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What are the implications for the Nordic countries?

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Abstract
Health care is an area that remains formally outside the competence of the EU. Despite this, the union's influence on national health care policies has increased substantially over the past decade. In a series of rulings, the European Court of Justice (ECJ) established a de facto system of patient rights, which, under certain conditions, entitle European citizens to receive health care in other member states at the expense of the social insurance system of their home country. This undermines the autonomy of the member states in the area of health, a key sector in national welfare systems. In 2008, the Commission proposed a new directive on patients' rights which builds directly on the ECJ rulings, thus consolidating politically the legal precedent set by the Court. The ECJ Court rulings have also spurred the initiation of a so-called OMC process in the area of health care, whereby the member states commit themselves to policy harmonization on a voluntary basis.

In this paper, we review the contents of emerging EU policies in the area of health and discuss their implications for the Nordic health care systems. A central question is whether any coherent, common European policy may be discerned and, if so, how it will affect health care systems of the Nordic type, which are tax-based and universalistic in orientation?

Keywords: European Union, Health care, European Court of Justice, Open Method of Coordination.

Sammanfattning
Sjukvård är ett område som formellt ligger utanför EU:s kompetens (beslutsområde). Trots detta har unionens inflytande på nationella sjukvårdssystem ökat markant det senaste decenniet. I en rad domslut har EG-domstolen i praktiken etablerat ett system för patienträttigheter, som, under vissa förutsättningar, berättigar EU-medborgare sjukvård i andra medlemsstater på bekostnad av hemlandets socialförsäkringssystem. Detta underminerar medlemsstaternas självbestämmande på sjukvårdens område, en central sektor i nationella välfärdssystem. År 2008 presenterade Kommissionen ett förslag till direktiv om tillämpning av patienträttigheter vid gränsöverskridande hälso- och sjukvård, som bygger direkt på EG-domstolens praxis, vilket politiskt befäster det prejudikat som utmejslats av domstolen. EG-domstolens domar har även drivit fram initiering av en så kallad öppen samordningsprocess på sjukvårdens område, genom vilken medlemsstaterna tillstår att på frivillig basis långsiktigt koordinera sina policys.

I denna artikel analyserar vi innebörden av EU:s framväxande sjukvårdspolicy och diskuterar dess implikationer för de nordiska sjukvårdssystemen. En central fråga är huruvida ökad Europeisk likriktning på sjukvårdens område går att skönja och, om så är fallet, hur det kommer att påverka sjukvårdssystem av den Nordiska modellen, som är skattebaserade och bygger på universalism?

Nyckelord: Europeiska unionen, Sjukvård, Europeiska gemenskapernas domstol, Den öppna samordningsmetoden.

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Disposition

The paper consists of five main sections. The first section reviews briefly the discussion on what drives European integration in the social area forward today. The second section treats the activities of the European Court of Justice (ECJ) and its role in promoting common European policies in the area of health care. After that, we turn to the second pillar of common European policy making in the health care area, the so called Open Method of Coordination (OMC). The fourth section discusses implications of European policy activities in the health care area for the Nordic countries, whose health care systems in some respects differ from systems in other parts of Europe. In the fifth section, we investigate how EU policy initiatives in the area of health have been responded to by policy makers in Sweden. In conclusion, we argue that, so far, the strongest pressures for adjusting national policies to common European objectives comes from ECJ rulings, recently codified by the Commission through a proposed Directive on patient mobility, but that these pressures remain rather limited in scope as long as patients who seek care abroad are so few. The OMC-process concerns broader questions regarding the organization and performance of national health care systems, but is, so far, fairly loose in its character and hence not seen as likely to push governments to adjust national health care policies in any significant way unless they choose to themselves. This might be true especially for the Nordic countries, which perform well on most indicators used within the OMC-health process and therefore may be subject to less pressure to alter current policies in the area of health care.

From courts and markets to OMC: Theoretical perspectives on Social Europe

The rapid progress of European integration after the 1980s in the area of social policy has come as a surprise to many. Previously, it was generally believed that the welfare states of Western Europe, with their different historical trajectories, would never subject themselves to regulation from a supranational body or take to the idea of convergence towards a common "European" model. Today, direct regulations of issues clearly within the realm of social policy are not uncommon within the union, for instance in the areas of public health, work and safety and access to health care. In addition, efforts are being undertaken on a voluntary basis by the member states to coordinate policies within core welfare areas like pensions, health services provision, poverty reduction and elderly care. These developments raise the possibility of convergence between national welfare systems, even though this might come about in a slow and uneven manner.

There are, however, many questions still to be answered about the dynamics of integration in European social policy and its effects on policy-making processes within national welfare states. Which are the main driving forces behind integration in this policy area and how do integration efforts affect political power balances at the domestic level? Who gains and who loses when the locus of policy-making shifts towards the supranational level? And what role do domestic political institutions play in shaping final policy outcomes as EU regulations and initiatives are implemented at the member state level?

One of the driving forces behind integration in the social policy field in recent years is undoubtedly what might be called *spill-over effects* from the creation of the Single European Market in the early 1990s. As the Market came into being, observers pointed to its potential threat to the social protection systems of the member states and demanded that it be amended by measures to safeguard the systems. As a result, the project of "Social Europe" was born; a discursive platform where pro-welfare forces, including politicians both to the left and right, EU civil servants, unions, lobby groups and policy experts, could gather to formulate an agenda oriented towards protecting existing welfare systems in the region but also to identify common goals for these. Such efforts were, however, hampered by the fact that the member states remained unwilling to delegate authority to the EU in the area of social policy. The goals formulated under the banner of Social Europe remained vague and non-committal and few concrete measures were taken to create social regulation that could balance the pro-market orientation of the EU Treaty. Exceptions include work and

safety standards in the labour market, which have been regulated through a string of binding directives during the 1980s and 1990s, and precautions taken in the wake of BSE (or Mad Cow disease) to ensure the safe transport of blood and donor organs.

In the late 1990s, social policy formation within the EU entered a new phase. The activities of the European Court of Justice (ECJ) drew more political attention, as the court started to deliver decisions that seemed to infringe on the autonomy of the member states in this highly sensitive political area. The most controversial aspect of the rulings, which typically went further than existing regulations in ensuring the right of access to national welfare systems on the part of EU nationals from *other* member states, was that the Court based its decisions not on the social regulations themselves but articles in the Treaty safeguarding the four freedoms that underpinned the Single Market. In order to move around freely in the region to seek work, the Court argued, all European citizens must have access to national social security systems on the same conditions as the inhabitants. This meant, in effect, that long-standing principles of social rights as linked to *national* citizenship and territorial borders were cast aside (Liebfried and Pierson 2000, Erhag 2004, Ferrera 2005). The recently proposed Directive on Patient Mobility on part of the European Commission has confirmed that the reasoning by Court concerning the rights of EU nationals in the area of health will indeed be part of a common European policy.

The heightened activity of the ECJ and its far-reaching implications for nation sovereignty can be seen as a sign of the increased legalism of European politics. Legalism became generally more important as a means to govern international relations during the 1990s. Examples include NAFTA, WTO, international criminal tribunes, and various quasi-legal agreements, like the KYOTO protocol (Goldstein et al 1998). Among such phenomena the ECJ stands out, however, as the extreme case of creating "hard" (*e.g.* binding) legal regulations in order to govern a community of sovereign states. As observed by Garrett et al, "the accretion of power by the European Court of Justice (ECJ) is arguably the clearest manifestation of the transfer of sovereignty from nation-states to a supranational institution, not only in the European Union (EU) but also in modern international politics more generally" (Garrett et al 1998, p.149).

Interpretations of the increased legalism of EU integration and its implications for the member states vary. To some, the increasingly important role of the ECJ in driving the integration process forward signaled that the member states had lost control over it and that they had

failed to see, in setting up the ECJ as a constitutional court and arming it with the Single European Act of 1986, what the consequences would be for their sovereignty. This so-called neo-functionalist interpretation stresses, moreover, that the activities of the Court have undermined the role of the nation states as political actors in the region in that its existence makes it possible for other social actors to appeal to it, thereby shifting political battles from the national political arena to arenas outside the reach of national policy makers (Alter 1998, 2000, Mattli and Slaughter 1998). In contrast, the intergovernmentalist perspective sees the Court more as an agent of the interests of the member states, and argues that they have been basically supportive of its integration agenda. According to this view, the ECJ is not totally unrestrained by the member states, but has to maneuver strategically in relation to them in order to preserve its political legitimacy (Garrett 1995, Garrett et al 1998). Looking specifically at the activities of the Court in the area of social policy and the predominantly negative reactions of the member states to its rulings in this area so far, it seems the neo-functionalist interpretation would have the most empirical support at present (Mossialos and McKee 2002, Alter 2000, Geer 2006). Some scholars goes even further, arguing that market-accommodating policies de facto are created by the ECJ in the social area, as the Court bases its decisions foremost on the articles in the Treaties safeguarding the Single European market (se for example Liebfried and Pierson 2000, Taylor-Gooby 2008).

Another characteristic of European social policies is that a growing part of it is formulated and enacted through voluntary agreements between the member states, reached within the framework of the Open Method of Coordination (OMC). The OMC refers to a process whereby common policy guidelines are formulated and translated into national policy objectives through agreements between the Commission and the member state in question. The subsequent process of implementing the objectives is driven forward by periodic monitoring, evaluation and peer review, based on agreed-upon indicators and benchmarks that compare the performance of the member states or have been identified as “best practice” in a given policy area (Borrás and Jacobsson 2004). The OMC was initially inspired by the use of Broad Economic Policy Guidelines (BEPG) for the member states introduced by the Maastricht treaty in 1992 to coordinate their economic policies (Hodson & Maher 2001; Mosher & Trubek 2003; Eberlein & Kerwer 2004; Zeitlin et al 2005). In 1997 the Amsterdam Treaty inaugurated the so-called European Employment Strategy (EES), which introduced the use of so called National Action Plans (NAPs) whereby the

members reported developments in relation to common employment policy objectives. Based on – and inspired by – this new form of governance the Open Method of Coordination (OMC) was presented at the Lisbon summit in 2000. Soon thereafter, the European Council resolved to use the OMC in several areas where the member states faced common challenges, but the union had weak or no formal competence. Since then, OMC processes have been instigated by the Commission in key welfare policy areas like employment, poverty reduction, pensions and health care. Like legalism, the OMC thus constitute a means to bypass the regular system of political decision-making within the union, with its joint decision traps and numerous veto points (Obinger et al 2005).

There are differing views in the literature on how the OMC-process in the social area should be interpreted. While some hold that it represents an important "third way" between competition and full harmonization of national social policies within the union (Zeitlin et al 2005, O'Connor 2005, Armstrong 2006), others point to that it has lead to few concrete results so far (Scharpf 2002, Taylor-Gooby 2008). Some commentators argue that also the OMC-process can be seen as market-accommodating as it invariably comes to reflect a market-bias in social policy by the Commission itself as well as in current EU treaties (Offe 2003, Moreno & Palier 2005). Hence, the recently launched OMC-process in the social area raises questions both about its policy content and effectiveness.

EU health policy initiatives since the 1990s

Prior to the 1990s, the EU had virtually no engagement in health policy issues. The subsequent emergence of an – albeit fragmented – European health policy is related foremost to the creation of the Single Market and its ramifications for national health care systems, which became apparent through a series of ECJ rulings in the late 1990s. An additional impulse for increased activity in this area originated from the so-called Lisbon process, where the promotion of health became linked to the larger goal of safe guarding 'social protection' in the region.

Although there was no common health policy in the EU and no open attempt to harmonize policies in this area until very recently, there was some regulation ensuring access to national health systems for migrant workers. Most important in this respect was – and is – regulation 1408/71, which ensures that workers abroad receive health services when needed. 1408/71 requires the migrant worker to fill out a specific form (E112) in order to request that he or she can seek care abroad. If the request is approved, the costs will be paid directly from the health insurance in the

country of origin to the care giver in the other country. For other individuals, 1408/7 stipulates that applications for care abroad can be approved only under two special conditions: that the needed treatment cannot be provided in the home country or that it cannot be provided within reasonable time. This has typically been taken to mean that care abroad is only an option for patients when adequate care for some reason cannot be given at home. Regulation 1408/71 has thus been used foremost in exceptional cases, as a last resort (although praxis in this regard has differed between countries), and its existence has remained largely unknown to patients. This was, however, to change in the 1990s.

ECJ rulings on patient rights

When the ECJ handed down its ruling in the case known as Kohll/Decker in 1998 it caused surprise and disbelief among national health policy makers as well as experts. There was open doubt as to whether the court was really saying what it seemed to be saying, namely that publicly financed health care in principle was to be regarded as a regular market service and thus subjected to the four freedoms of the Single Market. Both Mr. Kohll and Mr. Decker were citizens of Luxembourg, who had gone to Germany for health services and medical devices. The case of Decker concerned a pair of glasses, while Kohll had received dental care. In neither case had prior authorization for health care abroad been given in accordance with the procedures stipulated by regulation 1408/71; Mr. Kholl did request authorization for his treatment but had his application rejected; Mr. Decker never applied. Upon their return to Luxembourg, they both requested to be reimbursed for the costs of their treatment/devices but were denied this by their sickness fund.

When the case was referred to the ECJ, several member states participated in it by submitting their own opinions to the Court. Basically, all member states sided with the Luxembourg sickness fund, stating that the Court should uphold the decision of the fund to refuse reimbursement and that the requirement for prior authorization must be preserved. The main arguments of the Luxembourg sickness fund and the member states were: 1) if the requirement of prior authorization for treatment abroad was not preserved, cost control within national health care systems would be impossible, 2) prior authorization for treatment abroad was necessary to preserve quality control within the health care sector, and 3) the ability of the member states to provide access to health care for all citizens within their borders, and thus protect public health in the region, would be undermined by unregulated patient mobility across borders because this

would cause severe disruptions in the planning of care provision within the national systems and ultimately make it impossible to maintain control over the consumption of health services within their health care system (Mossialos and Palm 2003). The last argument was based on the recently adopted Articles 56 and 66 in the Amsterdam Treaty, which stated that the need to protect public health interests sometimes can justify interference with the economic freedoms of the Single Market.

The Court rejected all three arguments and ruled in favor of Mr. Kohll and Mr. Decker. As for the cost control argument, it stated that since the reimbursement claimed by Kohll and Decker was the same amount as what they would have been reimbursed if the treatment had taken place in Luxembourg, it did not matter financially to the sickness fund whether they were reimbursed for care received at home or abroad. Secondly, the Court held that there was no reason to assume that the quality of care would be lower in other member states, thus concerns about quality could not, in and of themselves, be valid arguments against the free movement of patients within the region. As for the argument that public health interests required that national health care systems retain the ability to plan and make necessary provisions for care provision for all citizens, the Court acknowledged its relevance in principle, but stated that it had not been demonstrated in this case that the reimbursement of Kohll and Decker by the sickness fund would threaten the operation of the Luxembourg health care system in this way.

Most controversial about the Kohll and Decker rulings was that the Court did not base its interpretations on the social regulations of 1408/71, but on the right to economic freedom of service provision on the part of health providers, as established in the EC Treaty by the SEA. The Court argued that health care services are, in principle, no different from other services produced in the region, even though they are financed predominantly by public means (ECJ Cases C-158/66 and C-120/95).

The Kohll and Decker rulings were bewildering to many national health policy makers, as they seemed to indicate that patients could seek care abroad at will and then have the right to full reimbursement by their domestic health systems – a right which would, some argued, undermine attempts at cost control and public planning within these systems. The rulings also left a number of questions unanswered. One was whether they applied only to systems of the Luxembourg type, where health care costs are *always* first paid directly by the patient, who is, thereafter, reimbursed by their sickness fund. Another question was whether the ECJ decision that prior authorization was not needed for health treatments abroad applied

only to out-patient services, like dental care, or to *all* sorts of medical treatment, including the more costly hospital care.

These questions were answered by the Court in 2001 in another landmark case, known as Smits-Peerbooms. This case concerned two Dutch nationals, Mrs. Smits and Mr. Peerbooms, who had sought hospital care abroad without prior authorization according to the 1408/71 procedure. The Dutch system provides health services free of charge to patients, as reimbursements are paid directly to care givers. Like the Kohll/Decker cases, the Smits-Peerbooms case established several principles which had a direct regulatory effect on all European health care systems. The first was that prior authorization could indeed be made a requirement in the case of hospital care. This meant that the decision on the part of the Dutch sickness fund to deny the request for reimbursement by Mrs. Smits, who had traveled abroad without applying for prior authorization, was upheld by the Court. Mr. Peerbooms' case was trickier in that he *had* applied to receive care abroad according to 1408/71, but been denied it on the grounds that the treatment he wanted was not usually given in the Netherlands (to people his age) as it was considered "experimental" and not proven effective. To this, the Court said that what could be considered medically appropriate and effective could not be based solely on national medical praxis, as this would constitute *de facto* discrimination against care givers in other countries. Therefore, rejections of requests for authorization to receive treatment abroad on the basis of medical judgments' must be based on *international* medical opinion, or, as stated by the court, what is "sufficiently tried and tested by international medical science" (ECJ Case C-157/99, paragraph 108; also cited in Mossialos and Palm 2003, p.18).

Perhaps most important, the Court also stated in Smits-Peerbooms that although there might be grounds for an exception to the basic right of freedom to provide services on the part of health care givers, and thus allow member states to have a requirement of prior authorization for hospital care abroad, the process of trying such requests must be made more transparent. The process, the Court stated, must be based on objective, non-discriminatory criteria known in advance, so that it was not arbitrary. In addition, decisions must be reached without too much time delay and be capable of being challenged judicially (ibid., paragraph 109).

The rulings of Smits-Peerbooms answered some of the questions raised by Kohll/Decker but also raised new ones, for instance what should be considered "international medical opinion" and whether the new principles of patient mobility established by the Court applied also to so-called tax-based, or NHS-type systems. In such systems, there is typically no

separation between the financers and providers of health services, as they are both part of the same public system of care provision, a condition which makes it less obvious on what grounds patients would be reimbursed for treatments costs acquired abroad. In more recent cases, the court has upheld the principles established by Kohll/Decker and Smits-Peerbooms, thus consolidating the legal framework it has created for patient mobility within the European Union.

In the 2000s, the ECJ has continued to carve out the legal basis for patient rights within the union, thereby adding pressure on the member states to co-ordinate their health policies. This was testified to recently by the awaited ruling in the case of Watts 2006. Many have hoped (and feared) that this case would settle the highly sensitive issue of what could be considered "undue" waiting time for treatment, which the Court had previously indicated would be considered a legitimate basis for the right to treatment abroad. The Watts case concerns an elderly British woman who was notified by her public care giver (a so-called Primary Care Trust, PCT) that she would have to wait at least a year for her hip replacement surgery, as this was the 'target' for the NHS for such treatments at the time. Her need was later reassessed by the PCT and the waiting time reduced to four months. Even so, Watts applied for authorization to receive the surgery abroad on the basis of undue waiting time, but was denied this by the PCT, which held that: a) the waiting time was not undue and, b) the right to seek care abroad as established by the ECJ on the basis of the four freedoms of the Single Market did not apply to health care in a system like the British, where health services are provided directly by the government.

The ECJ ruling in Watts, states very clearly, going against the written opinions submitted by the British as well as the Swedish government that prior rulings on patient mobility *do* apply to a system like the NHS. The costs of reimbursement in such cases should be calculated, the Court states, on the basis of the costs for the same treatment given within the national system. As for the waiting time issue, the Court states, as it has done in previous rulings, that what can be considered "undue" waiting time must be decided from case to case, with consideration taken to the condition of the patient, but that it does not consider the four months that Watts would have had to wait for her surgery to be "undue". The court also stated in the Watts ruling, however, that it considers policy "targets" for how long a patient will have to wait for treatment to be unacceptable from a legal point of view and that patients should be given definite information about the maximum waiting time, as was eventually done in the case of Mrs. Watts. With the Watts ruling, the ECJ thus eliminated all doubt: the newly established

European patients' rights to treatment abroad also apply to NHS-type health care systems like the British and Swedish (ECJ case C-372/04).

In 2008 the Commission presented, after pro-longed discussions, a proposal for a Directive on Patient Mobility. The Directive was drafted as a direct response to recent ECJ rulings, and the resulting uncertainty on their legal standing expressed by the member states. The content of the proposal tailors very closely to the Case Law on patient mobility established by the Court as described above. It confirms that the right to seek care in other member states does include patients in all health care systems in the EU and that there should – in principle – be free mobility also in the area of health care. Like the Court, the Commission proposes that the member states should have the right to demand prior authorization to reimburse in-patient care in other countries, but that out-patient care should have no restrictions. However, while the Commission insists that the member states should be allowed to make use of prior authorization, it also states that if the home-country can not provide care within reasonable time, member states may not reject applications.[1] In the proposed Directive it appears that the Commission would like member states to make use of prior authorization only if there is an ongoing or likely threat to the financial balance of member states' health care systems. Given the current low patient mobility in small countries, like the Nordic, it would not be able to introduce prior authorization unless they can show that the outflow of patients already has become - or is becoming - a serious threat.

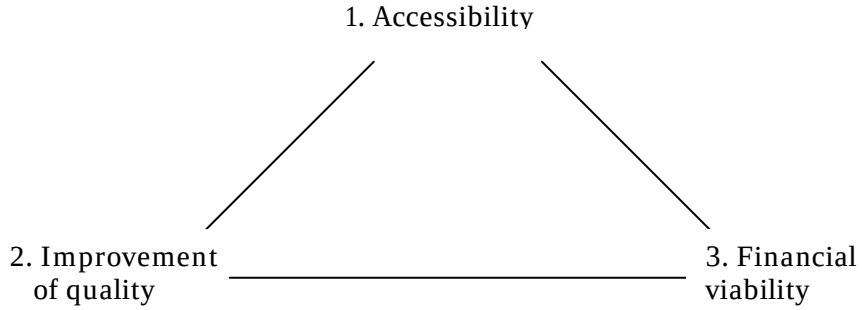
In addition, the proposed Directive clarifies the question of how the reimbursement sum should be calculated, which the Court had left open. According to the proposal, the reimbursement shall be based on the cost of the care received in the home country, not the country where the care has been given. This intends to help national health authorities to maintain cost control even if patients seek care abroad. It also implies that should a treatment be more expensive in the care-providing country, the patient must pay for the difference (COM (2008) 414/3 final).

A second avenue for European health policy: the OMC

The ECJ rulings raised general concerns over a possible spill-over effect from the Single Market to the health care area. In this way, they helped

[1] What are considered care "within reasonable time" is stated in p. 68 in the Watts case (C-372/04). The waiting time shall not exceed the time as an objective medical assessment of patient care is considered acceptable. The waiting list shall also be flexible and adaptive, that is if the patient becomes worse the waiting time should be shortened.

create a stronger impetus to establish an OMC process in this policy domain in order to take back some political initiative from the Court (Geer 2006). The initiation of the OMC process within European health care was speeded up by initiatives taken by the European Council and the Ministers of Health. They were concerned by the ECJ rulings, but also saw a potential for deepened co-operation among national health providers in their wake, for instance by sending patients abroad when the supply of health services ran short of medical needs in one country. In 2001, the Commission published a communication on the content of the OMC process that was being set up in the health area. It argued that the process was desirable in order to meet common health challenges among the member states, such as ageing, medical technology developments and raised expectations among citizens, but pointed also to the possibility of increased cross-border patient mobility as a result of the ECJ rulings, and noted that this added to the need for co-operation between the members in this area. The Commission identified three basic goals, which would later become targets for an OMC in health care:



1. Ensure that everyone has access to good quality health care
2. Improve the transparency and quality of health care systems
3. Improve the quality of public financing and ensure that adequate financing is provided for health care (COM(2001) 723 final, p. 14)

The goals were endorsed by the member states during the meeting of the European Council in Barcelona in 2002. At the same time, ministers of health took the initiative to speed up co-operation in the health care area and to orient it more closely towards the issue of cross-border care provision. The ministers identified four areas where they felt that the potential for cross-border care provision should be investigated further. These included highly specialized care, utilization of excess capacity in

other systems, access to care abroad for patients residing in border areas, and care provision for citizens residing in other member states (Swedish Ministry of Social Affairs 2006, p.99).

In a meeting in June the same year, the ministers also decided to establish a so-called High-Level Reflection Process on patient mobility and the developments within European health care. The process, which consisted of a series of meetings and the establishment of several working groups, resulted in a Final Report in 2003 (HLRP/2003/16). The report highlights especially the legal uncertainty concerning current EU rules within member states after the *Kohll* litigation. It proposes several types of measures to address these problems and construct a stronger framework for advancing common European objectives in the area of health: Treaty reform, Commission communication, secondary legislation, member state initiatives and bilateral cooperation, and a permanent cooperation mechanism at the EU-level.

The Commissions response came in April 2004 in the form of a Communication (COM (2004) 301 final) where it laid out 13 possible areas for common action.[2] Three areas were highlighted as particularly important: to provide better information to patients on their rights to obtain treatment in other member states; establishing the OMC to support national efforts to reform and develop health care; and to formulate an action plan on "e-health".[3] Noting the common challenges facing all member states in the area of health due to ageing populations, raised expectations as well as technological developments, the Commission argued that an "exchange of best practice would be valuable for all Member States" (COM (2004) 301 final, p. 10). It also referred to the *Kohll* litigation by the ECJ and the need for the member states to coordinate their responses in light of a possible increase of patient mobility between national health care systems.

Both COM (2004) 301 final and the HLRP Report also proposed "hard measures" in response to the legal uncertainties that had resulted from the *Kohll/Decker* rulings. The Commission identified three areas in which hard governance should be used for this purpose: the free movement of services;

[2] Rights and duties of patients; Sharing spare capacity and trans-national care; Health professionals; European centres of reference; Health technology assessment; Health systems information strategy; Motivation for and scope of cross-border care; Data protection; E-health; Improving integration of health objectives into all European policies and activities; Establishing a mechanism to support cooperation on health services and medical care; Developing a shared European vision for health systems; Responding to enlargement through investment in health and health infrastructure.

[3] Health care cooperation: Patients to benefit from new Commission proposal (Reference: IP/04/508, Date: 21/0472004)

the free movement of medical professionals; and data protection in the field of health care. The first area was originally covered by the well-known proposal for services directive COM (2004) 2 final/3, but was later revised in COM (2006)160 final, so that the part covering health services was removed. The second area resulted in a Directive on mutual recognition of professional qualifications (Directive 2005/37/EC). The third, data protection, was already covered by a directive from 1995 (Directive 1995/46/EC), but the Commission resolved that this needed to be enforced more forcefully in the future.

In same year, the Commission established an advisory body on health care policy, the *High Level Group on Health Services and Medical Care*. The Group consists of senior officials from the member states and is chaired by the Director General of DG SANCO (Directorate General for 'Health and Consumers'). The group was quickly recognized as an influential factor in the further formulation of health policy in the EU. It works on a wide range of issues, including cross-border health care purchasing and provision, health professional's centres of reference, health technology assessment, information and e-health, health impact assessment and health systems, and patient safety.[4]

Finally, in 2004 the Commission also launched an OMC process covering both health- and long-term care, guided by the common goals of European health care adopted at the Barcelona European Council in March 2002, i.e. universal access to care; high quality care; and financial sustainability of health care and long term care systems (COM (2004) 304 final). In October 2004 the Employment, Social Policy, Health and Consumer Affairs Council endorsed the OMC principles and thus formally enabled the method in the field of health care.

OMC in health care

At the Lisbon summit, the European Council stated that the OMC is divided in four phases (European Council 2000a): (1) Common objectives are set by the Ministers Council (Employment and Social Policy) on mandate from the European Council. These objectives aims to guide national policy (specific timeframes, divided into short-, medium-, and long-term objectives may be set); (2) Establishment of common indicators (quantitative and qualitative) and benchmarks tailored to each member state and sector by the Social Protection Committee (SPC), to allow comparison of best practices; (3)

[4] Documents of the High Level Group: http://ec.europa.eu/health/ph_overview/co_operation/mobility/high_level_documents_en.htm

Translation by the member states of targets from the European to the national level into *National Strategic Reports* (NSR, previous *National Action Plans*, NAPs),[5] with several different actors participating in the preparatory work (Johansson 2007); (4) Evaluation of member states in *Joint Reports* (JR) produced by the Commission and the Council based on follow-up of the NSRs and periodic monitoring of indicators, peer review, benchmark, emphasizing mutual learning. The process is to be implemented in a cycle that runs for two years.

This description illustrates the standard working procedure established for the OMC by the European Council in 2000. However, the procedure varies depending on area applied. The OMC process in employment, for example, places significant importance to identification of "hard" quantitative objectives and indicators can be considered as the core of the process, in particular as a basis for the evaluation and benchmarking phase. The OMC-social (social inclusion, pensions and health care and long-term care) is, however, considered weaker in this respect, especially in the health care strand as the different historical and cultural contexts makes it harder to quantify the common goals and compare health care systems (Hervey 2006). A possible exception may be financial sustainability of national health (insurance) systems. There have also been delays in developing the indicators by the Social Protection Committee. Until 2008, the health OMC had no complete set of indicators and timeframes were loose (EC 2006). There is also still a lack of data on how the health care OMC is functioning within the member states.

In May 2008 the SPC finally agreed on a full list of indicators to monitor the health care and long-term care objectives (EC 2008). The list has been produced by a so-called Indicators Sub-Group (ISG) and is made up of 18 primary indicators (indicators for monitoring), 12 secondary indicators (indicators for analysis) and 4 context indicators. Primary indicators are used to measure progress in relation to the common objectives, and are to be reported by the member states primarily through the use of EU statistics (EUROSTAT, EHIS, WHO-Health for all Database, ECHI, EU-SILC). Secondary indicators rely mainly on national statistics and need not be comparable in the same fashion as primary indicators. Context indicators may be used to describe the character of national health care systems, as well as "past...and future trends" within it. The list of indicators attempts to cover the three common objectives of accessibility, quality, and financial sustainability.

[5] In 2006 social inclusion, pensions and health care/long term care where streamlined in the OMC-process under the common objectives and to be reported in one single NSR.

Primary indicators

Regarding access to care

- Self reported unmet need for medical care (broken down by age, gender)
- Care utilization (number of doctor visits, broken down by age)
- Self-reported unmet need for dental care (age, gender)
- Dental care utilization (age, gender)
- The proportion of population covered by health insurance (gender)
- Life expectancy (age, gender)
- Life expectancy by socioeconomic status (and gender)
- Healthy life years (age, gender)
- Healthy life years by socio-economic status

Regarding quality of health care

- Vaccination coverage in children
- Cervical cancer screening
- Cervical cancer survival rates
- Colorectal cancer survival rate (gender)
- Satisfaction with health services (gender)

Regarding financial sustainability of health care systems

- Total health expenditure per capita
- Total health expenditure as percentage of GDP
- Long-term care expenditure as % of GDP
- Projections on health care as % of GDP
- Projections of public expenditure on long-term care as % of GDP
- Hospital inpatient discharges (per 100 000 inhabitants)
- Hospital daycases (per 100 000 inhabitants)
- Obesity (as % of obese persons measured by BMI>30, break down by age and gender).

It can be noted that the indicators appear fairly non-controversial, as they are often used in international comparisons of health acre systems in research contexts, and in reports by International Organizations such as the WHO and OECD. In this sense, the indicators seem more to reflect an "expert" perspective than any type of political agenda. It is also interesting

to note that waiting time is not used as an indicator of access, which sometimes is the case in other contexts.[6]

The Commission has announced that more indicators will be developed in the area of health to better reflect the ability of the member states to meet the common goals (Commission 2008). The ISG has agreed to consider developing other indicators covering the following dimensions:

- Mortality, life expectancy and healthy life years broken down in categories of socioeconomic-status to better reflect inequalities in health
- Care utilization by different socio-economic groups
- Out-of-pocket payments
- Screening for diseases (diabetes, cancer, asthma)
- Infections acquired in the course of medical care
- More data on long term care and mental health services

So far, National Strategic reports have been turned in by the member states on two occasions; in 2006 (when the indicators were still preliminary and under development) and in 2008. In 2007, the Commission produced a Joint Report on basis of the 2006 national reports and a second Joint Report is expected in 2009. In the report the Commissions notes that there are great variations between the member states in their ability to meet the common goals and that also the specific nature of the challenges facing individual members vary greatly (Joint Report 2007, pp. 10-13)

The Nordic health care systems in the European context

The impact of Europeanization on national health care systems depends, naturally, on their specific organizational features. The Nordic health care systems have several features that make them distinct in a European context. First, they are financed predominantly by different sources of taxation. This means that they have public authorities as "third party" financers of care rather than independent sickness funds, as is common in

[6] Notably also, given that EU health and social policies are sometimes said to have a "liberal" or market bias, is that none of the indicators measure any such characteristics. For instance, there is no effort to measure whether provision of health services is subject to competition, despite the fact that the Commission has said on other occasions that competition promotes efficiency and financial stability. Nor is there any mentioning of the availability of free choice of provider; which has been used in international comparisons as an indicator of "access". If there is any bias in the choice of indicators, it appears more "left-leaning" than market oriented, as there are several indicators reporting on values such as equality, access to health for all regardless of socio-economic status, etc.

continental European countries. The publicly controlled financing of care also implies that access to care is open to all Nordic citizens on equal terms, rather than regulated on basis of individual or occupation-based health insurance. The direct public control over health care systems in the Nordic countries is extended also to the provision side. In the case of primary care, provision is typically mixed, consisting of both public health centers and privately practicing GPs. In Norway and Denmark, a majority of primary care physicians are privately employed, whereas in Sweden and Finland the opposite is true. In all Nordic countries, however, primary care is publicly financed. The relatively high degree of public ownership and operation of health services provision can be said to be a typical Nordic feature, even if the same applies also to other tax-based systems, like the UK and Ireland. In the case of secondary care, public provision dominates completely, as hospitals and other care institutions are normally owned and operated by public authorities. The fact that health services are thus both financed and provided by the same public body – typically a local government agency – indicate that the Nordic systems could be described as integrated.

Another distinct feature of Nordic health care is the crucial role of decentralized political governance. The operation of the health care systems has typically been delegated from national authorities to local, self-governing bodies, either at the municipal, provincial, or more recently, regional level. In all cases but Norway (after its regionalization reform of 2002) the local bodies responsible for health care provisions are directly elected by the population. This is a feature which gives the Nordic health care systems a democratic character by international comparison. The relative independence of the municipal or provincial (or regional) health authorities in the Nordic countries means that the organization of health care provision can vary substantially from one location to the other.

The exact implications of Europeanization for the Nordic health care systems are yet hard to pinpoint, since much is still unknown about exactly what such a process will entail in the future. It is clear, however, that the Nordic systems are quite distinct from the kind of insurance-based system, with independent sickness funds acting in the role of payers, that the ECJ seems to have had in mind in most of its rulings in the health care area so far. This is noticeable, not least when the court discusses how care givers should be reimbursed by sickness funds and argues that it should not matter so much for the financer whether the care giver in question is located in the same country or not. Similarly, the court points out the value of free competition and creation of a non-discriminatory European “market” also for health services.

It can be argued that at least three different issues can be raised when it comes to possible effects of Europeanization for the Nordic model of health organization, each with distinct policy implications. The first issue concerns the role of care providers and the need to further develop systems for their reimbursement in the Nordic countries. If patients in all European countries are free to move across borders to seek care, there will be a need to standardize systems for billing and care financing and to determine the "prices" for various treatments. Such a development has more radical implications for care givers in the Nordic countries where, as noted above, resources have traditionally been allocated through public budgets. In effect, an open market for health services in Europe is likely to create an organizational logic where care givers operate more independently, both financially and administratively, also in the Nordic countries. Such a development has already been initiated in some countries (particularly Sweden and Norway) through so-called purchaser/provider separation, but is far from established everywhere.

The second issue has to do with the status of patient rights in the Nordic countries and the possible implication of the ECJ rulings and the Patient Mobility Directive in this respect. Generally, formal patient rights in the Nordic countries have tended to be quite weak, as health care has been provided by public authorities as part of a more general public service, open to all, rather than a service to which access is provided on basis of a specific insurance. The public provision of care and absence of individual insurance has created less need to legally specify obligations for insurers and health providers. This implies that the Nordic health care systems have, in some respects, had a less "legal" culture than some other systems in Europe and that courts have not had an important role within them. This may be changing, as several Nordic countries, Denmark and Norway in particular, recently have sought to strengthen patient rights by formal legislation. It seems obvious that this tendency will be reinforced by the new Patient Mobility Directive, which stipulates – just as previous ECJ rulings – that patients in all member states should be well informed about their rights to seek care abroad and that if prior authorization is required to do so, they must have the right to legal appeal.

The third issue raised by the on-going Europeanization of the health care sector concerns the implications for decision-making and governance within the area of health care in the Nordic countries. As noted above, health care in the Nordic countries is largely governed by local/regional bodies with a high degree of independence. However, implementation of European rules, court rulings and recommendations calls for *national*

policy adjustments, which imply that all actors within the system should adjust their working routines in a similar way, including local and regional governments. This could result in an implicit streamlining of local policies and an enhanced role for national governing bodies. Moreover, implementation of EU policy at the national level is an often complicated process, where new EU initiatives needs to be interpreted, their effects investigated, relevant actors consulted, etc, before new national regulation can be enacted or old amended. So for this reason as well, EU initiatives in the area of health may have the effect of centralizing policy-making powers. It is also still predominantly as *nations* that member countries are represented within decision-making processes within the EU and can influence future policies. Thus, Europeanization in the area of health care raises questions about how the current division of policy-making authority in health care in the Nordic countries will be affected and how a possible shift towards a more prominent role for national policy actors will affect central-local relations.

Europeanization effects within the Swedish system

Prior to the early 2000s, there was virtually no recognition in Sweden that EU policies in the area of health had any direct bearing on national health policy. During the recent decade this has changed and national authorities – particularly the Ministry of Social Affairs (*Socialdepartementet*) – now follow EU developments closely. A series of initiatives have been taken to adjust Swedish policies in the health care sector to new EU regulations, particularly in the area of patient mobility. The fact that these initiatives have been taken by the Ministry and a national court reveals, furthermore, a dynamic whereby the national governing bodies appear to have strengthened their powers within the heavily decentralized system. This development has manifested itself also in the tendency to propose *legislation* as a means to adjust domestic policies to European precedents, which constitutes a break with previous modes of "soft governance" and voluntary agreements between the central state and counties as a means to coordinate policies in the area of health care.

When they were handed down, the Kohll/Decker rulings received virtually no attention in Sweden, and, if they did, their importance was down–played. It was generally believed that ECJ-rulings did not concern an integrated health system like the Swedish. In the early 2000s, treatment abroad was hardly a known phenomenon in Sweden, and the country was among the most reluctant in the union to authorize such requests. Palm et al reported in 2000 that about 20 requests a year for health care abroad

were approved in Sweden, as compared to about 7,000 in Luxembourg (Palm et al 2000). Soon thereafter, however, European health policies started to get more recognition. In 2002, the Swedish Ministry of Social Affairs became part of the High-Level Reflection Process concerning health matters within the EU. In the same year, the Ministry appointed an expert group to investigate the organization of highly specialized health care in the country, which, like all hospital care in Sweden, is the responsibility of the county councils. In its 2003 report, the group proposed that this part of the system should be subject to special control on the part of the national government, and be led by a new national board (Ds 2003:56).[7] According to the then Minister of Health (1998-2004), Lars Engqvist, a prime motive for the proposal was the need for more central co-ordination of the provision of highly specialized care in the country, so as to be able to co-operate more effectively with other European member states in the area of health care (Enqvist 2004).

In 2004, the fact that the EU does indeed have a direct impact on health care provision in Sweden became obvious to all actors within the Swedish health care system. In January the Supreme Administrative Court of Sweden (*Regeringsrätten*) delivered a ruling based directly on previous ECJ rulings on patient mobility in which it overruled the refusal by a local Swedish authority to reimburse a patient for the cost of medical treatment in Germany. The patient had appealed for authorization according to the 1408/71 procedure but had been denied this on grounds that the treatment in question was not given in Sweden, as it was considered medically dubious. The court noted that the Swedish health care system did not have a satisfactory procedure for applying for health care abroad on the part of individual patients and, technically, no legal demand to seek prior authorization for care abroad, although there was a well-established administrative procedure. The court also noted that the treatment given to the patient by the German care provider was effective in curing her disease. As a result, the court ordered the local health authority in question to reimburse the patient for the full cost of the treatment (about 60,000 Euro), thereby setting a legal precedent that opened up the possibility for Swedish patients to seek both primary and secondary care abroad without prior authorization.

The ruling was first met with confusion among local health authorities, as it ran opposite to the previously established procedure for receiving health treatment abroad, which had been based on the 1408/71 system. The

[7] The recommendations were later turned into a legal proposal (prop. 2005/06) but have not yet been enacted.

court did not only overthrow this procedure, it also rejected the medical advice given in the case in question, which had typically been of great importance when patient demands for treatment abroad where decided upon. In the year following the ruling, applications for reimbursement for care abroad rose dramatically in Sweden, and an overwhelming majority (1,868 out of 2,037) was approved in 2006.[8]

The Ministry of Social Affairs quickly reacted to these developments by setting up an investigatory expert committee to propose a new, formally regulated, system for authorizing medical treatment abroad. In February 2006, the committee delivered its report, in which it proposed a new law that would regulate the processing of such applications. The content of the law was closely tailored to the legal precedent set by the ECJ, and thus made a distinction between hospital care, which would require prior authorization, and out-patient care, which could be sought freely abroad on the basis of the EC Treaty articles 49 and 50. The report also noted that authorization could not be denied by local health authorities if the medical condition in question was treated within the Swedish health care system, but adequate and effective treatment could not be given in the system within "normal" time (Ministry of Social Affairs 2006). The process of legally formalizing the proposal was later paused by the new center/right coalition government that went into office in 2006.

It can be argued, nonetheless, that EU initiatives in the area of health has served to highlight a weak spot in the Swedish system, namely swift access to care for patients. This was acknowledged by the Minister of Health in 2004, when he stated that Sweden meets two of the common health goals for the EU without any difficulty, namely high quality and financial sustainability, but has more problems with the third, access to care, and that this therefore must be a prioritized issue in future Swedish health care (Engqvist 2004). Access to health services has been a controversial issue in Sweden for years because of the sometimes long waiting time for treatment. The legal precedent set by the ECJ in the Watts case, which pointed to that waiting time might indeed be a basis for patients to be entitled to treatment abroad, could thus be seen as a potential threat to the Swedish system, just like to the British. This problem was addressed in 2005, when the Ministry of Social Affairs negotiated an agreement with the county councils that a national waiting time guarantee should be established within the system, ensuring that no patient in Sweden should have to wait longer than a

[8] According to The Swedish Social Insurance Agency website (www.försäkringskassan.se) this has fallen slightly in recent years: 2007, 1,175 out of 1,476 were approved reimbursement for care abroad, and 2008, 1,186 out of 1,547.

maximum of 90 days for treatment. The new guarantee went into force in November 2005 and has led to renewed efforts in the county councils in order to increase the supply of care and be ready to purchase additional services from other county councils or private care givers if the guarantee cannot be held. The recent ECJ ruling in Watts, where the court seems to ask for a specified maximum waiting time, but also holds that four months cannot be considered "undue", indicates that the Swedish waiting time guarantee would satisfy European demands for care delivered in reasonable time and that waiting periods for up to three months would, in most cases,[9] not constitute a basis for receiving care abroad. Thus, even though the Swedish waiting time guarantee was the result foremost of domestic political pressures, it appears well in line with emerging EU policies. It seems, moreover, that the implicit threat from the ECJ concerning the rights of patients to seek treatment abroad would be realized if the waiting time at home is too long, and this may have aided the Ministry in persuading the county councils to agree to the waiting time guarantee.

The Swedish reaction to the communication preceding the proposal for a Directive on patient mobility in was highly positive .In contrast to several other member states, including its Nordic neighbors, the Swedish government expressed no reservations, but "welcomed" a Directive, as it was seen as a strengthening of patient rights within the union (Government Office, Ministry of Social Affairs 2007). Clearly, the liberal orientation of the proposal corresponds to the ideological values of the current center/right coalition and its efforts to strengthen patient rights in Sweden, including the right to free choice of care provider. In a report, the government clarifies its position, stating that it foresees that the implementation of the Directive in Sweden will require legal changes, including new legislation on patients' rights to legal appeal, etc. (Government Office, Ministry of Social Affairs 2008). The report does not comment on the need for legislation to instigate a system for prior authorization. While the current government has yet to make its position on this issue known, leading conservative politicians has stated that they regard prior authorization requirements as an infringement of the rights of patients to freely choose provider. Hence, it is possible that the Swedish government will opt for a policy in this regard which is even more liberal than that proposed by the ECJ and the Commission.

The Swedish National Strategic Report (NSR) to the OMC-process in 2008 was also reflective of the government's liberal agenda. While most

[9] This depends, as stated by the court and later in the Commission's directive, on the nature of the disease and the degree of medical urgency in receiving treatment.

(primary) indicators were dutifully reported, the report also contained a detailed commentary on the health care policies of the government *itself*, such as its struggle to strengthen and legally formalize patient rights, enhance freedom of choice for patients, and increase the share of private providers. Hence, the report seemed more concerned with the national political objectives of the government than the common policy objectives as formulated within the OMC-social.

To summarize, a few observations can be made about a possible impact of the EU on the Swedish health care system. First, the open endorsement in Sweden of the ECJ rulings on patient mobility by the Administrative Supreme Court and Ministry of Social Affairs can be said to have strengthened the role of judicial review and formal regulation within the Swedish health care system, even though this runs against its previous tradition of more informal modes of governance. If new legislation is enacted to implement the Directive on patient mobility, this tendency will be further reinforced. It can also be noted that the ECJ rulings and the Patient Mobility Directive seems to lend support to current domestic political efforts to enact formal patient rights to care. In contrast, the Swedish government seems less concerned with socio-economic inequalities in access to health, which has been recently highlighted as a special area of focus by the Commission. It is apparent that the Swedish government has chosen, in accordance with its ideological predispositions, to see "access" as a matter foremost of consumer-based rights, such as legal entitlements and freedom of choice of provider.

A second observation is that the deepened European integration in the health care area may have an important effect within the Swedish system if it creates – as it seems that it does – legitimacy for an enhanced role for national governing bodies. The desire on part of the Swedish government to strengthen its control over the system and better coordinate local health policies has been apparent in recent years and is reflected in a number of political initiatives, such as the waiting time guarantee, agreements with the county councils concerning patient mobility within the country and proposals to formalize patient rights. This indicates that the Europeanization of health care can have an important impact not only with respect to policy content, but also when it comes to the distribution of power and relations between local and central actors in Swedish health care.

Conclusions

In this paper we have tried to describe the emerging European policies in the area of health as they have been formulated by the European Court of Justice and the European Commission. We have also attempted to discuss their possible implications at the national level for one category of the member states; the Nordic countries. Finally, in order to shred some light on the question of how the OMC-process affects policies and policy-making processes at the national level, we have given a brief review of responses and policy adjustments in one Nordic country; Sweden.

As we summarize our findings, we note that, so far, the ECJ rulings in the area of health and the subsequent proposal for a Directive on patient mobility by the Commission seems to have a far more direct and powerful impact on national health policies than the recently launched OMC-process. It contains directly binding legislation which, as illustrated by the Swedish case, in many cases will call for policy adjustments both in formal legislation and practice. What might diminish the impact of the Directive and the Case Law is that it is narrow in scope, as it concerns solely the issue of international patient mobility. As long as the number of patients seeking care abroad remains low, as it does in most member states, the impact of this legislation might well be rather limited. However, this clearly depends on national governments themselves. The Swedish case indicates that governments – if they choose to do so – can draw on ECJ rulings and the patient mobility Directive to promote a liberal agenda with regards to patient rights. For the Nordic countries, the possible implications of enhanced rights to patient mobility within the union may be even more far-reaching, if they are taken to mean that new practices for purchasing services abroad, competition among providers, and price-setting, must be developed.

The OMC-process is much broader in scope, as it concerns key aspects on the functioning of national health care systems, such as their coverage of the population, their ability to provide high-quality care and their financial condition. On the other hand, the OMC-process contains no binding measures and seems, so far, to have had limited success in convincing member states to adjust national policies to meet common objectives. As the Swedish example illustrates, it also leaves room for national governments to continue to set their own political agendas, regardless of EU policy objectives.

Appendix

Indicators regarding access to care (including inequity in access to care) and inequalities in outcomes (objective 1)

Primary indicators

Self reported unmet need for medical care **Care utilisation**	Total self reported unmet need for medical care for three reasons: financial barriers + waiting times + too far to travel. To be analysed together with care utilisation defined as number of visits to a doctor (GP or a specialist) during the last 12 months. (Age and gender breakdown)
Self reported unmet need for dental care **Dental care utilisation**	Total self-reported unmet need for dental care for three reasons: financial barriers + waiting timed + too far to travel. To be analysed together with dental care utilisation defined as number of visits to the dentist. (Age and gender breakdown)
The proportion of the population covered by health insurance	The percentage of the population covered by public health insurance (which is defined as tax-based public health insurance and income-related payroll taxes including social security contribution schemes) + the percentage of the population covered by private health insurance including: Private mandatory health insurance, Private employment group health insurance, Private community-rated health insurance, and Private risk-rated health insurance. (Gender breakdown)
Life expectancy	Life expectancy defined as the mean number of years that a newborn child (or that of a specific age) can expect to live if subjected throughout life to the current mortality conditions (age specific probabilities of dying). (Age and gender breakdown)
Life expectancy by socioeconomic status	Life expectancy defined as above but presented by socioeconomic status (such as level of education or income quintile) (at birth = socio-economic status of parents). (Gender breakdown)

Healthy Life years	Number of years that a person is expected to live in a healthy condition i.e. the numbers of years of life free of any activity limitation (also called disability-free life expectancy. Composite indicator. To be interpreted jointly with life expectancy. (Age and gender breakdown)
Healthy life years by socio-economic status	Healthy life years defined as above but presented by socio-economic status (such as level of education, income quintile) (at birth = socio-economic status of parents). (Gender breakdown)

Secondary indicators

Self-perceived limitations in daily activities	Self-perceived limitations in daily activities defined as the percentage sum of people reporting to be limited or very limited. (Age and gender breakdown)
Self-perceived general health	Self-perceived general health defined as the percentage sum of people reporting bad or very bad health. (Age and gender breakdown)
Infant mortality	Infant mortality rates defined as the ratio of the number of deaths of children under one year of age during the year to the number of live births in that year. The value is expressed per 1000 live births. (Gender breakdown)
Infant mortality by socio-economic status	Infant mortality as defined above but presented by socio-economic status of parents (such as level of education, income quintile)

Indicators regarding quality of care: effectiveness, safety and patient centeredness (objective 2)

Primary indicators

Vaccination coverage in children	% of infants reaching their 1st birthday in the given calendar year who have been fully vaccinated against pertussis (whooping cough), diphtheria, tetanus (DPT) and poliomyelitis. and % of infants reaching their 2nd birthday in the given calendar year who have been fully vaccinated against measles, mumps and rubella (MMR)
Cervical cancer screening	Defined as the % of women aged 20-69 that were screened for cervical cancer using a cervical smear test over the past 3 years.
Cervical cancer survival rates	Defined as the % of those still alive 5 years after the disease has been diagnosed compared to a non-diseased comparison group of similar age-structure (relative rates).
Colorectal cancer survival rate	Defined as the % of those still alive 5 years after the disease has been diagnosed compared to a non-diseased comparison group of similar age-structure (relative rates).
Satisfaction with health care services	Defined as the proportion of the population satisfied i.e. that find the following type of services good (very plus fairly good) a) GPs/family doctors b) specialists c) hospitals d) dental care services

Secondary indicators

Influenza vaccination for adults over 65+	% of those aged 65+ that have been vaccinated against influenza in the last year. (Gender breakdown)
Breast cancer screening	Defined as the % of women aged 50-69 that were screened for breast cancer using a mammography over the past year.
Breast cancer survival rate	Defined as the % of those still alive 5 years after the disease has been diagnosed compared to a non-diseased comparison group of similar age-structure (relative rates).
Perinatal mortality	Defined as number of foetal deaths (over 1000g) plus neonatal deaths (0-6 days) per 1000 live births.

Indicators regarding long-term sustainability of systems: expenditure and efficiency (objective 3)

Primary indicators

Total health expenditure per capita	Total health expenditure per capita in PPP.
Total health care expenditure as a % of GDP	Total, public and private expenditure on health as % of GDP (see definition of public and private expenditure next).
Total long-term care expenditure as a % of GDP	Defined as expenditure on long-term nursing care plus expenditure with administration and provision of social services in kind to assist living with disease and impairment. as % of GDP
Projections of public expenditure on health care as % of GDP	Age-related projections of health care, current level (% of GDP) and projected change in share of GDP (in percentage points) (2010-50)
Projections of public expenditure on long-term care as % of GDP	Age-related projections of long-term care, current level (% of GDP) and projected change in share of GDP (in percentage points) (2010-50)
Hospital inpatient discharges	Hospital inpatient discharges per 100 000 inhabitants
Hospital daycases	Hospital daycases per 100 000 inhabitants
Obesity	Defined as the % of obese persons in the population i.e. the % of the population with BMI >= 30kg/m2

Secondary indicators

Sales of generics	Defined as the % of generics sales in all prescribed medicine sales.
Acute care bed occupancy rates	Defined as the number of acute care beds effectively occupied in inpatient institutions divided by the number of available acute care beds and multiplied by 100.
Hospital average length of stay	Computed by dividing the number of days stayed in the hospital by the number of hospital discharges or deaths in hospital.
Regular smokers	Defined as the % of daily cigarette smokers in the population aged 15+ (Age and gender breakdown)
Alcohol consumption	Defined as the number of litres of pure alcohol per person per year. (Age and gender breakdown)

Context indicators

Physicians	Total number of practising physicians per 100.000 inhabitants. This indicator can be use to look at staff needs for the whole country and the distribution of staff across the country. Time trends may also help us identify staff shortages due to migration.
Nurses and midwives	Total number of practising nurses and midwives per 100.000 inhabitants. This indicator can be used to look at staff needs for the whole country and the distribution of staff across the country. Time trends may also help us identify staff shortages due to migration.
Public and private expenditure as % of total health expenditure	a) total public expenditure which includes government spending (central government, state/provincial government and local/municipal government) plus social security funds b) total private expenditure which includes private health insurance (private social insurance + private insurance other then social insurance) plus private households out of pocket expenditure plus non-profit institutions and private corporations other than health insurance such as private companies funding occupational health care c) private health insurance expenditure d) out-of-pocket payments expenditure as % of total health expenditure
Total expenditure on main types of activities or functions of care	This means analysing the proportion of total current health care expenditure that is allocated to the following activities or functions of care. a) services of curative + b) services of rehabilitative care (together) c) ancillary services to health care d) medical goods dispensed to outpatients e) prevention and public health as % of total current health expenditure This analysis is also to look at pharmaceutical expenditure in more detail by looking at expenditure on e) pharmaceuticals and other medical non-durables as % of total current health expenditure and as % of GDP

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