the interests of the member states and argues that the member states have been basically supportive of its integration agenda. According to this view, the ECJ is not totally unrestrained by the member states but has to manoeuvre strategically in relation to them in order to preserve its political legitimacy (Garrett 1995; Garrett et al. 1998). Looking specifically at the activities of the ECJ in the area of social policy and the predominantly negative reactions of the member states to its rulings in this area so far, it seems that the neo-functional interpretation would have the most empirical support (e.g. Alter 2000; Liebfried and Pierson 2000; Mossialos and McKee 2002; Geer 2006). Therefore, a general implication of the strengthened role of the ECJ in health and social policy would seem to be that the sovereignty of the member states has been undermined in these areas, despite the fact that this is officially guarded by exiting EU Treaties.

14.2.2 Coordinating European health policies

Another important feature of contemporary European social policy is that a growing share is formulated on the basis of voluntary agreements between the member states, reached within the framework of the so-called 'open method of coordination' (OMC). The OMC refers to a process whereby common policy guidelines are formulated and translated into national policy objectives through agreements between the Commission and the member state in question. The subsequent process of implementing the objectives is driven forward by periodic monitoring, evaluation and peer review, based on agreed-upon indicators and benchmarks that compare the performance of the members or have been identified as 'best practice' in a given policy area (Borras and Jacobsson 2004). The ECJ rulings in the late 1990s and early 2000s raised concerns over a legal 'spillover effect' from the Single European Act to the area of health care: a prospect that many member states have seen as undesirable. Thus, the activities of the ECJ seem to have, to some extent, acted as a prompter for the initiation of an OMC process in health care in order to take back some political initiative in this area (Geer 2006). The process has been actively supported by the European Council and the Ministers of Health, who see a potential for deepened cooperation among the member states in the area of health. The Commission, too, has argued that the process is desirable in order to meet common health challenges among the member states, such as ageing and medical technology developments as well as the possibility of increased cross-border patient mobility. It has also identified three basic objectives for the OMC process in health care: to

- to insure access to health care for all within each member state, regardless of income or social status
- to promote high quality of all health services provided in all of the region
- to ensure the financial sustainability of national health care systems

The goals were endorsed by the member states during the meeting of the European Council in Barcelona in 2002. In 2004, the OMC process in the area of health and long-term care was formally launched. Since then, the Social Protection Committee (SPC) has developed a list of indicators to monitor the...
performance of the health care systems of the member states in relation to the common objectives. The member states have reported their performance in the form of so-called National Strategic Reports on two occasions so far, 2006 and 2008. No common policy guidelines for the area of health care have been presented yet by the Commission, however. The OMC health is still in an early phase. In addition, many member states are still sceptical about formulating common policies in this area.

Like the ECJ rulings, the OMC can be seen as a means to bypass the regular system of political decision-making within the EU, with its joint decision traps and numerous veto points (Obinger et al. 2005). The emerging research on the OMC links the adoption of this new means to coordinate interests between the member states within the EU with a more general movement towards a less hierarchical and more negotiation-based mode of governance. Therefore, the adoption of the OMC process in the area of health care could also be seen as reflecting the broader tendency to shift from traditional, hierarchical governing techniques to more network-based and informal modes of governance in European politics (Rhodes 1997).

In 2008, the creation of a common European health policy took a further decisive step, as the Commission presented a proposal for a directive on patient mobility within the EU. The proposal reflected a general desire by the members to have more clarity of the rules in this area, given the apparent risk that the rulings by the ECJ would be interpreted differently by different member states. The directive proposal is tailored closely to the ECJ rulings and thus, in effect, confirms the policies already established by the court (see below). Hence, it seems a clear case of a legal spill-over effect whereby closer political integration in the area of health care has been propelled by activism on the part of judicial bodies.

It seems safe to conclude that the EU will play a more important role as regulator and knowledge centre in the health care sector in the future; a development which implies a movement towards increased policy coordination and systems convergence in this area.

14.3 Judicial activism and health care integration

Until 1998, access to foreign health care providers in the EU was regulated solely through the system coordinating social security rights for migrant workers (i.e. Regulation 1408/71). The member states, the Commission and the ECJ appeared to have found an interinstitutional consensus that European citizens were entitled to immediate and necessary health care in other member states as well as to other kinds of publicly financed health treatment, provided that they had been authorized beforehand by the competent national institution. The European health card regulates the right to immediate and necessary health care. Moreover, planned treatment in another member state is accessible through a form, E112, where the competent national institution prior to treatment has authorized the right to have it carried out in another member state. This institutional status quo was seriously upset from 1998 onwards when the ECJ initiated a series of case-law decisions questioning the justification for 'prior authorization' and through which the principles of the internal market have gradually been introduced into the health care policy field. The ECJ first laid down that health care is a service within the meaning of the Treaty. The requirement for prior authorization was, in principle, found to be a barrier to free movement. The immediate impact of the 1998 judgments was, however, modest in that they considered only non-hospital care (e.g. a pair of spectacles and dental treatment), and concerned the reimbursement-based Luxembourg health care system.

In subsequent rulings, the ECJ extended its interpretation across the full range of EU health care systems, including to national health systems such as the Nordic ones. The Genicot-Smits and Perdrix judgments of 2001 repeated this time with regard to the Dutch benefit in kind 'health insurance system' that prior authorization constitutes a barrier to the free movement of services. Such a barrier could, however, be justified provided that:

- the decision on whether or not to grant treatment abroad is based on 'international medical science', and
- an equivalent treatment can be provided in the competent member state without 'undue delay' taking into consideration the medical condition of the patient, broadly defined.

The ECJ further laid restrictions upon national discretion to grant or not to grant prior authorization by emphasizing that it can only be a justified barrier to the principle of free movement if it is based on objective, non-discriminatory criteria known in advance, so national authorities cannot control the procedure arbitrarily. Requests for authorization must furthermore be dealt with within a reasonable time and refusals to grant authorization must be open to appeal. In this way the ECJ initiates an emphasis on the citizens' possibility of judicial redress.

The third step towards an internal health care market took place two years later with the case of Müller-Faund and van Riet. In this case, the ECJ issued yet another expansive, and controversial, interpretation by introducing a distinction between hospital and non-hospital care. In the case of hospital care, the court restated its view that the requirement for prior authorization is justified on condition that it is exercised proportionately and that the national competent institution has no scope for acting in an arbitrary manner. The matter was, however, quite different for non-hospital care. The court laid down that national authorization constitutes an unjustified barrier to the free movement of services for non-hospital care. It did not further define non-hospital care. Given the increasingly blurred distinction between hospital and non-hospital care, the future implications and confusion of this judgment are rather extensive.

From the cases of Decker and Kohli onwards, it is clear that legal judgments have made a significant contribution to the integration of health care, whereas politics in the same period has been largely absent. Within a timespan of only five years, judicial activism laid down that EC law applies to a policy field which was previously taken as an 'island beyond the reach of Community law'.
14.3.1 Patient rights moving further into focus

On May 2006, the ECJ's Watts case was concluded. This was the first case to specifically concern a national health system such as that in the United Kingdom, which provides health care as primarily a benefit in kind and tax financed; similar systems exist in Ireland, the Nordic countries and the southern member states.

The case concerned the topical waiting-time issue, in terms of a hip replacement needed by Mrs Yvonne Watts, a resident in the United Kingdom. Mrs Watts requested authorization to receive treatment abroad. That was refused by the competent institution on the grounds that the examining consultant stated that Mrs Watts was in no more need of a hip replacement than any of the other patients on his waiting list. Mrs Watts was told that she would have to wait approximately one year for her operation. However, upon reexamination, the consultant recommended that she be operated on within three to four months, as her situation had now become worse. Despite this reduction in waiting time, Mrs Watts went to France to have her hip replacement and, on her return, requested reimbursement of her costs of £3900. The request was again rejected, on the argument that the reduction in her waiting time would have meant that Mrs Watts would have been treated without 'undue delay'. Mrs Watts took her case to the Court of Appeal, which referred the case to the ECJ.

In its judgment, the ECJ confirmed, and indeed furthered, its previous line of health-related judgments. One of the political implications of the case seems to be that it further reduced the scope for national institutions to exercise administrative discretion. Another implication is that it brings the rights of the European patient into sharper focus - and thus strengthens the position of the patient in future cases. In so doing, it intervenes in the national sphere of governance.

Once again the ECJ stated that, regardless of the specific health care systems and different individual features, all medical services are 'services' within the meaning of the Treaty.

It should be noted in that regard that, according to settled case-law, medical services provided for consideration fall within the scope of the provisions on the freedom to provide services . . . there being no need to distinguish between care provided in a hospital environment and care provided outside such an environment.

(Para. 86 of the judgment)

The court thus clarified that the characteristics of the United Kingdom National Health Service do not exempt it from EC law. The internal market principles apply regardless of the way the national system is organized (para. 90 of the judgment).

It is important, however, that the ECJ did not specify in terms of time period when a waiting time for a particular treatment can be considered to be 'undue delay' or beyond 'the time normally necessary'. But it did set out a criterion for determining whether a period of waiting time is acceptable in the context of EC law and further specified that national decisions must be reviewable. The waiting time must not:

- exceed the period which is acceptable on the basis of an objective medical assessment of the clinical needs of the person concerned in the light of all of the factors characterizing his medical condition at the time when the request for authorization is made or renewed, as the case may be

(Para. 79 of the judgment)

Furthermore, the decision as to whether the patient faces undue delay in accessing services must be based on:

- an objective medical assessment of the patient's medical condition, the history and probable course of his illness, the degree of pain he is in and/or the nature of his disability at the time when the request for authorization was made or renewed

(Para. 119 of the judgment)

This may prove to be an important extension to the rights of the European patient, since it sets redress limits to the time period and even went on to specify the institutional structures that member states must provide to protect those rights. The ECJ repeated the conclusions from the previous rulings, stating that the requirement for prior authorization cannot legitimize discretionary decisions by national authorities but must be based on objective, non-discriminatory criteria and allow for decisions on authorization to be challenged in judicial or quasi-judicial proceedings (paras. 115 and 116). But the court goes beyond a simple restatement of precedent and extends member states' obligation to provide transparency and legal certainty to European citizens:

To that end, refusals to grant authorization, or the advice on which such refusals may be based, must refer to the specific provisions on which they are based and be properly reasoned in accordance with them. Likewise, courts or tribunals hearing actions against such refusals must be able, if they consider it necessary for the purpose of carrying out the review which it is incumbent on them to make, to seek the advice of wholly objective and impartial independent experts.

(Para. 117 of the judgment)

In this way, the Watts case strengthens the position of the European patient. Not only has s/he been granted rights beyond the national borders, but s/he has also been provided with a structure and judicial procedures through which to bypass the national system or challenge its decisions. National systems where judicial routes to challenge administrative decisions are weak are particularly exposed to challenge on this extension.

The last bastion for resisting the general applicability of the ECJ's previous judgments has been rejected by this judgment, as the whole range of European health care systems and services must now be interpreted against the requirements of EC law.
14.3.2 Commission initiative and the responses of member states

One first Commission initiative to politically codify the rulings of the ECJ was through the proposal for a Directive on services in the internal market. The proposal precisely replicated ECJ’s decisions in its article 23, proposing (1) an internal market for non-hospital care, where the patient has a right to seek treatment in another member state without prior authorization and subsequently have the costs reimbursed by the competent national institution; (2) a right to hospitalization in another member state, provided that the member state of affiliation offers the same treatment, and that authorization has been granted beforehand. The health ministers turned the proposal down, refusing to have their policy area regulated as part of a general directive on services, placed under the responsibility of the Directorate General (DG) on internal market.

Hereafter, it appeared clear that European health care could not be regulated solely from an overall internal market perspective, but still the judicial integration needed political codification and more transparency. On September 2006, DG Health (SANCO) communicated a consultation procedure on health services. The communication called for stakeholders to state their opinions on a set of questions related to the free movement of health services. Almost 300 contributions were submitted up to 31 January 2007, and a large set of stakeholders took part. Among the contributors were member states and European Economic Area states, regional authorities, national parliaments, national organizations, international organizations, citizens, universities, commercial organizations and companies.

Initially, the Commission was supposed to adopt its proposal for a Directive on ‘patient rights in cross-border health care’ in late 2007, but the adoption of the proposal was postponed to 2008 (EUObserver, 19 December 2007). Apparently, the run-up to the presentation of the proposal contained conflicts and disagreements. The main political fault lines seem to have been internal disagreements in the College of Commissioners and Members of the European Parliament acting as veto-players.

Regarding the Commission, there appears to have been considerable disagreements between the commissioners behind the scene. Some commissioners expressed concerns about the impact of the directive on national health care systems, others pointing out the factor of timing and arguing that political timing to present the proposal was badly chosen in the shadow of the Lisbon Treaty (EUObserver, 7 February 2008). DG SANCO, which had been in charge of formulating the proposal, seems to have been unable to unify the College of Commissioners.

Within the European Parliament, members of the Party of European Socialists (PES) voiced strong opposition, putting forward arguments that the consequences of the proposal could become considerable. Dismantling national abilities to plan health care capacities and exert budget control. The PES members argued that the proposal compromised the control instrument of ‘prior authorization’ also regarding hospital care, and hereby went further than legal integrative steps taken by the ECJ.

The Commission moves one step further than the decisions from the European Court of Justice. It is highly problematic that prior authorization is no longer required regarding the right to hospital treatment in another member state. That deprives the member states the instrument of economic and capacity planning and implies a risk of financially draining the national health care systems, because the patients in this way can take money along outside their own member state.

(Christel Schaldemose (PES member of the European Parliament), quoted in Dagens Medicin, 1 February 2008; translated from Danish)

On 2 July 2008, the Commission was finally successful in proposing the directive on patient mobility. The final directive proposal is not fundamentally different from the version set to be presented in December 2007. The amendments to the December version seem rather minor; however, the timing and the reactions from the Members of the European Parliament were quite different. This time the presentation of the proposal was not vetoed. Furthermore, the proposal was presented as one part of a much larger social package, which to some extent diminishes the individual importance of the directive proposal. Currently (January 2009), the proposal is being negotiated in the Council and the European Parliament – and a long-drawn negotiation process seems likely.

14.4 The Nordic health care systems in the European context

The impact of Europeanization on national health care systems depends, naturally, on their specific organizational features. The Nordic health care systems have several features that make them distinct in a European context. First, they are financed predominantly by different sources of taxation. This means that they have public authorities as the ‘third-party’ financers of care rather than independent sickness funds, as is common in continental European countries. The publicly controlled financing of care also implies that access to care is open to all Nordic citizens on equal terms, rather than regulated on the basis of individual or occupation-based health insurance. The direct public control over health care systems in the Nordic countries is extended also to the provision side. In the case of primary care, provision is typically mixed, consisting of both public health centres and privately practising GPs. In Norway and Denmark, a majority of primary care physicians are privately employed, whereas in Sweden and Finland the opposite is true. In all Nordic countries, however, primary care is publicly financed. The relatively high degree of public ownership and operation of health services provision can be said to be a typical Nordic feature, even if the same applies also to other tax-based systems, like the United Kingdom and Ireland. In the case of secondary care, public provision dominates completely, as hospitals and other care institutions are normally owned and operated by public authorities. The fact that health services are both financed and provided by the same public body; typically a local government agency, means that the Nordic systems could be described as integrated.

Another distinct feature of Nordic health care is the crucial role of decentralized political governance. The operation of the health care systems has typically
been delegated from national authorities to local, self-governing bodies, at the municipal, provincial or, more recently, regional level. In all but Norway (after its regionalization reform of 2002), the local bodies responsible for health care provisions are directly elected by the population, a feature which gives the Nordic health care systems a democratic character in international comparison. The relative independence of the municipal or provincial (or regional) health authorities in the Nordic countries means that the organization of health care provision can vary substantially from one location to another.

The exact implications of Europeanization for the Nordic health care systems remain hard to pinpoint, as much is still unknown about exactly what such a process will entail. It is clear, however, that the Nordic systems are quite distinct from the kind of insurance-based system, with independent sickness funds acting in the role of payers, that the ECJ seems to have had in mind in most of its rulings in health care so far. This is noticeable, not least when the court discusses how caregivers should be reimbursed by sickness funds, and argues that it should not matter so much for the financier whether the caregiver in question is located in the same country or not, or when it talks about the value of free competition and the creation of a non-discriminatory European 'market' also for health services.

It can be argued that three different questions, at least, can be raised when it comes to possible effects of Europeanization for the Nordic model of health organization, each with distinct policy implications. The first concerns the role of care providers and the need to develop further systems for their reimbursement in the Nordic countries. If patients in all European countries are free to move more across borders to seek care, there will be a need to standardize systems for billing and care financing and to determine the 'prices' for various treatments. Such a development has more radical implications for caregivers in the Nordic countries where, as noted above, resources have traditionally been allocated through public budgets. In effect, an open market for health services in Europe is likely to create an organizational logic where caregivers operate more independently, both financially and administratively, also in the Nordic countries. Such a development has already been initiated in some countries (particularly Sweden and Norway) through so-called purchaser-provider separation, but it is far from established everywhere.

The second question has to do with the status of patient rights in the Nordic countries and possible implication of the ECJ rulings and the proposal for a Patient Rights Directive in this respect. Generally, formal patient rights in the Nordic countries have tended to be quite weak, as health care has been provided by public authorities as part of a more general public service, open to all, rather than a service to which access is provided on basis of a specific insurance. The public provision of care and absence of individual insurance has created less need to legally specify obligations for insurers and health providers (Chapter 6). This implies that the Nordic health care systems have, in some respects, had a less 'legal' culture than some other systems in Europe, and that courts have not had an important role within them. This may be changing, as several Nordic countries, Denmark and Norway in particular, have recently sought to strengthen patient rights by formal legislation. It seems obvious that this tendency will be reinforced by a new Patient Rights Directive that stipulates—just as previous ECJ rulings—that patients in all member states should be well informed about their rights to seek care abroad and that, if prior authorization is required to do so, they must have the right to legal appeal.

The third question raised by the ongoing Europeanization of the health care sector concerns the implications for decision-making and governance within this area in the Nordic countries. As noted above, health care in the Nordic countries is largely governed by local/regional bodies, with a high degree of independence. However, implementation of European rules, court rulings or recommendations in this area calls for national policy adjustments, which imply that all actors within the system should adjust their working routines in a similar way, including local and regional governments. This could result in an explicit simplification of local policies and an enhanced role for national governing bodies. Moreover, implementation of EU policy at the national level is often complicated process, where new EU initiatives need to be interpreted, their effects investigated and the relevant actors consulted before new national regulation can be enacted or old amended. So for this reason too, EU initiatives in the area of health may have the effect of centralizing policymaking powers. It is also still predominantly as nation that member countries are represented within decision-making processes within the EU and can influence future policies in this area. Therefore, Europeanization in this area raises questions about how the current division of policy-making authority in health care in the Nordic countries will be affected and how a possible shift towards a more prominent role for national policy actors will affect central-local relations in the Nordic health care systems.

14.5 The effects of European Union policies in single Nordic countries

In this section, the Europeanization effects until 2008 are analysed, primarily for the Swedish and Danish health care organizations. The responses of Finland and Norway are touched upon briefly.

14.5.1 The Swedish system

Prior to the early 2000s, there was virtually no recognition in Sweden that EU policies in the area of health had any direct bearing on national health policy. Since then, this has changed and national authorities, particularly the Ministry of Social Affairs (Socialdepartementet), now follow EU developments in this area closely. A series of initiatives have been taken to adjust Swedish policies in the health care sector to new EU regulations, particularly in the area of patient mobility. The fact that these initiatives have been taken up by the Ministry of Social Affairs and a national court reveals a dynamic whereby the national governing bodies appear to have strengthened their powers within the heavily decentralized system. This development has manifested itself also in the tendency to propose legislation as a means to adjust domestic policies to European precedents, which constitutes a break with previous modes of 'soft governance'
and voluntary agreements between the central state and county counties as a way to coordinate policies in the area of health care.

When they were handed down, the Kohll and Decker rulings received virtually no attention in Sweden, and, if they did, their importance was played down. It was generally believed that rulings did not concern an integrated health system like the Swedish. In the early 2000s, treatment abroad was hardly a known phenomenon in Sweden, and the country was among the most reluctant in the EU to authorize such requests. Palm and co-workers (2000) reported that about 20 requests a year for health care abroad were approved in Sweden, compared with about 7000 in Luxembourg.

Soon thereafter, however, European health policies started to receive more recognition. In 2002, the Swedish Ministry of Social Affairs became part of the so-called High-Level Reflection Process concerning health matters within the EU. In the same year, the ministry appointed an expert group to investigate the organization of highly specialized health care in the country, which, like all hospital care in Sweden, is the responsibility of the county councils. In its 2003 report, the group proposed that this part of the system should be subject to special control on the part of the national government, and be led by a new national board (Os 2003:56). According to the then Minister of Health, Lars Engqvist (2004), a prime motive behind the proposal was the need for more central coordination of the provision of highly specialized care in the country, so as to be able to cooperate more effectively with other European member states in this area.

In 2004, the fact that the EU does indeed have a direct impact on health care provision in Sweden became obvious to all actors within this system. In January, the Supreme Administrative Court of Sweden (Regeringsrådet) delivered a ruling based directly on previous ECJ rulings on patient mobility, in which it overturned the refusal by a local Swedish authority to reimburse a patient for the cost of medical treatment in Germany. The patient had appealed for authorization according to the 1408/71 procedure but had been denied this on grounds that the treatment in question was not given in Sweden as it was considered medically dubious. The court noted that the Swedish health care system did not have a satisfactory procedure for applying for health care abroad on the part of individual patients and, technically, no legal demand to seek prior authorization for care abroad, although there was a well-established administrative procedure. The court also noted that the treatment given to the patient by the German care provider was effective in curing her disease. As a result, the court ordered the local health authority in question to reimburse the patient for the full cost of the treatment (about 60,000 euro), thereby setting a legal precedent that opened the possibility for Swedish patients to seek both primary and secondary care abroad without prior authorization.

The ruling was first met with confusion among local health authorities, as it was in opposition to the previously established procedure for receiving health treatment abroad, which had been based on the 1408/71 system. The court not only overthrew this procedure, it also went against the medical advice given in the case in question, which had typically been of great importance in decisions when patients demanded treatment abroad. In the year following the ruling, applications for reimbursement for care abroad rose dramatically in Sweden,
guarantee would satisfy European demands for care delivered in reasonable time and that waiting periods for up to three months would, in most cases, not constitute a basis for receiving care abroad. Therefore, even though the Swedish waiting-time guarantee resulted primarily from domestic political pressures, it appears well in line with EU policies in this area. It seems, moreover, that the implicit threat from the ECJ concerning the rights of patients to seek treatment abroad if the waiting time at home was too long may have aided the Ministry in persuading the reluctant county councils to agree to the waiting-time guarantee.

Given the adjustments within Swedish health care to meet new European policies in this area, as described above, a few final observations can be made about the possible impact of the EU on the system. First, the open endorsement of the ECJ rulings on patient mobility by the Swedish Administrative Supreme Court and Ministry of Social Affairs can be said to have strengthened the role of judicial review and formal regulation within the Swedish health care system, even though this runs against its previous tradition of more informal modes of governance. If new legislation is enacted to implement the Commission’s Directive on patient mobility, this tendency will be further reinforced. It can also be noted that the ECJ rulings and the Patient Rights Directive have served to formalize patient rights. This indicates that the Europeanization of health care systems, which constitutes a basis for receiving care abroad. Therefore, even though the Swedish waiting-time guarantee resulted primarily from domestic political pressures, it appears well in line with EU policies in this area. It seems, moreover, that the implicit threat from the ECJ concerning the rights of patients to seek treatment abroad if the waiting time at home was too long may have aided the Ministry in persuading the reluctant county councils to agree to the waiting-time guarantee.

A second observation is that the deepened European integration in the health care area may have an important effect within the Swedish system if it creates, as it seems that it does, legitimacy for an enhanced role for national governing bodies in this area. The desire on part of the Swedish Government to strengthen its control over the system and improve the coordination of local governing bodies has been apparent in recent years and is reflected in a number of political initiatives, such as the waiting-time guarantee, agreements with the county councils concerning patient mobility within the country and proposals to formalize patient rights. This indicates that the Europeanization of health care can have an important impact not only with respect to policy content but also when it comes to the distribution of power and relations between local and central actors in Swedish health care.

14.5.2 The Danish system

The impact of the judicial interpretations of the principles of the internal market on Danish health policy, while clearly visible, can be described as diffuse and restrained.

The Danish Government was one of the first governments to react to the Decker and Kohli rulings. Before the rulings, the Danish member state had held the view that internal market rules had no impact on the health care system whatsoever. The government, therefore, found it necessary to set up an interministerial working group to analyse the implications of the judgments for Danish health policy. The working group reported that these rulings contained general premises that took the scope of the judgments beyond the lawsuits themselves. Therefore, Denmark acknowledged that the cases had implications for health care systems other than that of Luxembourg and were not limited to glasses and dental treatment. The Danish report, however, contained a narrow definition of what constitutes a ‘service’ – and this national service definition has been maintained since. To be a service according to the meaning of Treaty Article 50, the Danish executive argued that there needs to be an element of private pay involved:

It is the view of the working group that if, on the other hand, the treatment had been taken care of by the public hospital sector, the Treaty's Article 49 would not have applied. The reason is that Article 50 defines services as services normally carried out in return for remuneration . . . Characteristic for a service is thus that a service provider offers a service in return for remuneration.

(Danish Report on the Decker/Kohli rulings 1999, p. 23; emphasis added)

The Danish way of narrowing down the definition of ‘service’ could keep the large majority of Danish health care services outside the definition, since they are provided as benefits in kind, free of charge and therefore with no direct remuneration.

However, in acknowledging that the principles of the internal market – under certain conditions – apply equally to health care services, the interpretation of the working group marked a decisive break with the then current Danish view. The conclusions of the report resulted in a reform of Danish health policy as from July 2000. This reform allowed general and specialist medical treatment for persons insured under Group 2, as well as dental assistance, physiotherapy and chiropractic treatments for all insured persons, to be purchased abroad with subsequent fixed-price reimbursement from the relevant Danish institutions.

When the ECJ went further with its interpretations, Denmark decided to take an active position and deliver opinion in the case of Gereerts-Smits and Peerbooms. It is interesting to see that the conclusions of the Decker/Kohli report was used as a platform for the Danish Government and largely replicated (Interview, Danish Ministry of Health, 3 April 2001). The Danish Government stated that, due to the absence of remuneration, hospital treatment did not constitute a service within the meaning of Treaty Article 50 (Report for the Hearing, pp. 76-77). Beyond making this point, Denmark argued that another precondition for a service to be Treaty-related was that it must be provided with a view to making a profit (Report for the Hearing, p. 78).

The Court, however, overruled these observations and included in the understanding of ‘remuneration’ in Treaty Article 50 indirect payments such as those transferred by social security funds to cover health care costs.

Through domestic policy reforms, Denmark introduced ‘extended free choice’ from July 2002, meaning that patients received a right to treatment outside contracted public hospitals in the event that these hospitals could not provide the necessary treatment within two months. Since October 2007, the waiting-time limit has been further reduced to one month. Denmark has hereby defined what it finds to be ‘undue delay’ within the health sector. This reform institutionalized the obligation to refer patients to non-contracted health care providers in the event that care cannot be provided by the public sector within the specified waiting-time guarantee. However, in making it possible to opt for treatment by non-contracted health care providers, the Danish reform had to consider the EC principle of non-discrimination. The principle obliges member
states not to favour a nationally established, non-contracted (i.e. private) provider over a provider in another member state. The Danish proposal for reform directly referred to, and thus took account of the reasoning in the Smit and Peerbooms judgment (Legislative proposal 1.64, proposed 29 January 2002; adopted 19 March 2002.). The ECJ ruling thus impacted on Danish health care by granting a different exit opportunity other than private supply (i.e. health-care supply outside the national border).

It is nevertheless notable that the patient has not been granted the right to freely choose a foreign hospital whenever 'undue delay' of a publicly provided treatment occurs. The 'free choice' is restricted to those private and foreign hospitals with which the competent Danish authority has entered an agreement (Indenrigs- og Sundhedsministeriet: 'Frit Valg af Sygehus'). The Association for Danish Regions lists the private and foreign hospitals to which 'free choice' has been extended and with which an agreement has been concluded (http://www.sygehusvalg.dk/geoomraade.aspx). While 166 private hospitals or clinics in Denmark were listed in April 2007, only seven foreign hospitals or clinics were included, of which three were hospitals in Germany, two in Sweden, one in Spain and one is a German hospital established in Denmark. In practice, the condition that an agreement has to be concluded beforehand means that foreign hospitals are not treated on an equal footing with Danish private ones, and free movement of services has not been institutionalized when contracted hospitals in Denmark cannot provide treatment without undue delay. The central argument for restricting treatment to contracted foreign providers only is that this allows the Danish authorities to exercise control over the quality of provision through prior assessment of overseas facilities. Assuring standards and quality is still a national competence.

In several answers to parliamentary questions, the Danish Government restated that its interpretation of the concept of 'service' within the meaning of the Treaty is one that is carried out in return for remuneration and qualifies only when the insured person pays more than half of the health care costs. The Danish Government thus maintained the definition of service that it formulated in the wake of the Decker and Kothl judgment and which exempted most Danish health care services from the impact of the principles of the internal market. As late as May 2006 the Danish Parliament was notified by the executive that this was the governing interpretation.

Meanwhile the official definition of health care services remained restrictive: its correctness was discussed internally in the Danish Ministry of Health. Behind the official executive stage, discussions started in the wake of the Müller Fault and van Riet ruling – possibly earlier. Access gained to internal documents shows that civil servants in the Ministry of Health raised doubt that the Danish definition was in line with the European concept of services as early as June 2003 and notified the minister thereof in an internal note. Later, in March 2004, another internal note further examined whether the Danish reinterpretation was in line with the ECJ interpretation of the concept – and explicitly stated that it was not.

Nevertheless, the official policy remained restrictive, based on the original definition. During the same period, citizens increasingly raised the question about exactly which health care treatments they were entitled to access without a prior authorization from the Danish authorities. One such question came from a Danish pensioner who had received outpatient treatment at a hospital in Germany. He subsequently requested his costs reimbursed by the Danish health care fund, but the competent municipality refused on the grounds that the treatment had not been authorized beforehand. The pensioner complained to the Danish Social Appeals Board. In October 2003, the National Social Appeals Board turned down the complaint, reasoning its decision on the restrictive Danish definition, consolidated by law in 2000. In the refusal, the definition, as quoted above, was explicitly referred to. Only health care for which the patient paid more than 50 per cent of the costs qualified as services within the meaning of the Treaty.

The case did not end here. The pensioner went to the Danish Ombudsman, who began to examine the case and requested the Social Appeals Board to further qualify its decision, taking the ECJ decisions further into account. As a result of this dialogue, addressing national interpretations and the role of law as laid down by the ECJ, the Social Appeals Board in March 2005 decided to reconsider the case. The reexamination of the case took about 1.5 year – and in September 2006 the Board came out with its second decision on the case. It stated that the European Court seemed to interpret the concept of service in a broader way than the one stated by Danish law. However, although the outpatient treatment did fall within the extended understanding of a health care service, the Board still found that the pensioner was not entitled to have his costs reimbursed, given that he had not been referred to the treatment by a GP as the Danish law requires.

Over a year later the Danish Minister of Health came out with a law proposal, admitting to the new understanding of health care service. In the meantime, the Danish Ombudsman reminded the Ministry that the Social Appeals Board is the highest authoritative level for interpreting such uncertainty. The law was amended on 1 December 2008. As a result, specialist treatments outside the hospital sector can now be accessed in another EU state and the costs are to be reimbursed by Danish health insurance, irrespective of whether the patient pays a part of the treatment or not. The law amendment does not, however, mean that the whole spectrum of outpatient care can be received in another EU member state, only those sets of treatments where an agreement has been established between the health insurance and the specialist doctors in Denmark.

Meanwhile Denmark has taken another step towards implementing the ECJ decisions, and Danish health care has been Europeanized a little further: the Danish Government has initiated the negotiation process on the proposal for a directive on patient rights. The Danish position is that clarification is needed, and the government, therefore, declares itself positive towards European regulation, meaning clarification, but it has some reservations regarding whether the proposal is in line with the subsidiarity principle. Forthcoming negotiations will indicate how the more specific Danish position turns out, and how a compromise will be established.
14.5.3 Finnish and Norwegian responses

Finland responded to the Decker and Kohil rulings by new guidelines given by the Social Insurance Institution, opening up patient mobility based on Article 49 of the Treaty. An amendment of the Health Insurance Act, which entered into force March 2005, legislated that an insured person can have costs refunded when treatment is given in another member state—under a set of conditions. Although this allowed for some patient mobility, Finland has received a reasoned opinion from the Commission finding that Finland, in practice, restricts patient mobility by setting up a set of conditions for receiving treatment abroad (Sakslin 2006).

Norway is a member of the European Economic Area and has also delivered a contribution to the Commission's open consultation procedure. Norway noted that patient mobility to and from the Norwegian health system today is limited, but it expects it to increase in the future. Norway welcomed the Commission's intentions to establish further legal clarity and transparency within the area. It, however, appears to be more reluctant when it comes to how to ensure an accessible health sector for the national population, writing that it 'is a challenge to make sure that developments in the area of patient mobility and health services do not lead to greater social inequality with respect to accessibility to health services. A Commission proposal must make sure to prevent a situation where only the most resourceful patients are able to enjoy rights relating to patient mobility.' Norway furthermore finds that it should be justifiable to give higher priority to patients from the home social security system than from other member states—in order to ensure that treatment can be provided efficiently. This is a position it shares foremost with the newer member states and the United Kingdom, but a position which clearly goes against the fundamental principle of equal treatment within Community law.

14.6 Concluding remarks

The institutionalization of EU rules on patient mobility has been considerably furthered by European legalism since the mid-1990s. Although there are many factors making the integration process difficult, the impacts and challenges on health care policies in member states are increasingly identifiable. This is also true for the Nordic health care system, although its characteristics as tax financed, publicly controlled and organized, and with a decentralized structure, at first sight appear to shelter it from the market-correlating impacts of the internal market. The exact effects are still difficult to pinpoint and will become clearer with further time and developments. But the outline is there.

It seems safe to conclude that the EU will come to play a more prominent role as regulator and knowledge centre in the health care sector in the future, a development that implies a movement—albeit slow—towards increased policy coordination and some kind of system convergence.

The analytical comparison between Sweden and Denmark demonstrates that health care integration does not impact in a similar way. Instead, impact, as it has unfolded in the two Nordic countries so far, depends on the national administrative, political and legal responses to the supranational events.

Nevertheless, we argue that at least three converging responses and future unavoidable challenges are identifiable. First, one natural consequence will be a need to standardize systems for billing and care financing for European patients and to determine the 'prices' for various treatments. Public health care budgets will have to be made market transparent. Second, European legalism implies an increased focus on patient rights. This goes against the Nordic tradition, in which formal patient rights have tended to be relatively weak as health care has been provided by public authorities as part of a more general public service, open to all, rather than a service to which access is provided on the basis of a specific insurance and hence a set of specific rights. Rights will become more individualized and individually enforceable. This may further cause the Nordic state-society relation to turn more 'legal', opening up more health-related court cases and more prominent roles for courts. On this aspect, it is interesting to see how the Swedish court case paved the way for further reimbursement demands for the costs of treatment in other member states. Third, regions and local authorities within the health sector are not policy-makers in the integration process as it has unfolded so far. Therefore, Europeanization seems to be tantamount to centralization. There will be an increased need to balance the interplay between the different levels of health care governance. Governing authority has taken an unexpectedly centralized turn in Sweden. In Denmark, the regions note that, as supranational competence expands into their traditional sphere of control, they will need to demand new decision-making competences similar to those of the German Länders in order to maintain their traditional domain of governance. This suggests that the Europeanization of health care could have a significant impact not only for health policy content but also for the distribution of power and relations between local, regional and central actors in Nordic health care.

Much of the future scope and direction of Europeanized health care will depend on which collective political steps will be taken as the Commission's recent proposal is negotiated and compromises are established. It will also depend on the specific wording of the final legislative text. It is far from certain that member governments will manage to establish a coherent political agreement. If this is the outcome of the current attempt at policy formulation, the ECJ will continue to be the motor of integration in the field of health care. Then the scope and direction of future developments will continue to bypass the political level and be decided by the interplay between citizens claiming their rights, private interests seeking markets, national courts interpreting European legalism and the ECJ as authoritative decision-maker.

Notes

1. In the preparation of this chapter, the authors found very little published information on the impacts of EU integration on the health care systems of Norway and Finland.


4. A new regulation, 883/2004, was adopted on 29 April 2004 but does not enter into force before the implementation regulation is adopted by the Council. The proposal on the implementing regulation was adopted by the Commission on 31 January 2006, COM (2006) 16, and is currently negotiated in the Council Working Group on Social Affairs.

5. For a more detailed description of the series of judgments, see Martinsen (2005).

6. In the cases C-120/95, Decker, 28 April 1998 and C-158/96, Kohll, 28 April 1998.


9. As formulated by the Advocate General Tesauro in the 1998 cases of Decker and Kohll, which will be further examined below.


13. The recommendations were later turned into a legal proposal (Ministry of Social Affairs 2005) but have not yet been enacted.

14. This depends, as stated by the court and later in the Commission’s directive, on the nature of the disease and the degree of medical urgency in receiving treatment.


17. The present analysis in part builds on achieved access to internal documents, covering documents from the Ministry of Health, the National Social Appeals Board and the Danish Ombudsman.

18. This part of the analysis also builds on the achieved access to internal documents.

19. Decision S-2-06.


References


