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The Future of Health Sector in the Expanded EU

Dr Rifat A. Atun
MBBS MBA DIC FRCGP MFPH
Director, Centre for Health Management
Tanaka Business School
Imperial College London

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A “European social model”

“European integration and national health care systems: a challenge for social policy”

High level conference organised by the Belgium Presidency of the EU

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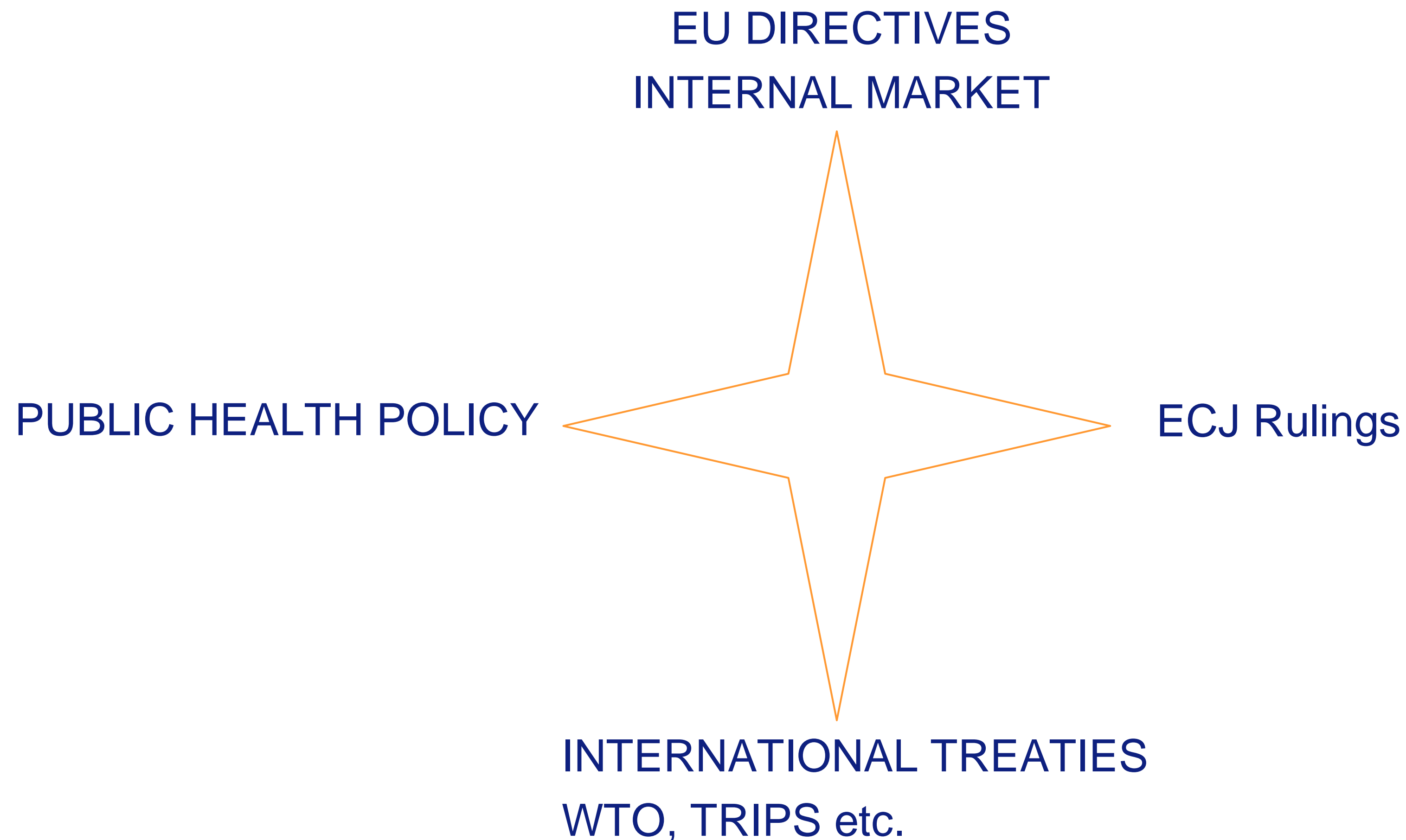
Sources of EU regulation affecting cross border trade in healthcare services



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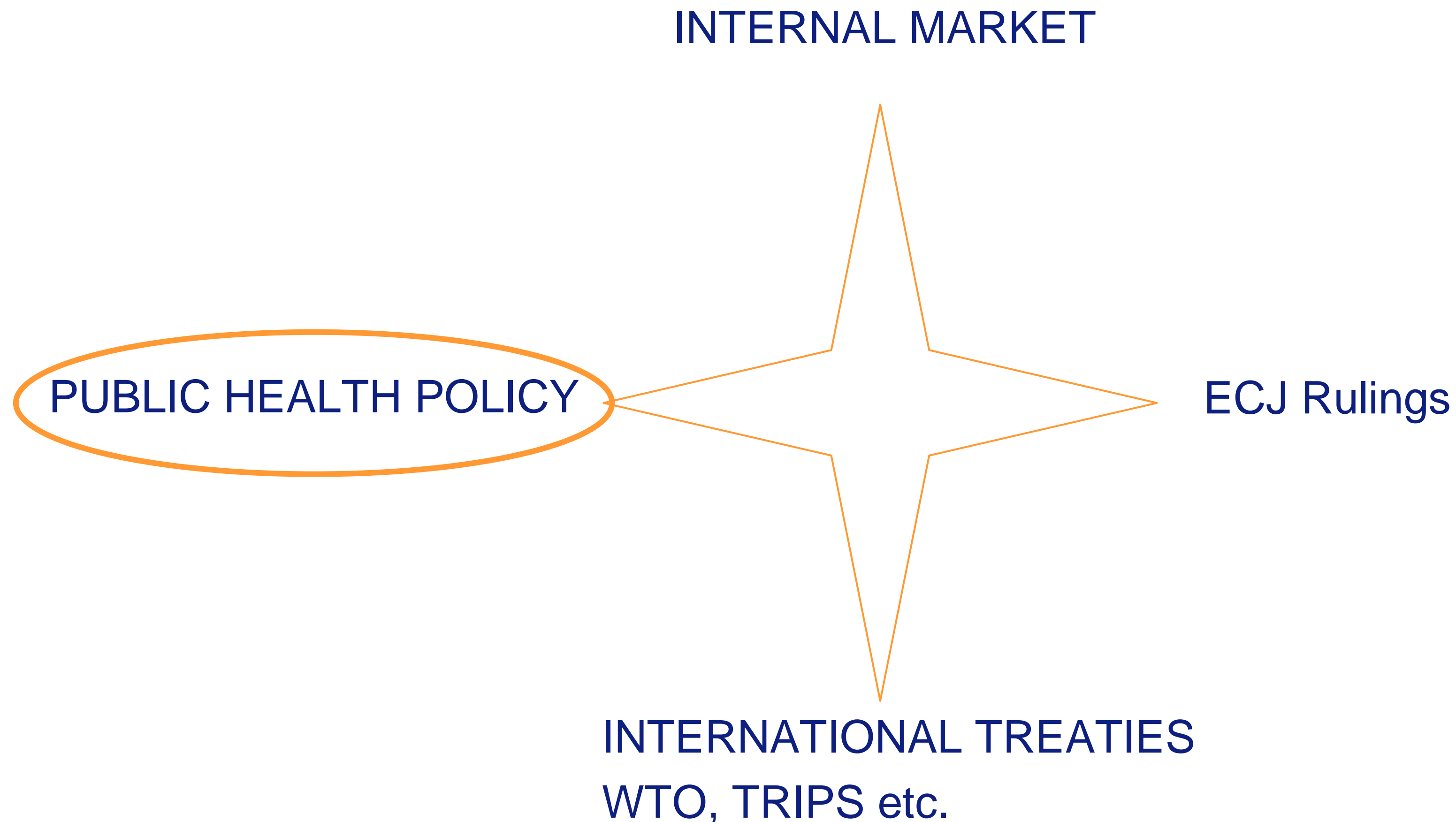

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EU and health : Article 129 of the Maastricht Treaty

- Explicitly recognizes the EU public health competence (also known as the “public health article”)
- “Community action shall be directed towards the prevention of diseases …”,
- “The Commission may, in close contact with Member States, take any useful initiative to promote such coordination”
- Recognized the “Subsidiarity” and did not impinge on the member states’ right to organise and finance their healthcare system

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EU and Health: Amsterdam Treaty Amendment

- Article 129 renamed article 152 and expressed even more overtly the political will of the member states by explicitly stating that "community action in the field of public health shall fully respect the responsibilities of the Member States for the reorganisation and delivery of health *services* and *medical care*…" and "… excluding the harmonisation of the laws and regulations of the Member States".
- Hence : "organisation and delivery of health services and medical care" are excluded from the Community's competence (according to article 152 EC)

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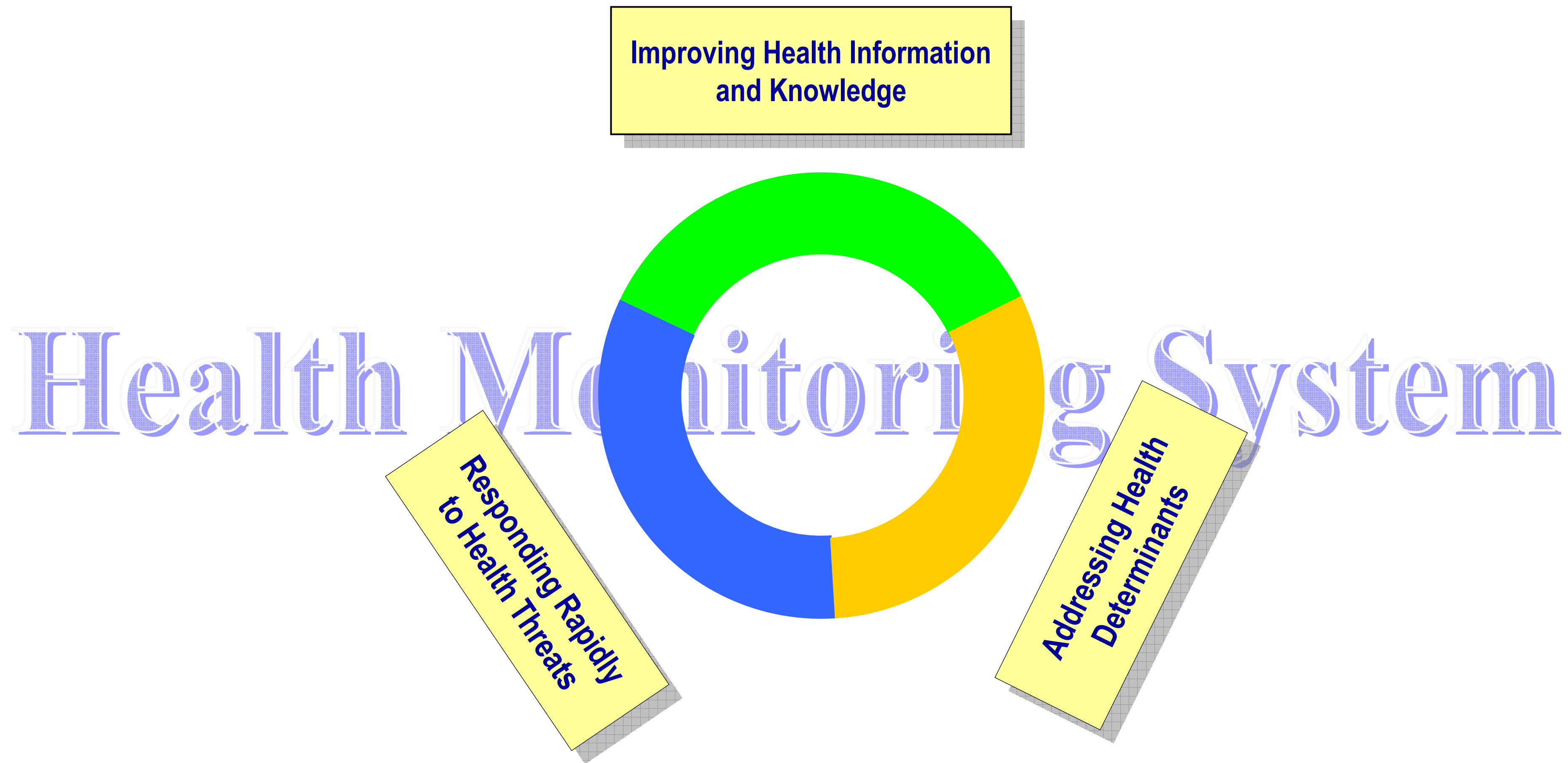
The three priorities set out in the Public Health Programme



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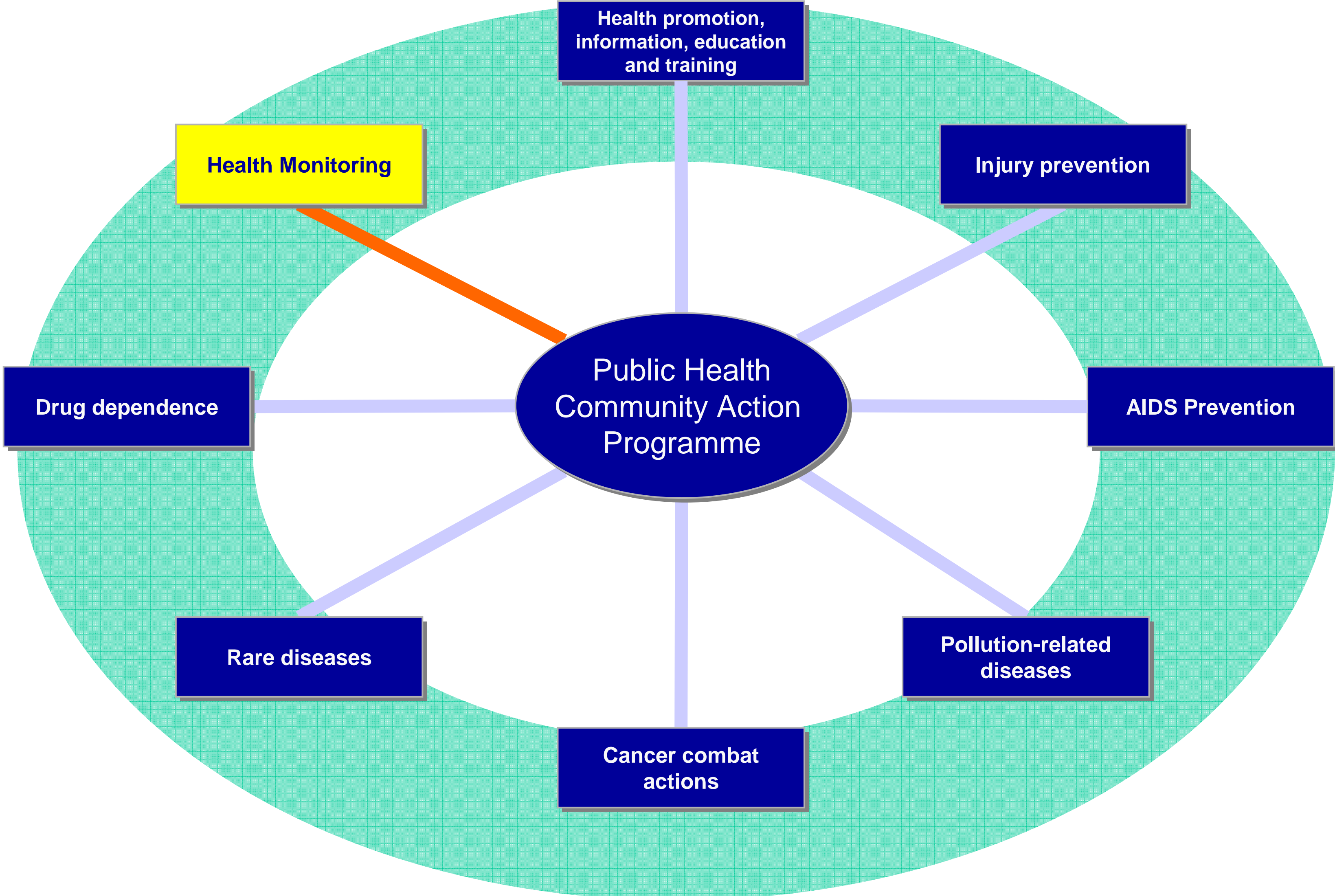
Community Action Programme in the Area of Public Health



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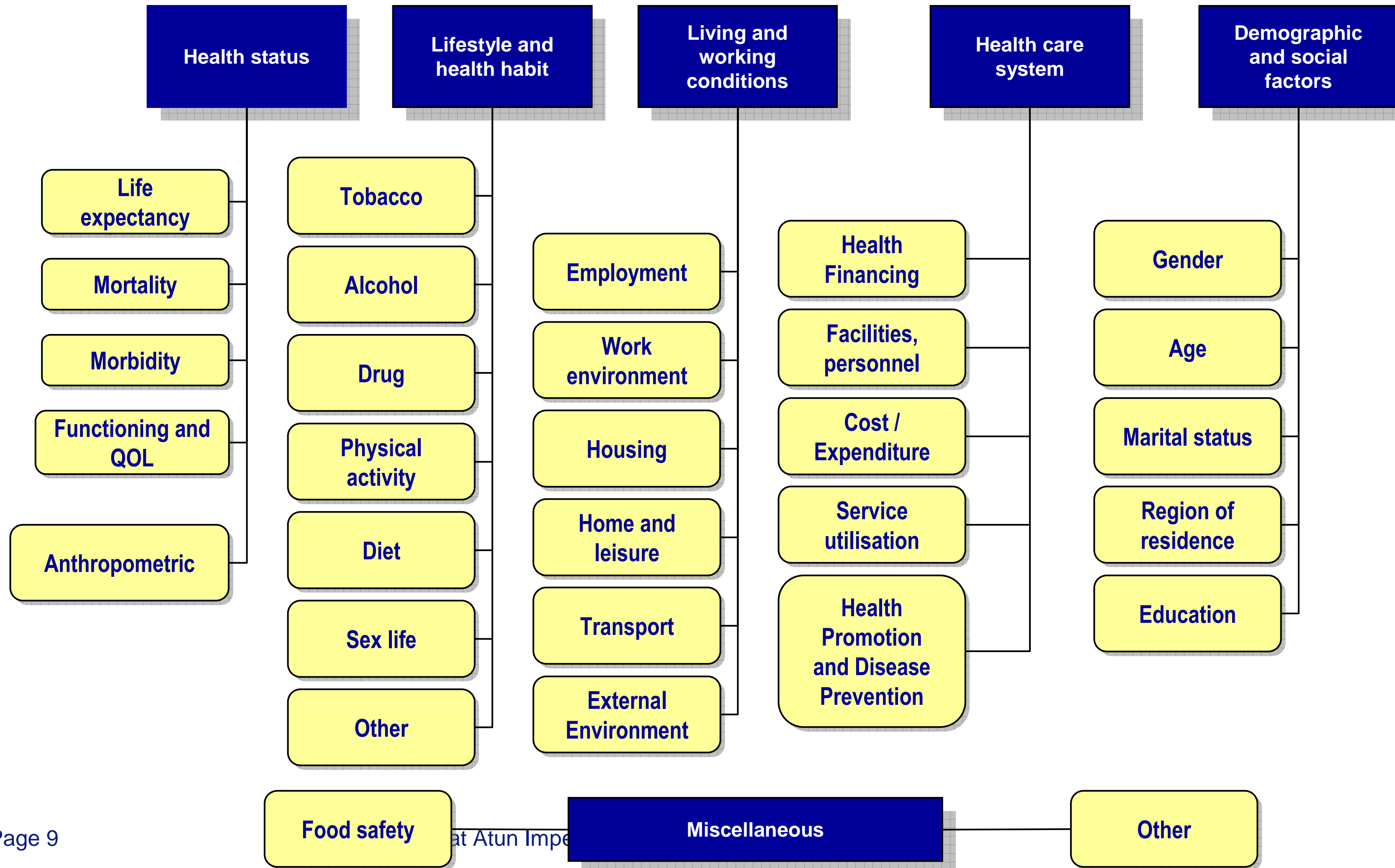
Adapted from: Dec. No. 1786/2002/EC

EU-Acquis recommended framework

Recommended for EU Member States

***Decision No 1400/97/EC** of the European Parliament and of the Council of 30 June 1997**



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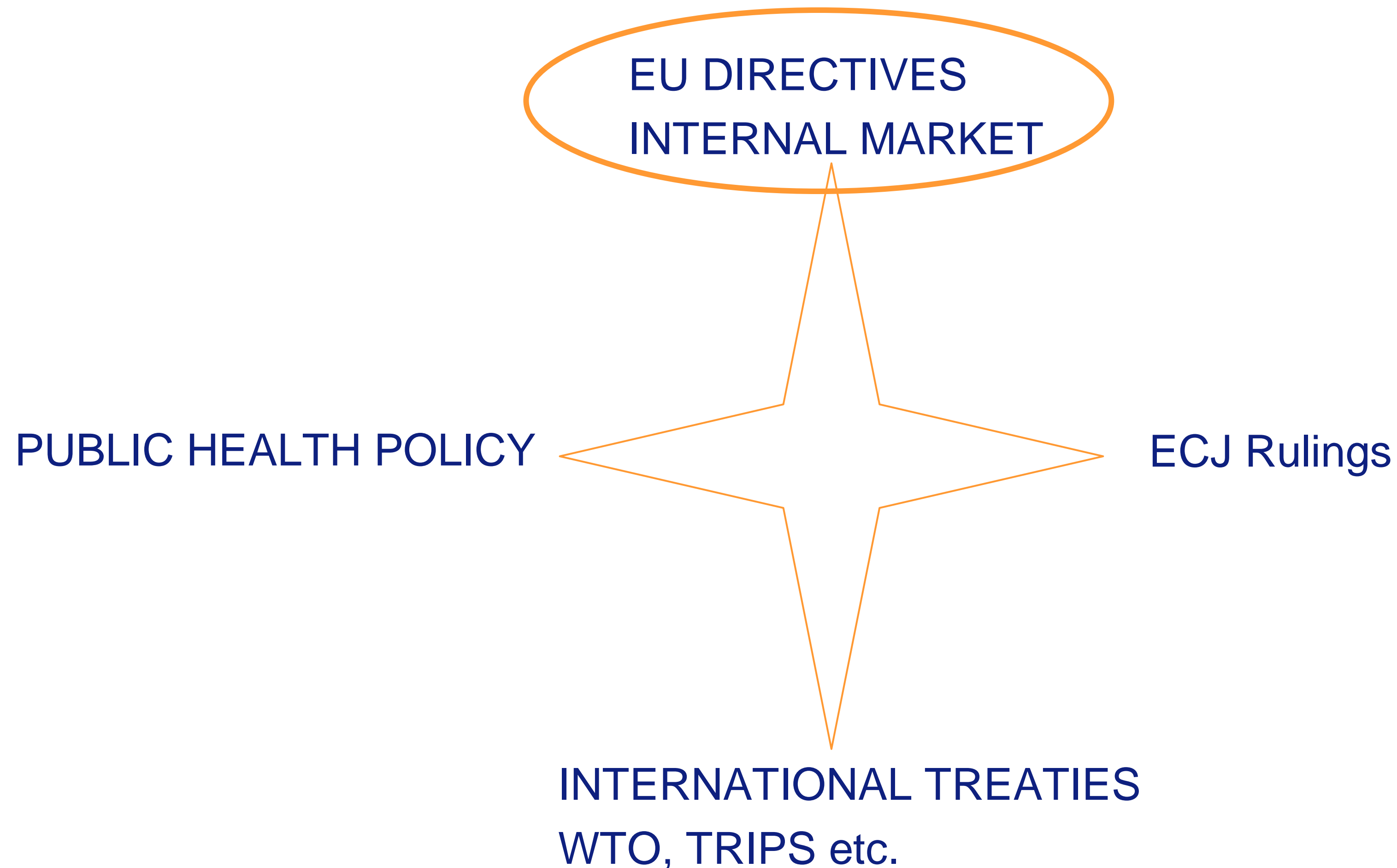

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EC Frameworks impacting on health

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European Single Market Framework

- Occupational health and safety requirements including injury prevention in the workplace
- Common limitations on radioactivity and electromagnetic exposure
- Free movement of health professionals and mutual recognition of qualifications
- Standards and training of medical and health-related staff
- Mutual Recognition of pharmaceuticals and European Medicines Evaluation Agency
- Medicines packaging, labelling and advertising requirements
- Consumer protection matters
- Safety of blood and blood related products
- Agricultural issues such as tobacco and pollution
- Food safety issues
- Specific environmental issues including levels of pesticide use
- Aspects of transport policy

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Public Health Frameworks

- Community Action Programme in the Area of Public Health
- Programmes on major “health scourges”
  - i.e. “Europe Against Cancer” and “Europe Against AIDS”
- Combating drug abuse
- Communicable and rare diseases
- Alzheimer’s Disease

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Other policy areas impacting on public health

- Structural funds
- Research (FP6)
- Aspects of environmental policy

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Single market framework

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The “four freedoms” and health

The number of internal market rules affecting healthcare trade, is substantially bigger than the number of rules that can be found under the specific treaty chapter for public health

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Regulations 1408/71 and 574/72 enacted in 1971 and 1972

Three principles of of equal treatment, of aggregation of the insurance periods and of exporting benefits.

1. The host country should not discriminate against other nationals who have the right to receive social benefits.
2. Safeguarding the cumulative acquisition and preservation of social benefit rights by obliging every social security institution to take into account all preceding periods of social insurance held in every other member state country.
3. Obliges the various national security organisations to expand the provided social benefits beyond national borders by indemnifying services received in another EC country

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The E106, E111 and E112 procedures

- E106: Right of frontier workers to benefit from a double access to healthcare
- E111: Right of access to health care in emergency situations during a temporary stay in another EC country– “urgent cross-border care”
- E112: Enables patients to receive treatment in another European country after *explicit* and prior authorisation from the competent national social security organisation - “planned cross-border care”

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Cross Border Trade in Health Services

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The number of people seeking and obtaining prior authorisation for treatment abroad in selected EU member states

Country	Year	No of requests for authorization	No of authorizations granted
Austria	Each year	N/A	850
Belgium	Each year	N/A	2000
Denmark	Each year	40-50	25-35
France	1996-1999	1240/ 4 years	789/ 4 years
Luxembourg	1998	7130	7082
Sweden	Each year	N/A	20
United Kingdom	Each year	800	600

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The EUREGIO projects

- Initiatives to facilitate the provision of healthcare services across national borders: bilateral agreements between member states and regional agreements involving two or more EU countries
- Netherlands and Belgium, between UK and Ireland, between Luxemburg and its surrounding countries and more recently between Germany and Norway

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The EUREGIO projects

- The EUREGIO Hainaut – Nord-Pas-de-Calais, between Belgium and France: began in 1992
- The EUREGIO Meuse – Rhine, between Belgium, France and Germany: initiated in 1997
- The EUREGIO Rhine – Waal, between Netherlands and Germany: began in 1997
- The EUREGIO Scheldemond, between Netherlands and Belgium: started in 1997
- The Transcards project to explore the potential of telematic and smart card technology: Belgium and France
- The Netlink project: telematic networking technology and the development of a health card: France and Italy

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Claims linked to co-ordination policy and this figure expressed as a proportion of public health spending in Europe (in p.p.p*)

	1989 (mio €)	1993 (mio €)	1997 (mio €)	1998 (mio €)
Invoiced claims (E125)	352.2	756.5	598.3	613.3
Lump-sum claims (E127)	108.2	346.2	295.6	144.3
Total claims (1)	460.5	1.102.7	893.9	757.6
Total public health spending in Europe (p.p.p.) (2)	265.093	369.315	471.036	-
(1) / (2)	0.17%	0.30%	0.50%	-

*Purchasing Power Parities (PPPs) are currency conversion rates, which express the purchasing powers of different currencies in terms of a common unit. PPPs are currency conversion rates, which eliminate the price differentials between countries.

Source: AIM Report, May 2000: p.37

The Euregios

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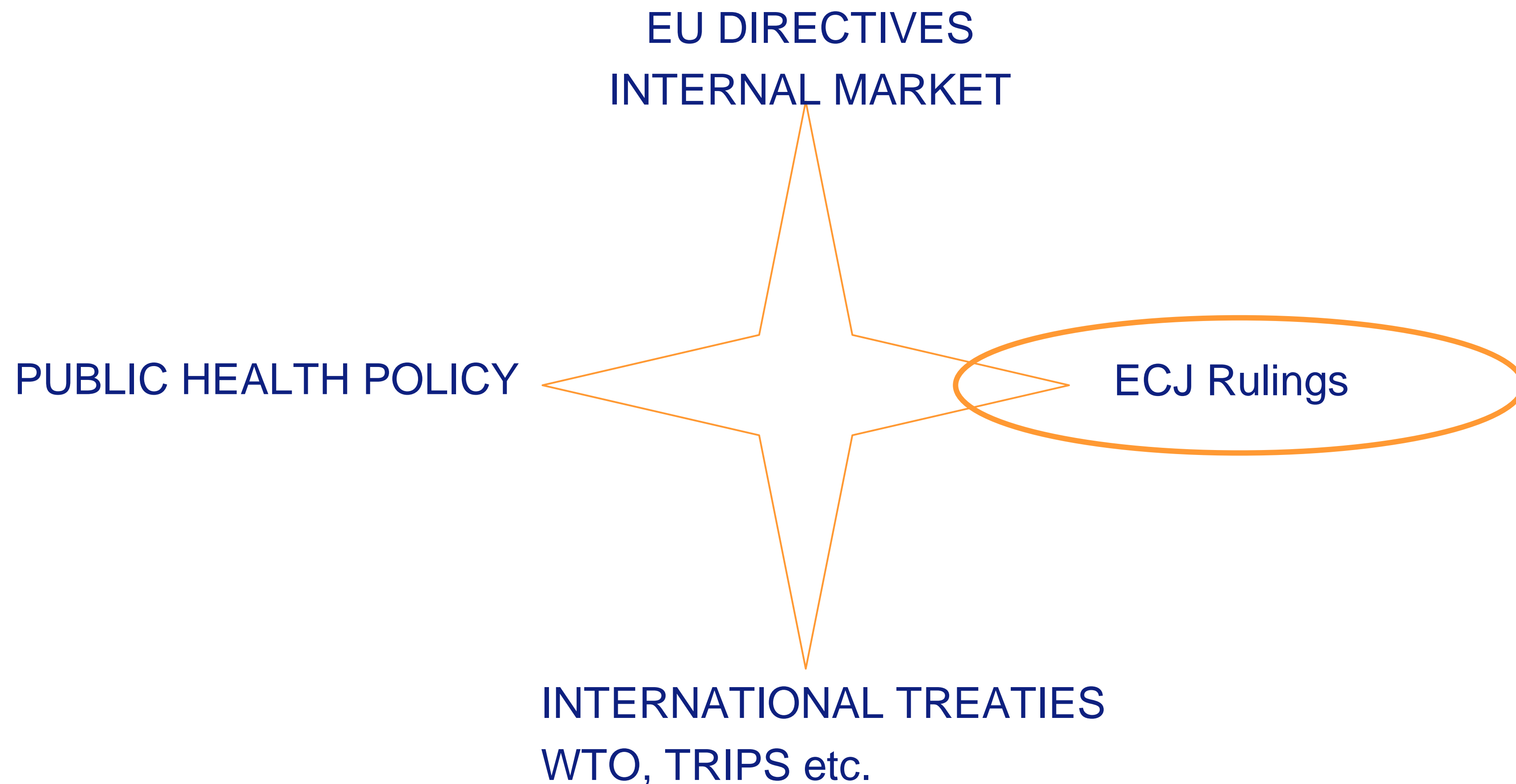

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The ECJ

- Final arbiter of EU law for disputes between
  - Member states
  - EU and member states
  - EU institutions
  - Individuals and the EU
  - Opinions on international agreements
- “preliminary rulings “
- A “constitutional” role in establishing European law
- A major determinant of healthcare policy within the EU
- Seen as having “de facto assumed the position of a policy maker in the health field” (Leiner, 2002)

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Health care related cases referred to the ECJ

ECJ code	Parties	Country of service	Country of insurance	Medical service/ good
C-117/77; C-182/78	Pierik I & II	D	NL	
C-120/95	Decker		LB	Glasses
C-158/96	Kohll	D	L	Orthodontic treatment
C-160/96	Molennar	F	D	Long term care
C-368/98	Vanbraekel	F	B	Orthopaedic hospital treatment
C-411/98	Ferlini	L	(EC)	Discriminating billing
C-157/99	Geraets-Smits Peerbooms	D A	NL NL	Inpatient Parkinson treatment Coma therapy
C-385/99-1	Muller-Faur Van Riet	D B	NL NL	Denture/implantable Athroscopic treatment

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Implications

The ECJ established a dual system:

1. Based on the normal E112 procedure upon which the individual is granted prior authorisation, receives treatment abroad and then reimbursement is settled directly between the two national social protection systems according to the tariffs of the country of treatment
2. Individual receives treatment in another member state *without* prior authorisation, pays the costs of treatment and at their return back home receives reimbursement according to the local prevailing rates of their affiliation country - entitled to reimbursement only for services received that exist in their home country's "healthcare basket" ("the Kohll/Decker procedure")

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Ruling by the Advocate General Ruiz-Jarabo on Case C-385/99

- The requirement for prior authorisation before out-patient treatment may be received and charged to a system of benefits in kind is justified on three grounds, namely:
  - risk of serious damage to the financial equilibrium of the social security system;
  - maintenance of a medical and hospital service which is balanced and accessible to all; and
  - maintenance of a capability to deliver medical treatment within the country, which is essential to public health
- Accordingly, **provisions relating to freedom to provide services do not preclude the requirement for prior authorisation since it is objectively justified.**
- **The condition "without undue delay" should be assessed from a strictly medical standpoint, regardless of the waiting time for the treatment requested**

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Key ECJ Rulings dealing with cross border healthcare trade in the EU

- Exposed the conflict and existing gap between member states' healthcare practices and the single market rules
- "from a health care perspective, Decker and Kohll can be classified as a revolution … from the perspective of European Community law, Decker and Kohll are not so much to be regarded as a revolution, but above all as an evolution" (Van der Mei, 1999)

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Key ECJ Rulings dealing with cross border healthcare trade in the EU

- authority in setting national healthcare policy diluted
- member states should always consider the implications and compatibility of their healthcare policies and practices within the EU context

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David Byrne, the European Commissioner for Health

- “no national health system can be regarded as exempt from the Treaty obligations”

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August 2001 UK Health Secretary, Alan Milburn

“It is my intention to make clear to health authorities and primary care trusts that they are able to commission services from other European countries as part of their wider efforts to reduce waiting times for NHS treatment …”.

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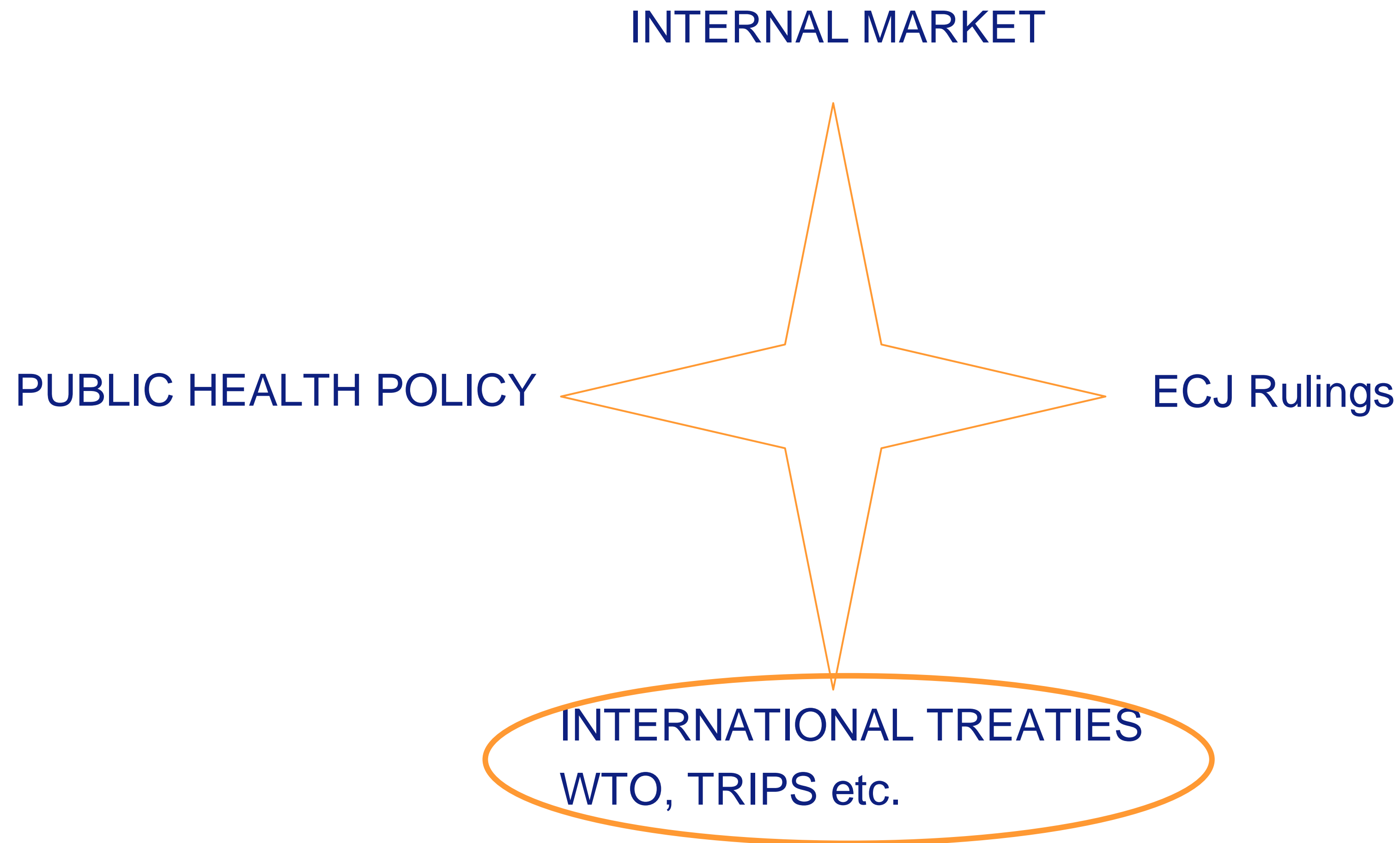

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Global trend in increased movement of goods and services in health

WTO member states committed to unlimited or limited foreign investment in medical, health-related and social services in 1999 (n=135)			
SECTOR	**Member states permitting unlimited foreign investment**	**Member states permitting limited foreign investment**	**TOTAL**
Medical & dental services	19	24	43
Veterinary services	19	14	43
Midwives, nurses etc	10	16	26
Other (including medical services)	1	2	3
Hospital services	18	17	35
Other human health services	8	4	12
Social services	5	13	18
Other health & social services	2	1	3

Source: Pollock, A.M. and Price, D. “Rewriting the regulations: how the World Trade Organisation could accelerate privatization in health care systems”, Lancet 2000; 356: 1995-2000

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Trend : A Move Towards an Internal EU Market in Health Services

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Moving to an internal market in health

- healthcare systems have recently incorporated market mechanisms through a variety of means (deregulation, public-private partnerships, contractual arrangements etc.) in an effort to eradicate their public systems' inefficiencies
- "…in practice, in most European countries, health service provision is in direct competition with commercial providers owing to decentralisation and public management practices or healthcare organisation based on insurance…" (Koivusalo, 2000)

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Convergence of health policies: The changing role of the State

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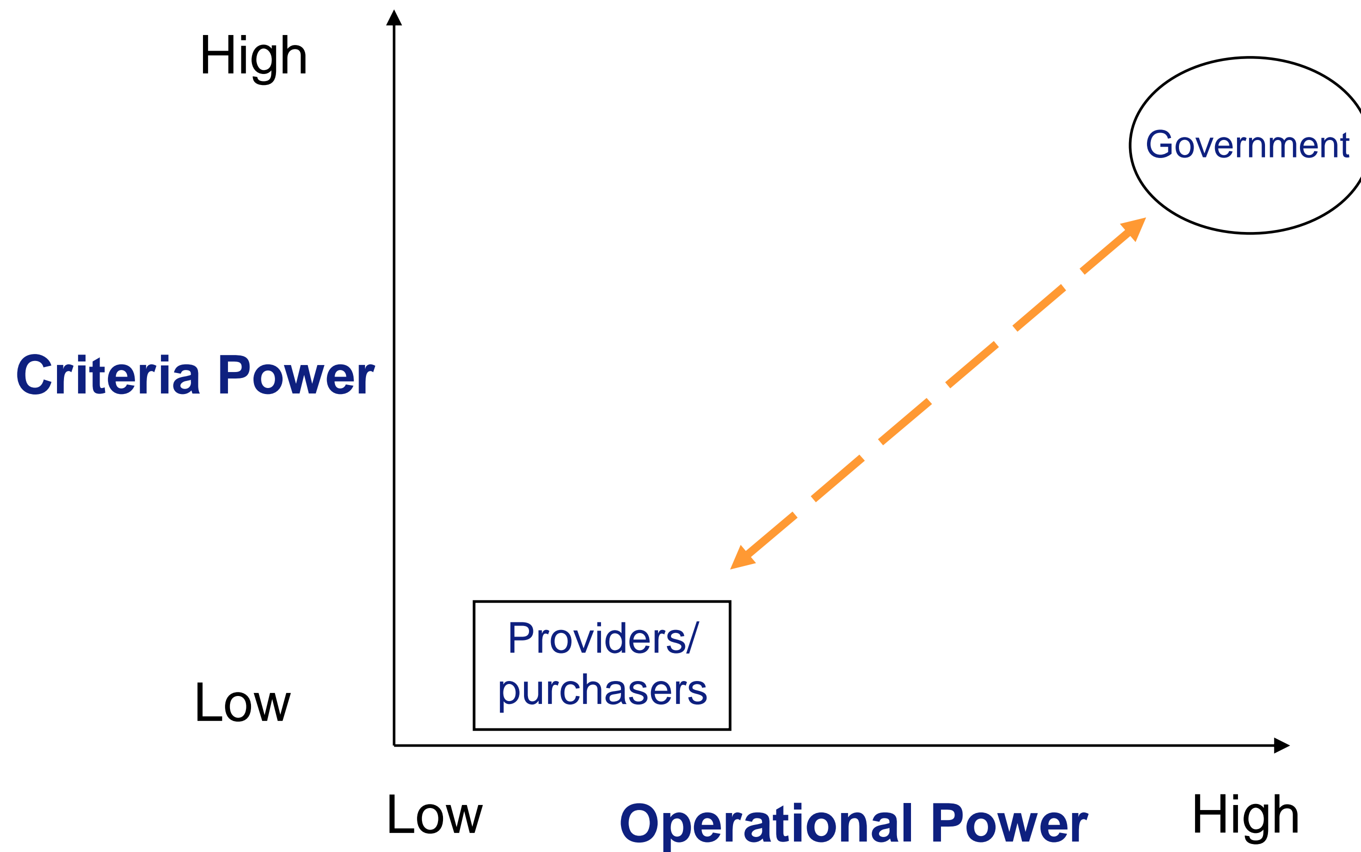
Redefining roles
Criteria v operational power
Past picture



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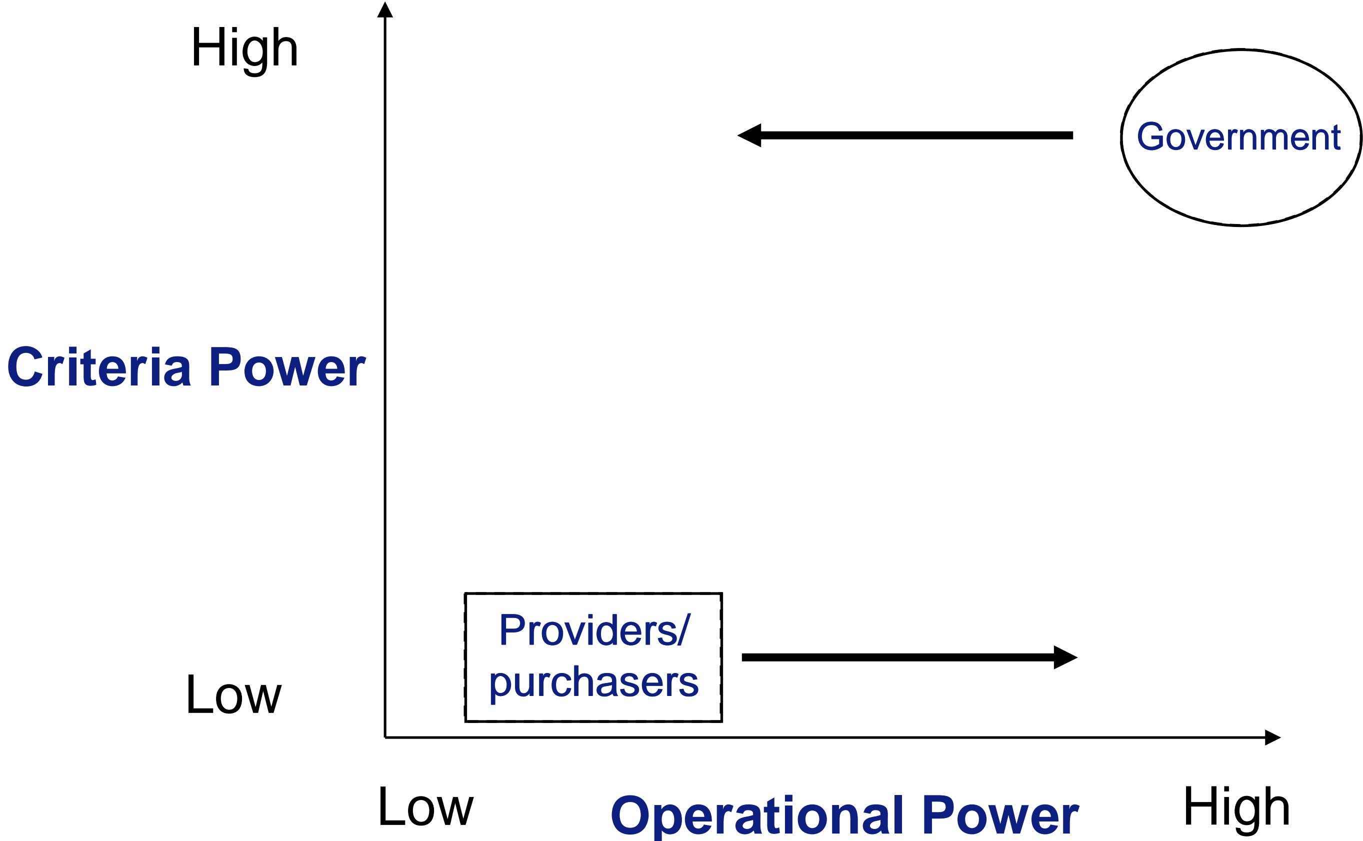
Redefining roles
Criteria v operational power



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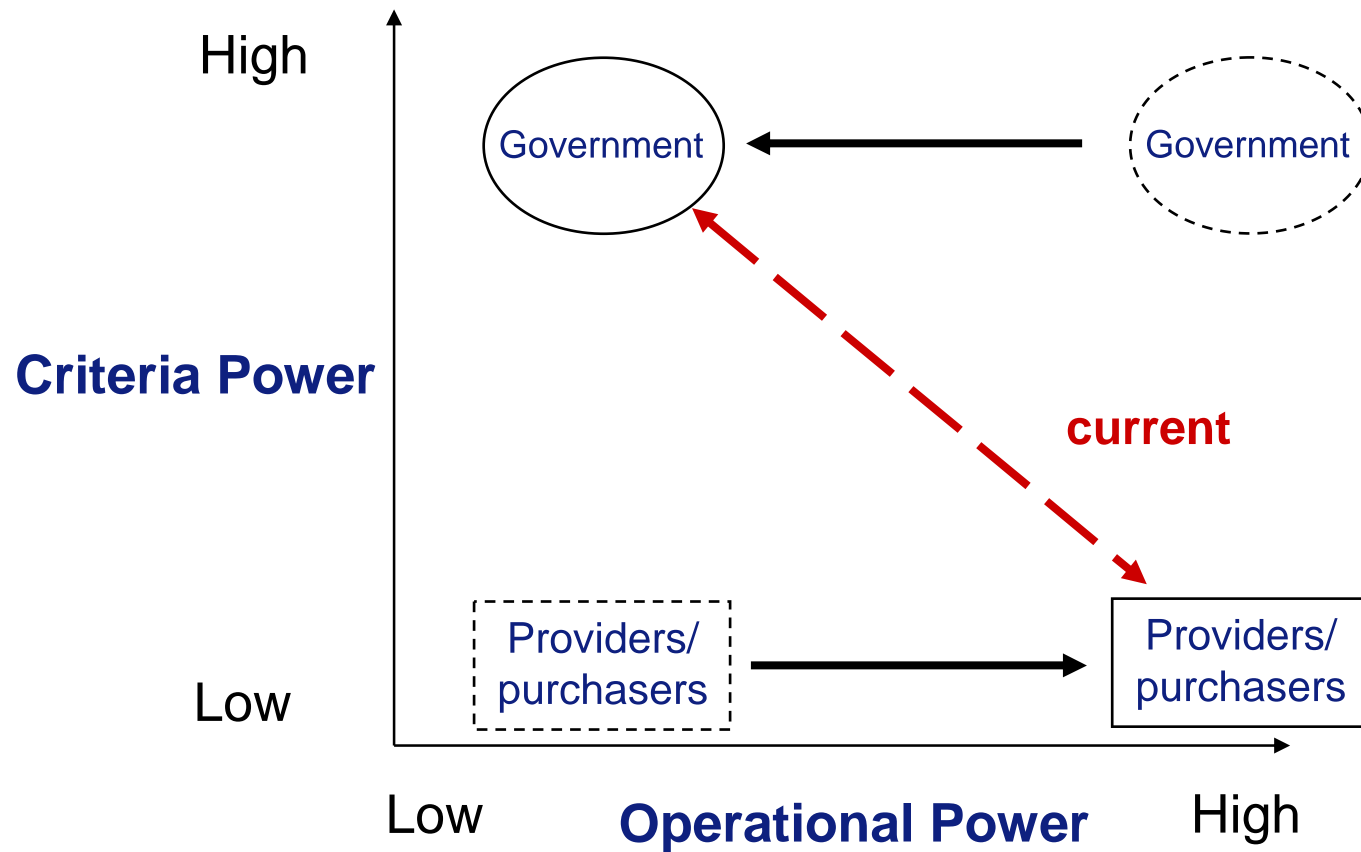
Redefining roles
Criteria v operational power



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Impact of Cross Border Trade in Health

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The “four freedoms” and health

Free movement of individuals	Free movement of goods	Free movement of services	Free movement of capital
Labour market for doctors and nurses	Pharmaceutical market	Private and Statutory Health Insurance	Infrastructure and development investments
	Medical devices and technologies market	Health Services	
	Public procurement goods	Short term services	
	Private choice goods	Long term services	
		Data and information	

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Impact of Cross Border Trade in Health on Patients

POSSIBLE ADVANTAGES	POSSIBLE DISADVANTAGES
•Wider choice and more competitive prices •Greater access to care in border areas •Access to European health care networks •Solution to waiting lists in country of residence •Financial advantages of price differences (pharmaceuticals) especially due to increased transparency of euro •Continuity of care in some cases (following stay abroad, retired cross border workers, etc.)	•Market saturation with no real choice criteria and guarantees of efficiency, quality or safety •No direct settlement by insurers (third party payers) •Insecurity in terms of supply, price (risk of over billing) and cover •No guarantee of provider's competence or quality of care •Possibility of waiting lists following use of service by foreign patients

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Impact of Cross Border Trade on public authorities, social protection and health systems

POSSIBLE ADVANTAGES	POSSIBLE DISADVANTAGES
•Positive effects of competition and greater choice: lower or stabilised prices, reduced corporatist reflexes, compensation for infrastructural deficiencies at national level, etc. •Financial advantage of price differences	• Having to guarantee quality of care •Difficulties in organizing supply of health care tailored to the needs of population •Increase in medical consumption and health expenditure as a result of greater supply and choice •Increased administrative burden to verify, assess and reimburse treatment obtained abroad

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Impact of Cross Border Trade on health care providers

•Positive effects of competition, leading to increase in potential demand, and a driver to innovate and improve quality	•Unfair competition from other Member State providers who are not bound by the obligations imposed by national authorities •Patient mobility

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Impact of Cross Border Trade on suppliers of medical goods

An increase in potential demand	Parallel imports of goods that are less expensive in other Member States

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