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Community relevance and built-in escape clauses in health policy implementation

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Getting to the roots of divergence among EU Member States (MSs) will inevitably involve the field of competitiveness, which is first of all determined by the human and social capital of the MSs themselves. From this perspective – beyond the traditions, cultural heritage and some other determining factors – the role of health policies, the way they are organized on a national level, the extent of market mechanisms and their exposure to competition regulation all have a remarkable impact on the final success of creating competitive human capital with which a country is able to catch up with leader societies. Within the EU the internal differences among Member States perhaps has a spill-over effect. There are differences in how a publicly financed healthcare market can cope with EU level competition regulation, and it has an impact on the possible integration of these markets as well. But it seems that the leeway is provided by the EU itself, and with the built-in gates, the more market actors does not necessarily mean the more instances of competition in this sector.

Keywords: health policy, healthcare, EU, competition regulation, SGI

1. Introduction to the role of health policy and the aims of the study

Arora (2001) examined the economic development of the last century and found that improving health conditions in the population are responsible for a 30-40 per cent potential growth in the economy. The latest data also indicates that countries with higher welfare expenditure to GDP ratio fill the top positions of economic competitiveness rankings e.g. Sweden, Germany and Denmark. Such data prove that a population's productive capacity is more robust than all other forms of wealth combined, as was the case earlier as well (Schultz 1961). Several studies have been published on labour force as a resource of productivity (Maudos et al. 1999, Hendricks 2002), or in general, about the relationship between health conditions and the aggregate output and future prosperity (Bloom et al. 2004, Orosz et al. 2013, Tzeremes 2014). With the latest technological developments, and revolutionary shifts to Industry 4.0, the relationship or balance between health and competitiveness is likely to change – it is becoming even more important (WEF 2017), so the human factor is holding its position. It is the responsibility of education to ensure people are capable and ready to adopt the technological revolution; but a highly advanced health status is a prerequisite for all that. In this context it is easy to understand why an advanced healthcare system[20] that is well budgeted and puts prevention first is not only indirectly a factor of economic prosperity but has a far broader meaning and outcome as well. '*…given parallel developments of increased longevity,*

[20] In this study, a health system is understood as a system that aims to deliver healthcare services to patients: preventive, diagnostic, curative and palliative – as it was laid down in EC (2014a).

rising expectations and constant innovation, health care is at the heart of modern society.' (Sauter–van de Gronden 2010, p. 33).

Evidence of the depth of the relationship between health and economy is provided by the numerous indicators and studies developed by different international institutions. The series of Global Competitiveness Index indicators for example, published by the World Economic Forum, show the competitiveness of a country or a region on an international level. To measure well-being and development, the OECD has also established its own conceptual framework. This framework reconsiders the relationship between human capital and economic prosperity (OECD 2013). Currently, the concept of well-being has two components: the "Quality of life" where health status has high significance and "Material conditions". These two components determine future well-being and competitiveness prospects as well.

The European Union is also developing its own system, the European Community Health Indicators (ECHI). The work is being undertaken on behalf of the European Commission (EC) – Directorate General for Health & Consumers (DG SANCO). The two-year survey of the European Commission about the *State of Health in the EU* provides policy makers, interest groups, and health practitioners with factual, comparative data and insights into health and health systems in EU countries. The cycle is being developed in cooperation with the Organization for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies.

Beyond the obvious determinative role of health status on productivity, other objectives are laid out. In its 2014 Annual Growth Survey, the EU emphasizes the need to improve the efficiency and financial sustainability of healthcare systems, meanwhile enhancing their effectiveness and ability to meet social needs and ensure essential social safety nets. Introducing market principles, increasing interdependence and common challenges call for closer EU-level cooperation. The extent of this Community relevance and one of its possible fields – namely competition regulation – will be examined in this study. The questions of the broader research will focus on the following questions:

- Do Member States (MSs) have the possibility to choose whether they refer to their healthcare services as Services of General Economic Interest (SGEI), and does this decision depend on the extent to which they let private actors enter the market?
- Does the longer and broader possibility on the part of the EU to get involved in and influence healthcare markets necessarily mean
  - higher exposure of national health system participators to competition regulation and as a consequence
  - an increase in the number of competition distorting actions?

The present descriptive study's aims are a bit narrower and only to provide a review of the basic determinants of how healthcare systems are being implemented throughout the EU. Still in a descriptive way, it will show how the familiar, earlier models of healthcare (HC) systems have changed recently. Then the attention will be turned to the Community's relevance in the health sector; first as an almost direct regulator (internal market perspective) and then as the controller (competition regulator) over the intended

competition in health sector. Finally, conclusions will be drawn with reference to the original aims of the study.

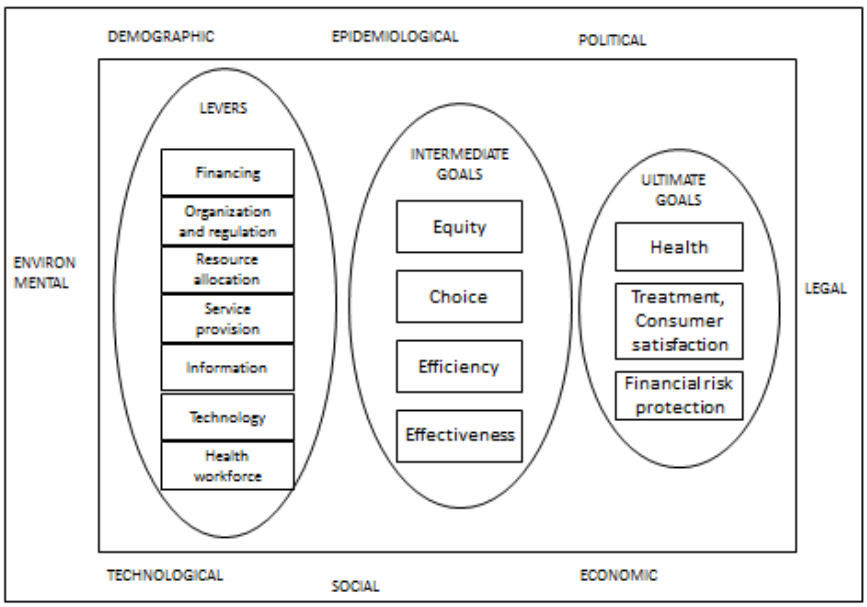
2. The determinants of implementing healthcare in the European Union

The EU is divided internally along both social and economic lines. Today the most powerful of these lines are the level of economic development, the competitiveness divide (structural or costs based) and health status – as this latter condition is observed by means of the European Core Health Indicators (ECHI). And of course, all these conditions determine the way MSs organize their national healthcare systems.

2.1 Basic determinants of the systems

When MSs are being surveyed by the type of national healthcare system they manage, it should be emphasized that, as Atun and Menabde (2008) claim, these systems are dynamic frameworks. The authors take the *wider context* into account within which health systems function. This context covers – what is referred to as DEPLESET – the demographic, economic, political, legal and regulatory, epidemiological, sociodemographic, environmental and technological contexts. Moreover, with healthcare system management, the authors' systems framework identifies *four levers/opportunities for influence* in the hands of policymakers: (1) stewardship and organizational arrangements; (2) financing; (3) resource allocation and payment systems provider; and (4) service provision (Figure 1).

Figure 1 Conditions and goals structure of national healthcare systems



Source: the author's own work based on Atun and Menabde (2008) and WHO (2000).

There are also four *intermediate goals identified* in the framework (equity; efficiency (technical and allocative); effectiveness; and choice) and three *ultimate goals* (health improvement; consumer satisfaction; financial risk protection). MSs run different systems, expectantly in line with the four levers and altogether seven goals, in accordance with their DEPLESET. During the comparison of the various healthcare systems, the above-mentioned four levers, or basic functions, that contribute to the success of a system, were later amended with the following factors: (5) information, (6) technology and (7) health workforce (WHO 2000).

From the above-mentioned levers, only financing and service provisions are highlighted now, because the way a member state manages its healthcare system is expected to be determined by its financing background and the way a member state refers to the services provided within this framework. This is expected to have a direct effect on how much member states have to respect competition regulations.

Due to these levers, health systems in EU Member States differ, reflecting different societal choices. However, despite organizational and financial differences, they are built on common values, as recognized by the Council of Health Ministers in 2006[21]: universality, access to good quality care, equity and solidarity (EC 2014b). One of the most important distinctions compared to other developed capitalist economies is that European countries have a well-constructed, inclusive welfare system protecting fundamental values such as universality, accessibility and quality, with active social policies pursued by governments (Farkas 2016).

The relationship between development and health status has been observed by Kuruczleki and Pelle (2017)[22]. On the basis of institutional background, competitiveness and health status 4 'groups' were created:

- Romania, Latvia, Croatia, Bulgaria, Hungary, Lithuania, Slovakia, Portugal, Estonia and Poland
- Italy, Czech Republic, Slovenia, Cyprus, Spain, Malta and Greece
- Finland, United Kingdom, Austria, France, Belgium, Germany, Denmark and the Netherlands and finally
- Sweden as an outlier.

2.2 From organization models to convergence?

Numerous studies – Atun and Menabde (2008), Thomson et al. (2009), Goddard (2015), Meheus and McIntyre (2017) – cover health sector regulations in general. The recent publications agree that present healthcare systems of the MSs cannot be explained with just one model. Each country devises its own set of arrangements to meet the three basic (or as it was described earlier: ultimate) goals of a healthcare system: keep people healthy (1), treat the sick (2) and protect families from huge medical expenses (3). The present twenty-eight MSs are countries of the developed world, where,

[21] Council Conclusions on Common values and principles in European Union Health Systems, OJ C 146, 22.06.2006

[22] The work in progress by Kuruczleki and Pelle (2017) was presented on the Italian Health Economics Association (AIES) conference in October 2017.

although local variations exist, the various healthcare systems follow some general patterns from which some basic models could be drawn up.

Traditionally three models existed: the Beveridge Model, the Bismarck Model and the Semashko Model (Kulesher–Forrestal 2014, Ecorys 2016). Since their introduction, health systems in MSs have undergone considerable changes in recent decades, so the differences between these systems have diminished and overlaps or similarities surfaced. This happened due to demographic conditions, namely, increasing life expectancies and the dramatic change in the shape of population pyramids over the past century. Experts[23] assume that the above-mentioned three former models may change by the determinants of the healthcare markets and leave only limited possibility for the functioning of the Beveridge Model, for example (HCP 2018). Beyond the diminishing of the markets where certain models may be able to work, the models are also expected to converge in some aspects, and they are likely to merge into a mixed one with some local specialties. For example, in many Beveridge type countries market mechanisms have also been introduced as an attempt to move towards (regulated) competition and increased efficiency (Ecorys 2016). This outcome is likely considering the efforts the EU puts into the integration of this special market as well.

The main sub-markets of the MSs' health sector show different levels of private and public involvement and budgeting. On the details of the differences in national health policies and healthcare management see Joumard et al. (2010), Kulesher and Forrestal (2014), Ecorys (2016), and ECR (2017). The variations are mainly due to national decisions, although the EU can have an impact on them.

3. Community relevance in the health sector

The EU has a powerful legal system, and it is able to enforce even "constitutional" provisions. Even so, lately its budget has had a cap of about 1% of the whole GDP produced within the EU (Greer 2014). Moreover, there are policies where the EU does not even have exclusive authority in introducing actions and measures. Despite these facts, based on its earlier experience in other sectors for developing sectoral regulation, the EU is trying to introduce positive integration first by liberalizing the sector in question (i.e. energy) and then creating common regulation on a Community basis. It is presumed that in the case of healthcare this template is a bit too simple as Guy (2017) found it.

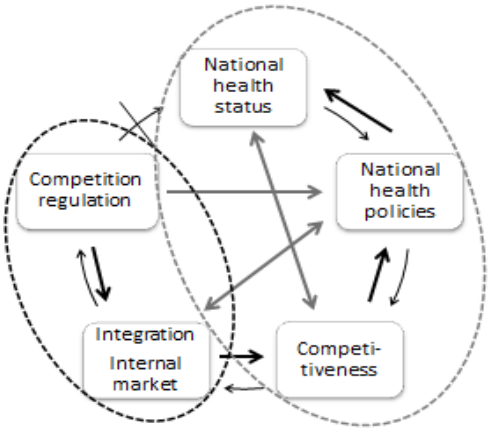
There is a two-fold strategy in the EU's role in the contribution to national health policies: one is a weak, cheap but effective public health intervention focusing on cooperation, and the other is the more powerful, but sometimes unpopular extension of internal market laws on healthcare services, and with that the European competition regulation (Greer et al. 2013). In setting up a European cross-border healthcare market, one arm is the legislation, but the other arm can be the active role of competition regulation.

[23] On a public event in Bruegel opinions were expressed on the topic: *Innovation and sustainability of European healthcare systems* (27 January 2016). http://bruegel.org/wp-content/uploads/2016/01/Sustainability-of-European-Healthcare-Systems-Bruegel-Event-Notes.pdf

3.1. The European Union's room for regulations

Health policy is a typical example for a field where national governments organize healthcare and ensure that it is provided in such a way that it facilitates – although indirectly – the future competitiveness of the state. The EU is without significant (let alone exclusive) authority, as written above. Moreover, national level healthcare management, due to its sensitive characteristics, has long been subject for debate. From these basics the EU is challenged to implement any kind of integrative actions within the healthcare systems of EU MSs. As shown in Figure 2 it has two possibilities, intervening within the framework of Internal Market legislation, and the other is the influence – by liberalization and competition control – of the contemporary state of competition on the relevant healthcare markets.

Figure 2 the fields of EU-level intervention and their interactions with national policies and national health status



Source: own construction

Healthcare policy belonged to the sole competency of the MSs, as it was decided decades ago in line with the Treaty of Rome. Furthermore, at the beginning of the 1980s, the EEC also demonstrated that opening the market for competition may not threaten social welfare (Anchini 2016). Although the Treaty of Maastricht and the Treaty of Amsterdam have brought *some legislature changes* e.g. the shared competencies between the different actors of regulation from local/national and Community level, the *neutrality principle* (Article 345 TFEU) against EU law intervention in public services has been kept intact. In the meantime, with the introduction of the free movement of workers and, later, of citizens, a need for a more flexible cross-border social system has increased. With the acceptance of services directive (2006/123/EC; EC 2006), market processes have been introduced into the social systems and covered some parts of social services as well.

Another factor that placed the issue of healthcare (within the social protection argument) on the European political agenda was a *push from finance ministers* (through ECOFIN) who, at the end of the 1990s, raised their voices in their reports on serious cuts in healthcare spending implemented in order to be able to cope with the

financial burdens of welfare spending (Greer–Vanhercke 2010). These circumstances also posed challenges because the de-regulation process causing negative integration was faster on the national level, and this outperformed the consolidating efforts of an EU-level regulation (positive integration) that was to become a substitute. This resulted in a vacuum for public policy decision-making. Parallel with the above-mentioned events, at the beginning of the new decade, a new type of governance, the so-called *Open Method of Coordination (OMC)* was introduced by the European Council in order to assist MSs in jointly progressing towards the goals of the Lisbon Agenda. OMC encourages learning and collaboration through the sharing of best practices, and an increase in policy governance between actors in areas that are primarily the responsibilities of the national governments, but with implications all across the EU (Papanicolas–Smith 2013). Most new governance processes in healthcare came into effect only after 2005. From the perspective of the MSs, the OMC, with its position outside traditional, hierarchical and legal mechanisms of Community method, has some positive characteristics. The first is that MSs can enter into dialogues with the Court and the Commission, while the second points to the fact that instead of a command-and-control mechanism there is a less rigid regulatory approach in place (Greer–Vanhercke 2010).

Today, for a relevant background, the EU relies on the TFEU, Article 168 which states that a "*high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities'* and *'Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action;*". The EU's present shared competence in public health means that the EU shall complement national policies, and according to the 2nd paragraph of Article 168: "*It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas.*" This may mean the achievement of their shared objectives, realizing positive outcomes through economies of scale and pooling their resources. The EU has a Health Strategy that helps to solve some possibly arising shared health challenges, like the impact of an increased life expectancy on healthcare systems. In the meantime, all "*Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care*" which covers the management of health services and medical care and the allocation of the resources assigned to them.

MSs are responsible for how their healthcare services are organized, financed and how healthcare priorities are set; these countries also having to cope with the pressure that they have to correspond with the basic, constitutional principles of EU law (Greer 2014). The Solidarity Title of the Charter of the Fundamental Rights of the European Union states that everyone has the right of access to healthcare and (the) "*Union recognises and respects access to services of general economic interest as provided for in national laws and practices, in accordance with the Treaties, in order to promote the social and territorial cohesion of the Union.*" This is an important factor when European competition regulation, more precisely state aid regulation meets MSs' measures in financing their health care systems.

Although nations are huge stakeholders in their health sectors, this sector is not excluded from the freedom of movement of goods, services, capital and people.

From an *Internal Market perspective*, the organization, the setting of the priorities and the financing of healthcare services are all the responsibilities of the MSs, but with the pressure to comply with the basic, constitutional principles of EU law (Greer 2014). Although there are huge national interests involved, the health sector is not excluded from the freedom of movement of goods, services, capital and people. In an internal market for health care, stronger cooperation between health systems could be beneficial when facing the increasing mobility of patients and healthcare professionals. The pressure that the four freedoms exert is substantial: there is an underdeveloped internal market for health care because these health systems could develop for decades in the relatively safe harbor of different norms, funding, levels of liberalization, and of course how "success" is measured in the context of health status. Due to the relatively fast recent advancement of the four freedoms, the EU health systems increasingly interact with each other. The increased mobility of patients and healthcare professionals also puts pressure on the internal market for healthcare. Although the Services Directive (2006/123/EC) has been adopted, health care services were removed from the draft Directive, and a separate instrument was announced. Due to the special nature of health care, it was regarded as inappropriate to treat this area in the same way as other services (Pennings 2011). Article 2(2)(a) of the Services Directive now provides that the Directive does not apply to "non-economic services of general interest" (NSGI) – discussed in detail later – and according to (f) it does not apply to health care services, whether or not they are provided through health care facilities, and regardless of the ways in which they are organized and financed at a national level, or whether they are public or private. Later the Directive on the application of patients' rights in cross-border healthcare (2011/24/EC) entered into force with more focus on this special market, and the EU health systems started to interact with each other increasingly within the internal market. Due to this, nowadays, healthcare services are even flourishing, and cooperation between health systems has grown stronger as well.

Besides this regulatory environment, the latest fiscal crisis of the EU again brought a push from outside the relevant market, because the crisis increased the need for re-focusing and re-shaping public services in line with economic interests.

Altogether, having seen the Community's relevance in the regulation of healthcare markets on an EU level, and despite this last-mentioned possibility that has been brought about by the two directives cited, one can assume that this segment of the MSs' economies still has huge national competences.

3.2. The crossroads of EU-level competition regulation and healthcare

The means by which MSs organize their health care systems determine how far EU-level competition policies may "go" in their surveillance of those actions that are delivered by actors of national markets to distort market/competition. From the opposite perspective, the most important issue is whether competition laws leave room for national health policies or rather competition laws exert a massive impact on the healthcare sector (Sauter 2013). The question can be asked in a different way: which regulatory method seems to be more effective or harder: principles of solidarity and

citizenship in healthcare – characteristics of public services – or maybe the competition principles and a new regulatory method may overtake and gain more importance.

Considering the first above-mentioned issue about the room for domestic interests allowed by Community level competition regulations, even though MSs are all in the same internal market, where competition policy acts as cement, due to the differences in their healthcare systems, there are different outcomes in relation to their exposure to EU competition authority measures and processes. As Guy (2017) expressed it, the varying extent to which competition is possible within an insurance-based model and a taxation-funded model arguably outweighs even Enthoven's model of "managed competition" from 1993.

Today, with the latest amendments, the EU competition law controls the behavior of undertakings with its cartel prohibition (Article 101 TFEU, the prohibition on dominance abuse (Article 102 TFEU) and controls the structure of a certain market with merger control regulation (139/2004).[24] In a broader – and from the point of the present article maybe even more important – sense the law also includes state aid regulations (Article 101 and 102 TFEU). Compared to the previously described Article 168 of the TFEU on public health, and Article 345 on the neutrality principle, more attention is paid to Article 56 TFEU on the free movement of services, and Article 107 of the EC TFEU that prohibits MSs from distorting competition within the Common Market by giving state aid to undertakings. The law also acknowledges categories that are exceptions in this prohibition of state aids, but due to conceptual differences in defining 'health expenditures', they are not listed among them.

Compared to the narratives of its sensitive characteristics and narratives of the many national interests, the regulation of HC systems, and the view of it from a competition regulation perspective, has a relatively old history. Court rulings such as the Kohll and Decker[25] cases were important triggers as well; and so were a number of other landmark cases with regard to the application of competition law to pension funds during the second half of the 1990s. Together, these cases made it clear to the Member States that social welfare services may fall under internal market rules (Greer–Vanhercke 2010). The enforcement of EC competition laws by the European Court of Justice (ECJ) and the national courts has been a significant driver pushing health policy onto the European Union agenda (Lear et al. 2010). During the practice of the ECJ, there is always a balance on a triangular relationship between patients, healthcare providers and the State(s) (Anchini 2016). This triangular view could be further enlarged with an EU perspective, since some decisions of the ECJ have also supported the opening up of the national healthcare service systems, as liberalization trends have become more and more general in the internal market.

[24] About the contemporary analysis of EU competition law's effect on health care sector see the article of Sautner and van de Gronden (2010).

[25] In Case C-158/96 - Kohll v Union and Case C-120/95 – Decker v Caisse the Court has stated that the national regulation about the reimbursement of healthcare services that appear in a different MS should not be bound to preliminary permission, because they may cause uncertainties among patients in relation to their possibilities to access healthcare services in a neighboring MS. Such decisions could be seen as an incentive to enhance access to cross-border health care at least in border areas.

3.3. The built-in gates in meeting competition regulations

In 2003, in harmony with the creation of an internal market for services and the liberalization of public services, the ECJ ruled on the assessment of public service compensation in the context of EU state aid rules[26] as a first possibility of exception. In 2003 criteria were laid down called the Altmark-criteria that must be met to avoid prohibitions to state aids. The Court stated that in case of Public Service Obligation (PSO) these funds do not constitute state aid. Therefore any compensation that meets the obligation to provide universal coverage is not state aid if it fulfils four conditions: (1) the public service should be clearly defined; (2) the parameters of the compensation should be objective and established in advance; (3) the compensation cannot exceed costs; and as (4) the company in charge of the mission should be either chosen through public procurement "which would allow for the selection of the tenderer capable of providing those services at the least cost to the community", or, if not, the costs of providing the public service must be based on the costs of a "typical, well-run undertaking".

Since this decision, a so called 'public service compensation' has been granted to certain undertakings entrusted with the operation of Services of General Economic Interest (SGEI).

The two ways that define how aids (investment/support/financial execution) within healthcare systems may be exempted from EU-level state aid rules are stipulated in the Article 107 (3) and in Article 106 (2) of the Treaty dealing with SGEI. The Commission adopted the first *SGEI package* which entered into force in 2005 and specified the conditions under which state aid in the form of public service compensation is compatible with the EC Treaty (now the TFEU). The ESIF states that the SGEIs represent economic activities that are identified by public authorities particularly important to the citizens and which would not be supplied if there were no public intervention. The SGEI provides the link between economic interest that comes with competition and the universal service obligation that arises from the social characteristic of healthcare. As Sauter and van de Gronden (2010) describe it, the possibility for MSs to define SGEI provides space for them to take into account technical, economic and socio-political developments.

It is no small matter that there is a *lack of clear terminology for the expressions:* "services of general interest" (SGI), "services of general economic interest" (SGEI), "non-economic services of general interest" (NSGI) and "social services of general interest" (SSGI) (Lenaerts 2012, Anchini 2016). Lenaerts (2012) says that it is accepted that the expression SGI is a general concept which contains both SGEI and NSGI. SGEI may be distinguished from NSGI in a way that only the former involves economic activities. In contrast to SGI, SGEI and NSGI, the expression SSGI is not even mentioned in primary EU law. The reason for that must be that healthcare services seem to have more economic relevance and thus they are closer to SGEI than SSGI (Anchini 2016).

The package has been revised, and in 2011 the European Commission adopted a new package of EU state aid rules for the assessment of public compensation of

[26] Case C-280/00 – Altmark Trans

services of general economic interest (SGEI). The new package clarified key state aid principles and introduced a diversified and proportionate approach with simpler rules for SGEIs that are small, local in scope or pursue a social objective; at the same time competition considerations for large cases have been taken more fully into account. Of course, this was also a response to the latest phenomenon to occur in HC systems, namely bringing market principles/characteristics into healthcare policies. The SGEI allows for a proportionate exception to the rules of EU competition regulation as exceptions to the general competition rules (Sauter–van de Gronden 2010).

Since the adoption of the latest SGEI package, many things have changed. Because of the stronger presence of the healthcare systems in the internal market, the ECJ's crucial role has only increased. As liberalization spreads, the growing importance of the EU's competition policy and the practice of ECJ (together with the national courts) in health policies are more and more on the EU's agenda. The EU balances upholding national measures that restrict economic freedoms in the name of non-economic interests, with at the same time, allowing market principles to appear at the level of funding, provision, and access to the services of the national healthcare systems whenever it is possible (Lear et al. 2010, Anchini 2016).

It seems that Article 107 further details the regulations on *undertakings,* but when the ECJ and the Court of First Instance (CFI) apply these regulations in their practice, a distinction is made among the different actors. The ECJ and the CFI decide whether actors are undertakings or not. Since the ECJ clarified that although not all entities pursue profit, antitrust laws deem healthcare providers to be undertakings. From this milestone onwards, competition policy relevancy is straightforward, and the above-mentioned conflict seemed to be settled via manual control: responsible EU bodies must investigate case-by-case the nature of the activities in question whether there is Community relevancy or not. This is important because again there seems to be a "gate" for the MSs for the interpretation of the state aid rules (van de Gronden 2009, Sauter–van de Gronden 2010). As Lear et al. (2010) describes, since the "accepted" definition of undertaking is more about its function rather than its status, the term can be easily applied to both private and public HC services. For example, when benefits are granted by public authorities to bodies that operate in state-oriented HC systems where solidarity is predominant, the process will not fall within the ambit of Article 107 (1) of the Treaty. '*The Commission had clarified that where national health system, by implementing the principle of solidarity, is mainly grounded on public hospitals that are funded directly from social security contributions or other state resources, and provide their services free of charge to affiliate persons on the basis of universal coverage, then "the relevant organisations do not act as undertakings."'* [27] (Anchini 2016). Meanwhile doctors and other providers who are engaged in economic activities–since healthcare is usually provided for economic consideration–will fall within the ambit of the same Article (ESIF 2014)[28]. It seems that from the point of competition regulation, healthcare providers are positioned

[27] T-319/99 - Fenin v Commission

[28] ESI Funds for health investments Hungarian national workshop, 2014, http://www.esifforhealth.eu/pdf/National%20workshops_compilation.pdf

between the two extremes depending on the sources of their system (taxes based on solidarity or insurance based on the principle of competition) even if, in fact, most national systems are mixtures of these two (Anchini 2016).

4. Conclusion

The great impact of domestic conditions and of course interests and the possible leeway in regulation result in the different nature of markets in healthcare. In this article the main intention was to reveal how the framework established by the EU for developing competition on the healthcare market can also lead to integration and bring about the intended outcome.

If a research result comes from an integrated (free flowing) public services market topic, the active role of the EU is vital, but much more could be done to support member states. With all the different kinds of healthcare systems coexisting in Europe, we have a unique learning environment. The danger of this diversity might be that MSs cannot pick those parts that seem to be promising, since those will not be consistent with their inherited healthcare systems, its whole structure, and it might only lead to a patchwork of best practices, which also lacks traditional roots in their societies. There is fear now that, in the NMSs, the mix of different solutions in different parts of the healthcare system does not result in synergy, but operations that are worse than earlier models. From the internal market aspect another observable result of the introduction of relevant Directives is that it may not simplify the former system and practice of member states. The critique that it raised at another level on deciding about the relevant rules and reimbursement methods (Pennings 2011) is of course true, but it is as it is in the case of almost every service on the Internal Market.

It is the common points of Community level regulation of competition and healthcare that confine the MSs. Overall, MSs have many possibilities to avoid following strict competition rules in their healthcare market, even if the countries are willing to liberalise. The first possible exception arises with the Altmark criteria in connection with state aid rules while the second exception is provided by the SGEI regulations and the third possibility is the definition of undertakings and their links to healthcare finance. MSs has the possibility to choose whether they refer to their healthcare services as SGEI, and it depends on the extent to which they let private actors enter the market, but according to the definition of undertakings only with respect to status and functions as well. Greer and Rauscher (2011) stipulated there are still multiple barriers to entry and weak incentives for patients, providers or governments to respond to the EU health policy either by competition or entry into new markets. Therefore, there is no remarkable reflection on EU law, and where there is, it is driven by domestic political agendas.

National Competition Authorities (NCAs) may contribute to the enforcement of EU competition laws, since they are not directly responsible for local social policy objectives. This may create conflict on a national level. It has been mentioned that the ECJ is broadening the triangular relationship between patients, healthcare providers and the State(s) with an integrative perspective. At the same time, when the NCAs decide, they are likely to form their opinion according to EU competition laws and market values and ignore general social interests or what is best for European

integration and take these into consideration only maybe indirectly (Lear et al. 2010). They are however also likely to develop diverging sets of competition rules for healthcare (Sauter–van de Gronden 2010), which will bring about more diversity and divergence on a market where some progress would otherwise not be achieved. Today national HC regulations, the Directives of the internal market and the case law of the ECJ create a three-tier-system which reflects the European principle of free movement of citizens but also the more intensive national will to protect national systems (Pennings 2011).

Moreover, within these domestic agendas, practice usually decides whether an intervention or investment in the healthcare market is considered to be state aid or not. Usually cases are analyzed and evaluated in detail and the ECJ/NCAs examine case-by-case (Lear et al. 2010, Anchini, 2016). For a move towards a more automatic evaluation in competition distorting cases within the healthcare market, a more coherent European framework and more integration should be necessary in social/healthcare services and also in the field of competition regulations. However, with all the above-mentioned "built-in escape clauses", flexibility of EU-level competition regulation and the practice allowing MSs to express these differences and decide on the degree and extent of the market, reforms may not bring the foreseen health market integration. This may be even more valid for the NMSs.

Further possibilities of this research require the profound analysis of the extent of private actors and private financing and their relations to each other. This may involve the detailed mapping of type and number of competition cases, if they appear in a great number or they are just "avoided" due to SGEI decisions. Finally, the exact positioning of the Hungarian system by its characteristics among the other Member States is one further direction this research could well take.

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