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The Europeanization of Health Care Governance – Implementing the Market Imperatives of Europe

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Abstract

The paper examines the Europeanization process and the impact of the European Union (EU) on national healthcare policies. The analysis reveals that although health policy formally falls within the competence of member states, the impact of the EU is becoming increasingly conspicuous and has contributed to a gradual restructuring of healthcare boundaries as well as some of its organising principles. Furthermore, the process and impact have a de-structuring effect on the more traditional governance tools used in relation to healthcare. The paper concludes that the EU has a significant impact and that we may be witnessing the formation of a new institutional legacy that represents the initiation of a Europeanised healthcare model: a model emerging around a new set of stakeholders, principles and structures, which include the market, principles of free movement, patient choice and patient rights institutionalised and safeguarded by the EU.

1. Introduction

This paper examines the impact of the European Union (EU) on Danish healthcare to identify the effect of the EU on a policy field which is formally regarded as falling within the realm of national

competence. In order to research *impact*, the study equally examines the *process* that has possibly Europeanised Danish healthcare *policy*.

Strong national public policy traditions, encapsulated by national boundaries and an implicit subsidiarity organisation makes healthcare one of those policy fields where we should not expect significant Europeanization to take place. Healthcare constitutes a core aspect of the national welfare state in the individual EU member states. It is one of the welfare policy areas that has traditionally granted rights according to national citizenship, long-term residence or territorial principles. The principle of territoriality in welfare policies states that welfare benefits or services can only be consumed within the borders of the competent welfare institution. Such benefits or services cannot be exported beyond the national territory (Cornelissen 1996). Social sharing within healthcare has thus traditionally built on strong elements of 'closure' (Ferrera 2005). A main organising principle is that of boundaries mirroring the nation-state that are intended to shield the provision of healthcare within the national community. This structuring closure condition is challenged outright by European integration (Ferrera 2005; Bartolini 2005). As the analysis below demonstrates, EU integration represents a major challenge to welfare policies by virtue of the circumstance that it provides new exit and voice opportunities to the Union citizen (Hirschman 1970; Ferrera 2005).

The Europeanization of healthcare is the sum of a wide range of supranational interventions. According to the Treaty (article 152), the EU has no formal competence to regulate national healthcare. From the perspective of comparative politics, the Europeanization of healthcare constitutes a 'critical' or 'less likely' case. Strictly speaking, the case does not represent a 'least-likely' case on the grounds that the free movement principles are constitutive for the EU and should

therefore also hold in relation to healthcare policy. However, it is a ‘less likely case’ for Europeanization, since the Treaty explicitly sets out that healthcare is a member state competence (for further discussion of the methodological and theoretical value of working with ‘least likely’ cases, see Eckstein (1975)). It is a critical case, because healthcare is formally regarded as a member state competence, where EU-induced change should not be expected. Furthermore, examining the meeting between EU principles and rules and the specific Danish case highlights the impact of the EU on systems organised as national health services (NHS), which in addition to Denmark counts the other Nordic member states, the UK, Ireland, Italy, Spain, Portugal and Greece. NHS systems were previously held to be sheltered from EU interference, as they offer healthcare as benefits-in-kind, free of charge, tax-financed and publicly supplied. Due to the characteristics of the national health service model, it was regarded as exempted from the Treaty’s understanding of ‘service’ (Section 5 below).

To the best of our knowledge, the impact of the EU on NHS systems has not previously been investigated in terms of process-tracing research from a political science and public administration perspective. The research for this paper includes different sets of interviews; 1) primarily with key respondents in the Danish Ministry of Interior and Health at several stages of the Europeanization process; 2) interviews conducted in the UK Department of Health to compare the findings of the Danish case; and 3) interviews in the European Commission, Unit of Coordination of Social Security. Furthermore, the research consists of documentary studies drawing on information from the archive of the Danish parliament in an attempt at quantifying the impact (see Section 3 below), parliamentary questions, debates and governmental notes. Both the interviews and the documentary study have served to separate national and EU influences on the identified healthcare reform process. On the basis of the research that has been carried out, the paper concludes that the EU is

having an increasing impact on the organisation and governance instruments of national healthcare – including those belonging to an NHS system – to the extent that it is possible to perceive a gradual restructuring of the contours and boundaries of healthcare as well as some of the organising principles and tools of governance.

In addition to the introduction and conclusions, this paper consists of five substantive sections. In Section 2, we discuss theoretical issues that arise when researching the dynamics and impacts of Europeanization. Section 3 presents a quantitative examination of the impact. The subsequent sections examine the contemporary governance of Danish healthcare, focusing in particular on the issues of patient choice and free movement. Section 4 outlines the key characteristics of Danish healthcare and details recent reforms with relevance to EU integration. Section 5 describes the new external, i.e. EU-driven, boundaries to the policy field with specific focus on healthcare integration formed through the influence of the EU internal market; while Section 6 examines the Europeanization of Danish healthcare. Finally, some concluding remarks are presented about the Europeanization of Danish healthcare as the outcome of the interface between national and supranational processes of change.

2. Researching the Dynamics and Impacts of the EU

The study of Europeanization aims to understand and explain both the *processes* of change that national policies, politics and polities undergo as a result of EU integration together with the specific *impact* resulting from EU integration. According to the definition by Radaelli, Europeanization involves both a process through which formal and informal rules are first defined and consolidated at the EU level and then incorporated in the domestic discourse, political structure, and public policies (Radaelli 2003, p. 30; Bulmer & Radaelli 2005, p. 341). The focus of the present

study concerns the Europeanization *process* and *impact* of European integration on national healthcare *policy*.

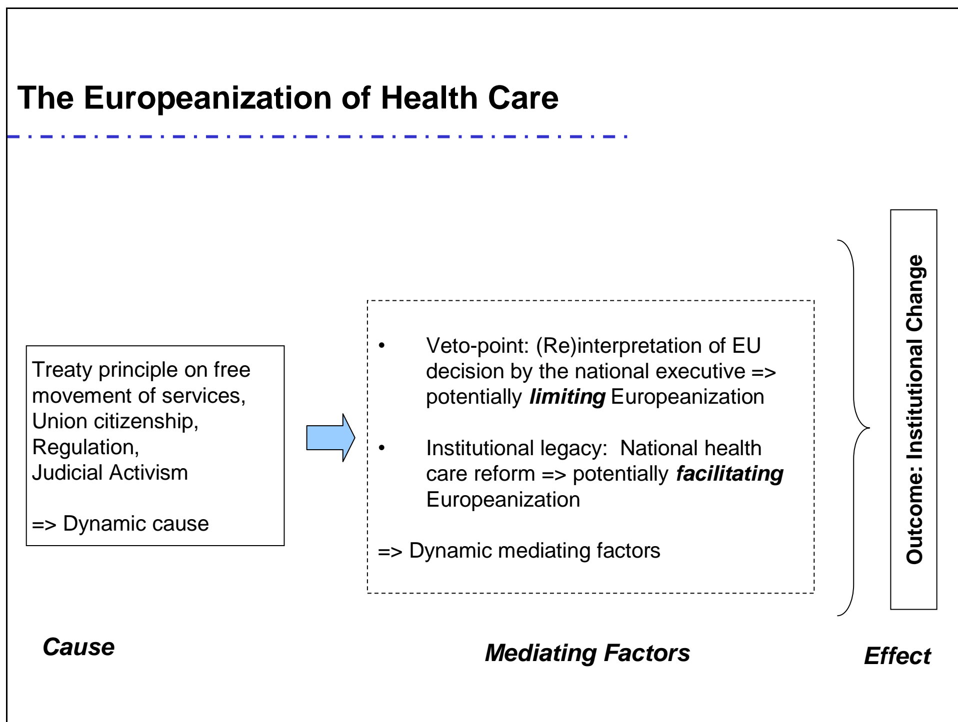
However, it is important to set off by clarifying the European cause that drives Europeanisation (Smith 2002). Healthcare integration is characterised by a fragmented degree of coerciveness. As a field of integration, healthcare is institutionalised in a scattered way, in the sense that it lacks the binding knots of political commitments. However, it is a field of integration which demonstrates the powerful role of law in transcending high spirited, but inconcrete, principles, such as the free movement of services and Union citizenship, into effective tools of governance. Thus law, through the creative and teleological interpretations of the European Court of Justice, appears to be a functional tool in adding and expanding dimensions of the European polity (De Búrca 2005; Stone Sweet et al. 2001; Mattli and Slaughter 1998). Such neo-functionalist logic of extending the scope and meaning of the EU does, however, not tell us much about how this form of legal decision-making is subsequently received nationally. The theoretical insights of Europeanisation studies are welcome supplements to better understand the complex dynamics of EU induced change.

Previous studies of Europeanization indicate that mediating factors transmitting the Europeanization process are detrimental to the final impact of European integration on national policies. Mediating factors are explanatory variables which explain how the same independent variable, European integration, may have very different outcomes. These variables bring domestic factors back into focus. They cover a wide range of both national actors and institutions, including administrative capacity, national legacies, veto-points and cultures of compliance (Schmidt 2002; Haverland 2000; Börzel 1999, 2005; Falkner et. al 2005). Some may facilitate the process of Europeanization while others limit it.

The present study will identify two mediating factors which are decisive to the Europeanization of healthcare. The first constitutes a *veto-point* and is the way in which the national administration (re)interprets EU-relevant decisions for health. This veto-point limits Europeanization from the start, as it provides the national administration with interpretive discretion hindering the full impact of EU integration. However, the analysis will point out that such a veto-point is dynamic, and the national discretionary scope may narrow as EU integration continues. The second mediating factor concerns *institutional legacy*, but from the perspective of domestic reform. It thus opens up a dynamic perspective on institutional legacy, as even heavily institutionalised policies undergo change. In the present case, the domestic reform undertaken supports the principles in the integration process. Due to congruence between the steps of integration and those contained in the national reform, this mediating factor facilitates Europeanization.

In general research, Europeanization is likely to be complicated by the fact that both independent and mediating variables are simultaneously in flux, i.e. it involves examining the effect of a dynamic cause transmitted by dynamic national institutions. In this way, Europeanization takes place as result of multiple influences rather than simply as a top-down EU-imposed or induced process of change.

Figure 1: The Europeanization of Healthcare Policy



As Figure 1 illustrates, we expect a certain degree of institutional change to take place as a result of Europeanization. However, the extent and eventual further effect of EU-induced change will not be detailed here, but on the basis of the following analysis.

This leads us to another challenge confronting the study of Europeanization: how do we measure the degree of change caused by European integration. For the future development of theory, it is essential that it is possible to measure the diverse *impacts* of the EU. Analysing the degree of European-driven change can be undertaken at a conceptual level – differentiating between retrenchment, inertia, absorption, accommodation and transformation, where the progression towards transformation signifies a greater degree of EU-induced change (Börzel 1999; 2005, pp. 58-59; Radaelli 2003, pp. 37-40). Although such description remains at the conceptual level, it is useful for labelling degrees of change. Relying on the methodological characteristics of the present case as a 'less likely' case of Europeanization, we should either expect inertia or only a slight

degree of change; i.e. absorption. However, the mediating factors may propel or even retrench the effect of EU integration.

The following analysis will first address whether the impact of the EU can be measured quantitatively. Subsequently, it will continue by conducting a qualitative process-tracing study.

3. The Quantitative Measurement of Impact

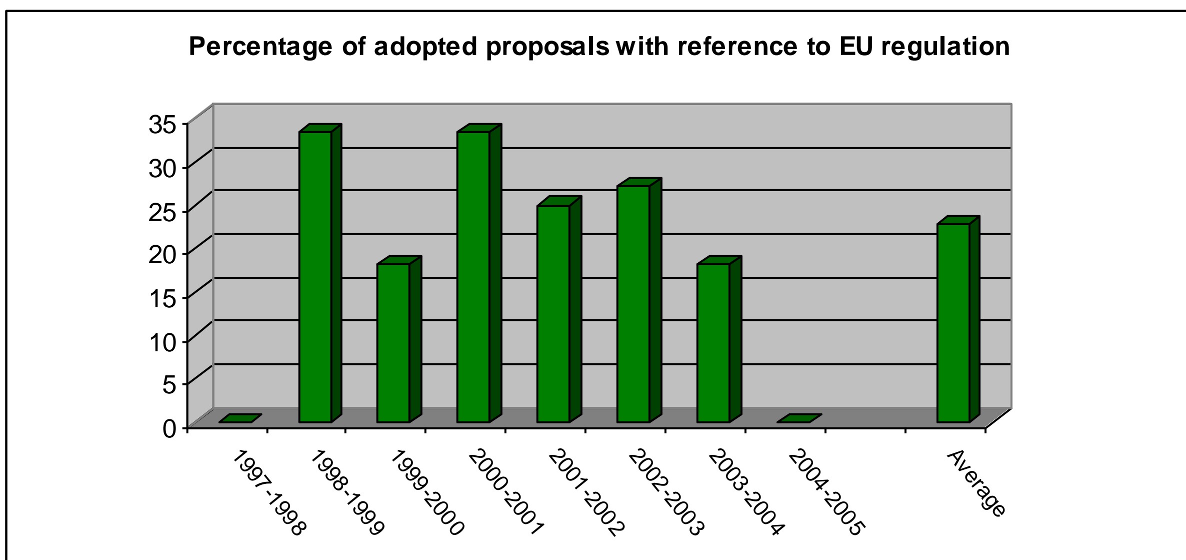
A precise and quantitative measurement of EU impact on specific policies would ideally serve the objective to ascertain the extent to which the EU reaches into the domestic realm. However, quantitative impact data are limited. Nevertheless, the archive of the Danish parliament makes it possible to quantify impact to some extent. Methodologically, we have examined the explanations attached to each legislative proposal on health policy in the archive of the Danish Parliament (Folketinget) to determine whether the proposal makes reference either to EU regulations or had been proposed in order to implement EU law. The archive provides data for the parliamentary years 1997-2005. Our analysis only investigates those proposals which were later adopted by the parliament.

Our dataset covers the Danish proposals which made *reference* to either EU 'soft' or 'hard' law, including measures beyond those that member states are legally bound to implement. Thus, the scope not only includes the laws that - partly or fully - aim to *implement* an EU directive, as well as those which simply refer to EU obligations in a broad sense. Implementation can be regarded as substantive Europeanization, whereas reference is likely to be largely formalistic. During the years covered in the data (1997-2005) approximately nine percent of the adopted proposals were

proposed in order to *implement* an EU directive, while around 23 percent made *reference* to EU regulation.

The quantitative data show that between 1997 and 2005, an average of roughly 23 percent of Danish healthcare legislation was influenced by or referred to EU law. Figure 2 shows that the impact of the EU was greatest, at 33 percent, during both the 1998-1999 and 2000-2001 parliamentary sessions and lowest during that of 1997–98, during which time none of the national laws adopted were influenced by EU rules.

Figure 2: Danish healthcare legislation adopted with reference to EU regulation



Returning to substantive Europeanization, an average of nine percent of Danish healthcare legislation that represented the implementation of EU law is indeed considerable for a policy field which, formally regarded, is national competence. However, it may only mirror part of Europeanization. The dataset merely indicates those proposals that were introduced by legislation and does account for the EU regulations that the Danish Executive chose to introduce via

administrative means, such as departmental orders and circulars. Indeed, substantive Europeanization may be introduced via this route. Furthermore, the quantitative analysis leaves out all of the EU-related changes that were not the consequence of Community directives. This is because Treaty provisions and regulations have a direct effect and are therefore not normally implemented through the national legislative process. Furthermore, Community 'decisions' are also excluded, as they only regulate specific parties or situations. Finally, the impact of the ECJ case law may be dispersed, as it is not generally implemented via laws but may nevertheless have significant impact and influence on administrative practices, legal reasoning and future policy reform (Martinsen 2005).

Other EU impacts may only be uncovered through a qualitative process-tracing study (Checkel 2005), which we will now undertake, first by outlining the key characteristics of the Danish healthcare system, then by mapping the emerging contours of EU-driven developments in the policy field, and finally examining the Europeanization of Danish healthcare.

4. Danish Healthcare; Characteristics and Recent Reforms

Danish healthcare can be characterized as a decentralized, public, integrated healthcare system. Responsibility for organizing and delivering services is placed in the hands of 5 decentralized, democratically elected, assemblies at regional level, while the 98 municipalities have responsibility for an number of prevention and rehabilitation services. The system is integrated in the sense that both financing and delivering secondary level services are public responsibilities. Primary care services are provided by mainly private practitioners, but publicly funded and integrated in regional planning. The regions operate within a framework of national legislation and annual agreements

with the national level and biannual agreements with professional groups concerning financial arrangements and service delivery.

The public healthcare system guarantees universal health coverage for all persons residing in Denmark. However, the general principle of territoriality implies that entitlement to Danish healthcare ends at the national border (Cornelissen 1996; Martinsen 2005).

Treatment is provided free of charge and general practitioners serve as gate keepers to hospital services. There are co-payments, mainly for pharmaceuticals, dentistry and physiotherapy, but with exemptions for chronically ill and low-income groups. There is a strong emphasis on equity in terms of rights to the same treatment for the same condition, regardless of social status, age, geography or ability to pay. The system is financed through taxation (a fixed health contribution of 8 percent of taxable income), which is redistributed to regional and municipal authorities as a combination of block grants and activity based contributions. Municipalities co-finance health services delivered by the regions.

National policy reforms

A number of changes have been implemented in the Danish healthcare system during recent decades. In general, they can be characterized as gradual adjustments rather than fundamental reforms (Pedersen et al 2005, Vrangbæk and Christiansen 2005). However, two trends with particular relevance for the analysis of Europeanization appear to have had a more profound impact over time. The first is the introduction of market elements and particularly patient choice, which is relevant for the discussion of free movement of goods, services and persons in the EU. The second is an ongoing trend toward centralization in both policy making and administration (Salomonsen

2005, Vrangbæk and Martinsen 2005). The centralization trend culminated in the decision on structural reform which was implemented January 1st 2007. The reform has changed the financing system (see above), has redistributed tasks and has reduced the number of regional authorities from 14 counties to five regions (0,6-1,6 million inhabitants) and the number of municipalities from 275 to 98 - with a population range from under 20,000 (less than seven percent of the new municipalities) to over 50,000 (37 per cent of the new municipalities). The centralization trend in Denmark (and other Nordic countries) is remarkable compared to decentralization trends in many other European health systems such as UK, Italy and Spain (Saltman, Bankauskaite and Vrangbæk eds. 2007).

A choice of 'insurance' plan for access to general practice and specialists has been in place since the early 1970s. Most Danes choose 'Group I' coverage, which, once registered with a specific General Practitioner (GP), provides free GP and specialist services and GP controlled access to specialists and hospital treatment. Patients may change their GP registration at regular intervals, free of charge, or between periods for a nominal payment. 'Group 2' coverage provides direct access to specialists for a co-payment. This option is chosen by only around three per cent of the population.

A policy providing a 'free choice of hospital' was introduced in 1993. Under this scheme a patient, once referred by a GP, may choose to have their treatment at any public hospital and some private not-for-profit hospitals at the same level of specialisation. An 'extended free choice' was introduced in 2002. This is linked to a treatment, or waiting time, guarantee and provides access to a range of contracted private and some foreign facilities, when patients are faced with an anticipated waiting time in the public health system that exceeds two months. The scheme is designed to increase the

service level by putting pressure on public providers, as the counties/regions are obliged to pay for services delivered in public or private hospitals outside their own jurisdiction. The waiting time guarantee institutionalizes the principle of access to private or foreign treatment facilities in cases of ‘undue delay’ in the national system. The waiting time will be reduced to 1 month as of October 2007. However, the Danish government maintains that the regions have the right to limit treatment abroad to selected facilities with which they hold a contract. This will be examined in more detail in section 6 below.

There appears to have been a slightly increasing trend in the use of both types of choice. Official estimates show a growth in the share of non-acute patients treated outside their home county from eight per cent in 1997 to 11.3 per cent in 2003 (percentage of non-acute basic level patients treated in other counties as percentage of total number of non-acute basic level patients) (Indenrigs- og Sundhedsministeriet 2004). This study includes patients treated at higher levels of specialisation outside the county and referrals made in accordance with general agreements between counties, but excludes choices made inside counties. Use of ‘extended free choice’ to private and foreign treatment facilities is estimated at 1,7 per cent of all treatment episodes. The extended choice scheme is mainly used for eye surgery, orthopaedics, ear, nose and throat conditions and plastic surgery (Amtsrådsforeningen et al. 2004).

The relatively limited use of the ‘free choice’ schemes reflects the generally short waiting times in Denmark, although variations in waiting times nevertheless persist. Preferences for treatment close to home, travel costs, custom and limited information on quality of provision may be other explanatory factors for the pattern of use (Vrangbæk et al. 2006; Vrangbæk 1999).

A Danish Diagnosis Related Groups (DRG) classification system for treatments and related pricing has been developed from the late 1990s. This has enabled a number of experiments with activity-based financing as a supplement to the regular block grants and global budgets. 'Free choice' patients across county lines are paid on a full DRG price basis. In most cases this has created incentives for counties to try to retain patients by reducing waiting lists.

In terms of healthcare policy debates, the role of the EU has so far been little debated. Adjustments to EU initiatives have mainly been treated as technical matters that have not given rise to major parliamentary or public debate. Within the health policy community some attention has been given to the development of the Service Directive, but as it became clear that this would not include healthcare the interest waned. Substantive EU impacts on healthcare have thus taken place rather discretely, insulated from wider debate.

5. New external health boundaries

At the same time as it undergoes domestic change, Danish health policy is increasingly affected by the initiatives and decisions of the European Union. National health policies are affected by EU intervention via different routes. While member state governments have for long held that they have full responsibility and control over their own health services, it is becoming increasingly clear that the Single European Market is having a substantial impact.

Assessing the specific competencies of the EU within the area of health is a complex task. On the one hand, article 152 of the Treaty states that the EU has certain competencies in securing a high level of public health but at the same time caveats this that "Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery

of health services and medical care" (Article 152 (5) of the Treaty). On the other hand, the EU intervenes in a wide range of national health policies, through a patchwork of different regulatory principles and provisions consisting of Treaty provisions, regulations, directives, decisions and the case law of the ECJ. Article 152 of the Treaty provides legitimacy for a wide range of activities designed to improve public health. Furthermore, healthcare services are affected by the acquis concerning public procurement, health and safety, company law, insurance, and the internal market etc. Other areas are more directly affected. This is clear in relation to the provision of cross-border healthcare services; but other areas also directly affected are the organisation of working time (Dir. 93/104/EC), health and safety, the movement of medical professionals (Dir. 93/16/EC), pharmaceuticals and medical equipment (see Permanand & Mossialos 2005).

Perhaps most significantly, EU intervention in the field of healthcare has developed due to iterative interpretations of the principles of free movement, authoritatively led by the European Court of Justice. Until 1998, access to foreign healthcare providers in the EU was regulated solely through the system coordinating social security rights, which aims to promote the free movement of workers, and with the recent amendment, all persons (extended by Regulation 883/2004). The coordination system gave a nationally controlled possibility to take up health care abroad. The instrument of control was that of *'prior authorisation'*. European citizens were entitled to healthcare in other member states, provided that it had been authorised beforehand by the competent national institution.

However, in a series of judgement from 1998 and onwards, the ECJ has questioned the justification for 'prior authorisation' and has gradually established that the principles of the internal market also apply to health policy (see Martinsen 2005b for a more detailed describtion of the series of

judgements). The Court first laid down that healthcare is a service within the meaning of the Treaty (C-120/95, *Decker* & C-158/96, *Kohll*, 28 April 1998). It later repeated that prior authorisation constitutes a barrier to the free movement of services, but may however be justified provided that (C-157/99 *Geraets-Smits & Peerbooms*, 12 July 2001):

- 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 later proceeded with its proactive course by introducing a distinction between hospital and non-hospital care (C-385/99, *Müller-Fauré & Van Riet*, 13 May 2003). In the case of *hospital care*, the Court restated its view that the requirement for prior authorisation is justified on condition that it is exercised proportionately and that a national treatment can be provided without 'undue delay. The matter was, however, quite different for *non-hospital care*. The Court laid down that national authorisation constitutes an unjustified barrier to the free movement of services for non-hospital care. Given the increasingly blurred distinction between hospital and non-hospital care, the future implications of this judgement are likely to be extensive. In 2006, a new contribution to the integration of healthcare was produced. In the recent case of *Watts*, the Court applied its line of reasoning to a National Health system, and considered for the first time the free movement of services principle against a health system providing treatment free of charge, publicly organised and funded through general taxation (C-372/04, *Watts*, 16 May 2006).

The European Patient in Focus

On 16 May 2006, the ECJ's long-awaited conclusions in the *Watts* case were made public. for the first time, the ECJ considered the implications of the logic of the internal market, for member states that otherwise separate the provision of healthcare from market considerations.

The case concerned a hip replacement needed by Mrs. Yvonne *Watts*, a resident in the United Kingdom. Mrs. Watts requested authorisation to receive treatment abroad, not accepting a waiting time for treatment in the UK for initially 1 year, later reduced to three to four months. Despite the later reduction in waiting time, Mrs. *Watts* went to France to have her hip replacement and, on her return, requested reimbursement of her costs of £ 3,900. That request was rejected by the English High Court, which argued 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, in turn, referred a long list of questions to the ECJ.

In its judgement, the ECJ confirms, and indeed furthers, its previous line of health related judgements. The conclusions remove the scope for national institutions to exercise administrative discretion and bring the rights of the European patient into sharper focus. In so doing, it intervenes in the national sphere of governance. Furthermore, the Court equips the European patient with institutional structures to claim those rights. It frames the right to appeal.

The Court repeated that 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 UK National Health Service do not exempt it from EC law. Article 49 of the Treaty applies regardless of the way the national system is organised (para 90 of the judgement). The general applicability of the Court's previous judgements is affirmative.

The central issue being that of waiting time, it is crucial to note that although the Court does not specify when a waiting time for a particular treatment can be considered to be 'undue delay', it sets out a (reviewable) criterion for determining whether a period of waiting time is acceptable in the context of EC law. 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 characterising his medical condition at the time when the request for authorisation is made or renewed, as the case may be" (para. 79 of the judgement).

The Court went on to specify the institutional structures that member states must provide to protect the rights of the European patient. The Court repeats the conclusions from its previous judgements, stating that the requirement for prior authorisation cannot legitimise discretionary decisions by national authorities, but must be based on objective, non-discriminatory, criteria and allow for decisions on authorisation to be challenged in judicial or quasi-judicial proceedings (paras. 115-116). Notably, the Court goes beyond a restatement of precedent and extends member states' obligation to provide transparency and legal certainty to European citizens:

> "To that end, refusals to grant authorisation, 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 judgement).

The *Watts* case is a further judicial step strengthening 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. In essence, the judicial activism of the ECJ has provided the Union citizen with new *exit* but also new *voice* opportunities beyond the national system. The response to this judgement by EU citizens, private interests, national courts and member state governments will decide the next steps in the further development of patients' rights and the structures to guarantee them. Also the politicians and stakeholders have through the Commission's open consultation procedure, running September 2006- January 2007, been granted the opportunity of voice. Many opinions have been formulated, and the next step is for the Commission to take. Throughout 2007, the Commission will work on the formulation of a Community proposal on patient mobility (interview, European Commission, February 2007), which, hopefully, will reintroduce some political direction and vision.

6. The Europeanization of Danish Healthcare

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. Denmark is one of the member states, which has responded to the development of caselaw by partially integrating the foreign supply of goods and services. This implementation has effectively broken down the principle of territoriality in healthcare.

The Danish government was first alerted to the direction that EU policy was taking by the Decker and Kohll judgements. The judgements contradicted the then current view that internal market rules had no impact on health benefits and services - which caused considerable consternation among Danish health authorities. As a consequence, the government set up an inter-ministerial working group to analyse the implications of the judgments for Danish health policy. The working group reported that the Decker/Kohll rulings contained general premises that took the scope of the judgements beyond the lawsuits themselves. Thus, Denmark acknowledged that the cases had implications for healthcare systems other than that of Luxembourg and were not limited to glasses and dental treatment (Danish Report on the Decker/Kohll rulings 1999, p. 22). The Danish report, however, contained a narrow definition of what constitutes a 'service'. To be a service according to the meaning of Treaty Article 50 (ex. Article 60), the Danish executive argued that there needs to be an element of remuneration 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/Kohll rulings 1999, p. 23. Own translation, emphasis added).

Denmark's (re-)interpretation of the concept of 'service' meant, perhaps not surprisingly, that the large majority of Danish healthcare services fell outside that definition, since they are provided as benefits in kind, free of charge and thus with no direct remuneration. Thus, while Denmark had conceded that *Decker* and *Kohll* had an impact, the national definition of what constituted a service within the meaning of the Treaty allowed for the exemption of the entire public hospital sector, as well as all types of non-hospital care provided free of charge.

However, in acknowledging that the principles of the internal market – under certain conditions – apply equally to healthcare services, the interpretation of the working group marked a decisive break with the then current Danish view. This decisive break meant that healthcare services for which insured persons themselves paid one part and the competent institution the other, were considered to fall within the concept of 'service' contained within the EC Treaty. The conclusions of the report led directly to the reform of policy, effective from 1 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 (The policy reform entered into force by law no. 467 of 31 May 2000 and BEK no. 536 of 15 June 2000).

While Denmark took this initial step to respond to developments in ECJ case law concerning healthcare goods and services outside the hospital sector, domestic reforms and initiatives, were also moving along similar lines. As shown in section 4 above, these national reforms introduced a greater element of market competition into demand for healthcare by increasing patient choice, while at the same time centralising governance and control of supply. These processes have also facilitated the introduction of the dynamics of Europeanization into the hospital sector.

Denmark took an active stance in the subsequent case of *Geraets-Smits and Peerbooms,* being among the governments that intervened to give an opinion. The Danish opinion restated the conclusions of the *Decker/Kohll* report (Interview, Danish Ministry of Health, 3 April 2001) 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, disagreed with these observations and extended the understanding of 'remuneration' in Treaty Article 50 to include indirect payments such as those transferred by social security funds to cover healthcare costs (Hatzopoulos, 2002, p. 693). Thus the Court's interpretation directly overruled the Danish definition of 'service'.

As discussed in section 4 above, 'extended free choice', effective from 1 July 2002, provides Danish patients with a right to treatment outside contracted public hospitals in the event that these hospitals cannot provide the necessary treatment within two months. As of October 2007, the waiting time guarantee will be further reduced to only *one month*. The intention of the policy reform is to reduce waiting lists and, at the same time, ensure patients a degree of choice if the service provided within the public health sector is insufficient. This reform institutionalised the obligation to refer patients to non-contracted healthcare providers in the event that care cannot be provided by the public sector within the specified waiting time guarantee. However, the freedom to reform national healthcare policy had already been restricted by the ECJ 2001 judicial ruling, where the Court clarified that the principle of non-discrimination means that once a treatment cannot be provided by the contracted national provider, the member state must not 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, at least in part, took account of the reasoning in the *Smits-Peerbooms* judgement. (Legislative proposal L 64, proposed 29 January 2002. Adopted 19 March 2002). The ECJ ruling thus impacted on Danish healthcare by granting a

different exit opportunity other than private supply, i.e. healthcare supply outside the national border.

In this way, the degree of congruence between supranational steps toward integration and domestic change directly promoted further Europeanization. Although the decision to treat Danish private hospitals equally with hospitals in other member states represents a significant change, it is important to note that Denmark's implementation of the principles of the internal market in healthcare is nevertheless limited. 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 institution has concluded 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 are listed, only 7 foreign hospitals or clinics are included, of which 3 are hospitals established in Germany, 2 in Sweden, 1 in Spain and 1 is a German hospital established in Denmark (as of April 2007). 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 institutionalised 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.

The requirement that foreign hospitals must have signed service agreements is not the only restrictive Danish response to the development of ECJ case law. The Danish government recently restated its interpretation of the concept of 'service' within the meaning of the Treaty (answer to Parliamentary question no. 89, 28 June 2005) - that a 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 healthcare costs. The Danish government thus maintains the definition of service that it formulated in the wake of the *Decker/Kohll* judgement and which exempts most Danish healthcare services from the impact of the principles of the internal market.

The day after the *Watts* judgement was delivered, the Danish Minister of Interior and Health was asked by an MP to clarify the impact of the judgement on Danish healthcare (answers to parliamentary questions no. 4965, 4967 and 4969, 17 May 2006). The government viewpoint is that due to the waiting time guarantee, which will be lowered to one month by October 2007, the judgement will not have any practical effect. The answers to the parliamentary questions, however, again repeat the Danish restrictive definition of service - that a service, within the meaning of the Treaty, is one provided with the intention to make a profit where the insured person pays more than half of the costs (answer to S 4967, 17 May 2006). It is remarkable that the Danish government continue to contradict what has been clarified and repeated by the ECJ. This substantiates that opposition may manifest in (the lack of) implementation.

It is clear that in the view of the Danish executive there are, at least, two conceptions of service - public services; and services within the meaning of the Treaty, with a private element. However, the boundary between the public and the private elements has been moved by the Court so that the restrictive Danish interpretation is not now compatible with that set out in the *Watts* case.

Thus while ECJ judgements on health services have, so far, had a limited influence on Danish healthcare policies, further impacts can be expected. It is likely that these impacts will be felt in the following areas:

- The restrictive Danish interpretation of the concept of a service is not compatible with the interpretations of the ECJ. This suggests that the Danish reform of 2000 in response to the Decker and Kohll judgements is far from in line with the current status of EC law.
- The requirement for prior authorisation is an unjustifiable barrier to the free movement of non-hospital services as treatment is increasingly carried out without the need for hospitalisation. The restrictive list of healthcare goods and services which the reform of 2000 allows to be purchased outside of the Danish healthcare sector without prior authorisation should be extended to the whole spectrum of non-hospital care in order to become compatible with evolving Community law.
- The requirement in Danish legislation that a patient facing undue delay who chooses to be treated outside the contracted Danish healthcare sector is restricted to hospitals with which an agreement has been concluded beforehand clearly conflicts with the Court’s interpretation of the principles of free movement. Furthermore, the condition produces de facto discriminatory effects between private Danish hospitals and hospitals in other member states.
- Finally, the principles of the internal market challenge national control over the supply and distribution of medical products. Medicine purchased in other member states and through the internet are outcomes of these developments, but give rise, in turn, to questions concerning how quality can be ensured while avoiding distortion of competition due to the enforcement of national standards.

The contours of healthcare services within a political union based on the rule of law and guided by principles of free movement can already be identified. Their further evolution depends on the response to these developments by European citizens, private interests and national courts. A supportive institutional structure to expand European rights is already in place, essentially based on new cross-border exit and voice opportunities. Unless member state's policy makers act in consort to de-institutionalise the emerging internal healthcare market, future healthcare governance will continue its process of Europeanization.

7. Concluding Remarks

Although diffuse, the EU *impacts* on NHS systems are many and far-reaching. The more significant effects are the re-structured boundaries for the organisation of the policy field; an increased obligation for the member states to integrate foreign suppliers into the domestic healthcare mix; and a de-structuring of the traditional tools of governance.

The *process* involved in the Europeanization of Danish healthcare has been transmitted by two types of mediating factors. The Danish administration has played a key role, since it has constituted the most significant *veto-point* in the process, occupying the space of control through which the ECJ decisions have been re-interpreted and 'translated'. On the one hand, the administration has allowed a certain impact. At first glance, it has proven its reputation as complier with EU obligations (Falkner et al. 2005). On the other hand, it has attempted to steer and reduce the effects of the EU on Danish healthcare. The administration has defended its discretionary scope by maintaining a definition of service, which de facto goes against the definition developed by the ECJ. In this way, impact has been reduced. Furthermore, its implementation of the new exit option to allow foreign

treatment to patients if they cannot be treated nationally without 'undue delay', i.e. 2 months as of now (one month as of October 2007), is not simply the implementation of unrestricted free choice. Through the means of contracts, control remains in the hand of the Danish administration, and de facto foreign hospitals are not treated equally with private and public hospitals established in Denmark.

The manner in which the Danish executive exercises its veto-point through a creative and autonomy-preserving re-interpretation of the meaning of ECJ decisions comes to limit the full impact of EU integration. Nevertheless, the other mediating factor, *domestic healthcare reforms*, introduces new principles in Danish healthcare governance. This indeed propels Europeanization, as the congruence between the paths of national reforms and that of EU healthcare integration is high. Free choice of hospital, waiting time guarantees, the free movement of Union citizens and services and an intensified focus on patient rights all go hand-in-hand and facilitate the Europeanization process.

The concrete impact is a result of these two contradicting mediating factors. Among the impacts are legislative amendments integrating both non-hospital and hospital foreign supplies, thus indeed re-structuring the traditional boundaries of Danish healthcare. The principle of territoriality as a tool of healthcare governance has been compromised, and its future legitimate exercise is called into question by the supranational polity. This has significant implications for governance. Whereas the state and counties traditionally controlled the supply – and thus the organisation and quality of healthcare – free choice introduces a very different logic of governance. Free choice has a clear analogy to the market, and its logic is backed up by patient rights. The customer, i.e. the patient, decides. And via an EU exit opportunity, the healthcare market will become immense as compared

with the national healthcare systems of the present – when the member states implement their European obligation in full scope. Furthermore, the EU polity provides the Union citizen with voice, should her rights be violated. Not only can the Union citizen rely on the EU judicial system, but the interpretations of the ECJ oblige the member states to administer EU rights transparently, objectively and provide appeal structures if the welfare supply of other member states is denied. Against this background, it is also clear that the governance tool of administrative discretion is severely challenged. Exit opportunities, as supported by EU-institutionalised voice (Hirschman 1970; Ferrera 2005; Bartolini 2005), de-structure the traditional means of healthcare governance, and the logic introduced places the ultimate (and smallest) unit in the system in focus: the EU citizen, the patient, the welfare consumer. Their (free) welfare movements may prove difficult to govern. In spite of healthcare as a 'less likely' case of Europeanization, impact goes beyond the light mode of absorption. Healthcare is being made to accommodate the European principles affecting the traditional means of governance and organisation. Future impact may scale beyond accommodation. We may witness the formation of a different institutional legacy, initiating a Europeanised healthcare model. A model emerging around a new set of stakeholders, principles and structures, which includes the market, principles of free movement, patient choice and patient rights institutionalised and safeguarded by the EU.

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