

The future of the welfare state: paths of social policy innovation between constraints and opportunities

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Who's OMCs darling in health care?

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Introduction

After welfare state reforms in the unemployment and pension sectors, politicians turned their attention to health care. Following the example of the former two, they also created an Open Method of Coordination (OMC) for health and long term care. On an EU level they search for best-practice models to learn a lesson from the reforms conducted in other member states.

This paper focuses on the health care part of the OMC, to figure out which country would be best suited to become a role-model for efficient health care reforms. After a short introduction to the OMC, it proceeds in three steps. First the indicators developed under the Open Method of Coordination in health and long term care are analysed. In a second step it is analysed if this role-model is also the Commissions favourite, therefore the official OMC publications and the responsible DG Employment are studied. In a last step the identified role-model is tested on its coherence with other EU policies impacting on health care.

The Open Method of Coordination is a soft policy instrument, employed in policy areas, where the European Union has no competences, but the need for coordination is felt.

The OMC is rooted in the common agreement that the EU should not interfere in the way member states provide social security for their citizens. Thus the OMC just proclaims aims and objectives, whereas the implementation is up to the member states.

Every second year, the member states submit National Strategy Reports (NSR), which are in the following year evaluated by the European Commission and the Social Protection Committee in the Joint Reports (JR). The evaluation is based on the common objectives and a set of agreed indicators.

The mechanism was first developed as the European Employment Strategy (EES). In the framework of the Lisbon agenda 2000 the EES was integrated into the treaty and expanded to the areas of pension and social inclusion.

To activate this process, the Social Protection Committee was founded (Art. 144). It consists of high level bureaucrats from the member states. At the Göteborg Summit 2001 it was decided to expand the OMC to health care, but it took another three years until the Commission officially proposed to include health care in the process of the OMC in April 2004, which was endorsed by the Council in October 2004. The Council asked the Member States for statements regarding the main challenges faced by their national systems, on which the Social Protection Committee drafted the November 2005 memorandum, the basis for the definition of common objectives: access, sustainability and quality.

In 2005 social inclusion, pension and the new field of health and longterm care were integrated into one process. In 2006 the Member States for the first time submitted reports on their national health care systems and planned reforms. Based on these, three objectives – access, quality and sustainability – were developed and healthcare was included in the 2007 Joint Report. Indicators were developed in a sub-committee of the SPC and agreed upon in 2008.

Indicators

Also the OMC process took off in 2007, the development of concrete indicators was lacking behind. Health care systems are much more complex than pension and unemployment policies. The most important obstacle is that outcome in health care can not be measured in Euros.

The OMC indicators are based on the work previously conducted by the OECD, which already in 2004 was charged by the health care ministers to develop indicators for input, output and outcome of health care systems.

In July 2008 the Social Protection Committee presented the first catalogue of indicators for the three overarching objectives of access, quality and sustainability.

In analysing the indicators of the OMC, it is not to be forgotten that the list is the result of a political process. The pattern of laggards and leaders is the result of a careful choice of indicators. The Member States learned from the naming and shaming exercises of the first OMCs and pushed for indicators, which present their system in a good light.

Next to political and methodological issues, data limitations severely hamper the selection of comparable indicators.

Developing the indicators for health and long term care was much more complex than for pension and unemployment benefits. The relation between contributions or taxes indicated for the system and benefits received, as well on an individual as on the national level, is not as straight forward. Instead of a more or less complicated formula, a whole economic sector mediates between the two. This has to important implications for the development of indicators. First, the differentiation between output, as medical goods and services received, and outcome, as the overall health status of

the population is salient. Second, improving the efficiency of health care systems, offers a win-win solution. The core question for the OMC comparison is to identify efficient practices, which can be transferred to other member states.

Comparatively measuring efficiency of health care systems poses a lot of methodological problems. The biggest methodological problem is posed by the fact that the health status of the population is not the sole result of the health care system. On the contrary, as Rosenbrock and Gerlinger note for Germany, just 10-40 percent of the overall health status are the result of the health care system (Rosenbrock, Gerlinger 2006). Especially among the western affluent societies, where diseases like pest and cholera are eliminated and access to care is nearly universal, the differences in the performance of the health care sector can not be simply measured in life-expectancy. Nutrition, climate, working conditions, risk behaviour, environment and a variety of further factors influence the life-expectancy.

The overall health status of the population is therefore the outcome of a variety of policies and also of factors like climate, which can not be politically influenced.

The direct output of the system is medical goods and services, which can be counted and compared. To determine their efficiency, data on the health improvement of the patients are needed. For survival rates of cancer, the health care system can be attributed a strong causal influence, also here the problem persists, that differences in prior health status may result in differences in healing results. However with survival rates for different sorts of cancer, the indicators measure the effectiveness of medical treatments as closely as possible.

The second problem in the development of the indicators was the very nature of the OMC, leading by goals, which can be reached by all national ways equally.

Nevertheless, certain indicators like vaccination rates already imply a certain policy. A 100% vaccination rate is much more easily reached by governmental regulation, then by free medicine. Figures on obesity, smoking and alcohol consumption have been included in the set of indicators. Also there is a scientific consensus that obesity, smoking and alcohol consumption are harmful for human health, many Member States endorse a liberal view, not to interfere with adults life-style decisions. It is therefore not clear if low numbers are a common goal, or if these indicators just reflect the challenges posed on the system.

Disaggregating morbidity data by socio-economic status (SES) induced the conclusion that the observed differences are unjust. Up to know such data have not been made available by the Member States. The Commission writes quite frankly: "We are aware that the data are available and would request Member States to provide it." (European Commission 2008a, S. 1).

This leads directly to the last big problem of international health care comparison: Data limitations.

As the OECD already started earlier with their health at a glance project, the selection of indicators as well as the corresponding data computing relies on (previous) work of the OECD. The cooperation between the two institutions, especially at a working level can be characterized as very good and the Commission outsources studies to the OECD. At a political level the status of Cyprus poses a problem. The country is not a member of the OECD and Turkey blocks all official cooperation between the Cypriot government and the OECD. As a resort the European Commission asks Cyprus for data, which are then forwarded to the OECD to compile statistics required by the EU. The complications implied in this process are already visible and reflected in meagre data coverage for Cyprus. Eurostat in cooperation with the national statistical offices is working on an own data set, but sometimes even the Commission uses WHO-data instead of Eurostat-data.

In some countries, data protection regulations do not allow for close monitoring.

A further point of interest – the impact of the current financial and economic crisis on health care systems and overall health status – can not be evaluated as data are just available until 2006, mostly just until 2005.

Next to indicator and data problems, the OMC is also a political process. The Member states within the SPC agreed, that their national systems are too diverse to be compared on more detailed variables. Most of the indicators are therefore marked as “commonly agreed national indicators” in contrast to “commonly agreed EU indicator” on which comparison and benchmarking is deemed to be possible. The second list is quite short and comprises today just two indicators: life-expectancy and vaccination coverage in children. As soon as data from the European Health Information Survey are available, a review of the classification for many quality indicators is envisaged.

Being aware of these limitations, this paper nevertheless compares the countries on all available data to single out a possible role model. In a second step the result of the data analysis is scrutinized against the current EU policies within the OMC and outside, concerning healthcare.

If not noted otherwise all data are taken from an overview publication of the Commission¹.

The indicators are developed under the headings of the common objectives: equal access to care, quality of care and sustainability. On each indicator the five best performing countries are indicated and awarded one point. The indicators on access and quality give an overview of the effectiveness of the respective health care systems. Taking sustainability into account as well, paints the picture of efficiency – the Holy Grail of health care reforms.

¹

http://ec.europa.eu/employment_social/spsi/common_indicators_en.htm

Indicators regarding access to care (including inequity in access to care) and inequalities in outcomes

The headline of this objective changed over time, to give health inequalities more scope. In the April 2008 update it reads now: accessibility and health inequalities. The indicators describe overall access to care, inequalities in access to care and inequalities in health outcomes.

This selection of indicators poses the methodological question if the data are to be interpreted under the objective of efficiency or under the objective of equality. As health inequalities are a topic expanding beyond the realm of health care systems, this paper focuses on efficiency of the medical system.

1. The proportion of the population covered by health insurance

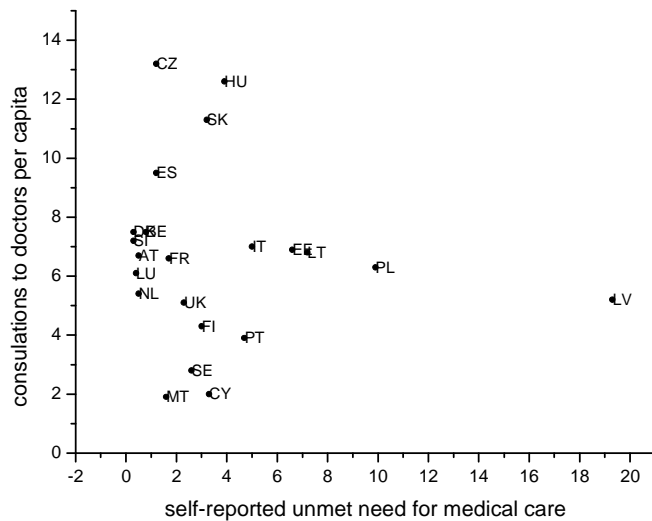
Half of the member states have a National Health Service and therefore a 100 % coverage rate by law. Among the remaining countries, just the Netherlands and Germany show lower rates, as people with a substitutive private health insurance are not included in the data. As the latest available data are from 2005, the major Dutch reform of 2006 unifying the two systems is not yet reflected in the data set. Best-practice countries can not be identified, as the majority of countries has a universal coverage rate.

2. Self-reported unmet need for medical care and care utilisation

We would expect to find a correlation between low consultations per capita and high shares of unmet need in the population. Such a correlation can not be detected (see figure 1). Indeed Malta, Cyprus and Sweden are clear outliers of this hypothesis. They combine a low share of consultations per capita (around 2) with unmet need rates of 2-3%. Cultural differences might influence the perception of need for care.

Best-practice: Sweden, Malta, Cyprus, Netherlands, Luxembourg as defined as lowest results of unmet need plus consultations.

Figure 1: consultations and unmet need



3. Self-reported unmet need for dental care and dental care utilization

Data for dental care utilization are not as comprehensive as for doctors' consultations. In general the variation in visits per year and capita is not as wide as for general care. The countries with the best relation between unmet need and utilization are LU, MT, AT, DK and UK.

4. Life-expectancy and life-expectancy by Socio-Economic Status

As outlined above data on life-expectancy by Socio-Economic Status do not exist (yet). Life-expectancy as an indicator for access to health care has to be seen critically, as most of it is defined by living circumstances, closely linked to working conditions, income and education. Looking at the best performing countries, with life-expectancies over 80 a geographically wide pattern emerges: Spain, Sweden, Italy, France, and Cyprus.

5. Healthy life years

It has been widely recognised, that it is not just important to live longer, but to spend the additional years in good health. Therefore the indicator health life years (HLY) has been developed. International comparison is complicated by the cultural definition of "good health". Also here, data on socio-economic status are not available. Plotting HLY against life-expectancy and ordering them to increasing shares of life lived in bad health, five forerunners emerge: Poland, Malta, Denmark, Greece and Italy. These include also two of the countries with the highest life-expectancy. The laggards are Germany and Finland, with shares over 30% spend in bad health. This can also be an indicator for a high development of medical technology, due to which patients survive also in bad

health. This easily leads into complicated moral questions, which can not be answered in a benchmarking process. The simple life-expectancy in good health is therefore taken as the benchmark here. The most good years are lived in: Malta, Denmark, Greece, Italy and Poland.

Life-expectancy and healthy life years provide a good overview on the overall health status of the population, but the relative contribution of the healthcare system remains unclear.

6. Self-perceived general health, by income quintile

Like unmet need this indicator can also be criticised for its subjectivity. Perceptions of bad and good health are culturally defined. Also effort is made to standardize the questions, they are never the same in all languages and all wordings².

The countries with the highest average self-perceived good health are Ireland, Netherlands, United Kingdom, Sweden and Greece³.

Self-perceived general health is the first indicator available by income quintile. The list for the most just countries, measured as difference between very good and good health in the first and fifth income quintile, looks totally different from the forerunners on average good health: Poland, Slovakia, Italy, Luxembourg, and Denmark.

As the focus of this paper is efficiency and not equality, the first five are taken as best-practice.

7. self-perceived limitations in activities people usually do as a result of health problems that lasted at least the past 6 months, by income quintile

The countries with the lowest share of limitations, both severe and to some extent are United Kingdom, Malta, Greece, Ireland and Spain.

Breaking the figure down to SES, the picture equals the leaders of the self-perceived good health, proving some consistency in the data. The leader in equality are Poland, Sweden, Denmark, Luxembourg and Slovakia.

8. Infant mortality rate

Together with life-expectancy infant mortality is the only indicator selected for EU comparison. The leaders are: Sweden, Luxembourg, Finland, Czech Republic, Portugal. The last two ones indicate, that infant mortality is not just a question of economic wealth and expensive medical technology, also Romania and Bulgaria occupy the last two places in the list.

² Taking a closer look at the data, some irregularities surprise. The share of people in very good health rose in Malta from 2005 to 2006 by average 10% in all income quintiles.

³ Interestingly the subjective indicator on general health does not match the pattern of HLY, which is supposed to be composite indicator based on self-perceived limitations.

Leaving the available breakdowns for socio-economic status aside, the indicators subsumed under objective one *access* expand beyond access to care and draw a picture of the overall health status of the population. The country with the overall best scores on access, life-expectancy and self-perceived health status is Luxembourg (5 points), followed by Denmark (4 points), Italy, Poland, and Sweden (all 3 points).

Indicators regarding quality of care: effectiveness, safety and patient centeredness

Measuring quality and efficiency of different treatments and care systems is at the heart of medical evaluations. Producing European wide comparable data is a complicated task, which is reflected in the indicators chosen and the data available.

9. children vaccination rates

This indicator is composed of many sub-indicators, giving the vaccination rates at first birthday against diphtheria, pertussis (whooping cough), tetanus (DPT) and poliomyelitis, as well as at second birthday against measles, mumps and rubella (MMR). Both DPT and MMR respectively are normally given as a combination.

The last year for which full data are available is 2004. Taking the average of vaccination rates of DPT, MMR and Polio for the first time a clear pattern emerges: the new Member States perform best. The top 5 are Hungary, Slovakia, Poland, Latvia, and breaking the pattern Luxembourg.

A strong public health tradition with a central role for the state, seems best suited to implement full vaccination rates.

10. Cervical cancer screening: Percentage of women aged 20-69 screened

France, Sweden, Finland, Slovenia and Germany are the countries with the highest screening rates for cervical cancer.

11. Cervical cancer survival rates

Cancer survival rates are the best available indicator to measure health status as a result of the medical systems performance. The top5 are six for this indicator, as Denmark and Italy perform alike. The first four are Sweden, Netherlands, Spain and France.

Apart from Sweden and France, high screening rates do not translate into high survival rates.

12. Colorectal cancer five-year relative survival rates

Data are just available for six countries and different years. Benchmarking is therefore not possible.

13. Satisfaction with health care services

Data just exist for sub-indicators of satisfaction with dental care, hospitals, general practitioners and surgery. Taking the average of the four, Belgians are outstandingly satisfied with their health care system, with over 90% in all categories. The other four among the top five are: Austria, France, Malta and the Netherlands.

14. Influenza vaccination for adults over 65+

Data are limited to 13 countries. The highest shares have Netherlands, United Kingdom, Spain, Italy and France.

15. Breast cancer screening

Breast cancer is an supportive indicator to cervical cancer. The highest screening rates exist in Sweden, Finland, Netherlands, Ireland and France.

16. Breast cancer survival rate

High screening rates are matched by high survival rates. The top 5 are Sweden, France, Finland, Italy and Spain⁴. As breast cancer is the most prevalent cancer for women in whole Europe, this indicator can be based on a solid data set.

17. Perinatal Mortality

In contrast to infant mortality, which comprises the first life-year, perinatal mortality is defined as foetal deaths plus neonatal deaths (up to one week after birth). This indicator is attributed to quality of care as it is assumed, that the baby is under medical observation during this time span. The lowest rates are reported from Slovakia, Austria, Denmark, Czech Republic and Finland⁵.

Summing the indicators for objective two *quality* up, France performs outstandingly good (6 points), followed by Sweden, Finland and the Netherlands (all 4 points). The best-practice recommendations deriving from these indicators are quite simple and politically agreed: promoting high vaccination and cancer screening rates. It has to be noted, that just cervical and breast cancer treatments are included in this analyses, nothing can be said about the treatment of non-life-

⁴ Data comprise breast cancer for men and women. However the incidents for men are so low, that they do not change the picture. Data taken from European Commission Health Information http://ec.europa.eu/health/ph_information/dissemination/echi/echi_28_en.pdf

⁵ These are Eurostat data. The Commission itself uses WHO data for the OMC reports.

threatening diseases like flu or dental care.

Indicators regarding long-term sustainability of systems: expenditure and efficiency

To answer the question, which health care system is most efficient, the evaluated indicators on access and quality have to be analysed in relation to expenditures.

Under objective three long-term sustainability, next to overall expenditures also data on systems output are provided. This paper measures efficiency not in an input/output relation but on an input/outcome relation and therefore takes average length of stay and number of doctors and nurses as background information on why certain systems are more efficient than others.

18. Health expenditures per capita in PPP

Expenditure figures are just telling, when put into context. Low expenditures as such are not yet an indicator of an efficient health care system – they can also indicate underfunding.

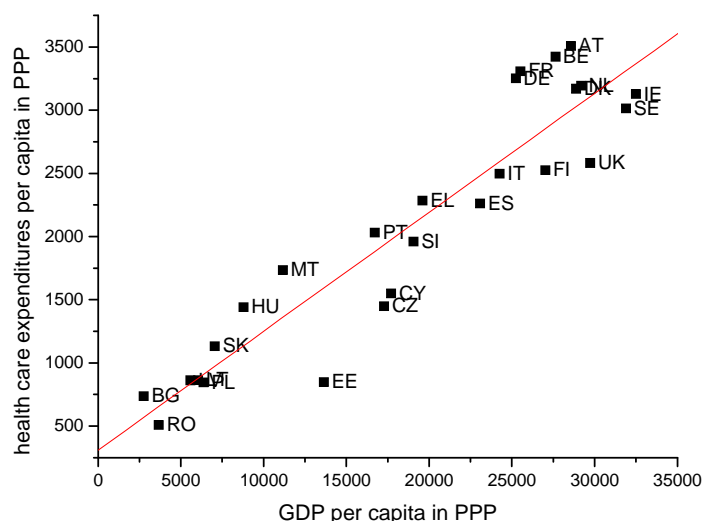
Mapping health care expenditures per capita in PPP against GDP per capita in PPP a clear convergence emerges. Richer countries are not just spending more in absolute term, but also in relative terms (see figure 2).

The five countries spending significantly less, than the correlation line⁶ would suggest are: Estonia, the Czech Republic, Cyprus, Finland, the United Kingdom and Sweden. It is telling that no social insurance country is to be found among those. They are found at the upper end of the expenditure scale, including Austria, Belgium, France and Germany. Also Malta spends more than the convergence line would suggest.

The picture drawn above repeats itself with the % of GDP figures, also not as sharply cut.

Figure 2: Wealth and expenditures

⁶ To allow for comparison, Luxemburg with its GDP per capita twice the second country has been left out.



Identifying the most efficient health care system

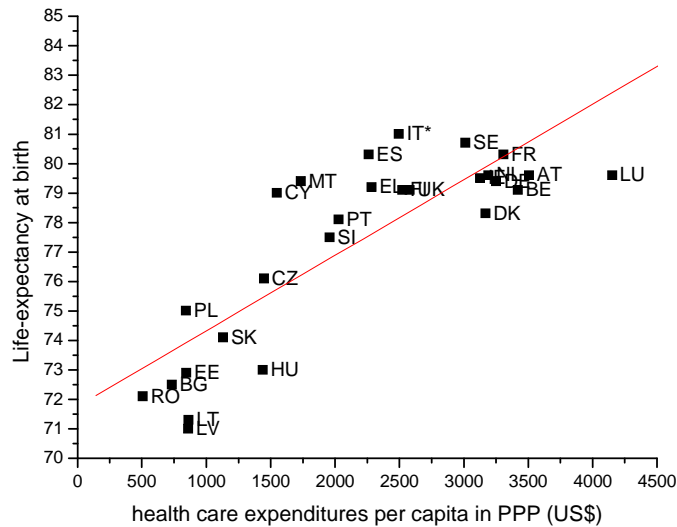
Sweden is the only member state ranging among the top five on all three objectives. It combines universal access with low rates of unmet need. The good performance on quality is mainly the result of good values on cancer screening and survival rates. Besides being the only country, scoring good both on access and quality, it also spends comparatively less on healthcare.

France performed best on the quality indicators, but obviously this high quality comes at a price. The only two countries spending even more per capita – Belgium and Austria - receive outstanding satisfaction rates in return. Finland also combines high quality with low expenditures, while the Netherlands spend slightly more. Here again the problem occurs, that the figures are from 2005, not taking the major Dutch reform into account.

Comparing expenditures with the best performing countries under objective one *access*, Luxembourg poses a statistical problem. The GDP per capita is twice as high as that of Ireland, the second richest member state. Prolonging the regression line for the correlation of expenditures as % of GDP and GDP per capita, Luxembourg would have to spend 18% to fit the picture. The extreme richness of the country hampers comparison. Luxembourg and Denmark, the second best on access, have significantly low life-expectancy rates compared to the expenditures per capita and do therefore not qualify for an best-practice example of efficiency (see figure 3).

Both healthcare expenditure and life-expectancy can be regarded as dependent variables of GDP. Especially good relations between expenditures and life-expectancy have Spain, Italy, Malta, Cyprus and Greece (see figure 3). This leads to the conclusion that the Mediterranean climate, way of life and nutrition could be an explanatory factor.

Figure 3: life-expectancy and expenditures



Denmark is often mentioned as the negative proof for this hypothesis, high smoking-rates (third in the EU), beer and fat, salted pork result in a relatively low life-expectancy, despite a good health care system.

Among the non-Mediterranean countries, Sweden, Finland, United Kingdom as well as Slovenia, Czech Republic and Poland have a good life-expectancy in comparison to their expenditures.

To sum it up, the Swedish health care system would qualify as best-practice model in the OMC process. The health inequalities dimension, included in objective one, has not been taken into account in this analysis, but these Sweden can also serve as a role model there. Health inequalities show an almost direct correlation with status inequalities, which are quite low in the Scandinavian countries.

Commissions favourite

The Open Method of Coordination already presented Scandinavian role models in the past. Most prominent the Danish Flexicurity approach to labour market reforms. In pension reforms they supported the World Bank three pillar model, for which Sweden served as a model how to implement these reforms.

As outlined above Sweden could serve as a role-model for health care reforms, from a technical point of view. The following part looks at the more political Joint Reports and the policy of the responsible DG. Despite its intergovernmental character, incorporated by the Social Protection Committee, the European Commission is the central actor in the Open Method of Coordination, as

it is charged with drafting the Joint Reports. The responsible DG is DG Employment, Social Affairs and Equal Opportunities, in particular Unit E.4 social protection and social services. Nevertheless, the Joint Reports do not solely reflect the opinion of the Commission, but are agreed upon by the Member States in the SPC. Politically sensitive messages are therefore written in capital letters in between the lines. However the Commission can set spot-lights; in health care it emphasises health inequalities. Health care has up to now been included in three Joint Reports (JR): 2007, 2008, and 2009. 2007 was the first full examination exercise, based on the National Strategy Reports 2006-2008. Unfortunately the set of indicators was not developed by then. In 2008 an interim report was published, focussing on health inequalities. As the OMC cycle was changed, in 2009 the next full examination exercise took place, which could draw on the common indicators.

In the following, the three Joint Reports are analysed on their appraisal and recommendations.

Special attention is paid to Sweden, as it was identified as the best-practice country in the indicator section.

In general, the best-practice examples given in the Joint Reports just highlight concrete actions and never appraise whole systems.

The JR 2007 already emphasises health inequalities under the first objective “access to care”. Here increasing co-payments are named as resulting in increasing inequalities in health. For Sweden they are said to have adverse effects on dental care already (European Commission 2007, S. 396). Under the second objective “quality” quite concrete policy solutions are proposed, also without naming countries. The list includes health technology assessments, integrated care concepts, gatekeeper model and market mechanisms (purchaser-provider split). Alongside with prevention and healthy life-style promotion these are also seen as improving financial sustainability. According to the country profile, Sweden follows all these policy recommendations. The reform to improve access and choice has been positively evaluated and the Swedish quality registers are mentioned as a best-practice example.

In the years without full reporting exercises, the Commission publishes Joint Reports, which highlight special issues, based on the same National Strategy Reports. The health chapter in the Joint Report 2008 was dedicating to health inequalities (European Commission 2008c).

Universal access to health care is stressed as a common value of all Member States and central to combat health inequalities. Just countries with universal health care coverage, based on citizenship or residency qualify therefore as a role-model. Even if universal rights exist access can be hampered by geographical distance, co-payments or restricted care basket. Also universal access is legally

granted, Sweden does not qualify as a role-model, because extraordinary high rates in unmet need for dental care among the two lowest socio-economic groups are reported⁷.

Interestingly the main indicator chosen to indicate differences in health between Member States is male life-expectancy at birth, on which Sweden performs best. On life-expectancy for both genders Italy would perform best. Sweden has low rates of health inequalities as it is a very equal society. However no data are reported broken down by SES.

Next to health inequalities the Joint Report 2008 also tackles possible efficiency gains.

The Commission suggests a long list of concrete measures, stressing at the same time increased cooperation and competition between providers and insurers (European Commission 2008c, S. 77)⁸.

The only country, which introduced a health care market are the Netherlands, which would therefore rather qualify as a role-model than Sweden.

The Joint Report 2009 was the second full reporting exercise in health care. Member States submitted National Strategy Reports 2008-2010, which very much relied on the NSRs submitted for the JR 2007. Health is right from the beginning presented as contributing to the Lisbon goals. Good health is to increase productivity, postpone early retirement and reduce absenteeism at work.

Furthermore it is an important economic sector, enabling growth in disadvantaged regions and providing working opportunities for women (European Commission 2009, S. 115). The tone of the report is in general more liberal than before. More salience is attributed to individual life-style choices, like smoking, drinking and lack of physical exercise, charging more responsibility on the patient.

The Joint Report 2009 is carefully avoiding any value judgement and just neutrally summarizes the National Strategy Reports. Countries are therefore highlighted just for examples provided by themselves in the reports, as no additional figures have been collected for systematic comparison. Health inequalities remain an important issue, objective one is now headed "Addressing health inequalities and inequities in access to care".

Sweden is just mentioned for its policies to reduce waiting-times and the ambitious goal to reduce health related infections. Also on policies where it performs among the best, like breast cancer screening rates or integrated care, it is not mentioned⁹.

Driven by Member States priorities in the NSRs more emphasis is placed on prevention and promotion of health life-styles. Finland's health promotion strategy is mentioned as a positive example¹⁰. It also is a positive example for strengthening primary care.

⁷ 15,3 1Q and 10,3 2Q. Among the old Member States, just Portugal shows higher numbers.

⁸ Also the Commission reports the critic by some "participants" on introducing market mechanisms in imperfect markets as health care and calls for caution.

⁹ Just Finland has higher breast-cancer screening rates.

¹⁰ However just in the summery, not in the part devoted to prevention and promotion.

Concerning their structural marked reform the Netherlands are not positively mentioned. On the contrary, it is criticized, that is not clear what happens to uninsured people and that co-payments (deductibles) have risen, contrary to the JR 2007 objective to reduce financial barriers to access (European Commission 2009, S. 118). New topics in the report are sustainability of the workforce and cost-containment for pharmaceuticals.

To sum it up, despite its heading performance on the indicators, Sweden is not presented as a role model in the Joint Reports. This is on the hand one due to inherent logic of the OMC to highlight policies and reforms instead of outcomes and on the other hand on the careful avoidance on behalf of the Commission to create another flexicurity case. Especially the Joint Report 2009 relays were much on the NSRs, Sweden did not make an effort to become a role-model in this report.

These findings are confirmed by research within the DG Employment, Social Protection and Equal Opportunities¹¹. None of the Commission staff working on health and long-term care has a favourite national model. On the contrary, they are quite careful just to highlight limited policies and never full country models. The experiences showed that the praised country failed after three or four years.

Other potential role-models

Depending on further priorities of the OMC, other countries would qualify as a role model.

Currently DG Employment in cooperation with DG SANCO is preparing a Commission Communication on health inequalities¹². When it comes to concrete policy measures, the Commission favours comprehensive national strategies to tackle health inequalities. These have first been set up in the United Kingdom¹³ and in Finland. However in the Health inequalities impact assessment the pattern is reported, that no country is appraised as a whole, but always small initiatives, aiming for example at increasing vaccination rates among migrants.

During its 2005 presidency the United Kingdom brought health inequalities to the European stage by commanding the first comprehensive report “Health Inequalities: Europe in Profile”.

Until today, the UK and its regional NHS branches are very active on the European level to raise the issue salience of health inequalities. The history shows, that countries pushing a problem to the EU stage are often successful in linking it with their national solution. The UK already manages to frame the discourse and its policy statements and definitions are quoted also in the Joint Reports (European Commission 2009, S. 123, 131).

¹¹ Findings are the result of an internship in the Unit E.4 1.4. - 20.6.2009.

¹² Expected for end of October 2009

¹³ "The UK states that parts of Wales (notably the former mining and industrial areas of south Wales) and parts of Scotland have some of the worst health indicators of Europe and certainly Western Europe." European Commission 2009, S. 123

The policies regarded most efficient to tackle health inequalities are promotion and prevention. Finland is often positively mentioned for its comprehensive promotion and prevention policy. In general the Joint Reports are more process than outcome oriented. If market conformity is to become a priority the Dutch “regulated competition” would qualify as a role model. This could be the result of a consolidating process within the European Commission on its manifold health care policies.

Other Policies

The Open Method of Coordination is not the first policy initiative the Commission takes with regard to health care systems. On the contrary, a full range of regulations, networks and policies were already in place, when the OMC health care was initiated in 2006. Do the already existing policies favour one organisational model? Does the Commission as a whole already have a policy stance on health care? The following part gives a short overview of existing EU-policies to see if promoting Sweden as a role-model within the OMC would be consistent.

"Health care policy in the European Union has, at its centre, a fundamental contradiction."

(Mossialos et al. 2000, S. 27)

On the one hand, Art. 152 explicitly reads "excluding any harmonisation of the laws and regulations of the Member States". On the other hand, is health care an important economic sector employing between 3 and 10% of the workforce in the member states. It is therefore also subject to the four fundamental freedoms. It is a constant dispute how far the free movement of goods also applies to pharmaceuticals and devices, free movement of people to health care professionals and patients and free movement of services to health care funders and providers.

"The argument, therefore, that subsidiarity applies to health services is not fully sustainable, within the context of the SEM [Single European Market]." (Busse et al. 2002, S. 2).

Mossialos and McKee argue, that this inherent contradiction can not be solved as long as legislators and the ECJ have no reference framework of health care, which is to be respected.

Thus "basic economic freedoms and European competition law are part of primary Community law and so prevail in any legislation in the field of social security or health care." (Mossialos et al. 2000, S. 31).

The Council made an attempt to establish such a framework in its Council Conclusion of 2006 "Common values and principles in European Union Health Systems". It is a clear statement, that the member states do not want health markets enforced upon them. They furthermore call for a clarification of the EJC rulings concerning health care. However, due to the disparities between national systems just common values could be agreed upon, no common structures.

Due to its market character health is a subject in many DGs. Generally DG Market supervises the application of the four fundamental freedoms of the single market. Also social security systems are generally excepted from this rules, it is still unclear how they are applied to private health insurances, a question especially hot for the Netherlands, who transformed their social insurance system into a regulated competition. The strongest regulation takes place on pharmaceuticals.

Already in 1989 the directive 105/89/EEG regulated the pharmaceutical market. DG Competition just recently closely scrutinized the pharmaceutical market to detect cartels. At the same time DG

Industry protects the pharmaceutical companies to strengthen the European competitiveness worldwide.

The above mentioned DGs follow a clear market logic instead of a public health logic.

The lack of a health framework of reference leads to contradictions in the EU policy from a health perspective. The most widely cited example is tobacco. While the Common Agricultural Policy subsidises tobacco growing, the EU at the same time runs the *Europe against cancer* program with a clear focus on lung cancer caused by smoking. In 2002 the corresponding campaign *feel free to say no* was launched (Guigner 2004).

Public health as an overall priority is enshrined in DG SANCO. To insert its issue into the overall Commission priorities, SANCO had to reframe it in economic terms (Guigner 2004). The DG sponsored studies calculating the economic gains of reducing health inequalities (Mackenbach et al. 2007). Already in 2001 SANCO published an impact assessment guide to mainstream health in other policies. However this did not find the same attention as the gender or environmental mainstreaming. Currently two important initiatives for the future of European health care systems have been issued by DG SANCO: patient mobility and health workforce.

Patient mobility

The proposed directive “on the application of patients' rights in cross-border healthcare” (European Commission 2008b) is based on Article 95 of the treaty, which means its purpose is to guarantee the functioning of the internal market.

Health care is defined as a service, for which the free movement of services applies.

Historically health care was already included in the service directive, but massive public protests lead to the outsourcing into an own directive. Nevertheless the market logic is maintained. The directive has been blocked by the European Parliament and the future of the directive is in the hands of the new parliament.

From a theoretical point of view, NHS would be disadvantaged by this directive, as central planning and prioritising are endangered. In reality however the United Kingdom and Sweden already bought health care abroad in a systematic way to reduce their waiting lists. They would be favoured by the new regulation.

Health workforce

In December 2008 DG SANCO presented a Green Paper “On the European Workforce for Health” (European Commission 2008). It aims at implementing the free movement of workers – one of the four freedoms enshrined in the treaty – for doctors, nurses and other health care personnel. Also the logic behind the paper is clearly market based; it is expected to favour the western national health

services most.

In the United Kingdom, Sweden, Finland and the Netherlands a short cut of medical professionals exists or is expected for the near future. The countries suffering from “brain drain” are the new central and eastern European member states. Increasing mobility is expected to "require workforce managers at local and/or national level to review the adequacy of their recruitment and professional development measures." (European Commission 2008, S. 9).

The underlying logic of the green paper is at the same time governmental planning and competition between these regional or national planning units. Interestingly the Council Conclusion condemning further market integration in health care is not mentioned in the document. The country profiting most from this regulation, if it is going to be enacted, is expected to be the United Kingdom.

Busse et al. draw up a worst case scenario for the implications of further integration of the single market on health care. The Beveridge systems are expected to be severely endangered as their public character and the prioritising are challenged (Busse et al. 2002, S. 2). However, the reality shows, that the impact of further integration differs not so much between NHS and social insurance systems, but between rich and poor member states. The latter are losing qualified personnel. Their patients will not benefit from the patients mobility directive, as the price difference between the home system and the receiving has to be covered by the patient. Possible winners in these countries are private clinics targeting at western Europeans.

In general the two scrutinized directives do not show any sympathy towards an abstract structure for health care systems, be it either NHS or social insurance. Nevertheless in reality the United Kingdom and Sweden will profit most from these two regulations and both are said to have been pushed forward by the United Kingdom. From an actors perspective the former has a quite strong stance in EU healthcare policy, be it health inequalities, patient mobility or health workforce.

Conclusion

Who is OMCs darling in health care? – Nobody.

Also Sweden would qualify as a role-model based on the indicators chosen under the Open Method of Coordination, this labelling does not take place for a variety of reasons. The first is already rooted in the OMC-indicators itself, where the Member States could just agree on European wide comparison on life-expectancy and infant mortality.

The second is to be found in the DG Employment, Social Security and Equal Opportunities, which does not want to promote one country as a role-model. Also the famous example of Danish flexicurity was more enforced on them, than their own favourite.

In the Joint Reports there is no clear line on preferred structures, which would increase efficiency. Also market mechanisms are appraised, the Netherlands, which implemented them the most far reaching, are criticised for the negative consequences of it. Already in 2002 Busse et al. named “regulated competition” as the health care model best compatible with the Single Market logic (Busse et al. 2002). The Netherlands reformed their system towards “regulated competition” in 2006. Unfortunately data for the implications on output and outcome of the reformed system are not yet available.

As no coherent model exists, there can also not be coherence with the other policy initiatives like patient mobility and health care workforce, they follow the common line of further integration of the single market. A consistent role-model is desperately needed if health care as a social policy and common good is to get on an equal footing with market principles. The OMC would provide a starting point to develop such a framework of reference but is not used up to know. From an indicators point of view, Sweden would qualify for this role. However from an actors point of view, the UK are much more active to bring health issues and their special concerns, like health inequalities, free movement of patients and health care personal, as well as purchaser-provider split to the European agenda. They maintain good relations with both responsible DGs Employment and SANCO. An implicit framework of reference might therefore also be based on the British NHS.

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