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HEALTH POLICY IMPLEMENTATION AT THE CROSSROADS OF COMPETITIVENESS AND EUROPEAN COMPETITION REGULATIONS[1,2]

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Abstract:
With the financial and technical support of the Third EU Health Programme, the European Union (EU) takes action in the field of health policies and adds an EU-level value to the improvement of health status for its citizens. Also, the EU has another instrument that helps those efforts and these are usually made on national levels: through the extension of the Internal Market to those services that are formerly organized only on a public health level, and supervising all these actors through competition regulation, there is a chance for added results. The EU has limited influence on how effectively Member States (MSs) organize their national healthcare systems. National health depends on several factors: the national regulations, the financing schemes and to what extent public/private actors are involved as investors and moreover as providers.
This article is part of a research in connection with the role private actors play in the healthcare market: is their appearance increases the level of competition. This research phase is now focusing on the possibilities of EU-level involvement in competition of healthcare market and in competition cases. According to the article competition is mainly appearing on sub-markets that are evolving according to market principles and furthermore the competition-for-market type changes are also visible. A second focus point is what type of competition distorting actions these changes may bring. A majority of state aid relevance is seen here; so all those possibilities will also be presented (e.g. SGEI) with which MSs are able or try to avoid the effects of EU-level involvement.

Keywords: EU, healthcare, health policy, competition regulation, services of general economic interest, SGEI.

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1. THE RELATIONSHIP BETWEEN COMPETITIVENESS, NATIONAL HEALTH POLICIES AND EUROPEAN COMPETITION REGULATIONS – THE SCOPE OF THE ARTICLE

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). Arora (2001) has examined the economic development of the last century, and found that the 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 take the top positions of economic competitiveness ranking e.g. Sweden, Germany and Denmark. Such data prove that a population's productive capacity has always been more robust than all other forms of wealth combined (Schultz, 1961). Although 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 becomes even more important (WEF, 2017) – the human factor still holds its position. It is the responsibility of education that people are capable and ready to adopt the technological revolution; a highly advanced health status is a prerequisite for all that. In this context it is easy to understand why an advanced healthcare system[3] that puts preventions 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, rising expectations and constant innovation, health care is at the heart of modern society.'* (Sautner & van de Gronden, 2010).

The best evidence for health and economy relationship is the series of Global Competitiveness Index indicators, published by the World Economic Forum, which indicators 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.

As the Commission's working document: "Investing in health" reveals, health status, competitiveness and economic growth are among the objectives of both the Member States and the European Union. This document is part of the Social Investment Package (EC 2013). On an EU level, through an integration process, these objectives are intertwined even further in healthcare. In this context integration means the acceptance of EU principles like the free movement of services and the introduction of competition in formerly publicly managed fields of the economy. In the meantime, with the amendments of public service special categories and the neutrality principle in force, which guarantees MSs a level of discretion in healthcare regulation, the integration process also respects a nation's right to fund its healthcare system and allow access to that system. This leads to the topic of competition regulation that aims to support EU intervention on even social rights while simultaneously focusing on market economy issues. MSs however have followed a different path or taken a different view on how competition in healthcare is to be visualized. Their image has strong roots in their own national origins and traditions. On the long run, one may discover some links between the introduced or chosen healthcare system and national competitiveness, but in the short run there is evidence only for an increase in the number in competition cases that involve certain healthcare systems.

This article is part of a longer and broader research into the possible connection between competitiveness seeking economic and healthcare policies. At this point, it is important to note that in general, excluding the differences in domestic HC systems, the EU laws apply uniformly within the European Union. Right here the first question is whether different healthcare models are still viable or visible by different MSs. Due to the EU-level involvement in healthcare regulation, internal market and competition regulation, it is supposed that the earlier traceable borders of models are now becoming increasingly blurred. Here the details of each system will not be shown; only some partial summary of healthcare budgeting, management and the extent of market mechanisms will be highlighted.

When introducing the level of private sector presence in the healthcare market (i.e. liberalization of the market), either as investors or providers, their level of competition, their competition distorting actions (visibly

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

through the increased number of cases at the European Court of Justice) it is inevitable to analyse whether competition and its regulation may have an influence on healthcare integration.
Here appears the second question/hypothesis about how far the EU can go with integrating healthcare markets and, right in connection with this, how big room the MSs have in implementing their own policies on healthcare market?
Since the paper is the first part of a longer research it has a descriptive nature, with the aim of describing the nature of healthcare affairs in the European Union. Its aim is also to broaden the description with the introduction of present possibilities of the EU and to put a highlight on current EU-level issues of management of healthcare systems. Besides its descriptive nature some limitations are expected during the research. These arise firstly from conceptual differences. Secondly due to the lack of information on organizing financial backgrounds, i.e. the rate of out-of-pocket payments is usually estimated because these payments are, by nature, sometimes part of the grey or black economy. And finally even if economic indicators are available, and so the increase of spending may be surveyed, their effective use on the long run will only be seen within decades, if at all.
So, in this phase only the role of EU-level competition regulations, the level of competition, the way of liberalization and the different "gates" that provide peaceful islands for healthcare in the MSs will be presented. It is also the aim of this paper to evaluate whether, with respect to the differences, EU-level added value is real value added to the domestic HC systems, and at the same time it will be investigated whether these countries are among the pre-1995 MSs or the New MSs.

2. HEALTH STATUS IN MEMBER STATES

Although the European Commission has no specific framework to assess healthcare system performance, it may still carry out performance evaluation. An analysis of health status in the EU MS populations can be based on the European Community Health Indicators (ECHI) Data tool. The work by Kuruczleki & Pelle (2017)[4] relied on such data possibly from 2015, the last available year, and in some cases from 2004 onward[5]. Their statistical research also included the GDP figures per capita in PPS (2015) for each member state, and in the second phase of the research, the authors examined health performance indicators according to the Global Competitiveness Index scores of the MSs.

Table 1: Health status of Member States with respect to their wealth and competitiveness

Low performance indicators (0.2-0.45) and low (14,000-24,000€) GDP/capita in PPS (2015)	Middle performance indicators (0.45-0.55) and middle (24,000-28,000€) GDP/capita in PPS (2015)	Best performance indicators (0.49-0.71) with the highest average (28,000-38,000€) GDP/capita in PPS (2015)	An outstanding performer with a 0.89 indicator and high (38,000€) GDP/capita in PPS (2015)
Romania Latvia Croatia Bulgaria Hungary Lithuania Slovakia Portugal Estonia Poland Greece →	Italy Czech republic Slovenia Cyprus Spain →	← Malta Finland United Kingdom Austria France Belgium Germany Denmark The Netherlands	Sweden

[4] The work in progress by Kuruczleki & Pelle (2017) was presented on the Italian Health Economics Association (AIES) conference in October, 2017.
[5] Health indicators used in the analysis are for example (a) at risk of poverty rate, (b) +(c) healthy life years at birth for both men and women, (d)+(e) healthy life years at age 65 both for men and women, (f) infant mortality rate, (g)+(h) life expectancy at age 65 and at birth, (i) Live birth per 1,000 population, (j) proportion of persons who assess their health to be very good or good and finally (k) total fertility rate.

GCI score range from 4.1-4.75	GCI score range from 4-4.6	GCI score range from 4.95-5.5	GCI score for Sweden is 5.41

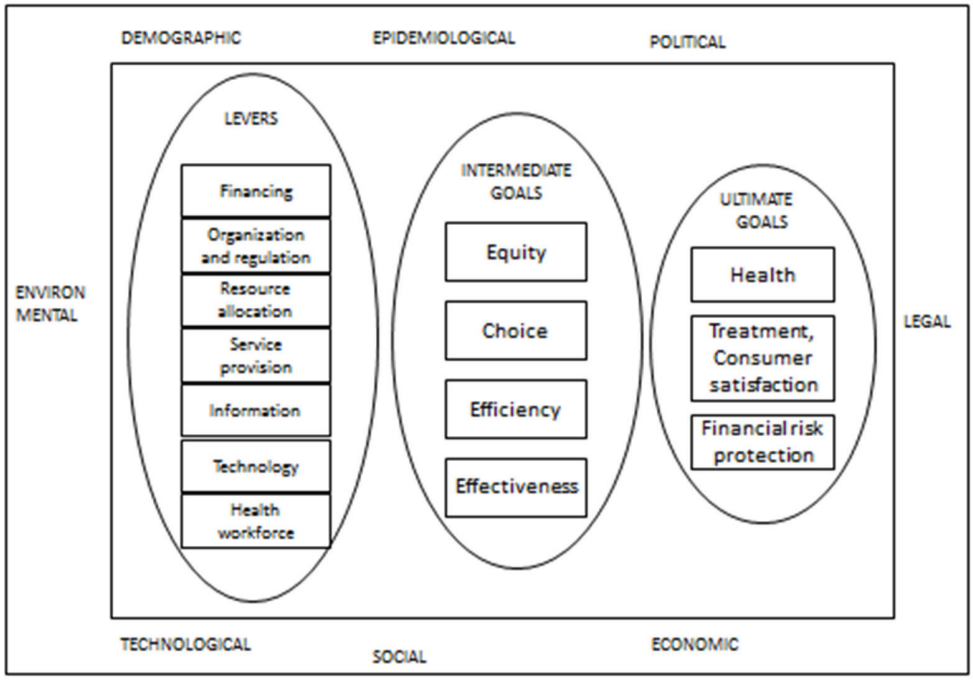
Note: if we check the health status from competitiveness aspect (the bottom of the table) we found that Greece and Malta moves from their original position to the second group of MSs.
Luxemburg and Ireland stands out because in the year 2015 these countries have a relatively high GDP/capita in PPS.
Source: the author's own work based on data by Kuruczleki & Pelle, 2017.

If, in the study of Kuruczleki & Pelle, the other two dimensions are being compared of one can see that the relationship between GCI scores and health indicators show a similar but not identical picture: Greece stands at a better position, meanwhile Malta is closer to the second group. Sweden is a separate group on its own because this country has the highest health performance indicators compared to competitiveness.
From the scores and the results it is visible that health status is not only about wealth expressed in GDP/capita and not determined even by a competitive background: there are cases where two groups greatly overlap each other indicating that almost the same level of health status is avaliable, while these groups differ from each other enourmously in the other two factors. Therefore researchers should be agreed when they claim that geographical, traditional and cultural origins determine the health status of a country's population. These together construct a social capital factor – containing also social connections/networks, norms and trust– from which who have strong basis, can gain even economic benefits. Moreover it can be even cumulated and perform as a precious property for both communities and nations (Pöschl & Valkova, 2015).
In the following, health status results will be compared with the healthcare systems in the MSs to discover whether there is a link between health status and financial background and the way these factors are managed.

3. HEALTHCARE SYSTEMS IN EUROPE

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 from the part of the governments (Farkas, 2016). But in the meantime 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 was described above. From the point of view of this study, the differences in the way health policies are organized on an MS level are planned to be mapped.
When MSs are being surveyed by the type of national healthcare system they manage, It should be emphasised that, as Atun and Menabde (2008) claim, these systems are dynamic frameworks. The authors took 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 systems management, the authors' systems framework identifies *four levers/opportunities for influence* in the hand of policymakers: (1) stewardship and organizational arrangements; (2) financing; (3) resource allocation and payment systems provider; (4) service provision. 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, have later been amended with the following factors: (5) information, (6) technology and (7) health workforce (WHR 2000).

Picture 1: conditions and goals structure of national healthcare systems



Source: the author's own work based on Atun and Menabde, 2008 and WHR, 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 determine its financing backgrounds 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.

3.1. Healthcare finance – public and private investments in healthcare

When looking at the structure of public expenses, one can see that in general all developed and successfully emerging economies are investing in education, infrastructure and, as a key element for all these, considerable healthcare expenses are incurred. It is also important to mention that, depending on how a state declares and describes its own roles and duties, support, welfare expenses and health expenditure are weighted differently in each state's budget. Furthermore, in the developed world, where health and its contribution to future prosperity are managed properly, and not determined by short-term political goals, where structural planning and coordinative management are functioning, health becomes more and more an issue of service provision, liberalization and the introduction of market conditions.

The health financing goals that had been set up by the WHO correspond with the values of the EU health systems (universal coverage, solidarity in financing, equity of access and the provision of high quality healthcare), as asserted by the Council of the European Union, and also with the European Commission's common principles (accessibility, quality and long-term sustainability) (Thomson et al., 2009). These points could only be supplemented with transparency and administrative efficiency. Without offering a full picture on each MSs' financing mechanism, here only the most important ways these mechanisms are put in place will be shown. One method to analyse the role and presence of competition on the healthcare market is to map its financing structure. This reveals whether the insurance coverage is provided by a national, local or common insurer (single-payer system), or there may be multiple, competing insurers present on the market (Goddard 2015).

Table 2: Sources for MSs in budgeting the healthcare systems

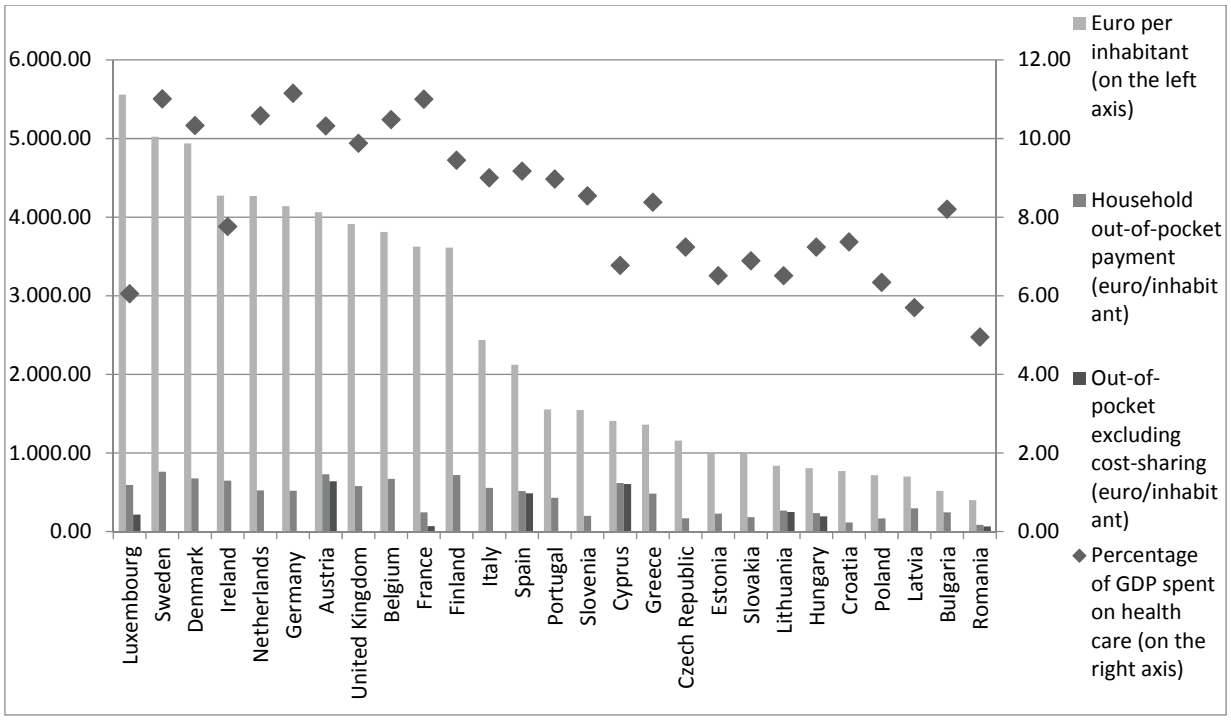
Financial sources	Contribution mechanisms	Collection organizations

Individuals, households and employees Firms, corporate entities and employers Foreign and domestic NGOs and charities Foreign governments and multilateral agencies	*Public* Direct and indirect taxes Compulsory insurance contributions (earmarked taxes) *Private* Private insurance premiums Medical Savings Account Out-of-pocket payments (direct payments or cost sharing/user charges)	Central, regional or local government Independent public body or social security agency (jointly, for all social benefits, or for health benefits alone) Public insurance funds or private non-profit-making or profit-making insurance funds

Source: Thomson et al. (2009, pp. 51.)

Thomson et al. (2009) provides a detailed introduction to reforms, trends and recommendations in health care financing within the EU. Moreover, the authors draw up the evergreen sustainability issues of financing healthcare. Necessary reforms in healthcare and long-term care systems that ensure quality and affordable access in a fiscally sustainable way, appears also in the Annual Growth Surveys (AGS) of the European Commission year-by-year (COM(2017) 690).
Another interesting issue is whether higher rates in social expenditure lead to better health outcomes. According to Table 1, there is a link, but that does not explain all the results. Rubin et al. (2016) examined this topic in their cross-national empirical analysis of social expenditure and population health measures.

Picture 2: Basic data on healthcare expenditures to GDP ratio and population (2015)



Notes: On Slovenia only 2014 data has been available; the relevant data on Malta is missing. Percentage of GDP spent on healthcare[6], Healthcare spending per capita[7] Out-of-pocket healthcare spending per capita[8]
Source: the author's own work based on Eurostat[9] data.

These data in Figure 2 are interesting from the different-income perspectives. The results of Rubin et al.'s (2016) empirical analysis are in harmony with the findings of Farkas (2016) on the possible grouping of MSs based on their social systems, indicating that income inequality has a huge impact on the overall success of these systems. Moreover, differences in income raise new questions about the potential to progress toward a universal health coverage and promote inclusive social and economic development at the same time. It is necessary to strengthen domestic resource mobilization, as it is demonstrated by Meheus & McIntyre (2017). MSs should cross these objectives with other economic interests even if a country's economic development level does not predetermine its spending levels (Meheus & McIntyre, 2017). Government revenue can be increased through improved tax compliance and an efficient revenue collection; revenue can also be maximized from minerals and other natural resources, and tax rates can be increased, where appropriate. Increasing government revenue through taxation is however not advisable in each field or time period. Recently, the European Commission has been more pro-active in investigating tax rulings granted to companies, and, in several member states, has ruled against "selective tax advantages" deeming these to be illegal under the EU competition policy state aid rules. The EU is not only competition neutral, but its fiscal governance also means that the EU must play a part in keeping states within (or close to) the Stability and Growth Pact (SGP) compliance, even if the states in question cut back on their health systems, and still cannot escape their economic plights, or if they are willing to invest more in healthcare. These asymmetries produce a very distinct and narrow vision of health services. Health systems must comply not only with competition law, and rely on state aids, but states must also convince the Commission and the Council that the countries' health policies are unlikely to contribute to the breach of the SGP rules (Greer, 2014).

3.2. Healthcare management on a Member State level

The MSs' healthcare systems 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, treat the sick and protect families from huge medical expenses. The present twenty eight MSs are developed world countries, where, although local variations exist, the various healthcare systems follow some general patterns from which some basic models could be drawn up. Traditionally there were three models: 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 the 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[10] assume that the above-mentioned three former models should converge even more and formulate a mixed one. For example, in many Beveridge type countries market mechanisms have also been introduced as an attempt to move towards (regulated) competition and increase efficiency (Ecorys 2016). From this aspect, it seems to be more effective to use the governance-based classification of the European

[6] Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health, but does not include water and sanitation provisions (World Bank).
[7] Total health expenditure is the sum of public and private health expenditures as a ratio of the total population. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health, but does not include of water and sanitation provisions (World Bank).
[8] Out of pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure (World Bank).
[9] Data have been extracted from http://ec.europa.eu/eurostat/data/database?node_code=hlth_sha11_hchf
[10] 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

systems, and the type of payers and of providers that are presented in these classifications. The following types have been made known by Docteur & Oxley (2003) and the OECD (2004) and referred to in the ECR (2017):

- The 'public-integrated model' is characterised by public payers and public healthcare providers, i.e. healthcare professionals are for the most part public sector employees.
- The 'public-contract model' combines public payers and private healthcare providers.
- The 'private insurance/provider model' applies when private insurance entities contract private healthcare providers.

Table 2: The role of private actors on different levels

	Public-integrated model	Public financing and mixed (public and private) service provision	Public-contract model	Public financing with a higher proportion of private financing, mixed services provision	Private insurance and provider model
MSs	Denmark, Luxembourg, Romania, Spain, United Kingdom	Austria, Belgium, Bulgaria, Croatia, Czech Republic, Finland, France, Germany, Hungary, Ireland, Italy, Lithuania, Malta, Poland, Portugal, Slovakia, Slovenia, Sweden	Estonia	Cyprus, Greece, Latvia, the Netherlands	

Source: the author's own work based on the ECR, 2017.

Private actors are not only sources for healthcare funding, but they also play a growing role as providers. But, it is important to mention that Rubin et al.'s (2016) research with empirical analysis found that the relationship between social spending and health was stronger and resulted in better outcomes for health status when public and private expenditure are separated, and only public social spending is taken into consideration.

Within the framework of the OECD, surveys (2008, 2010) have been carried out. These surveys have appeared to be important in understanding the relationship between the organisational features of health systems, their performance and the level of health spending. The one from 2010, a study by Joumard & André & Nicq (2010) was focusing on the degree of reliance – heavy or limited reliance on market mechanisms and heavily regulated public systems – of health systems on market mechanisms and the regulations concerning the demand and supply sides of health services.

Table 3: The extent to which health services provisions rely on market mechanisms

Degree of reliance on market mechanisms in health service provision	Very significant private providers	Limited private supply, but wide choice	Limited choice of providers, heavily regulated public systems with gate-keeping
	Austria, Belgium, Czech Republic, France, Germany, Greece, Luxembourg, Netherlands, Slovakia	Sweden	Denmark, Finland, Hungary, Ireland, Italy, Poland, Portugal, Spain, United Kingdom

Source: the author's own work based on Joumard & André & Nicq, 2010.

With an expected increase in private services, more focus is placed on the relationship with consumers and less with the state. This fact however also increases the likelihood of a financing conflict. If more healthcare is financed from state resources while, in the meantime, the providers market is becoming more service and consumer oriented, and managed by private actors, the more probable it is that questions arise about how this fact affects the internal markets of healthcare services.

Due to the above-mentioned reasons, and since not all MSs have introduced new principles and opened up their national social systems for competition in healthcare, the implementation of public healthcare policies has become heterogeneous and fragmented. As Goddard (2015) claims, the term "competition in healthcare" covers many variations, meanings and even practical interpretations. She describes the differences in how competition may take place in HC markets as follows: firstly, competition does not equal with private sector provision, since competition may take place within public providers also. Secondly, even private actors may be funded from public sources. Thirdly, competition can evolve independently from prices only if there is a possibility to choose among providers. Fourth, healthcare systems are in a way similar to network industries because competition for the market may sometimes (in case of a limited number of actors) be more important than competition in the market. In this field public procurements have a great role, and consequently competition rules or public procurement rules apply. So it seems that the debate is not about competition versus no competition, but rather about choosing the optimal level of regulation (the most effective level), the combination of local, central or EU-level regulation, and the level of market players or market sources involved. Furthermore, the establishment of an optimal structure leans on the circumstances under which this structure delivers its best results. This will depend on the slight differences in the political and cultural conditions that exist in the different countries. Even in the European internal market there are settings and occasions when competition is considered to be a problem, while, simultaneously, in other markets or other periods of time (under the rule of different political parties) competition appears to be the solution (Goddard 2015).

4. COMMUNITY RELEVANCE IN HEALTHCARE

Although the EU is a so called "regulatory state" with a powerful legal system and enforcing "constitutional" provisions, 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. But even so, based on its earlier experience in other sectors for developing sectoral regulation, the EU is trying to introduce positive integration through first liberalizing the sector in question (i.e. energy) and then creating common regulation on a Community basis. It is presumed that in case of healthcare this template is a bit too simple as Guy (2017) found it.

Health policy is a typical example for a field without significant (not even mentioning exclusive) authority, as written above. So national governments organize healthcare and ensure that it is provided in such a way that it facilitates the future competitiveness of the state. Even this national level healthcare management, due to its sensitive characteristics, has long been subject for debates.

It was decided decades ago that, in line with the Treaty of Rome, healthcare policy belonged to the sole competency of the MSs. In the beginning of the 1980s, the EEC has already 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, but 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), 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 about serious cuts in healthcare spending done 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-regulating 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 point 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, realize positive outcomes through economies of scale and pool 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 have 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 correspond with the basic, constitutional principles of EU law (Greer 2014). Although there are huge national interests in it, the health sector is not excluded from the freedom of movement of goods, services, capital and people. An internal market for health care, a stronger cooperation between health systems could be better off when facing the increasing mobility of patients and healthcare professionals. Due to the relatively fast advancement of the four freedoms, the EU health systems increasingly interact with each other. The pressure that the four freedoms exert is high: there is an underdeveloped internal market of health care because these health systems could develop for decades in a relatively safe harbour with different norms, funding, level of liberalization, and of course how "success" is measured in the context of health status.
In this system, the latest fiscal crisis of the EU brought again a push from outside the relevant market because the crisis increased the need for re-focusing, re-shaping public services in line with economic interests. Moreover increased mobility of patients and healthcare professionals put also a pressure on the internal market for healthcare. Since the Services Directive and the Directive 2011/24 on the application of patients' rights in cross-border healthcare have entered into force, the EU health systems interact with each other increasingly within the internal market. Due to this healthcare services may even flourish and the cooperation between health systems could be stronger as well.

4.1. The crossroad of competition regulation and healthcare services

The means by which MSs organize their health care systems determine how far EU-level competition policies may "go" in the 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, 2012). The question can be asked in a different way: which regulatory method seem 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.
There is a two-folded 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 more powerful, but sometimes unpopular with the extension of internal market laws, and with that the European competition regulation, to healthcare services (Greer 2013). In the setup of a European cross-border healthcare market one arm is the legislation, but the other arm can be the active role of competition regulation.
Compared to the narratives of its sensitive characteristics and narratives of the many national interests, the regulation of HC systems, and their view from a competition regulation perspective, has a relatively old history. Court rulings such as the Kohll[11] and Decker[12] 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 significant drivers 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.
Today, with the latest amendments, the EU competition law controls the behaviour 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).[13] 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 from this prohibition of state aids, but since healthcare has high national sensitivity, it is not listed among them.

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 compensations in the context of EU state aid rules[14] 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 (hereinafter referred to as PSO) these funds do not constitute state aid. Therefore any compensation that meet the obligation to provide universal coverage is not state aid if it fulfils four conditions: the public service should be clearly defined (1); the parameters of the compensation should be objective and established in advance (2); the compensation cannot exceed costs (3); and 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" (4).

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 (hereinafter referred as 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

[11] Case C-158/96 - Kohll v Union
[12] Case C-120/95 - Decker v Caisse
[13] About the contemporary analysis of EU competition law's effect on health care sector see the article of Sautner & van de Gronden (2010).
[14] Case C-280/00 - Altmark Trans

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 what 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 Sautner & van de Gronden (2010) describes it, the possibility for MSs to define SGEI provides space for them to take into account technical, economic and socio-political developments.

It is not marginal 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 involve 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 be having 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 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 better into account. Of course, this was a reply also to the latest phenomenon that occurs in HC systems, namely bringing market principles/characteristics into healthcare policies. The SGEI allows for a proportionate exception to the rules of the EU competition regulation as exceptions to the general competition rules (Sautner & 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 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 between upholding national measures that restrict economic freedoms in the name of non-economic interests, and in the meantime, when it is possible, the EU allows market principles to appear at the level of funding, provision, and access to the services of the national healthcare systems (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, Sautner & 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.*"'[15] (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)[16]. It seems that from the point of competition regulation, healthcare providers are positioned between the two extremes depending on the sources of their system (taxes based on solidarity or insurance based

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

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

on the principle of competition) even if, in fact, most national systems are mixtures of these two (Anchini, 2016).
As introduced in the first part of the article, high level domestic interests and possibilities in regulation result in the different nature of markets in healthcare. With the framework established by the EU for developing competition, and with all the above-mentioned “gates” and flexibility built into the competition regulations so that MSs can express these differences and decide on the degree and extent of market, reforms may not bring the planned health market integration.
As Greer & Rauscher stipulated in 2011, 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 to EU law, and where there is, it is driven by domestic political agendas. It is the Community level regulation of competition and healthcare that confines 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. Finally, practice usually decides whether an intervention or investment in the healthcare market is considered to be state aid or not.
These are more valid for the NMSs. Usually cases are analysed and evaluated in detail and the ECJ/NCAs are examining 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. That is to say the automatism exists, but also the means to avoid the relevancy of EU level competition regulation with respect to this field of the economy. National Competition Authorities (NCAs) may contribute to the enforcement of EU competition laws, since they are not directly responsible for social policy objectives. This may bring more conflicts on a national level. It has been mentioned that the ECJ broadens 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 the EU competition laws and market values and directly neglect the general social interests or what is best for the 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 (Sautner & van de Gronden 2010), which will bring more diversity and divergence on a market where some progress may be achieved.

5. CONCLUSIONS

Member States’ health policies are defined by at least three different groups: the “economic”, “social” and “health” advocates, who naturally have different agendas, measures and understandings of health policies. Within such circumstances any EU-level action has a small chance to speed up policy-making; if national healthcare policies are placed on an EU-level they find themselves in an area within unclear EU framework, powers and little basic agreement.
Human capital is the investment in human resources in order to increase its efficiency. In fact, the costs of this investment are provided for future use and its efficiency is not foreseen. Healthcare is only one category of this investment. As the results of related research have presented, there is no perfect correlation between health status and the amount of money spent on healthcare. As it was shown in the introduction on the health status part, the social, geographical and traditional determinants have more influence on health. Healthcare models may also have some impact on the different health status of countries, but as it was shown the differences between the earlier models diminished and although local variations exist, the various healthcare systems follow some general patterns. Due to demographic and financial reasons health systems have undergone considerable changes in the recent decades and even overlaps or similarities surfaced. For a more detailed description of possible existing models further research is needed, but with the EU’s contribution in healthcare integration the former models necessarily converge even more and may formulate a mixed one. This EU-level involvement in influencing HC markets is undoubted due to internal market, services directive and competition regulation as a set of rule of the game.
However, healthcare regulation still occurs on a national level, and several “gates” exist for MSs to avoid competition regulation. The ways competition appears in the healthcare market may differ, and the principle of competition for the market instead of competition in the market appears also. If a MS is committed to

integration, and follows Community-level regulations, it also may enjoy the possibilities of a certain confine because there are more possibilities for MSs to avoid strict competition rules in their healthcare market. The first possibility of exception arises with the Altmark criteria in connection with the state aid rules. The second exception is provided by SGEI regulations and in how they define their own HC services. The definition of undertakings and their relationship with financing is the third possibility. And finally, the decision whether an intervention or investment in healthcare market is considered to be state aid or not is usually determined by practice. Thus, opposing the original hypotheses that liberalization on the healthcare market will bring more competition cases, we can expect to see only small changes in their numbers due to the several possibilities to escape EU's competition regulations.

If a research result comes from an integrated (free flowing) public services market or inequality 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 is that MSs cannot pick those parts that seem to be promising, since those will not be consistent with their whole structure and only lead to a patchwork of best practices, which also lacks the 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 bring synergy, but operations that are worse than earlier models.

Another fear is the analogy of relationship between inequality and poorer health. If this is translated to the conditions of the whole EU, it is not difficult or surprising to see that inequalities between regions on EU-level have the same worsening effect on health status, even if the EU introduces common actions. Each MS opens up its healthcare market on a different level: different amounts of money are spent and different approaches are introduced. Any EU-level common action that is derived for example from the competition regulations with the intention to support internal market on this certain market as well, will face difficulties arising due to these differences.

One further direction of future works in research of healthcare's contribution to competitiveness is planned to be conducted on an EU-level. Their interactions – short term cuts in the expenditures or long term structural reforms in healthcare in order to achieve a more competitive environment and from a counterpart the contribution of health status improvements to the increase of national competitiveness – a may be analysed with the help of statistical toolkit. Another way of broadening present research is to go into detailed analysis of especially Hungary's healthcare policy; whether Hungarian government is open towards EU-level initiatives in this field of the economy, or our DEPLESET contexts and the implemented 'gates' allow us to keep healthcare system in national 'hands'.

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