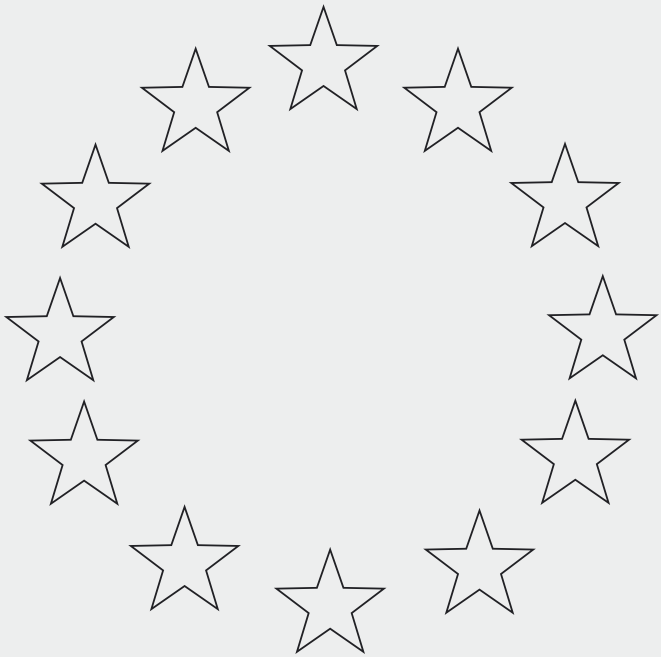
CARING FOR EUROPE



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Preface

Between April 2006 and April 2007 a group of top managers, policymakers and opinion leaders from the Dutch healthcare sector studied the developments in healthcare in the European Union (EU). The group was led by Professor Pauline Meurs, connected to the Erasmus CMDz (Centre for Management Development in Healthcare) of the Erasmus University in Rotterdam, and Piet-Hein Buiting, at the time CEO of the Amphia Ziekenhuis in Breda/Oosterhout, one of the largest hospitals in the Netherlands.

The aim of the study group was not only to map out the developments in healthcare itself, such as the increased mobility of citizens and the establishment of hospital chains operating supranationally, but also to translate the development of the EU into the effects this can have on healthcare. Eventually, the objective was to gain insight in the influence these developments have on each other and to give an idea of how this mutual influence can affect the development of the EU as a whole and in particular healthcare.

The group primarily worked from a historical and social-scientific perspective, dealing with each subject from three different levels: the level of the individual citizen, patient or care provider, the level of the Member State or national health system and the level of the EU as a whole. The emphasis was on the position of healthcare in its broader social and political context on the one hand and the organization of the healthcare system itself on the other hand.

For the purpose of the research, in addition to consulting relevant literature, the group spoke to a wide range of experts from the Dutch perspective, from the perspective of the EU and the European institutions and from four other EU Member States, in order to reach a representative reflection of the subject. The countries that were visited were Belgium, with cross-border care as the focal point, Hungary, with the new Member States issue as the focal point, Spain (and more specifically Catalonia), with the role of the regions as the focal point,

and finally Sweden, with the role of healthcare in the social services system.

In all countries that were visited general themes such as the position and mobility of the patient, the manner of practice of the profession and training of the professionals, the organization of the healthcare system and the general relation to the EU were also studied.

In this report we have chosen to make a synthesis of all information we collected during, prior to and after the various meetings and country visits. We have not included any direct references here, but have used consulted literature or reports of discussions. The sources this report is based on are available from the Erasmus CMDz.

Hopefully, the study trip and this report will initiate a long-term search for the development of healthcare in and of Europe, which will be one of the study topics of the Erasmus CMDz.

Piet-Hein Buiting
Pauline Meurs
Dung Ngo

November 2007

1. Introduction

This year the European Union celebrates its 50th anniversary. In 1957 the Treaty of Rome laid a basis for one of the largest and, in many respects, most successful political and economical projects in the history of the world. Since then the EU has experienced a tremendous growth, both from a geographical viewpoint and as regards to its contents. Based on the principle of subsidiarity, as observed within the European treaties, the policy with respect to healthcare has always been considered the exclusive domain of the individual Member States. This means that there has been no specific attention from the Union for healthcare, neither has a policy been made, for example by formulating directives, with respect to care. For a long time, this situation could exist, without causing any substantial problems.

By now, there are a number of developments, however, that introduce a new phase for European healthcare and that will have to lead in particular to a re-evaluation of the principle of subsidiarity of the European Union with respect to care. For example, more citizens claim care in other Member States and more and more often the European Court of Justice needs to render increasingly drastic decisions on the legitimacy of these claims to care that these citizens want to assert in other EU countries. The European Court does not have a legal framework that is geared to healthcare and assesses the individual cases based on the directives of the free traffic of persons, goods and services within the EU. Also, in several Member States, more and more companies are active in the (health) insurances markets and in the healthcare sector itself and the first centers of EU-oriented hospital chains can be distinguished. The developments mentioned show that a new phase has begun in the position of healthcare in the EU that requires a reassessment of thinking and acting in the healthcare sector and in the EU in relation to each other.

2. Developments in healthcare

For a proper understanding, it is important to describe the developments that are going on in healthcare in Europe in their mutual relationship. At the same time, two major changes are taking place. First, there are the autonomous developments in healthcare and society that are happening simultaneously in various Member States and that get the similar response in the Member States, but that do not arise from international issues as such. Examples are the rise in the ageing population and the increasing demand for care caused by this, or the developments in medical technology that make new treatments possible, but also raise new questions concerning the affordability and accessibility of care. Second is the domain of the increased mobility. This concerns patients and professionals as well as internationally operating care providers. This mobility, which has increased simultaneously on different fronts, causes existing national rules and practices in healthcare to be under pressure or to fail on all sorts of levels.

2.1 The autonomous developments

In all European Member States healthcare faces a number of big challenges. Europe is a continent that wrestles all-round with a sharp rise in the ageing population on the one hand and with a decline in the young population that is just as important on the other hand. This results in a sharply increasing pressure on healthcare. The demand increases in terms of volume as the number of elderly people with an increased healthcare consumption grows in absolute numbers, while the effect of this is intensified by the success of growing treatment possibilities of age-related diseases, such as cardiovascular diseases and oncology. These improved treatment possibilities increase the relative pressure of this category, because this group of elderly people lives longer, but does require extra care in this period. On the other hand, a growing part of the working population – due to the progressive decline of the young population – should enter the healthcare sector in order to meet the demand for care. In the future, this will become an intolerable situation in all European countries.

In terms of economics, these problems are translated as an increasing claim to that part of the gross domestic product that is spent on healthcare. The responses of the Member States to these challenges are to a certain extent similar. By stimulating free market processes, admitting or not admitting new entrants, introducing a system of output pricing and the government taking on a regulating role instead of a controlling role, they try to create incentives for patient-friendliness and effectiveness. However, the transitional processes caused hereby often go beyond the mere rearrangement of activities within the existing institutions and existing care providers. With the increased liberties and possibilities that have arisen in healthcare thanks to these developments, some Member States are seeing an influx of foreign capital by investors from outside the branch, the creation of chains and increase in scale, change in real estate positions and the arising of international and often listed hospital chains. The manner in which these developments will have effect on a national level is also determined by the national systems and the pertaining cultures and traditions in care provision. In Spain, for example, where traditionally a separation between publically and privately financed healthcare already exists, we see that this development takes place faster, making it an attractive country of business for foreign investors. The Netherlands, on the other hand, traditionally has a hybrid system in which the mixed public/private order is an essential characteristic of the healthcare sector. In the Netherlands, the development towards increased free market processes continues in this mixed order. For foreign investors, however, the Dutch climate is as yet too regulated and obscure for investing. Although there turn out to be clear differences in course and pace between the Member States, the developments show the necessary parallels in the various Member States.

In addition to the mentioned demographic and economic developments, there is also a common technological trend. Traditionally, the scientific development as regards medicine has been of an international nature. However, in the healthcare delivery there have always been large local and national differences. These differences could arise, and continue to exist, because the actual healthcare delivery was relatively isolated.

Thanks to the increasing possibilities of communication by the application of IT (the so-called E-health), the exchange of know-how on implementation practices has increased, both among care providers and patients. This has increased both the speed and the intensity of mutual influencing. This knowledge and experience becomes visible if patients have gained experience with care in another country and, for example, realize the pros and cons of direct access to specialist care without mediation of the family doctor. Another example is the medication policy. There are large cultural differences in the prescription of medicines. Roughly speaking, we can say that the southern countries pursue a generous policy, while the northern countries are reserved. Letting illnesses run themselves out without any prescription is routine in family doctor practices in the Netherlands. In Belgium, on the other hand, a patient hardly ever leaves the practice without medication. Another difference concerns the way patients are treated. The degree of obligingness and courtesy differs for each country, just like service-orientation, for example, with regard to waiting times or the willingness to pay extra home visits. Also, the nature of the relation between doctor and patient differs greatly. In some countries this is much more hierarchic than in others.

2.2 Increasing mobility

The last few years have been characterized by a strong and increasingly further growing mobility of persons and products as well as services. This is facilitated by the European treaties on this matter and is also enforced by an active EU incentives policy. For the time being, the mobility of persons is seldom aimed at care itself. Due to the increasing flow of tourists, more and more situations occur in which citizens of one Member State are treated in another Member State, for example.

Still, this group can be considered as incidental care demanders, causing no other effects than the proper handling of the acute problem, the only structural (side) effect being that if the experiences are good, patients bring those experiences to their own country and will put greater demands on the provision of healthcare services.

The story is different for the groups that stay in other Member States for a longer period of time or permanently. These groups are still growing strongly in number and consist of three categories. It already starts with students. The EU has set up an extremely successful exchange program, called the Erasmus program. This program stimulates students from EU Member States to follow part of their studies in other Member States. The purpose is to promote integration within the EU. This is supported in two different ways. To start with, a harmonization in higher education has been initiated through the Bologna protocol, making it possible to gear curricula to one another and examinations to be mutually recognized. In addition to this harmonization as regards content, there is also a financial contribution. To give a picture of the numbers: in 2005 over 100,000 students participated in the program and after a modest start at the end of the eighties, by now more than one million European students have participated. An important effect is that now a new generation grows up in all European countries simultaneously to which Europe is a natural part of their life, the so-called new Europeans.
In addition to the increased mobility of students the labor migration has strongly increased as well, for short-term periods and on a temporary basis as well as for permanent or long-term periods. These latter groups need to establish themselves in the Member State they work. These groups of citizens in principle make use of the healthcare in the country they live in. They do, however, bring their experiences and customs and have their demands on effectiveness, service and accessibility. It can be expected that as the experiences increase, this group will also be more selective where possible and will actively choose treatment in a specific country.

Brussels

A final important group is the so-called pensionados. This group, mainly consisting of citizens of the more northern Member States, such as Germany, the Netherlands and the UK, has established itself in large numbers in the southern Member States. Also a lot of Dutch people that have established themselves just across the border in Belgium fall into this group. They are of great importance to healthcare, because contrary to students and labor migrants, they have a high healthcare consumption that they preferably want to receive in their new country of residence according to the standards and customs of their country of origin. According to European regulations, they are entitled to care such as it is provided in the country of residence. Often this is organized differently and, in the eyes of this group, of less quality and/or not matching their own culture. This situation has already led to massive protests. By now, care providers from, for example, the Netherlands and Germany have responded to this need, by offering on-site care to this target group by e.g. building sheltered housing complexes in the Spanish Costas, but also by setting up a German hospital in Mallorca.

Belgium and cross-border care

In 2006 the Belgium population consisted of 10.5 million people. The average life expectancy for men was 76.5 years and for women 82.4 years in 2004. In 2004, 9.3% of GDP was spent on healthcare. The Belgium healthcare system is organized on two levels: federal and regional. The government is responsible for the regulation and financing of healthcare. The regional administrations have the task of promoting public health and are also responsible for child welfare and geriatric care. The system is based on principles of equal access to healthcare and freedom of choice. The health insurance system is influenced by the Bismarck system. There is a compulsory health insurance (National Health Service) and a private system of care provision. Residents partly contribute to the insurance themselves and third parties finance the remaining part.

Unlike most EU countries, Belgium has an oversupply of doctors. In 2004, there was an average of 4 doctors per 1000 inhabitants. This is higher than the EU average of 3.5 doctors per 1000 inhabitants. The past few years, attempts have been made to implement a quota system to reduce the number of med students (this also applies for that matter to students in dental surgery, physiotherapy and other medical professions). In concrete terms, this means that candidate students have to take an entrance exam. This exam can be considered a way to apply numerus fixus, because the examining board itself determines the maximum number of mistakes allowed during an exam. Also, only 700 doctors are allowed to graduate annually.

An advantage of the surplus of doctors is that waiting lists are practically non-existent in Belgium. Because they do exist in the Netherlands, more and more cross-border care takes place. Databases show that for a number of years now, a steady growth can be seen in the number of Dutch patients traveling to Belgium for care. In 2005, approximately 40,000 clinical patients were concerned, approximately 1% of the total healthcare volume. Reasons to go to Belgium for care are: gaining time (bypassing waiting lists in the home country), the higher level of service, among other things evident in the fact that diagnosis are made

easier, surgery and medicines are prescribed easier, patients are referred to specialist faster and patients are treated in a more friendly manner. All this leads to a high(er) patient satisfaction. Also, the traffic of persons and services is facilitated by the similar social/cultural orientation. This trend seems to continue in the years to come, especially since, despite the reduction of the waiting lists in the Netherlands, the growth seems to continue. It is therefore debatable whether cross-border care can still be seen as a mere kind of safety valve (cyclical effect) or whether we are dealing with a structural effect.

By now the impact on the Dutch care providers in the (wide) border region has become clear. With the current growth of competition in healthcare a loss in market share of a few percents across the border is already significant. The active marketing of the care providers in this field enforces this effect. The indirect effect is also that the experiences of patients in Belgium are starting to contribute to the expectations of Dutch healthcare, especially when it comes to speed and patient-friendliness.

By now the impact of this trend to the Belgium care system is also substantial due to the increasing numbers. In Belgium this is viewed as either an opportunity or threat, depending on the perspective chosen. That is because the accessibility of healthcare for Belgium patients might suffer. Also pressure arises on the rates and commercial behavior by the health facilities is encouraged. On the other hand, there are a number of parties in the market and the political system that view care as a new export product that can give an extra boost to the economic development.

3. Position of healthcare in the EU policy

3.1 Healthcare: a national issue?

In the European treaties healthcare has always been considered as a policy area of the national governments of the Member States. This is based on the so-called principle of subsidiarity. This principle, developed in the post-war Federal Republic of Germany, departs from the idea that a subject is handled on an administrative level that is as basic as possible, and that it is only pulled up to a higher administrative level in order to solve transcending or common problems. As long as this is not the case, this higher level (in this case the European Committee and with that the complete EU system) cannot interfere in the individual policy of the basic administrative level in that area (non-interference). Translated to healthcare this means that the EU does not have a legal basis to engage in the healthcare policy of the Member States. Based on this principle of subsidiarity, the EU also does not have its own healthcare policy, with the exception of a number of subjects from public health, such as prevention programs regarding alcohol and drugs or potential cross-border epidemics such as SARS and avian influenza. There is also an active policy regarding product safety in pharmacy and food safety. As regards organization, this part of public health has been classified under DG-SANKO, whose main task is consumer protection (in the broadest sense) for that matter.

This does not mean the EU does not further regulate healthcare. Indirectly, in particular the policy areas dealing with the internal market and social issues strongly influence healthcare. This is for example reflected in the harmonization of the educational courses and diplomas of healthcare professionals, in rulings of the European Court on refunds of aids and in the effect of, for example, the EU directives regarding working hours. After all, a substantial part of healthcare can (also) be seen as a regular activity in the economic traffic and, thus, all kinds of EU directives that regulate the free traffic of persons, goods and services also apply to healthcare. The problem that arises in this respect

is twofold. First, there is a formal administrative problem: in the preparation of these kinds of directives their effect on healthcare is not proactively taken into consideration, because of the principle of subsidiarity described above and the non-interference arising hereof. Conversely, specific issues in healthcare cannot be solved via this route for the same reason.

Second, an at least equally important problem has to do with the resulting blind spot of the EU as regards to problems in healthcare. Because healthcare is not a formal administrative policy area, there is also no attention for the effects of the directives on healthcare or the problems taking place in this field, as a result of which no official and administrative infrastructure is being built to develop this policy area. As a consequence, the political attention for care is hardly present and, therefore, the status of care in the EU discourse is small. In this manner, healthcare - representing almost 10% of GDP – is one of the poor cousins in the Brussels arena. One of the most important consequences of this situation is that if an international problem in healthcare arises, in practice only the route via the European Court in Strasbourg is open. This started modestly with the refunding of a pair of glasses (Decker-Kohl). But now, however, the most recent ruling (Watts) threatens the complete budgetary policy of the English National Health Service. In this case, it also applies that in the absence of specific directives, healthcare is measured based on the generally applicable economic directives of the EU.

As mentioned before, two main tendencies in European health can be observed that transcend the national scope. The first is the similar response of the Member States to the common, demographic, economic and technological changes; the other is the increasing mobility in all kinds of manifestations. We will analyze the effects of both of these tendencies here successively as regards the perspective of the individual citizen, the perspective of the professional and the perspective of the national Member States. In the next section the consideration of the effects for the EU as a whole will follow.

3.2 The perspective of the individual citizen

Although the mobility of citizens in the EU has strongly increased, at first sight it seems like the mobility of the patient as such falls behind. The total quantity of healthcare that is provided in the EU to citizens from other Member States is of the order of magnitude of 1% in curative care. In long-term care and mental healthcare these figures are even much lower. There are several reasons why these absolute numbers are low. Important decisive criteria – especially with acute and chronic care – are proximity and permanent availability. That is why care remains a strongly local/regional product. There is also an important cultural component, with a strong preference for care that is provided in people's own language and culture. Still, these motives proof not to be absolute. If there is a large difference in accessibility, perceived quality or price, the European patient proofs more and more willing to travel, especially in elective care. And although the percentages are still low, the past five years they have quadrupled between the Netherlands and Belgium. In 2005, a total of 40,000 Dutch patients were admitted to Belgium hospitals for clinical treatment. Not only the patients are willing and inclined to take this step across the border, but also insurers show the willingness to facilitate this step, especially if healthcare services in another country are more effective and/or efficient.

In addition to accessibility, there turns out to be a second important reason to travel farther: the accessibility in another country of a treatment of higher quality. These differences in quality can be based on differences in regulations of countries on, for example, the accessibility of expensive, state-of-the-art technology, but can also be the result of actively established or autonomously created Centers of Excellence. Except for the fact that in certain cases these quality differences are actively stimulated, it is especially important that the knowledge of these quality differences is more easily available than before. Examples can be found in oncology care, but also in case of more refined or advanced surgical techniques, such as with scopic hernia or prostate surgery. An important aspect in this matter is that the technology in these kind of cases could also be applied by specialists in the home country, but that these kind of innovations are often not permitted or being facilitated for budgetary reasons, for example.

A further consideration of the search and select behaviour across the border shows that there are three factors that enforce this behaviour:

1. The patient is increasingly informed of the possibilities elsewhere through the internet, patients' association, care provider and/or health insurer.
2. The patient is increasingly prepared to bear the consequences of extra traveling, cultural and administrative barriers.
3. The patient increasingly often succeeds in shifting the financial consequences of his choice on to his existing, national health system, either or not through legal action.

Irrespective of the answer to the question how far the numbers will continue to rise, it can in any case be concluded that it is impossible to imagine life today without this phenomenon. From the point of view of the individual patient, the numbers are irrelevant. In a sense, the individual patient can be seen as pars pro toto for the complete range of bilateral and multilateral agreements that are required to solve the mobility issue. After all, for each patient the whole range of aspects as regards medical, administrative, legal and financial aspects must be arranged. Originally, this was done without any special arrangements and no action was taken until the problem arose. By now, it is no longer possible to only handle this bilaterally, as an "exception": It turns out that the volume and diversity of the existing mobility is already so extensive, that it leads to structural implementation problems, particularly in a country such as Spain, that has a relatively large number of New Europeans and pensionados from a large number of countries, the Spanish health service missing out on substantial amounts of money that should be provided by countries such as Germany and the Netherlands through settlement.

3.3 The perspective of the professionals

There are huge differences in the EU between the circumstances in which professionals are educated and need to work. Based on the articles of free traffic of persons, there is a fundamental equality for all professionals. However, a proper exchange requires more: an equal point of departure based on education and similar working conditions. Thanks to the harmonization of training programs and final attainment levels, in so far as implemented up to now, and the availability of the Internet a lot is possible in the field of theoretical training. However, the circumstances in which in particular Eastern European professionals are trained are so poor, that they fall behind in working in practice and in modern technology. Because the working conditions within the EU differ so much, both as regards facilities, salaries and positioning, a migration can be observed of professionals from in particular Eastern Europe and to a lesser degree Southern Europe to, for example, Scandinavia and Great Britain. For the Eastern European countries the most important motive is that the low salaries and the existence of an informal economy with a widespread use of bribes in combination with overdue maintenance of buildings and equipment are very unattractive for professionals. A clear migration of doctors from Hungary to Scandinavia can be observed, for example, with the opening vacancies partly being filled again by doctors from the Hungarian minorities in Romania and Slovakia, where the circumstances are ever worse, if possible. In Spain, this kind of phenomenon can be observed to the UK, and Latin Americans are primarily filling the vacancies.

Despite the free traffic of professionals the host country can demand that the equivalence of diplomas is proven on objective grounds. In the Netherlands this is done by the MSRC (Committee for the Registration of Medical Specialists). Currently, the traffic of professionals is still limited. However, based on the current developments in the world of students – in which following part of the studies in another Member State is becoming increasingly usual, resulting in the level growing closer and closer and the borders being seen less and less as a barrier - it can be expected that the coming generation of professionals will increasingly work across the border.

3.4 The Member States

From the perspective of the Member State, a number of issues are added. For example, in case of increasing mobility of citizens or professionals, disruptions of the balance within the national health system can easily arise if the inflow does not match the outflow. This regards both the provision and the maintenance of the capacity to provide healthcare and the finances. Two examples: The British government has a policy of strict budgetary control in the NHS. This results in waiting lists, for example for hip replacement surgery. Elsewhere in the EU these waiting lists often do not exist. British patients for example go to France and have enforced the NHS to pay the bill for this through the European Court in Luxemburg, invoking the free traffic of persons and services, also on the grounds of the unacceptable long waiting time. In doing so, the stability of the British budgetary system has been undermined through the route of legal proceedings on EU level and the EU turns out to have consequences after all for the health system in the individual member state, despite of the principle of subsidiarity. A second example regards the disproportionately large number of pensionados and people who spend the winter in Spain. If they need care, this is to be provided by the Spanish health system based on the existing agreements. The costs of this can then be recovered from the country of origin via a settlement system. However, due to the laborious administrative procedures involved in this, many of these settlements never take place, so that the costs of care are borne by the Spanish collective resources, with substantial overruns as a result.

The conclusion is that due to the increased mobility the problems for patients and Member States have increased to such an extent that it is already impossible to solve them within or between the national systems alone. This has subjected non-interference based on the principle of subsidiarity subjected to such great pressure that a review has become inevitable. In the following section the manner in which this review could take shape will be discussed.

For a long time Hungary was known as one of the better examples of the countries that made the transition from communism to democracy after the fall of the Berlin Wall in 1989. The accession first to NATO and later (in 2004) to the EU is considered both nationally and internationally as proof of the successful conclusion of this transition. Although this is basically correct for the developments, close investigation shows that in the further execution of the system there are still some large gaps. This applies, for example, to the interpretation and stability of the democratic process on a national level. A crisis has been going on for over a year already that has arisen after the controversial statements of the prime minister and political leader of the largest government party, that he and his party have lied consistently. In spite of this, he is still in power and there is a deep impasse in the democratic process, for the time being without the prospect of a solution. This situation is comparable to a number of other new Member States, such as the Czech Republic, Slovakia and Poland. In the meantime, there is a long road ahead to make the Hungarian society completely meet the requirements of a full membership of the EU in the short and the long run. This means that a lot of reforms are still to be completed or initiated, while the support for such interventions is declining. One of the fields in which these reforms are to take place is healthcare, in which the transition must be made from a fully input-oriented system, with too little incentives for effectiveness and quality, to a more modern system with increased diversity and output control.

In 2007 the Hungarian population consists of over 10.1 million people. The average life expectancy in 2002 was 68.4 years for men and 76.6 years for women and still lags behind compared to the average life expectancy of the other EU countries. Almost 8% of GDP is spent on healthcare. Healthcare is financed by both public and private resources. On paper, healthcare, as a remainder of the old communist system, is accessible for everyone, without any thresholds or selection. It is remarkable, however, that an extensive informal (additional) payment system exists that plays an important role in the actual obtaining of healthcare. Most doctors consider informal payments as a necessary addition to their income, because the salaries in healthcare are traditionally relatively low and have not grown with the development of the market sector. Due to this system, the population becomes responsible for the accessibility of care. Actual solidarity is non-existent.

Since the accession to the EU in 2004, some trends have been visible. First, there is a ‘brain drain’. Due to the poor financial circumstances, it is attractive to go and work in another EU country for a lot of highly trained citizens. The result of this is that a lack is created of highly trained personnel in Hungary, which in turn has led to an ‘invasion’ of Romanians and Bulgarians. Second, based on a widely supported political ideology, there is a strong preference for the implementation of free market processes in traditionally publically organized systems such as healthcare. Because there is no consensus on how this is to be realized and because there has been a quick change of responsible ministers from various political movements, no consistent reform agenda has been used, causing various trends and phased of reforms to exist next to and through each other. Finally, the urge to cram Hungary for the Euro is very great. In order to achieve this, government expenditure needs to be cut substantially. One of the fields in which they want to make savings is healthcare, where the care budget, that is already small compared to the European average, will be reduced even further. This is all the more distressing, since from a Dutch perspective, the care provisions in Hungary are already on a low level and the buildings and equipment are very outdated.

It has to be concluded that although conceptually harmonization with the EU is sought and in that way modernization as regards substance is promoted, the accession to the EU has had a destabilizing effect on Hungarian healthcare so far. Hungarian healthcare is in a deep crisis, in which there are no actual possibilities to invest in healthcare due to the political and economical imperative of accession to the Euro.

4. Recent developments of the EU

The European Union has seen a couple of important periods of development in the course of its fifty years of existence. There has not so much been a steady development, but rather phases of optimism can be recognized with acceleration and broadening of activities, alternated by phases of skepticism, characterized by stagnation and re-evaluation of the objectives. In the nineties, there was a clear euphoria after the fall of the Berlin Wall and the German unification. During this phase the foundation was laid – based on a strong French-German rapprochement – for the addition of the ten countries to the EU in 2004, followed by Romania and Bulgaria in 2007. Also, initiatives were made to give the EU a stronger position by increasing its power to compete through a large-scale innovation-oriented program, the so-called Lisbon agenda. Also from an administrative point of view, a further reinforcement was prepared, in the form of the European constitution.

However, the past few years, this euphoria has changed among other things due to the poor economic climate as a result of the bursting of the Internet bubble. By now, many view Europe as a burden rather than a blessing. Due to its technocratic nature, the emphasis on economic issues and the decision-making process that is perceived as slow and unwieldy, the EU has lost touch with large parts of the European population. Due to the accession of ten mainly Eastern European countries in 2004, the pressure on the administrative system and the decision-making processes has increased even more. And in conclusion, it turns out that many view the ten new countries mainly as new internal competitors on the (labor) market instead of a reinforcement of the EU. In order to be freed from this negative spiral, the EU must renew its working method. There is a need for a new discourse in which the scope of the EU is to broaden from unilateral economic themes to themes such as education, environment and healthcare, focusing more attention on the quality of society than is done now. Also, leadership needs to become less technocratic and less bureaucratic. In order to achieve the latter, the EU will have to make more use of techniques such as the Method of Open Communication to pursue convergence from the bottom up, instead of making use of the formal-legal methods such as

directives that realize centrally controlled enforceable harmonization. In EU terms: make less use of the hard acquis and introduce more soft law. Under the German chairmanship in the first half of 2007 these trends have become manifest also to the general public. The discussion on the European constitution has been resumed, although cautiously. The consensus that was reached during the EU summit in June 2007 clearly shows that the Member States want to proceed, but that they also need to consider the countries that have more reserves (the Netherlands, the UK and France) and countries that want to increase their influence on EU level (Poland). A constitutional treaty – it turned out - is one step too far, but the process of organization of the EU continues, both in a procedural sense and as regards substance. There is, however, certain duplicity. After all, it was exactly the constitutional treaty that led to a stronger national orientation and emphasis on vetoes and principles of subsidiarity for a number of countries. The Dutch debate on Europe is a great example of this. Although a majority of the Dutch people recognizes the importance of the EU membership, the majority also believes that the EU has too much influence, possibly at the expense of the national identity.

The recently concluded climate agreement is generally considered a breakthrough though. It remains to be seen to what extent this will actually work out well for the climate. In any case, it is a breakthrough in the development of the EU. A clear non-economic subject that is cherished by a large part of the population has been addressed energetically by the EU.

Barcelona

Spain, Catalonia and the role of the regions

Within the EU, the role of regions is highly valued. One of the less known central decision-making bodies besides the European Committee, the European Council and the European Parliament is the (advisory) European Committee of the Regions. In addition, the importance of the regions for particularly the economic development is pointed out from different sides, which are often considered as more real entities than the national states. Dutch examples are the Randstad or the Maastricht/Aachen/Liege Euregion. For the rest of Europe, Northern- Italy and Catalonia are the clearest examples. A region is primarily characterized by its geographic and economic and often also cultural entity. According to advocates of the region as centers of development, a large degree of (political) autonomy should go with it.

In 2005, the Spanish population consisted of over 44.1 million people and its position in Europe is the mirror image of the Netherlands: where the Netherlands is the largest of the small countries, Spain is the smallest of the large countries (following Germany, France, the UK and Italy and recently Poland). Spain has a strongly centralized administration in which the regions have a high degree of autonomy for example as regards infrastructure, education and healthcare. Within Spain, Catalonia is the most autonomous region, both because of its size (7 million inhabitants and a strong economic position) and its cultural and political identity, with its own history, language and culture. The Spanish healthcare system is based on the NHS system. The system is publically financed, mainly through taxes, and has a regional organizational structure. There is a universal coverage and inhabitants have free access to care. Only 12% of the population holds a (additional) private insurance. The life expectancy in Spain is one of the highest in Europe. On average, men reach the age of 76.42 and women the age of 83.15. However, Spain has the lowest birth rate of Europe (1.23 children per woman in 2003), which in the (near) future will lead to a rise in the ageing population.
In 2003, 7.4% of GDP was spent on healthcare. All doctors receive a salary, based on government standards. However, regions have the possibility to fill in some components of the salary themselves, which leads to large differences in salary between the various regions. Doctors that work in a private environment are paid per procedure (fee-for-service).

During the visit to Catalonia it turned out that although the autonomy in healthcare is extensive on paper, in practice it is strongly restricted due to the fact that harmonization on a national level is pursued after all. Proposals to initiate certain developments or take, for example, decisions on the size of the package for policymakers are eventually all made in Madrid. The manner in which this process is established can serve as a great example, however, for a European model of harmonization in healthcare: similar to the principle of subsidiarity, the point of departure is regional autonomy, proposals are formulated decentrally and centrally 'only' harmonization is sought after. Of course, the decisive factor in a process like this is how and by whom decisions are eventually made. It became clear that if the departing principle is that if your neighbor is doing better, you yourself will probably be doing better as well, there is a solid foundation for common decision-making. This principle of harmonization might very well be practicable for healthcare in the EU as a whole.

In Catalonia it also became clear that autonomy exists merely by the grace of consideration by the central administration of this autonomy. In the case of the cross-border small hospital in Puigcerda, a joint initiative of the Catalonian government and France in order to provide care to an isolated valley in the Pyrenees, the progress proved to be dependent of the decision-making on a national level. The central administration in Madrid clearly did not appreciate the regional interest of Catalonia and the Catalonian government's urge to use this as a sample project to pursue a proper "foreign" policy. In the absence of any formal power of expression of the Catalonian government in international traffic or the EU, the project turned out to be doomed to be stuck in the conceptual phase for now, despite all the finances and administrative energy the Catalonian government put into it.

5. Design of healthcare in the EU based on common values

5.1 New perspective?

At this moment, the development of the EU can be interpreted in terms of cautious, often reserved steps forward, with at the same time a strong emphasis on the importance of national frameworks. We do see a broadening of the EU domain. Not only the economic pillar is an issue, but also the social and legal pillars gain interest. For the developments in healthcare especially the social pillar is of importance. Based on our study so far, we find that the increasing cross-border traffic in the field of healthcare is such, that it can no longer be ignored. Furthermore, we expect that this trend will continue in the future. The question arises whether the EU Member States can continue to allow themselves to label healthcare as an exclusively national issue. As pointed out above, the increased mobility and the common trend towards more influence of the market on healthcare and the rulings of the European Court arising from this, have initiated such disruptions in the national balances, that there is a need to provide care with a supranational perspective as well.

In our judgment, the time is starting to get ripe for a change of perspective. This perspective does not so much amounts to bringing healthcare under the jurisdiction of the EU as a policy domain. Not much support can be expected for a formal-legal approach like that. A change of perspective should be based on the importance of high-quality and generally accessible healthcare in all Member States, on the one hand, and, on the other hand, on the practice of cross-border care. In other words, there is work to do, both on the level of values and principles and also on the level of the concrete supranational problems in implementation practice. Healthcare as a new policy area of the EU could get its grip on exactly these two levels.

In order to color this perspective further we will sketch two scenarios. Before we do that, first a few remarks on common values in healthcare. From the various conversations and visits, on first sight a large

difference emerges regarding 'good healthcare'. In Hungary, what strikes the most is the hierarchical nature of relationships in healthcare, the poor facilities, long waiting times and the extensive system of 'informal payment': if you need care, you need to pay extra, accepting the fact that this leads to differences in care provision because not everybody is able to do so. In Spain we see a large –institutionalized difference in terms of comfort, speed of treatment and the like between publically and privately financed healthcare. As regards the substance of care, we already pointed out the different practices of medication and more generally of surgery: from a very proactive and sometimes invasive approach in some countries, to a policy of careful deliberation and finding the least radical treatment in others. A first observation leads one to suspect that Sweden has the most in common with the Netherlands. We also suspect – plenty of indications, but have not inquired into it specifically – that the differences between the countries will even be much greater in geriatric care and psychiatry.
Despite these differences – partly caused by the organization of the system – there is a common ethos on the level of the professionals: there is less difference of opinion on the professional standards as might seem at first sight. The professionals we talked to aspire to a similar level of healthcare, with focus on quality, safety, timeliness, and based on a respectful approach. Despite the fact that in the various countries, the accessibility is definitely also determined by money, the general believe is that anyone, irrespective of financial means or limitations, should have equal access to healthcare. We can carefully say that professionals have a common basis for the establishment and pursue of good care. It is still unclear to what extent this is also the case for the European citizens in general. On the one hand, based on the common development that the countries have experienced in the course of history, a number of clear common basic values can be recognized, such as solidarity, equal development opportunities for children and care for a long-lasting development combined with an active protection of the environment. On the other hand, there is a great variety in level and shape of the realization of these common values, to such a degree that the common basic values are not always recognizable anymore for or shared by all citizens.

The theme of the common values has of course also been one of the motives of preparing the European constitution. One of the ideals expressed in it is the idea of a Europe that holds the values of dignity and humanity in great esteem and protects them. The paradox is that especially in the field of the services with a social bias in the public domain – a domain that is anxiously kept within the national jurisdiction – a lot could be done to put dignity and humanity into practice as principles. Examples are healthcare, education, housing, welfare, participation and the like. Rather than just an economic and legal union, Europe could distinguish itself by focusing attention on these values and formulating a common policy aimed at the confirmation and putting into practice of these values among the Member States. At the same time, the EU could proof its added value by propagating these values outside the Union and where necessary actually employing them (mediating in centers of conflict, investing in the development of countries, etc.). This value perspective is expressed in the two following scenarios to a lesser (scenario 1) and to a greater degree (scenario 2).

5.2 Two scenarios

For the EU healthcare is a relatively new policy area and there are numerous uncertainties about how the EU process will further develop and to what extent healthcare will be part of the EU agenda. Now – the middle of 2007 – the EU has for the first time started a consultation among the Member States to obtain more insight into the current problems and on the manner in which a EU healthcare policy could take shape. The results of this consultation are not yet known. There was not very much enthusiasm for it in the Netherlands for that matter.

Scenario 1: mobility

The increasing pressure arising from the increased mobility of citizens, professionals and institutions will lead to an increased building of solutions in conformity with the current basic approach: the principle of subsidiarity is maintained, but in practice will be undermined further and further. Increasingly more transparent solutions will be required in order to solve differences between the countries involved. In case of further positive progress – according to the advocates of this scenario – the EU will solve the implementation problems manner step by step as a learning community, without the need to change the underlying national care systems. The consultation that has been started fits this approach, because it is strongly aimed at the current problems and explicitly invites practical solutions. This scenario actively abandons a farther-reaching vision on the role of the EU in healthcare. This scenario works with the different opinions on good basic healthcare such as they exist together in various countries. It is very likely that little by little there will be a process of gradual convergence based on gained experience; a harmonization of basic principles imposed more from the top down is not at issue. Should the differences lead to major social problems, two pathways are possible:

- The experiences gained lead to increased mutual trust and a joint tackling of problems. The countries or regions involved develop an ambition to serve as an example for a broader movement of cross-border care. The demands are high and investments are made in innovation and exchange of know-how;
- The collaboration remains focused on the solution of individual problems. There are little incentives to continue and it is primarily focused on determining what is minimally necessary. One of the possible risks of this approach is that the inevitable convergence that will arise anyway, can lead to convergence on a minimum level. In any case, this scenario does not have a guiding effect to a desired average or optimum level.

We have seen – budding - examples of both. The case of Catalonia makes it clear that farther-reaching, geopolitical motives are at issue as well in the pursuit of an innovative approach of cross-border care. It did turn out that the high ambitions remained stuck in the unmanageable implementation problems of daily practice of cross-border regulations. The cross-border care between Belgium and the Netherlands is rather practical and of an opportunistic nature. We have seen that from the perspective of the Netherlands, Belgian healthcare has served as a safety valve in a time of waiting lists and shortage in the Netherlands. Time will tell to what extent people like going to Belgium - which generally is perceived as a positive experience in terms of patient friendliness - so much, that it will continue anyway irrespective of the waiting lists in the Netherlands.

Puigcerda

The advantages of this scenario are clear. Harmonization in practice and empirical outcomes are sought after. The problems are solved where they occur and the experiences gained are used to go on. This gained experience can lead to a growing trust across the border. In the long run, these bilateral experiences might also influence policy-making on EU level. In that case we are dealing with a typical example of policy development starting from the bottom and slowly growing into a clear factor in the EU field of influence. This scenario is vulnerable and laborious and, as said before, might get stuck in a convergence on the minimum level. It greatly depends on people who want to make an effort and who want to dedicate themselves to high-quality healthcare irrespective of the country this care is provided in. It is very well possible that the process of convergence will be controlled to a great extent by citizens and companies that manage to enforce their interests through the directives in the field of free traffic of persons, goods and services via the European Court or via lobby groups. This keeps the process unpredictable, which involves risks, both as regards substance and speed.

An additional problem is that the current neglect of healthcare in the EU and the low status in the political debate that goes with it will remain. The result of this neglect of healthcare as an EU theme will be that the influence from, for example, economy and social affairs on healthcare will remain as great as it is, without being compensated by specific and substance-driven input from the health system itself. As the trend in the direction of increased free market processes and liberalization of healthcare continues, this will also mean that the regulations on competition, as is the case right now, will be the dominant regulative framework for healthcare.

Scenario 2: a stability pact for healthcare

The second scenario departs from an active attitude of the EU. Based on the common development in healthcare and departing from the structurally present and probably only increasing mobility of citizens, professionals and care companies, the EU develops a coherent vision on healthcare and provides the necessary tools to realize this vision. Of course, this is a long-term pathway, given the enormous current diversity and given the fact that it is by no means obvious for all parties involved, that this development will actually continue. The point of departure in this scenario is that in all Member States every citizen is entitled to high-quality and accessible healthcare. This means that every country needs to work on:

- A health system based on principles of solidarity and thus offers guarantees of affordability and accessibility;
- A system that focuses attention to offering 'good' healthcare and also continues to publically stress what good care is;
- The promotion of public health in a broader sense, including attention for public health;
- The improvement of quality of medical practice;
- Guaranteeing patient safety, patient-orientation and patient rights;
- Sharing know-how and experience that is gained in practice;
- A culture of compassion for the sick and disabled.

In this scenario good healthcare is used as a central reference point for the Member States: a standard of civilization for the EU (in addition to other standards in the field of social benefits and humanity). Member States want to and must meet a certain level of healthcare in their country, if they want to participate as a full member. Just like the economic standards upon accession, we could now work on care standards in order to shape a Europe that actually is the Europe of the Citizens. Good health is after all something that is considered a precious commodity by all citizens. A Europe that can contribute to its preservation will contribute to a positive assessment of Europe by the Member States.

Bringing this scenario closer is anything but easy. First of all, it does not fit the current discourse of Europe. More important is however that

the strategy to realize this cannot and may not be top-down. If Brussels would impose a pact, there is a good chance that it will become a technocratic and slow process.

Traditionally the EU has two forms of integration: harmonization and convergence. Harmonization involves central policy-making that can also legally be enforced and is linked to rules, procedures, directives and schedules. Convergence can be centrally promoted, but is primary based on free participation and works with protocols and incentives. Just like in the first scenario, here also the pathway of convergence is indicated. More than in the first scenario, it is also necessary that agreement is reached on a central level on the importance of good healthcare in the EU and what this should look like in general. It can even be more attractive if a 'leading group' presents itself in order to take the lead in this field. The question, however, is: what is the urgency? Why would this be necessary? There are two important leads.

The first is the increasing mobility. More and more citizens will refuse to accept the differences in healthcare and require that they are treated on the highest level. The second lead is the enlargement of the EU itself. An alliance such as the EU in the long term cannot get away with accepting the great differences in healthcare we are seeing today. Take for example the differences between Romania and Sweden, to name the two extremes. The accession of the new Member States has already led to migration of professionals from East to West. This development has been disruptive for the new Member States and eventually these kind of developments can negatively affect the collaboration on EU level.

Realizing the importance of good healthcare for everyone and the negative consequences of differences that are too great and too harrowing should be an important incentive for the more prosperous countries to take the lead in this matter. Doing so they also act in their own interest: they can make their standard of healthcare 'the' standard and prevent a 'race to the bottom' from taking place in healthcare. The European Centers of Excellence could possibly contribute to the realization of this scenario. This is a subject for further study.

Stockholm

Sweden, a welfare state

Sweden is known in Europe as the furthest worked out example of the welfare state. The past few years it has been dramatically reformed and cut back in scale in order to remain future-proof. Nevertheless, the level of provisions, also in healthcare, is still one of the highest in the EU. On top of that, Sweden is also a country that is strongly internally oriented, while it is a full member of the EU. This has for example become manifest in their non-participation in the Euro, but also applies in other areas. That is why it is an interesting object of study, as an example of the principle of subsidiarity that has been carried through very far. In fact, the Swedish healthcare system is strongly grafted onto this principle. It is organized on three levels: national (government services), regional (county councils) and local (municipal administrations). The county councils are responsible for the supply of healthcare in primary healthcare and in hospitals. Public and preventive care is also regulated regionally. On a local level, healthcare is provided in the 'immediate' environment of the inhabitants: schools, social bodies, roads, water, sewer system, etc. The central government supervises the regional and local administrations. All inhabitants are compulsory insured against medical expenses. For the most part, this is financed through the employer. Private insurances are rare, also because the public package offers a very full coverage: in 2003, only 2.3% of the inhabitants held a private insurance.

In 2004, the Swedish population consisted of 9 million people. In 2003, 12% of the inhabitants were immigrants. Over 85% of the population lives in the urban areas of Sweden. Life expectancy is regarded as one of the highest in the Northern countries: 77.9 years for men and 82.4 years for women in 2003. The birth rate is very low: 1.64 children per woman in 2002. Currently, Sweden has one of the most aged populations of the world. Over 17% of the population is over 65 and 5% of the population is even over 85. In 2002, 9.2% of GDP was spent on healthcare. Sweden has three family doctors per 1000 inhabitants. This average is below EU average. Over 60% of the doctors work in a hospital. They all receive a fixed monthly salary (5,300 Euros per month in 2003).

Doctors that work in the (very small) private sector are paid per procedure.

The Swedish system is primarily financed through taxes. Solidarity is an important condition in the system. Both the regional and the municipal administrations are entitled to levy proportional income taxes. Healthcare is the most important field of policy for the county councils. 90% of the income in taxes of the county councils is spent on healthcare. Sweden has 21 different counties and thus 21 different, regionally integrated systems. This makes it difficult to make a proper comparison between the counties, because each county can be considered a separate health system. From its centrally coordinated past, there is still a lot of similarity between the counties. However, in the future problems might arise because of the increasing freedom of policy of the county councils in the organization of their integrated systems, while there really is a need for mutual harmonization for highly specialized healthcare among other things. Also it is socially unacceptable, that too big a difference would arise in the level of provisions. The objectives for the future are: opening up the markets in healthcare, introducing private parties in the hospital sector (such as for example Capio, by now active in dozens of countries), decontrolling the pharmaceutical market and increasing transparency in order to achieve better controllable quality.

The 'European' perspective in healthcare is miles away in Sweden. Reasons for this are its relatively isolated location, which does not stimulate mobility (and cross-border care), its exclusive orientation to the Scandinavian region and its high level of provisions, combined with a strongly developed sense of self-worth. The Swedish themselves do not yet really like the idea of working together with the neighboring Baltic States.

6. Follow-up questions

Although many questions remain unanswered, one thing is abundantly clear: the genie has left the bottle. A scenario in which healthcare in the EU is only regulated from the individual Member States in the coming period is inconceivable and the application of the principle of subsidiarity regarding healthcare at the very least needs to be thoroughly re-evaluated. How things will develop and in what way those developments can best be adjusted in the interest of the European citizen/patient remains unclear, however. This requires further study of five large themes.

Similarities and differences in standards and values on which care is based now in the various Member States
It has to become clearer whether there are mainly a number of shared European values in the field of healthcare right now, on which a common vision can be built, or whether the differences are predominant.
If the latter is true, it must be verified to what extent and which Member States show sufficient correspondence to act as a forerunner or center of development (comparable to the situation around the introduction of the Euro, that also started with a number of Member States that were more advanced in this matter than others).

Similarities and differences in professional practice and education
There is a clear common basis as regards substance for the profession, but the differences in the manner in which it is practiced are huge.
If the mobility of professionals and citizens increases, these differences will increasingly lead to unfulfilled expectations and practical problems in, for example, file administration, transfers and follow-up treatments.
More insight will have to be gained in the fact whether these differences should be reduced and how this can best be done.

Similarities and differences in organization, control and intended level of the current systems
Based on the different historic developments and political and economic circumstances in the Member States, the systems were all created autonomously. By now there is a lot of comparative material available on the

organization of those systems and the differences between them. Relatively little is known neither about the relevance of these differences, nor about any desired or undesired consequences hereof. Interchange about this between the Member States or from the perspective of the EU as a whole is still in its infancy. By focusing specifically on the relevance of differences, it can be better decided in what manner the principle of subsidiarity should be re-evaluated, or in other words, it can be better assessed which subjects should be part of the central EU policy and which not.

Intended scope and level of a common health system (stability pact for healthcare)

In addition to, and partly also apart from the questions of a more empiric nature with a decentral point of departure as referred to above, an image should be formed of what a common scope and level of healthcare (stability pact for healthcare) should involve. This should then become the reference point for the converging developments and offer the opportunity to make specific adjustments. Is it possible (at all) to make such a description in a way that can serve as a reference point for the various Member States, without lapsing into a rigid and impracticable directive with a bureaucratic effect?

Mechanisms that can adjust the intended convergence, specifically aimed at the position of healthcare, related to the principle of subsidiarity

Apart from the question whether a stability pact is conceivable or desirable, there is at least a need for a set of instruments that can control these developments at points where convergence is required or where bottom-up takes place, in an appropriate manner. What instrument is effective, what adjustments in the organization of the central EU institutes are required to give care a more solid position in the political discourse and to what extent will the current application of soft law be sufficient to guide this process?

Although there still remain questions to be answered and the developments can take a lot of directions, one thing has become manifest in this research: healthcare and the EU are on the verge of a process of much farther- reaching mutual influencing and entanglement than could be anticipated until recently. Monitoring this process and being attentive to both opportunities and threats arising from it is of great importance and will be the subject of future activities of the Erasmus CMDz.