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‘Does European integration of health policy only benefit a small minority of mobile individuals while it endangers collective institutions that protect the majority at the national level?’

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During the past 15 years, there has been a rapid increase in EU free movement law relating to health care despite EU law explicitly excluding any harmonisation of national health care systems. This development is mostly visible in CJEU case law, which has increasingly promoted patient mobility and the application of competition law in health care based on grounds of market integration. However, the traditional territoriality principle in health care makes this Europeanization trend appear particularly puzzling. Historically, social insurance had been rooted in national boundaries for optimally ensuring its relevant aims, namely solidarity, equity, efficiency and universality. Also, even though there has been some increase in ‘health-tourism’ lately, the number of mobile individuals in the EU is rather small: only 2.5 per cent EU citizens currently live in another Member State. The consequent conflict between Member States providing health care based on solidarity and EU bodies mainly seeking market freedom seems obvious. Thus, this paper – which is the current state of the art of my forthcoming master’s dissertation – will show that even though not only few mobile individuals benefit from health care integration, national room for manoeuvre in health care policy has sharply been restricted. The success of further European health care integration will finally depend on the extent to which the EU achieves counterbalancing market integration and social security protection.

Introduction

During the past 15 years, there has been a rapid increase in EU free movement law relating to health care (Martinsen and Vrangbæk 2008; Van de Gronden and Sauter 2011) despite EU primary law only providing very limited capacities for EU involvement in national health policy legislation and explicitly excluding any harmonisation of Member State health care systems (Art. 168 TFEU). This development is mainly due to an increasingly important role of the Court of Justice of

the European Union (CJEU), which has become a vital actor in promoting European integration (Stone Sweet 2010), so as well in the field of health care. For example, from 1958 to 2000, more than 250 EU regulations, directives, recommendations and rulings referring directly to health care have been introduced with one third of them originating from the European Court of Justice (EHMA 2000). With regard to the particular issue of patient mobility among EU countries, the recent Directive 2011/24/EU on cross-border health services presents a major leap towards a more integrated European Union in the sphere of social security. All these trends of extending the width of policy areas covered by the Single European Market (SEM) introduced in 1992 from mainly the free movement of goods to increasingly the free movement of persons, services and capital (Art 26(2) TFEU) clearly show classic examples of 'spill-over effects' as elaborated in Haas' neofunctionalist theory (1958).

However, the traditional principle of territoriality in health care makes this Europeanization trend appear particularly puzzling. Historically, public social insurance had been rooted in national boundaries for optimally ensuring its relevant aims such as solidarity, equity, efficiency and universality (Ferrera 2005; Sieveking 2007; Mossialos and Lear 2012). Therefore, while the recent integration of different Member State health care policies surely increases patients' rights in receiving cross-border medical treatment in Europe, the traditional autonomy of national policy-makers in health care is at stake (Greer 2009). Domestic health care systems are required to adapt to relevant EU law and their capacity to provide efficient and equitable health care services might eventually be distorted (Montgomery 2005). Nevertheless, even though there has been some increase in 'health-tourism' since the SEM completion (Sieveking 2007), the number of mobile individuals in the EU is rather small. In 2011, only 2.5 per cent (12.8 million) of all EU citizens lived in another Member State (Eurostat 2012) and only 0.2 per cent (1.2 million) were cross-border workers (COM 2012).

Consequently, the obvious conflict between Member States providing health care based on the solidarity principle, on the one hand, and the supranational EU bodies mainly seeking to ensure market freedom, on the other, poses a salient question: *Does European health care integration only benefit a small mobile minority while it simultaneously endangers the equity and efficiency of national health care systems that serve the majority of the population?*

While recent publications have commented on theoretical implications of EU patient mobility law on health care systems in different Member States (e.g. Mossialos and McKee 2002; Rothgang and Götze 2009), there has been little research on the actual empirical effects. Especially, the implications of the 2011 Patient Mobility Directive (PMD) have not yet been taken into account thoroughly. This directive is, however, fairly important as it is the first piece of EU legislation that regulates Member State health care systems directly and makes them subject to actual harmonisation (Vasev and Vrangbaek 2013).

This paper will therefore scrutinise the effect of European integration on national health care systems by focusing on recent developments in patient mobility and competition law in health care provision. It will become clear that not only a few mobile individuals benefit from European health care integration but that, however, national room for manoeuvre in health care policy has sharply been restricted. The success of further European health care integration will finally depend on the extent to which the EU will succeed in counterbalancing market integration and social security protection.

Exactly the latter question will then be analysed in the forthcoming master's dissertation. Therefore, this paper will also present the research design of this follow-up master's thesis, which will aim at shedding light in more detail on how specific Member States are dealing with this 'uninvited Europeanization' of domestic health care (Greer 2006: 134). More specifically, the current transposition processes of the directive into Member State law will be scrutinised with taking the examples of the United Kingdom and Germany, which represent the purest examples of the two ideal-typical European health care systems types, namely 'National Health Service' (NHS) and 'Social Health Insurance' (SHI). Thus, the dissertation will first answer the first order question of how the financing, service provision and regulation of domestic health care are affected by the implementation of the PMD. Then, the second order question will be scrutinised and find explanations for variations in the transposition of the PMD in the UK and in Germany with particular respect to the health care system type itself, its financing, service provision and regulation, its institutional structures as well as its different actors, and their ideas, value systems and perceptions. The methodological approach will build on tracing relevant national legislation on patient

mobility, establishing pre-existing experience on the issue of cross-border health care and conducting semi-structured expert interviews.

European health care integration (I): patient mobility

Health care systems in Europe are fairly diverse as regards their financing, service provision and regulation. However, a categorisation of two different health care system types can be made which features their main characteristics: on the one hand, there are tax-based, universalistic 'Beveridge' or 'National Health Systems' (NHS) with coverage based on citizenship and service provision that is generally free of charge at delivery. This system type can be found in Member States such as the United Kingdom, the Nordic countries (Denmark, Finland, Sweden), and in the South (Italy, Spain, Portugal). On the other hand, 'Bismarckian' or 'Social Health Insurance' (SHI) system types are based on employment status and corporatist self-regulation of, e.g., sickness funds. This health system type prevails in continental European countries such as Germany and Austria or France, Belgium, the Netherlands and Luxembourg but also in most Central and Eastern European countries.

In 1971, with Regulation 1408/71 (extended by Regulations 883/2004 and 465/2012), a first major step in European social security coordination was taken: from then on, according to the principle of *lex loci laboris*, all workers staying in another Member State were entitled to the same social security benefits as domestic nationals. For non-residents temporarily staying in another EC country, urgent medical treatment was covered. Yet patients who travelled to another Member State for the purpose of non-urgent medical treatment were obliged to get so-called 'prior authorisation' from their home social security institution beforehand.

However, until the 1990s, the different national health care systems generally still operated in isolation from external European influences as any form of harmonisation of Member States health care systems was explicitly excluded in the treaties (Art. 168 TFEU). Though, only few years after the completion of the Single European Market in 1992, the *Kohll and Decker* cases of 1998 marked the beginning of several CJEU decisions that profoundly supported patient mobility and, therefore, integrated different national health care systems in the EU. Here, the Court ruled that

prior authorisation of cross-border outpatient medical treatments was a violation of the freedom of services and goods and that the resulting costs are to be borne by the social security institution of the patients' country of origin. From then on, the CJEU continuously questioned and limited the principle of prior authorisation as in *Vanbraekel* and in *Geraets-Smits and Peerbooms* (all 2001). Here, the Court held that prior authorisation may only be refused if the state of affiliation can provide the same treatment within a medically justifiable time limit (*undue delay*). Moreover, this also applied to hospitalisation from then on. This view was soon repeated in the cases *Mueller-Fauré and Van Riet* in 2003, with the addition that the CJEU now differentiated between in- and outpatient care: the Court stressed that national authorisation constituted an unjustified barrier to the free movement of services for outpatient care, thus leaving it only possible for hospitalisation. In 2006, the last major CJEU case relating to patient mobility, *Watts*, then made clear that the previous judgements also applied to National Health Services, such as in the UK. The Court thus underlined that benefit in kind health care systems, which provide medical treatments free of charge and are funded by general taxation, are equally to comply with the four Fundamental Freedoms of the SEM, just as social insurance health care systems based on cost reimbursement.

Recently, the *European Health Insurance Card* introduced in 2006 as well as the *Electronic Exchange of Social Security Data*, which had been initiated by Regulation 883/2004 and will be fully operating from 2014, are facilitating EU health care and social security coordination through data exchange. Also, as a soft law measure in the framework of the *Open Method of Coordination* (OMC), the Commission currently fosters the foundation of *European Reference Networks* for rare diseases and cutting-edge medicine (COM 2013).

Finally, the recent Directive 2011/24/EU 'on the application of patients' rights in cross-border health care' (Patient Mobility Directive, PMD) gathers the principal content of the before mentioned highly relevant CJEU health care judgements. It mainly focuses on better accessibility of information to patients, guaranteeing quality, safety and efficiency of health care and promoting cooperation among Member States in various health care issues such as rare diseases. In a number of medical services, Member States achieved to retain the method of prior authorisation, which they consider essential to maintain extensive discretion over the regulation of their

domestic health care systems. These cases include treatments which require special planning or hospitalisation, which are highly specialised, cost-intensive or particularly risky to either the patient or the general public, or which give reason for serious quality concerns. However, the burden of proof was reversed: national social security funds now automatically have to grant permission and reimburse cross-border health care if the patient is normally entitled to that specific treatment on domestic grounds and if the principle of undue delay does not apply. The directive is currently in its process of transposition into Member States law until 25 October 2013.

European health care integration (II): competition law

Recently, EU competition law has paved its way for involvement in EU health care integration as the Commission and the CJEU can currently assess most health care practises in consideration of competition (Art. 101 and 102 TFEU). This results from the fact that health services in most Member States nowadays comprise public as well as private involvement, e.g. public funding and private service provision. Therefore, health care providers are generally considered to be *undertakings*, meaning that they have the right to conclude contracts based on negotiations (Prosser 2005), and thus fall within the scope of EU competition law as shown in the *Pavlov* and *Glöckner* CJEU cases (Van de Gronden and Sauter 2011; Mossialos and Lear 2012).

Yet whenever these health care schemes are predominately grounded on solidarity, have compulsory membership and statutorily defined contribution as well as benefit levels, they are exempt from competition law, which is assured by the 'Services of General Economic Interest' (SGEI) exception (Art. 106(2) TFEU). However, this line is not clearly drawn and mostly depends on the Court's particular interpretation of each case (Davies 2006; Van de Gronden and Sauter 2011; Mossialos and Lear 2012). Again, as with the patient mobility cases, the CJEU has repeatedly favoured deeper market integration over safeguarding Member State health care schemes. Therefore, through applying competition law to health care services, the EU's influence over health care policy has steadily increased (Mossialos and Lear 2012).

State of the art: assets and drawbacks of EU health care integration

As it has been shown by different scholars, the ECJ has become one of the most powerful actors on the EU level as it can block Member States laws that are not in line with EU legislation (Weiler 1994; Alter 1999; Mattli and Slaughter 1995; Peterson and Bomberg 1999; Leibfried and Pierson 2000; Pollack 2003; Leibfried 2005; Stone Sweet 2010). This is as well true for social policy issues: as Caporaso and Keeler (1993) have shown, only from 1968 until 1992, even before the Single European Market, there has been an increase of social policy cases from 3.3 per cent to 8.1 per cent.

Generally, political scientists have not been interested very much in European integration of health care (Altenstetter 2001) until the beginning of the millennium which brought a whole new series of EU related health research (e.g. Freeman 2000; Hervey and McHale 2004; Steffen 2005; Dawson and Mountford 2008; Greer 2009; Mossialos *et al.* 2010). This research depicts some common conclusions: for example, health policy in the EU is largely shaped by methods that had been developed for other EU policy fields and come to the conclusion that activities by the EU level in the field of health incrementally increases and will eventually undermine national autonomy over health system governance.

Furthermore, it became clear through the above account of patient mobility integration in the EU that patients' rights have profoundly been strengthened. Therefore, first of all on the positive side and most importantly here, the CJEU has gradually broadened the possibilities for EU patients to receive health care in other Member States on the basis of the four Fundamental Freedoms. This does not only relate to emergency incidents but also to planned outpatient care as well as hospitalisation abroad. It is also a universal right that all EU citizens can claim regardless of whether their home health care system is a social insurance one or a National Health Service. This shows that the EU level, mostly in the form of the CJEU, views patients increasingly as customers since they have an exit option and can almost freely choose where to receive medical treatments. However, this particular advantage certainly only applies to the small, before mentioned group of mobile individuals.

Secondly, the PMD will possibly increase mutual policy learning as well as improve national health care systems due to pressures on health care quality through increased patient choice (Baeten 2012). In this regard, also the *European Reference Networks* for rare diseases will not only foster cutting edge medical research throughout Europe but particularly give advantage to smaller or less well-off countries that could otherwise not afford so. Therefore, this argument demonstrates that European integration in health care does not only benefit mobile individuals. However, as this is only a soft law measure through the OMC, its functioning might be less reliable.

Thirdly, as Leidl (1998; 2001) as well as Hitiris and Nixon (2001) have shown, the EU has a positive effect in converging health care expenditure in different Member States. This model is based on the concept of *beta-convergence*, which claims a negative correlation of growth rates with initial levels (Sala-i-Martin 1996). Therefore, the EU may stipulate catch-up processes in low spending European welfare states, thus improving the relevant social security systems altogether. However, Nixon (2003) challenges his own argument and points out that the EU effect might be only minor as also non-EU countries have recently shown a similar development. Interestingly, also the opposite argument of European integration inducing a 'race-to-the-bottom' in social and health care standards is refuted by several scholars (cf. e.g. Kvist 2004; Kovacheva 2008).

On the negative side, firstly, it has been shown that all CJEU decision relating to European health care integration mainly followed economic rationales based on SEM functioning and the four Fundamental Freedoms. None of them really took any social policy aims such as equity, efficiency or high quality of service provision into consideration. This was only broadly mentioned in the recent Directive 2011/24/EU and will need to be scrutinised after its full implementation in all Member States. This depicts exactly the dilemma mentioned in the very beginning between national social policy objectives and European integration mechanisms. In this regard, Scharpf (2010) has argued that public welfare systems that are more generous are particularly vulnerable to European integration based on mobility in Europe. Particularly, the 'Court has weakened or eliminated the nation-state's control over the balance of contributions and benefits and the boundaries of state generosity' (ibid: 238). Adding to that, Menéndez (2009) argues that the CJEU is in fact eager to

prefer Member States converging towards liberalisation reflected by assuring only a minimum level of social protection.

Secondly, of the same tenor, EU competition law may apply to social security schemes, which are classified as undertakings, and thus judging the before mentioned health care policy aims as anticompetitive and unlawful. Also, as SGEI are not clearly defined, it is particularly difficult for policy makers to rule out competition law, therefore limiting their policy options drastically (Mossialos and Lear 2012) and possibly disequilibrating national health care systems.

Thirdly, further equity issues arise as patient mobility will only benefit a small group of EU citizens. Solely those people that are mobile, can afford travelling or live in cross-border regions, speak different languages and generally have a higher socio-economic status will be able to invest in health care abroad. These considerations did not play any major role for the CJEU until it was mentioned in the *Watts* case as a side note (Rothgang and Götze 2009). And as Sieveking (2007) points out, most Member States did not even properly inform their citizens about their rights and different possibilities to receive medical treatment abroad, therefore making the choice for them even more difficult.

Fourthly, Vasev and Vrangbaek (2013) have shown that the PMD might have a particular strong influence on Central and Eastern European Countries with taking the examples of Poland and Bulgaria. They show that CEE Member States, which have joined the EU only very recently with prior significant changes in their health care systems, are thus more constrained in terms of resources and also have less well established institutions. Therefore, the PMD influences their domestic health care systems more strongly.

Finally and most importantly, the more restricted use of prior authorisation has sharply reduced Member States' room to manoeuvre. This tool had always been considered by Member States as essential to maintain control over domestic health care systems (Altenstetter 2001). Here, particularly the following control mechanisms in health care policy might be disturbed: prioritisation of treatments on the basis of medical necessity, rationing of medical goods and services through waiting lists, and gatekeeping of consulting medical specialists only through referral by a general practitioner. It becomes evident that National Health Services are hit even harder

than social insurance systems in their ability to plan as their control mechanisms of waiting lists and gatekeeping can thus be circumvented. Therefore, several problems might arise: demand planning for in- as well as outpatient treatments might lead to insufficient or idle capacities; tax-based financing of hospital care is difficult to justify when tax payers and patients are not congruent; remuneration on the basis of global or sectoral budgets risks to be paid twice when health care services are used in another Member State; and in the case of public provision of health care (as in National Health Services), prices of medical treatments first need to be calculated when receiving foreign patients and reimbursing home patients (Rothgang and Götze 2009; Baeten 2012). Also, McHale argues that particularly the issues of varying health care quality standards across the EU, patient safety and patient information with regard to different languages in cultures in the EU might all eventually lead to litigation.

Research Questions

In the following paragraphs, the research design of the forthcoming master's dissertation will be presented. First, the research questions build upon the prior chapter on assets and drawbacks of European integration in health care. Secondly, relevant hypotheses will be formulated. The following figure shows an illustration of the mechanisms in question.

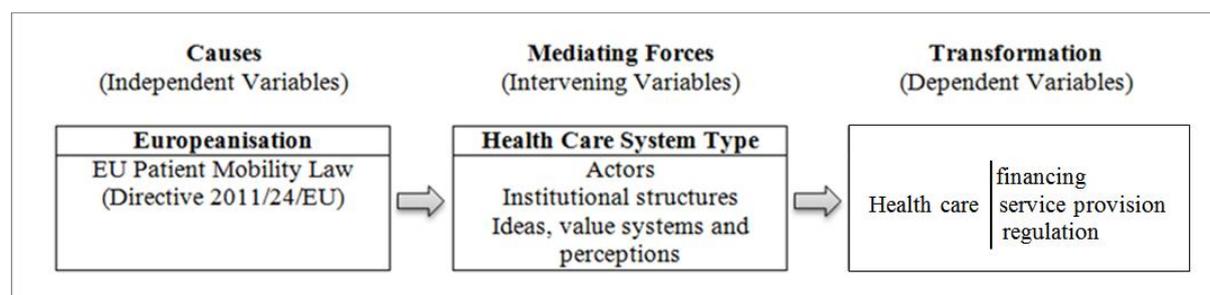


Figure 1: The Europeanization of national health care systems (own; cf. Martinsen and Vrangbæk 2008; Schmid *et al.* 2010)

Transformation

How are the health care systems of the United Kingdom and Germany as examples for NHS and SHI systems affected by the implementation of the PMD?

Financing

How will national contact points be financed? How large will administrative costs be? How large will it be in terms of employees and budget?

How will the reimbursement of outgoing patients be planned? Will reimbursement of travel costs be included? How will the principle of 'undue delay' be specified? In which specific cases will prior authorisation actually be retained?

For example, one crucial steering mechanism in the German health care system is the so-called 'Morbi-RSA' (= morbidity risk compensation scheme; balancing good and bad risks between different sickness funds through compensation payments). How will this be affected by the PMD? A possible consequence might be that more bad risks, i.e. patients that suffer from more serious illnesses, receive treatment more quickly in another Member State such as it happened in *Watts*. Therefore, sickness funds possibly have to reimburse more costly treatments in the same time period than before, eventually potentially leading to higher expenditures even though the amount reimbursed will stay the same as in the domestic country.

Service provision

Will capacity planning be affected by incoming as well as outgoing patients? Here, either over-capacities due to many patients leaving, or under-capacities, especially for highly specialised treatments might eventually take place. How will, thus, be made sure that enough doctors will be available and that there is sufficient health care coverage? For example, the dynamics of the PMD might lead to even fewer doctors particularly in rural areas such as in Eastern Germany, thus, neglecting the equity principle of social policy.

How many European citizens are expected to seek treatment in other Member States (as for the moment, mobility is rather low (2.5. per cent)? And how many of those patients are privately insured? How does this affect the sums reimbursed?

Which treatments will be mostly sought? Will these dynamics lead to these kinds of treatments being offered more or less often in certain Member States?

Will sickness funds have to provide information on cross-border health care to patients in addition to the national contact point? Will the health ministry directly provide information?

How is after-care organised? How will necessary data be made accessible? How much will this cost?

Regulation

Will there be changes to the specific characteristics of domestic health care regulation, e.g. German corporatist self-regulation?

How exactly is the PMD transposed into German and British legislation? Which (sub-)requirements of the PMD were already in line with the German and British health system, which not? These requirements of the PMD include, again e.g., reimbursing cross-border health care; treating patients coming from other Member States; pricing medical services; limited use of prior authorisation; setting up national contact points for patient information; cooperation in rare diseases research.

What happens in case of faulty treatments received in other MS? Is there an (possibly supranational/EU) oversight over (possibly common) health and safety standards?

How will the principle of 'undue delay' be specified? In which specific cases will prior authorisation actually be retained?

Mediating forces

How can variations in the transposition of the PMD in the UK and in Germany be explained with particular respect to the health care system type itself, its financing, service provision and regulation, its institutional structures as well as its different actors, and their ideas, value systems and perceptions?

Actors

Who plays a role in shaping the transposition process? How are, for example, MPs, officials from health insurance funds/health ministry, doctors/patients/hospital associations, and other lobbies involved? Who is formally taken into account and who informally? Here, two processes where different actors come into play are

critical: (1) transposition into national legislation, and (2) the implementation at the executive level such as social insurance funds in Germany.

Institutional structures

Here, the main characteristics of the British NHS as well as the German SHI, particularly in terms of health care financing, service provision and regulation, will be filtered. Furthermore, it will be scrutinised whether there is any prior experience with cross-border health care in the two countries. For example, how did the British and German health systems deal with the preceding CJEU judgements? E.g., is there already information for patients on cross-border treatments? And had there already been legislative changes or amendments due to these CJEU judgements? One example for this is the so-called 'Patientenrechtegesetz' in Germany in §§ 630a ff. BGB since 26/02/2013.

Ideas, value systems and perceptions

How do relevant actors perceive the fact that even though Member States agreed in the treaties to prohibit any form of social policy harmonisation as reflected in the principle of territoriality that the PMD is now directly regulating MS health care systems, making them subject to actual harmonisation? How do these perceptions affect the implementation of the PMD?

Research relevance and conclusions

Which overall trends can be observed and which generalisation can be gained? To what extent might national health care systems be distorted by EU integration in their functioning? What are the key determinants? Which systems 'fit' intended EU integration better?

Hypotheses

The current process of transposition of Directive 2011/24/EU gives a unique opportunity to conduct research about the national implementation processes, which include two different aspects: (a) the quality of formal legal transposition of the directive into Member State legislation, and (b) the perception of the new national

legislation by relevant health care institutions such as sickness funds, which eventually influences the completeness and timeliness of its transposition (cf. also Vasev and Vrangbaek 2013). This analysis will show the different changes that the UK and Germany will have to make to their national health care systems in terms of its financing, service provision and regulation. It will then be scrutinised how well the initial legal framework of their domestic health care system fits the requirements made by the European level with a higher degree of misfit resulting in more changes necessary at national level (H_1).

H₁: The better the configuration in financing, service provision and regulation of a national health care system fits the requirements made by the European level, such as the PMD, the fewer changes it has to make to its national legislation in the process of transposition.

Secondly, based prior research of successful implementation of EU directives (Steunenberg *et al.* 2006; Thomson *et al.* 2007; Treib 2008), key determinants for variations in the transposition of the PMD will be scrutinised, which are the perceptions of actors involved, institutional structures, as well as ideas and different value systems (H_2).

H₂: Variations in the transposition of the PMD in different countries can be explained by the perceptions of actors involved, institutional structures, as well as ideas and different value systems.

The following section will show how these hypotheses will be approached in the forthcoming master's dissertation.

Approach

As the master's dissertation is aimed at scrutinising the empirical effects that EU patient mobility law has on the functioning of Member State health care systems, it will therefore follow a comparative approach, including in-depth case studies. These will reflect the two ideal-typical health care systems prevailing in Europe, NHS and SHI, exemplified by the UK on the one hand and by Germany on the other. The following detailed description is again reflected in figure 1.

First of all, as described before, the latest development in this sphere has been Directive 2011/24/EU, which comprises most of the older CJEU case law and which will therefore serve as the independent variable. The most interesting parts of it will most probably be the calculation of prices for health services (Art 4(4); particularly interesting in NHS), the reimbursement of cross-border medical treatment (Art 5a), and the principle of 'undue delay' combined with restricted prior authorisation (Art 9(3) and Art 8(2)a).

Secondly, the thesis will explore which actual changes in financing, provision and regulation of Member State health care systems result from the implementation of the PMD. It will particularly be scrutinised whether and how these changes differ in the two ideal-typical health care systems. Here, it will obviously be important to control for other intervening variables such as globalisation, medical technological progress, demographic change or individualisation (cf. Schmid *et al.* 2010). However, as these processes will most probably show similar trends in the UK as well as in Germany, these variables can precautiously be omitted. Also, other parts of EU law need to be controlled for, such as competition law and the 'Services of General Economic Interest' (SGEI) exception, which have been described in more detail above.

Thirdly, the rather descriptive second part will be analysed through different intervening forces. As Schmid *et al.* (2010) argue, the most important will be the health care system itself, i.e. NHS and SHI. This intervening variable will be complemented by the following explanatory factors: actors, institutional structures, ideas, value systems and perceptions as (ibid.). Here, the methodological approach will be to trace relevant national legislation on patient mobility and to establish pre-existing experience on the issue of cross-border health care. Additionally, semi-structured expert interviews with relevant actors from the field of domestic health care, such as health ministries, public and private health insurance funds, regional and local administration, politicians, NGOs related to health care, or academia shall explore ideas, value systems and perceptions.

Conclusion

This paper has scrutinised the effect of European integration on national health care systems by focusing on recent developments in patient mobility and competition law in health care provision, particularly the 'Patient Mobility Directive 2011/24/EU and the 'Services of General Economic Interest' (SGEI) exception (Art. 106(2) TFEU). More specifically, as laid down in the 'principle of territoriality' (Ferrera 2005), social insurance aims such as solidarity, equity, efficiency and universality are argued to be best attained in national boundaries. Therefore, the increased European health care integration during the past 15 years, mainly initiated through the CJEU, posed the salient question whether these developments might only benefit a small minority of mobile individuals while it endangers collective institutions that protect the majority at the national level.

In this paper, it has become clear that not only a few mobile individuals benefit from European health care integration but that, however, national room for manoeuvre in health care policy has sharply been restricted, reflecting an 'uninvited Europeanization' of national health care systems (Greer 2006). In this regard, benefits of European health care integration include the strengthening of (mobile) patients' rights, an increase in mutual policy learning and an improvement of national health care systems, as well as converging expenditure on health care expenditure across the EU. On the other side, drawbacks include, among others, the neglect of social policy aims, particularly in the CJEU following mainly economic rationales, as well as the application of EU competition law to social security institutions, thus limiting policy options of national policymakers. Also, equity issues arise as patient mobility will only benefit a small group of well-educated EU citizens. Moreover, CEE countries will be hit particularly hard due to their currently still constrained resources and less well established institutions. Most severely, the more restricted use of prior authorisation has sharply reduced Member States' room to manoeuvre as, e.g., prioritisation of treatments on the basis of medical necessity, rationing of medical goods and services through waiting lists, and gatekeeping of consulting medical specialists only through referral by a general practitioner might be circumvented by patient mobility.

Yet despite all these facts not being negligible, it can be summarised that the crucial competences of regulating Member State health care systems still rests with the nation-state (Rothgang *et al.* 2010a). Finally, the success of further European health care integration will thus depend on the extent to which the EU will succeed in counterbalancing market integration based on the four Fundamental Freedoms and social security protection that considers important health policy goals.

Therefore, this research question will further be analysed in the forthcoming master's dissertation of which this paper has given an overview over the relevant research design. The dissertations impact will eventually be to show whether the current approach to integration of domestic social policies on the EU level – with taking the example of patient mobility – is one that preserves sufficient discretion to continue a proper functioning of social security systems and if so, how. An alternative conclusion might find that the idea of extending the Single Market rationale from goods to services is difficult to prove feasible.

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