Part V

The future

Scenarios on the future of healthcare in Europe

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Abstract. In this chapter three scenarios on the future of European integration in healthcare are developed and analysed. Scenario A is based on the assumption that healthcare should remain entirely in the competencies of the Member States and their regions. Scenario B is based on two assumptions. First, the free movement of individuals, goods, services and capital has to be applied to all structures and processes of healthcare. Second, it is acknowledged that healthcare is part of the European Social Model and therefore the SEM has to be contained in a social framework to ensure that a basic set of rules on equity and solidarity is not undermined. Scenario C is characterised by the absence of an overarching or consensual policy vision.

1. Introduction

In this chapter, three scenarios on the future of European integration in healthcare are developed and analysed. The scenarios are not designed to predict the future. They aim at discussing "ideal types" and their consequences. According to Max Weber, ideal types do not necessarily have to be identical with current or future settings but resemble typical features which are based on the logical development of basic assumptions.

The purpose of these scenarios is to distance the debate from the short term political, economic and social interest in regard to European integration and healthcare. By developing scenarios it is intended

- to facilitate a debate on the vision on European integration and healthcare,
- to discuss consequences of theses visions and
- to identify the technical, economic, juridical, social and political requirements of these visions.

The scenario approach as presented here does not start from the political will or the interest of stakeholders as currently expressed, nor from current institutional settings and their developmental tendencies. Not even intensely debated European visions such as a federal Europe will guide these scenarios. The common starting point is an assumed tension between the Single European Market (SEM) which is universal across Europe on the one hand and the European welfare states – which are unique to each Member State – on the other. The scenarios are not designed either to abolish welfare states nor to abolish the SEM.

Each scenario is developed by starting with a policy vision, based on a number of assumptions and characterised by some key features. From that policy vision, the consequences of the scenario are explored in terms of the distribution of competencies and accountability as well as the financing and delivery of services.

In a second step the scenarios will be assessed in terms of their inherent conflicts, the winners and losers they produce, and the likelihood that they will occur.

Finally, the lines of argument will be drawn together to specify key issues of the role of European integration in healthcare and the role of healthcare in European integration.

2. Scenario A: bi-lateral and multi-lateral agreements

Scenario A is based on the assumption that healthcare should remain entirely within the competencies of Member States and their regions. A functional extension of cross-border care and service provision is in principle feasible but is not a task of the European Union. The development of a further "internationalisation" of healthcare is based, rather, on bi-lateral or multi-lateral agreements between Member States and their regions. Regulation 1408/71 on the coordination of social systems should only be applied very closely to the purpose of the free movement of people. This regulation should not be applied beyond this purpose and therefore it should not serve any health or healthcare related activities.

Functional requirements of cross-border care in densely populated border areas or in typical tourist regions should be met by bi-lateral or multi-national agreements and contracts. The key features underpinning these agreements and contracts are networks, interfaces and co-ordinating systems.

A universal right for European citizens to the use of healthcare facilities or health-related goods across the Member States of the EU is not intended. Any legal provision, whether in the Treaty Establishing the European Community (TEC) or in secondary legislation which is ambivalent in this respect has to be clarified in order to give the domestic courts and the European Court of Justice (ECJ) a clear account of the political will concerning the extent of European integration in regard to healthcare, and to prevent rulings like those on Decker and Kohll or Geraets-Smits/Peerbooms.

According to the health policy vision, European integration in this scenario is neither a matter of principle nor a vehicle for thorough reform or reorientation of health policy in the Member States.

2.1 Distributing competencies and accountabilities

The intended political order of Scenario A entails a return to an ideal type "classic" domestic responsibility and accountability for health policy making – a return to pre-TEC times.

But for some Member States, especially the smaller ones, this "classic" order in regulating and developing health services has never existed and, for the larger Member States in some border regions, close social, economic and cultural ties have always existed – making cross-border healthcare a valuable endeavour. Nevertheless, the argument is made that health policy in terms of health services should not be a Community or EU responsibility. That is not to say that the Community has no role to play in health. On the contrary, it is conceivable that, as the perfect complement to the exclusive right of the Member States to regulate all affairs in regard to health services, a more effective integration of public health considerations into all community policies would be desired. The Community's role would therefore be restricted to a very specific public health domain. Problems such as BSE would be dealt with on the European level. But to interfere with health services in Member States is entirely out of question.

The Community's role in health policy making will be very restricted. It will focus exclusively on those policy areas where the Community has a legislative right – including

public health, the free movement of goods and services (as long as healthcare is not concerned) and agricultural policies.

To prevent ambiguities, the Community is held responsible for disentangling those policies where the four freedoms may overlap with health service provision – particularly in the complex areas of the health professions, pharmaceuticals and medical devices (see appropriate chapters). Due to the policy vision and the derived political order, the right of free movement and establishment may be restricted. The same applies to cases when certain mechanisms are interpreted in a more "pro-EU" way by the ECJ.

The Member States regain their undisputed sovereignty on health service policy, they are free to use their competencies to intensify cross-border collaboration – whether in the area of patient care or, for example, on a joint strategy on pharmaceutical reimbursement.

Some of the regions, especially those with long and relatively densely populated borders with other Member States, have an intrinsic interest in developing co-ordinated services and in facilitating the establishment of networks or integrated care arrangements as part of a regional social and economic development strategy. As long as domestic legislation is not violated, they are certainly free to develop those cross-border relations. But in their attempts to do so they may not refer to the Treaty, to Regulation 1408/71 or to any other source of European law.

Nevertheless, the different political status of regions across Member States may form an impediment to setting up cross-border ties. Some will find it extremely difficult to articulate their interest, let alone to become actively involved in planning and negotiating bi- and multilateral agreements.

Due to the bi- or multi-lateral development in cross-border care, the provider and purchaser organisations stay in contact Europe-wide but do not implement solutions according to any universal principle. Each solution to cross-border care will be unique.

2.2 Providing and financing health services

In terms of service provision, the territorial boundaries of health services are not superseded by European legislation insofar as no payer or provider may invest in health service institutions across the border or engage in a joint-venture on the basis of the TEC. Still, if domestic legislation allows cross-border ownership, they are free to do so. The cross-border use of facilities by patients relies entirely on contractual relations between competent institutions or governments in the Member States or regions.

Harmonisation of the scope of services provided by Member States or regions is not intended. Healthcare baskets – as far as they are explicitly defined – remain entirely in the accountability of the competent institutions and political bodies. However, the contractual partners are free to adjust services as long as domestic legislation is not interfered with.

Each contractual partner is held responsible to keep in line with domestic legislation or funds. An unbalanced transfer of money or even an extra income for service providers is not intended, since this may result in a loss of resources for domestic providers. Nevertheless, the uneven distribution of holiday travel may cause – in small quantities – net transfers.

2.3 Ensuring co-ordination

Member States realise that existing regulations like 1408/71 leave gaps in terms of access to health services. Rather than implementing new rules at the EU level, they are addressing the problems bilaterally if appropriate. Sweden and Spain will probably sign an agreement

to define access and benefits for each other's citizens, but Estonia and Portugal probably not.

Equally, the improvement of cross-border care for workers who reside in one country but work across the border in another country is addressed where it is relevant. Some Member States also allow cross-border choice of care for residents in defined areas without working in the other country and therefore extend the legal provision, but these agreements are strictly based on bi-lateral contracts.

Some border regions try to improve cross-border resource management. Co-ordination in border regions might be of value in terms of allowing rescue services in both border regions, of using jointly hospital capacities or to overcome short-term bottlenecks with specialist services. In terms of centres of excellence cross-border coordination could be useful both for patients if they are not required to travel far and for more efficient use of spare capacities.

2.4 Designing interfaces

Individual interfaces will be designed to allow cross-border service provision for patients in areas such as Euregios. In each particular case, they will be designed to regulate eligibility to cross-border services, cross-border transfer of money and transfer of patient records or other patient data.

Robust interfaces require a solid juridical foundation which is designed to serve them. Questions of data-exchange in regard to the patient records, their usage and the resulting expenditure have to be clarified, especially if the patient flow using the interface is substantial or asymmetric.

Interfaces often use smart card technology. This technology can be introduced to facilitate cross-border care – e.g. through an EU-wide patient card. This is, however, against the spirit of Scenario A and will not be pursued. Rather, it could be used to allow a seamless integration of the chain of service provision across borders in particular areas or between certain countries which agree to do so. Moreover, the technology may be used to improve efficient use of capacities either in border areas or for highly specialised centres of excellence. Smaller countries might be able to avoid unnecessary investment in facilities which could be available in neighbouring countries, if usage abroad is possible without bureaucratic complexity – especially if post-operative treatment could be carried out in the domestic environment.

3. Scenario B: regulated European competition

This scenario is based on two assumptions. First, it is acknowledged that the free movement of individuals, goods, services and capital has to be applied to all structures and processes of healthcare. Second, it is the common understanding in the EU that healthcare is part of the European Social Model and therefore the SEM has to be contained in a social framework to ensure that a basic set of rules on equity and solidarity is not undermined. The desired competition aims at efficiency and not at profits.

Consequently, free access to basic healthcare and to different competing competent financing institutions across all Member States is an established right of EU-citizenship but at the same time, a tight European regulatory framework is put in place to contain their competition.

European integration in this scenario is a matter of principle. Furthermore, it is used as a vehicle both to develop healthcare provision attuned to the preferences of patients and to

introduce more competition between both payers and provider of healthcare not on a merely regional or national level but on a European scale. Competition takes place in three dimensions: 1) European competition for citizens by payers; 2) European competition for payers by providers; and 3) direct competition between providers for patients. The key elements are pooling mechanisms to allow a socially acceptable competition, a European Basic Benefit Package which will clearly define the services and goods in the competition and a contribution/tax collecting system, which allows both tax based and social insurance systems to operate in the SEM.

3.1 Designing a "European Basic Benefit Package"

One of the basic principles of the competition-based European Social Model is the equality of available benefits throughout the Union for two reasons. First, if access to healthcare is an universal right for citizens which goes beyond rhetoric, it is essential that patients are aware of their rights and informed on what these rights entail. Second, competition can only be carried out if the product or the service is specified. Following the direction set by the ECJ in its "Peerbooms" ruling, all healthcare services and medical goods (e.g. pharmaceuticals) which are internationally sufficiently tried and tested are included in the European Basic Benefit Package (EuBasicBP). Any financing institution has to offer the whole scope of benefits services defined within the EuBasicBP.

3.2 Setting up a system of European accreditation and certification

In order to guarantee the quality of services and goods provided, a European system to accredit healthcare facilities and to certify health professionals will enhance transparency. This system builds on existing domestic institutional settings by harmonising goals and criteria but not necessarily means.

Accreditation and certification gain overwhelming importance in the light of the future enlargement of the EU. An effective system would both improve quality and raise trust in healthcare institutions in other countries. In regard to the patient, it is a question of consumer protection, and in regard to regulated competition, it is question of transparency.

3.3 Earmarking taxes for health

Tax-based systems are, in Scenario B, in a somewhat awkward situation, whether the tax is levied nationally, regionally or locally. To allow them to compete with SHI-based countries, the health-portion of taxes has at least to be earmarked. During preparatory negotiations, Member States will have to decide among various options how to handle the situation. One option is that the earmarked part is directly passed into the European Healthcare Finance Pool (see below). A second option is that those citizens who wish to change from the competent financing institution, currently called the NHS, to another receive an equivalent allowance or are freed from the "health tax" altogether.

A possible compromise between Beveridge and Bismarck countries could be that taxes will be reduced (in the tax-based systems) but introduced in all Member States as a financial basis for funding healthcare which does not only rely on the contributions of individuals. The tax-part could be spend on population-based health activities (e.g. prevention) or included in the pooled financial resources to be allocated to the competent financing institutions.

3.4 Pooling financial resources

The systems of collecting the financial resources remain largely intact, but to prevent competition based on cream-skimming for low risk and high income citizens which would put less wealthier (or less healthier) European regions at a disadvantage, a pooling mechanism – the European Healthcare Finance Pool (EuHFiP) – is introduced. Each competent financing institution pays the collected contributions into the pool and in turn receives a European Standardised Per-Capita Allocation (EuSCAl) for each enrolled citizen. The standardisation of the EuSCAl aims at levelling out differences in morbidity as well as income and regional purchasing power parity on an EU-wide level. The EuSCAl guarantees each purchaser the average costs of patient care. But a purchaser which manages its affairs efficiently would gain a surplus. Since all purchasers remain non-profit organisations, the surplus can only be used for refunds or to offer additional services.

To guarantee that extremely costly patients are equally well treated, the EuHFiP also manages an European High Risk Pool (EuHiRiP), out of which parts of the costs for patients suffering from diseases like AIDS, cancer etc. is covered directly.

3.5 Ensuring Europe-wide choice, preferences and service provision

Citizens have in principle a free choice of doctors, specialists and – within given restrictions – a free choice of hospitals. Yet, competent financing institutions are free to tie the provision of services included in the EuBasicBP to specified settings and to organise the chain of service provision according to patient preferences and efficiency criteria. A financing institution could, for example, offer various forms of integrated care including primary healthcare and gate keeping. If that would result in a more efficient service provision, the financing institution could offer additional services beyond the EuBasicBP or pay back part of the contributions. If services cannot be financed out of the EuSCAl (plus possibly the EuHiRiP), the competent financing institution has to raise additional contributions from its insured.

3.6 Distributing competencies and accountabilities

Inevitably, Europe-wide regulated competition entails a redistribution of competencies and accountabilities. The political aspect of the health policy vision is not based on a hierarchical understanding of regulating health services but on a European multi-layer system, where the various layers (EU, national, regional, self-government and local levels) are linked and dove-tailed in various ways.

The Community's role in health and healthcare is changed completely and made more explicit. The EuBasicBP, the EuHFiP and the EuHiRiP will not have to be embedded in a revised Treaty directly, though. Alternatively, they could be the result of a coordination process among Member States. It is also possible that, as with the Euro, not all Member States will initially participate. But EU citizens will win a new benefit since access to healthcare will be established as a universal right.

More practically, Community institutions – existing (e.g. Eurostat) or newly established – will handle the data needed to facilitate the regulated European competition in healthcare. Nevertheless, in most areas the Community does not become involved in managing health services.

The Member States will largely lose their right to define the healthcare basket independently, although they can still influence the basket. In order to limit the EuBasicBP, each Member State has the right to commission Health Technology Assessment (HTA)

reports in order to find out whether a given service in the benefit package is inadequate. If that is the case, the service will be taken out of the EuBasicBP. The competent financing institution is free to keep those services on offer for an additional premium. It will be an important marketing instrument for the financing institution to serve preferences which go beyond conventional medicine and expand to those based on social values or tradition. Clearly, some of the services which are at stake have been in Member States' benefit baskets for a long time because of social values attached to them and not because of their effectiveness – an issue which will have to be dealt with at European level as well.

For some of the regions, regulated European competition provides the opportunity to develop a strategic health profile and to make health, healthcare and related products and services the centre piece of their regional economic strategy. This is a reaction to the high relevance of healthcare in terms of the GDP and employment.

3.7 Providing and financing health services

Almost everything seems to be possible. Investment across-border, joint ventures, contractual co-operation and co-ordination. In terms of the healthcare basket, beyond the evidence-based EuBasicBP, financing institutions are free to offer extra services which go beyond the narrow definition of academic medicine and may offer complementary medicine, wellness, comfort healthcare and esoteric health following demands of patients who are willing to pay more for their preferences.

4. Scenario C: muddling through

This scenario is characterised by the absence of an overarching or consensual policy vision. It extends today's status quo on the role of European integration in healthcare to the future. Clearly, the different players in the emerging European health policy arena do hold different incompatible policy visions, often in stark contrast with their national governments.

But this will become more difficult since the health systems do not fall into two categories like the Bismarck and the Beveridge model but there are also mixed systems. Moreover, some of these systems are subject to rapid changes. And these changes may not be in line with the rulings of the courts since it becomes increasingly difficult to understand Europe's position on health services.

In the absence of a coherent political will in a policy field which is not yet politically defined, domestic courts and the ECJ are frequently called upon in order to interpret secondary European law in the light of the TEC. Without a explicit policy vision established in the TEC, the courts have to "read between the lines" and provide a policy surrogate. Yet, due to political pressure and the complexity of the subject as well as the fact that Advocates General and Judges are neither specialised on social law or healthcare law and certainly have only a basic understanding of the health services in the Community, rulings will appear insufficient, inadequate and incongruent.

This poses a difficulty to the actors in national health services, because the interpretation of a given case is unpredictable. Health management, which is always carried out under the circumstances of insufficient information, will find it more difficult to act in a proactive way. This is a highly relevant issue since the European legislation beyond Decker and Kohll has severe consequence for health services. This is, for example, the case for competition law.

Healthcare managers will be urged to use these inconsistencies in order to gain benefits for their organisations. They may try to use inconsistencies in ECJ rulings to have some

legal backing for action which would otherwise not be allowed by the Member State. For example it remains questionable whether Regulation 1408/71 is a proper legal foundation to organise cross-border care beyond matters of urgency. Managers will use Regulation 1408/71 as a legal lever against domestic law, which would not allow cross-border activities.

Like managers, patients will try to use the uncertainties and inconsistencies to receive the services abroad. Without an established "safety valve" they will use cross border care and will put their competent financing institution under pressure. They will try to use the E111 procedure under Article 22(1)(a) of Regulation 1408/71 to obtain medical goods and services for free which are not in the healthcare basket of their country. Another strategy will be to pretend that they need urgent treatment in order to meet the criteria for the application of Article 22(1)(c) of Regulation 1408/71. Others will go abroad to by-pass waiting lists and will demand reimbursement, threatening the competent financing institution with public exposure to personal hardship and unfairness for withholding treatment which is readily available elsewhere. This has already proven to be a strategy that works in healthcare systems which have introduced competition between purchasers.

5. Assessing the scenarios

In this section the conflicts inherent to the scenarios and technical and political aspects will be discussed.

5.1 Inherent conflicts

Obviously, none of the three scenarios offer a conflict free or instantly convincing solution in terms of combining SEM dynamics with health services of Member States. But the scenarios serve to make explicit these conflicts. Some of them are already at work today.

To restrict the TEC and secondary European legislation to areas not related healthcare, as suggested in Scenario A on bi- and multi-lateral agreements, is – if possible – a difficult task. But even if it was possible, the question of the consequences remains. For the health services, the consequences are relatively small. Those institutions which enjoy the legal right to establish cross-border care will have an advantage in their domestic systems. Yet, they will establish links across borders for their own purposes and will not necessarily pursue their patients' interests. The result would be a patchwork of different pilots and projects. Existing differences in service provision, usage and probably outcomes would increase both on a European and domestic level. Instead of an economic convergence, the (regionalised) healthcare sectors would diverge also in economic terms in regard to expenditure and employment. The heterogeneity of interests in healthcare would increase. Eventually, this development would contribute to a disintegration and fragmentation of the medical, political and economic aspects of healthcare both on a European and domestic level.

Scenario B on regulated European competition establishes more problems than solutions. First, it is clear that insurance systems are at an advantage compared to tax-based systems. The changes necessary for tax-based systems in terms of financing and organising the systems would be enormous. In many Member States, health services are financed out of a variety of sources combining contributions, user charges, general taxation and earmarked taxes. Fair European competition would need to disentangle these sources or to find mechanisms of compensation – a task which would be highly complicated if not impossible on a mere technical level.

Moreover, it is likely that sickness funds might find it easier to develop a business approach to healthcare provision than health authorities. Strategic thinking, investments, joint-ventures, mergers and the development of new business-ideas will be easier for them, at least if they are based in countries which have already opened up such opportunities. That will disadvantage health authorities and sickness funds which currently have monopolies based on geography or occupational factors. While certain sickness funds may aggressively enter European competition and may even invade the territory of national health services, others will face severe competitive disadvantages.

Open competition across Europe would be difficult for other reasons too. While the EuSCAl aims at levelling out discrepancies in the level of contribution due to differences in wealth and possibly healthcare needs, it is difficult to assess the role of medical fee schedules. Should there be a unified European medical fee schedule or none at all? Should the reimbursement level in the fee schedule vary from region to region or should it just establish a ceiling?

Clearly, the diversity between regions and systems is – despite convergence in some areas of health systems – still too large to find an easy solution. But the differences in systems are not only a matter of historical or technical settings. To have – and to keep – a national health service instead of a statutory health insurance is also a matter of values. Regulated European competition would be indifferent in regard to such national values. Systems which find it easier to operate in a competitive context will be at an advantage and will expand over borders. Even if it were conceivable to implement such competition, a European health service would emerge not on the basis of what European citizen desire politically but on the basis of aggregate consumer preferences. That would put an end to health policy-making in the "European sense" by political interest mediation and would entirely surrender system-development of health services to market or quasi-market forces.

Moreover, it will be extremely difficult to define a EuBasicBP. As experience in various countries has shown, politically restricting benefit packages is very difficult. It is therefore likely that the EuBasicBP would include all in-patient services. Areas which in some health services are already excluded – such as dental care – could be reintroduced. Another difficulty will be to bridge cultural gaps. Some health services, for example, refer to the concept of solidarity to define both the distribution of financial burden and the right to healthcare, while others are based on equity. As a result it is likely that - instead of a restriction - an upward dynamic could be triggered which would put a high financial burden particularly on some tax-based systems.

At first glance, Scenario C on muddling through seems to be the most convenient way to handle the inherent conflict between the SEM and the territoriality of Member State based health services. The political costs appear to be the lowest, compared to the other scenarios since no decision has to be made whether to go down the road of further integration or reverse the process and to erect firewalls between the health services by excluding them entirely from the TEC. Political rhetoric may pay lip-services to both the protagonists of integration and those of segregation. If something undesired happens it is always possible to put on the blame on the ECJ or the Brussels bureaucrats, neglecting that they act on behalf of the political will once articulated by the Member State governments as manifested in the TEC.

For organisations in the Member States it will, however, be very difficult to adjust themselves to the uncertainty of European integration. Moreover it could happen that Member States with statutory health insurance systems are hit harder by European competition law than others, because they are detached from the state and come almost instantly under the suspect of acting as undertakings.

5.2 From today's health services to scenarios

In terms of technical and organisational aspects already at work – whether fully developed or just at an embryonic stage – almost nothing is inconceivable. In fact the race to define the future of healthcare in European integration has already started on a technical and organisational basis too.

There are a variety of cross-border agreements or pilot agreements involving the Netherlands, Belgium, Grand-Duchy of Luxembourg, the UK, Ireland and various European Regions (see the chapters on context and consumer choice of healthcare services). Additionally, some regions and organisations have been very active the recent years to establish cross-border care. These pilots may be considered a testing lab for European integration in healthcare.

The quest for efficiency in healthcare provision by inserting market mechanisms into the institutional settings of health services has been the hallmark of healthcare reform during the 1990s across Member States in rhetoric and to a certain degree in reality. To create competition inside socially financed health services has become an acceptable instrument to develop health services. Competition between payers has been introduced in some Member States. And in others, competition between providers for payers has also been introduced.

The idea to extend this competition beyond national borders is no longer an intellectual consideration. A German company based sickness fund, the Siemens BKK, tried in 1999 to alter its statute to allow cost-reimbursement across all Member States. This was denied by the competent authority but the sickness fund took the case to the Social Court in Munich where it is currently pending (file S 18 KR 367/00). Moreover, this sickness fund is developing a far reaching European strategy which entails selective contracting abroad for integrated care, the right to establish new funds abroad (according to domestic rules) and, eventually, the free choice of insurer for European citizens. It appears, therefore, that actors are beginning to appear in the emerging European health policy arena that have an intrinsic interest into Europe-wide competition for insurees and a Europe-wide competition between providers for payers.

A (possible) paradox becomes evident: While the "drivers" for pan-European healthcare are trying to escape from some of the perceived restrictions of regulated competition on the national level, the development this triggers might end up with similar mechanisms on a European-wide scale, as the Scenario B suggests.

6. Concluding remarks

If we knew the final outcome of European integration, it would be far easier to develop a vision on the future of healthcare in Europe. But since European integration is an open process of conflicting concepts and interest, we can only assess what the role of Europe in healthcare – and vice versa – could be in relation to the three scenarios.

Only scenario B on regulated European competition gives Europe a definite role in healthcare. All actors in healthcare shall enjoy the freedoms established in the TEC. But although the scenario is based on the assumption that these freedoms should take place in a framework of a solidarity and equity, the political dimension of healthcare seems to vanish. As far as system development is concerned, market forces would probably be dominant. In Scenario A on bi- and multi-lateral agreements, there is no role for Europe in healthcare. The competent financing institutions may use the opportunity of cross-border service

provision according to their own interest. Scenario C on muddling through remains neutral in relation to the role that Europe has to play in healthcare.

In regard to European citizens all three scenarios produce severe conflicts. The regulated competition scenario B endows the European citizen with a (slightly restricted) universal right to healthcare across Europe. But this implies a citizenship in terms of the "Bourgeois" based on economic freedom and liberalism, transferring the patient into a consumer, needs into preferences, planning into competition and policy into strategic marketing. But at the same time – due to the overwhelming role of competition – citizens may be stripped of their political powers. Competition will drive system development at the expense of health policy reform. New developments will not be a matter of different values, political concepts or democratic interest mediation. The "Bourgeois" is not accompanied by the "Citoyen", who is not only the sovereign of market decisions but also of political decisions. The process of moving European integration from a mere market based approach into a political and social Union would be reversed in the area of healthcare.

A positive statement on the role of healthcare in Europe can only be derived from the regulated competition scenario, under which convergence will occur over time. Convergence is enforced by those organisations which will operate most successfully. The scenario on bi- and multi-lateral agreements offers no role for healthcare in Europe, at least not in terms of the Community. And again the muddling through scenario is neutral.

But this again poses a paradox. There is a growing awareness that healthcare is not only an economic burden in terms of welfare state expenditure but also an economic asset as a major source of employment and a necessity for sunrise industries such as telematics, e-business, new pharmaceuticals. It is almost inconceivable that healthcare should not, sooner or later, play a role in European integration.

From the previous chapters and these three scenarios, it is clear that new challenges to research, the establishment of a European health policy arena and domestic legislation arise.

Some of the pilots in cross-border regions have already produced evaluation reports of their activities. While some of the data on the extent and direction of patient flows is interesting, it is far more important to assess the political, technical, juridical and managerial issues involved in setting up those interfaces. The evaluation will help to assess what needs to be changed in order to make cross-border care managerially effective and efficient.

Comparative research in benefit packages has to be commissioned very soon for a variety of reasons. In all three scenarios – to different degrees – a growing need to know what is provided on "the other side of the border" becomes evident. The scenario on regulated European competition requires the knowledge of healthcare basket for the merger into the EuBasicBP. For the scenario on bi- and multilateral agreements, some substantial knowledge on what is provided abroad is also important, in order to find partners and reach sensible agreements. Even the muddling through scenario will require some understanding of the benefit packages from abroad since patients may want to know whether it is possible to go abroad intentionally for treatment.

At the same time, the chain of service provision and the institutional setting in which healthcare is provided appears on the research agenda. While it is on one the hand "only" a descriptive task to portrait service provision in other Member States and regions, it could also be an analytical task for HTA to expand from "stand alone technologies" to "complex technologies". The assessment of the effectiveness and efficiency of the complete chain of service provision from preventive, ambulatory, hospital and rehabilitative services in regard to a given indication in different healthcare settings would be both a good argument for (or

against) integrated care across borders and could, at the same time, trigger a convergence by learning from best solutions.

The issue of social values embedded in healthcare institutions and health services seems to be a much neglected issue in comparative terms. Nevertheless, the Commission claims, for example, that there is a common "European Social Welfare Model" which is based on values and which makes Europe distinct from other places around the world. If convergence or integration will take place at least to some degree, it will become important to understand the commonalities and differences between the values and belief-systems embedded in health services of Member States and regions.

Last but not least, we know little about what the European citizen or patient thinks and desires in relation to the European dimension in healthcare. There is some research, for example on the knowledge of frontier workers on their healthcare rights. Other studies have tried to quantify the potential willingness of (healthy) patients going abroad when sick. But little is known about experiences in other health services or, for example, pensioners living abroad.

According to the three scenarios, Europe is at the same time a threat, a challenge and a opportunity for patients, providers and financiers. To prevent the worst and promote the best, it will be necessary for all actors to become more involved into European politics both at informal and at official levels. It will be crucial that health managers on the operational level will also be involved both in terms of understanding European issues and transferring institutional and operational knowledge into the political process.

On the one hand, existing legal provisions, such as Regulation EEC 1408/71, clearly do not sufficiently serve the careful development of pilot projects and interfaces. At the European level it should be acknowledged that cross border care may not only be a matter of facilitating the free movement of workers but, at the same time, a desirable end in itself.

On the other hand, a complete and thoughtless application of SEM legislation to healthcare would be devastating and has not been explored here as a scenario. The scenario on regulated European competition takes into account that acknowledging the SEM in health services necessitates the setting of new, European rules if the European Social Model should be preserved.

Logically, all scenarios demand as a first step a European health policy – not the least to address openly the question of the EU's healthcare future.