Technische Universität Berlin

EU health legislation and policy – towards a European health market

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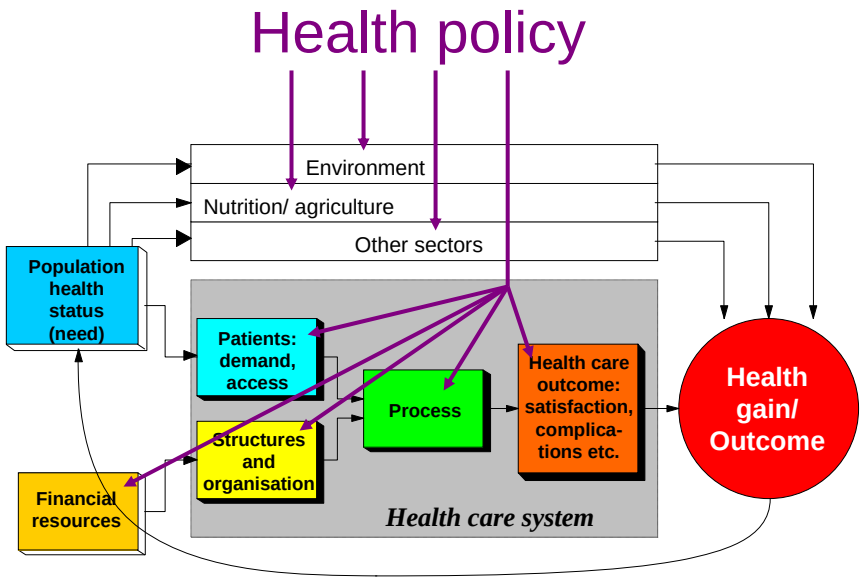
European Observatory on Health Systems and Policies

European Observatory on Health Systems and Policies

1. Introduction: Health policy and the EU treaty

Health policy =
all measures to specifically protect/ improve health of population, i.e. prevention, cure ("health care") and rehabilitation

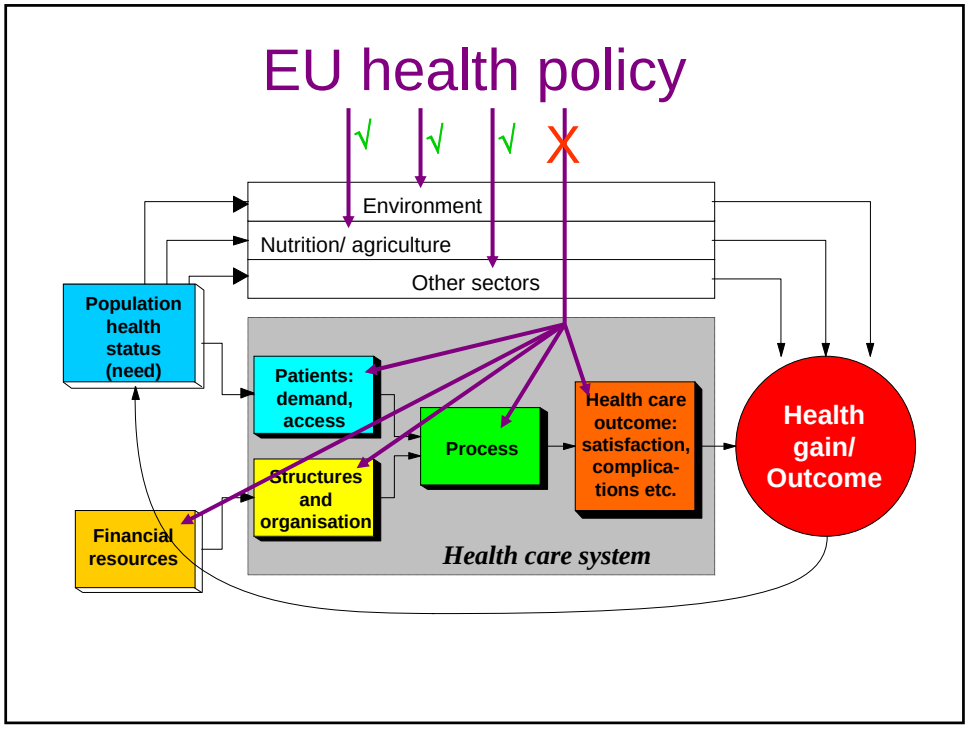


Health (policy) in the EU Treaty

Article	Contents
3 par. 1 (p)	a contribution to the attainment of a high level of health protection
30	*restriction of free movement of goods in regard to health protection*
39 par. 3	*restriction of the free movement of workers in regard to public health*
46 par. 1	*restriction of right of establishment in regard to public health*
95 par. 3	attainment of a high level of health protection in regard to the approximation of laws
95 par. 6	*restriction of approximation of law in regard to public health*
95 par. 8	obligation to inform Commission in case of public health problems in field which has been a subject to prior harmonisation
137	health protection in the working environment
140	prevention of occupational accidents and diseases
152	**public health**
153	health protection as part of consumer protection
174 par. 1	health protection as part of environmental protection
186	*restriction of free movement of workers from associated overseas countries or territories in regard to health protection*

Article 152

- A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities.
- Preventing human illness and diseases
  - fight against the major health scourges
  - promoting research into their causes, their transmission and their prevention
  - promoting research in health information and education
- "… excluding any harmonisation of the laws and regulations of the Member States. … Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care."

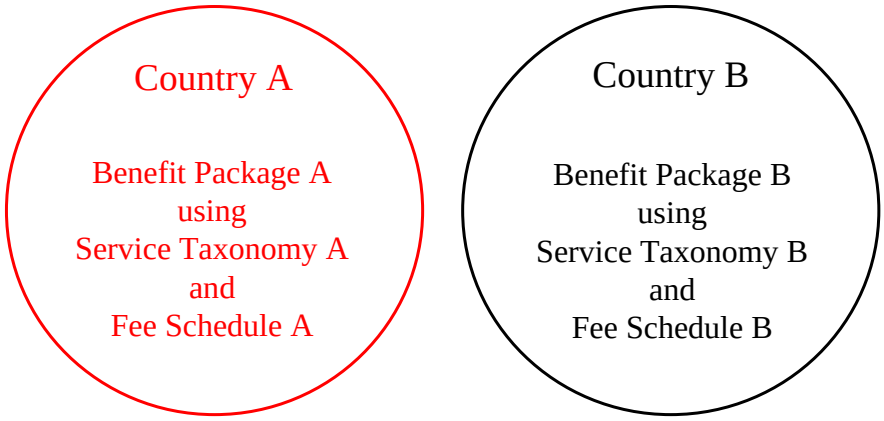


BUT:

- Article 152(5) only relates to Public Health measures
- Other EU policies do interfere with health systems, i.e. do not fully respect the responsibilities of the Member States:
  - occupational law (working times in hospitals!)
  - competition law (reference price setting)
  - Single European Market (internal market) – *especially as interpreted by the European Court of Justice*

2. The free movement under Regulation 1408/71

Many difficulties for persons moving between EU Member States but EU guarantees freedom of persons, goods, services and capital



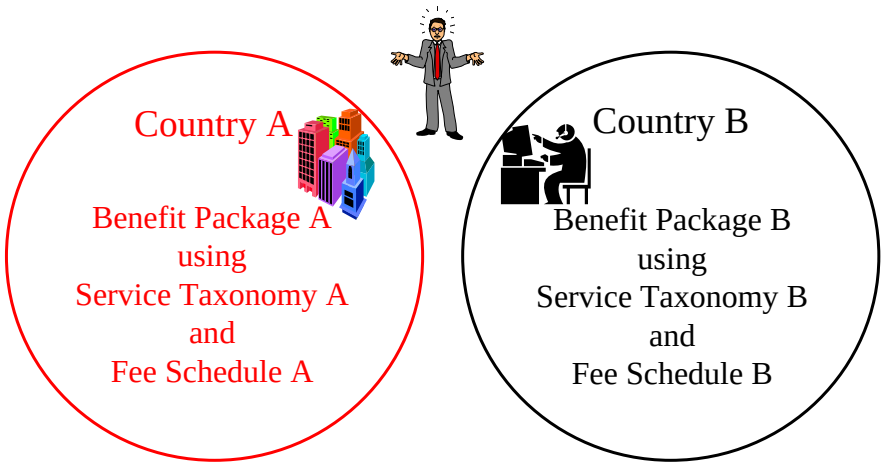
Solution: EU Regulation 1408/71

but increasingly this is seen as insufficient – as demonstrated by the cases in front of the European Court of Justice (ECJ)

Table 4: Instruments of Community policy

	Instrument				
	Regulation (No./Year)	Directive (Year/No.)	Decision	Recommen-dations	Other resolutions
Addressees	All citizens of the European Community	All Member States	All or individual Member States	All Member States (and in rare cases individual Member States)	EC institutions and the administration
Effective-ness	Generally and directly effective	Binding objectives, but free selection of the means	Individual or specific regulation of the individual case	Statement which is not binding, but which is politically authoritative	Internally effective
Content	Of an abstract and general nature	Skeleton legislation	Individual Member States, administrative acts, all Member States, skeleton legislation	Random	Autonomous resolutions, organisational acts

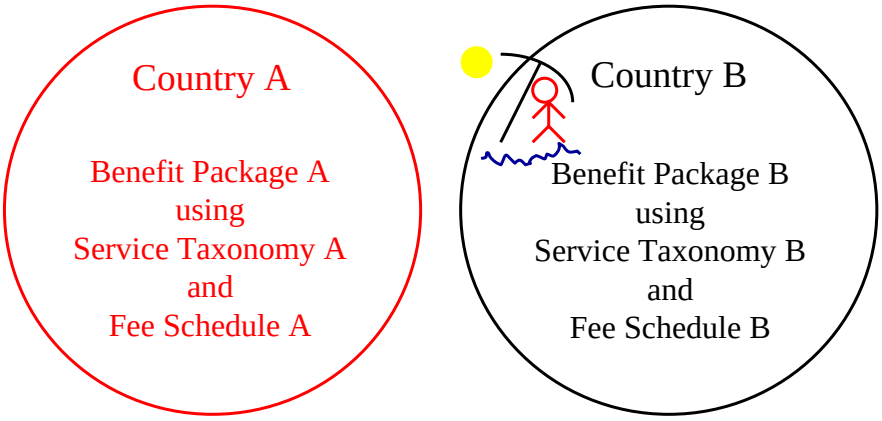
Situation 1: Person wants to live (with his/ her family) in Country A but to work in Country B.



Solution: Form E106

- Insurance in country of work place (Country B)
- Enables frontier workers and their dependents have choice to receive services in both countries (under national conditions)
- Patient presents E106 to provider in Country A (but insurance card in Country B)
- Sickness fund in B will reimburse providers in A based on fee schedule in Country A

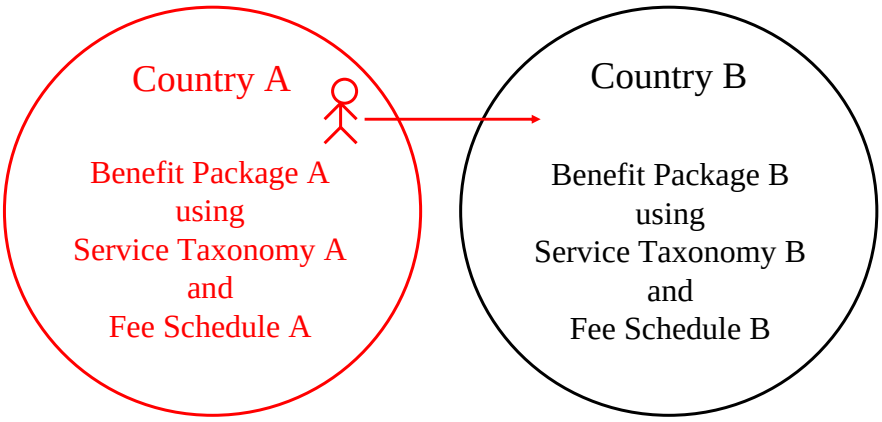
Situation 2: Person from Country A happens to be in Country B (for tourism, business ...) when he/she falls ill and needs treatment.



Solution: Form E111

- Patient takes E111 from his/her sickness fund in Country A and gives it to provider in Country B
- E111 entitles to benefits covered in Country B which are immediately necessary (copayments etc. as in Country B)
- Sickness fund in A will reimburse Country B (via national offices) – if there is no waiver agreement
- CAVE: Country B has to ensure that money reaches providers (e.g. Spain keeps money in Madrid!)

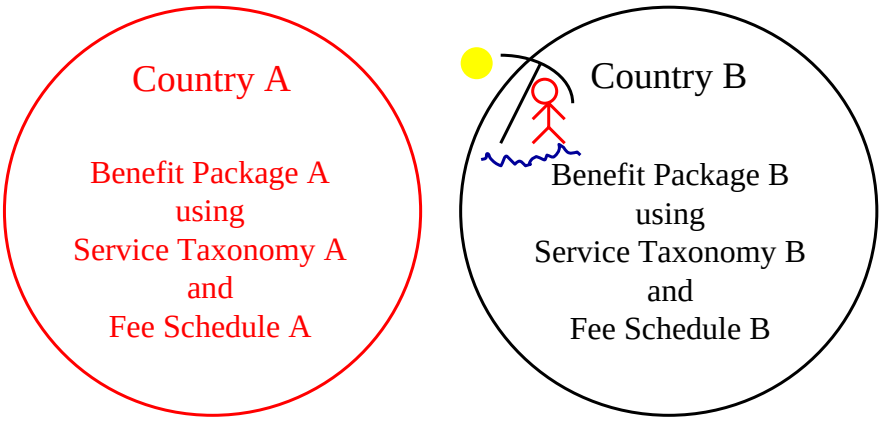
Situation 3: Patient from Country A needs go to Country B for treatment as it is not available in Country A.



Solution: Form E112

- Patient applies to his/her sickness fund in Country A for authorization to get treatment in Country B
- E112 entitles to specific service in Country B (coverage and copayments as in Country A)
- Sickness fund in A will reimburse provider in Country B based on fee schedule in Country B

New Situation 1: Retired person from Country A wants to live in Country B (including receiving health care there).



Solution: Extension of Form E111

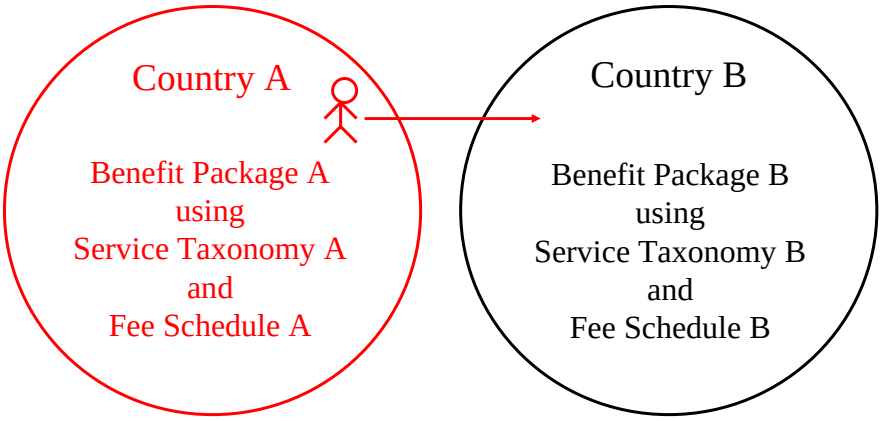
- Retired people receive all medically necessary benefits covered in Country B (not only those immediately necessary; under Reg. 883/2004 extended to all persons)
- Sickness fund in A will reimburse country B (via national offices) – if there is no waiver agreement
- CAVE: Country B may be more generous than Country A (e.g. no co-payments for elderly in Spain)

European Health Insurance Card replaces E111

“Another piece of Europe in your pocket”

A health insurance card which will, on top of all other objectives, foster intra-EU mobility

New situation 2: Patient from Country A *wants* go to Country B for treatment – to bypass waiting lists in A, because of perceived higher quality ...



Not included in Regulation 1408/71!

Two major developments:

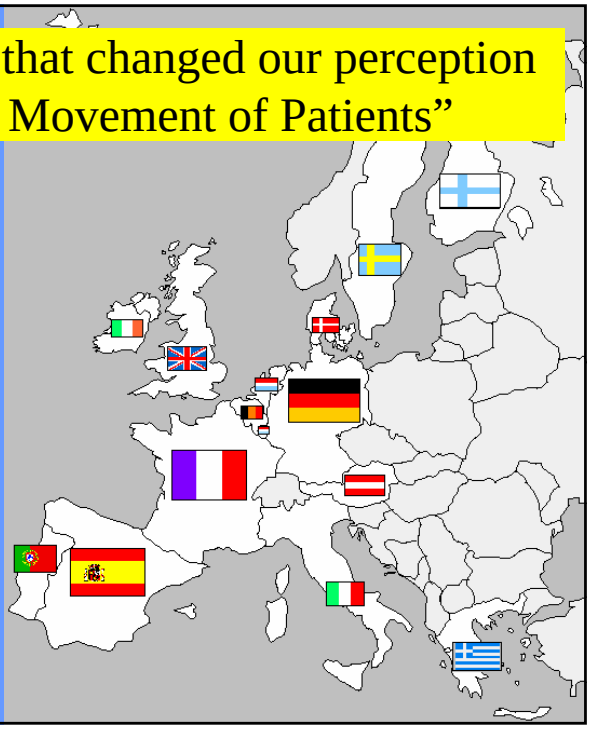
1. Extension of network of contracted providers across borders, especially in EuRegios – patients are treated as if inside their country.
2. Patient-enforced flexibility – starting with Kohll and Decker going from Luxembourg to Belgium and Germany and claiming reimbursement afterwards which the sickness fund refused but the ECJ granted (at fee rate in Luxembourg).

3. Three rulings that changed our perception of the "Free Movement of Patients"

Decker (C-120/95)
free movement of goods

Kohll (C-158/95)
free movement of services

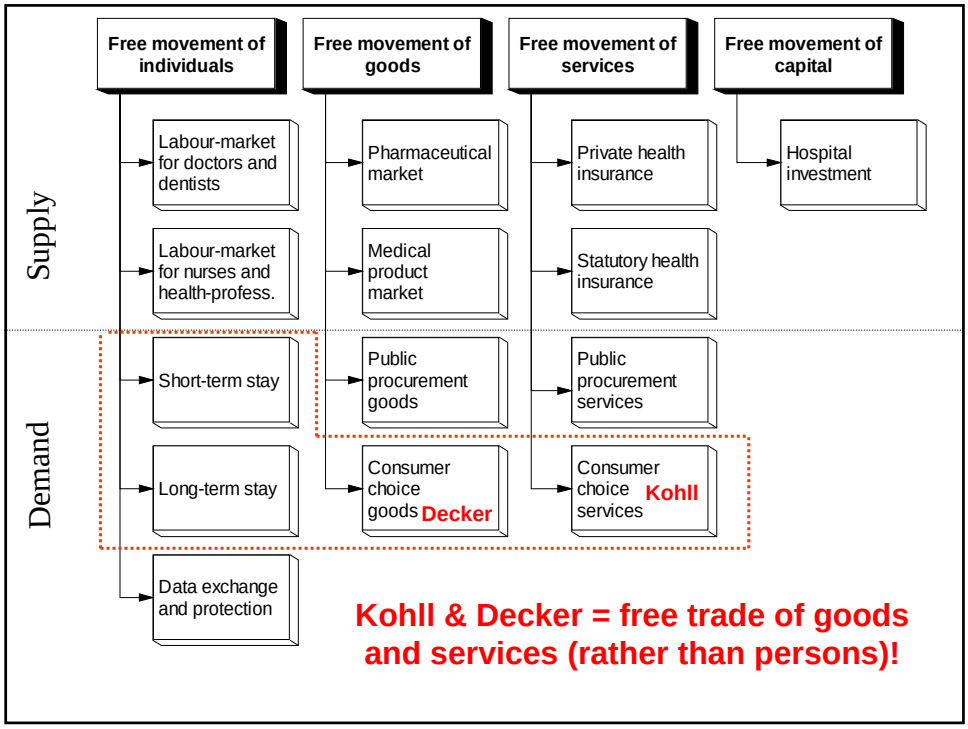
Molenaar (C-160/96)
free movement of service-equivalent cash-benefits; definition of what belongs to health service and what not



Kohll ruling

"The fact that national **rules** fall **within the sphere of social security cannot exclude the application of Art. 59 and 60** of the Treaty. While Community law does not detract from the powers of the Member States to organise their social security systems, they must nevertheless comply with Community law when exercising those powers, i.e. the fact that a national measure may be consistent with a provision of secondary legislation, in this case Art. 22 of **Regulation No 1408/71**, does not have the effect of removing that measure from the scope of the provisions of the Treaty."

Legal source	Articles, paragraphs or rulings of relevance
TEC	• Art. 23 (ex-Art. 9), Free movement of goods • Art. 28-30 (ex-Art. 30, 34, 36), Prohibition of quantitative restrictions between Member States • Art. 49-50 (ex-Art. 59-60), Free movement of services
Secondary legislation	• EEC 1408/71 (Art. 13, 19, 22), modified/ extended by EEC 1390/81 [self-employed], 2791/81 [modification following the Pierik cases] and 1606/98 [civil servants] • EEC 574/72
ECJ	• C-117/77 & C-182/78 Pierik I & II • C-120/95 Decker & C-158/96 Kohll • other cases currently pending at the ECJ: C-368/98 Vanbraekel; C-385/99-1 Müller-Fauré/ van Riet; C-157/99 Geraets-Smits/ Peerbooms



- Regulation 1408/71: free movement of persons (esp. workers)

ECJ rulings:

- 1998 Kohll & Decker: free movement of goods and services also applies in health care (only in ambulatory sector?, only in cost-reimbursement systems?)
  was interpreted to establish a parallel way to 1408/71
- 2001 Peerbooms & Smits-Geraets:
  exclusion of benefits need to be evidence-based
  (in the medium run = EU benefits catalogue?!)
  pre-authorisation may not be refused in cas
  unduly waiting times or capacity shortag
- 2003 Müller-Fauré & Van Riet: gene ment
  for reimbursement of ambulatory
  for hospital services, this may be , but the
  criteria must be clearly defined (*but*: what is
  ambulatory? what services must be planned?)

clarified conditions for care under 1408/71

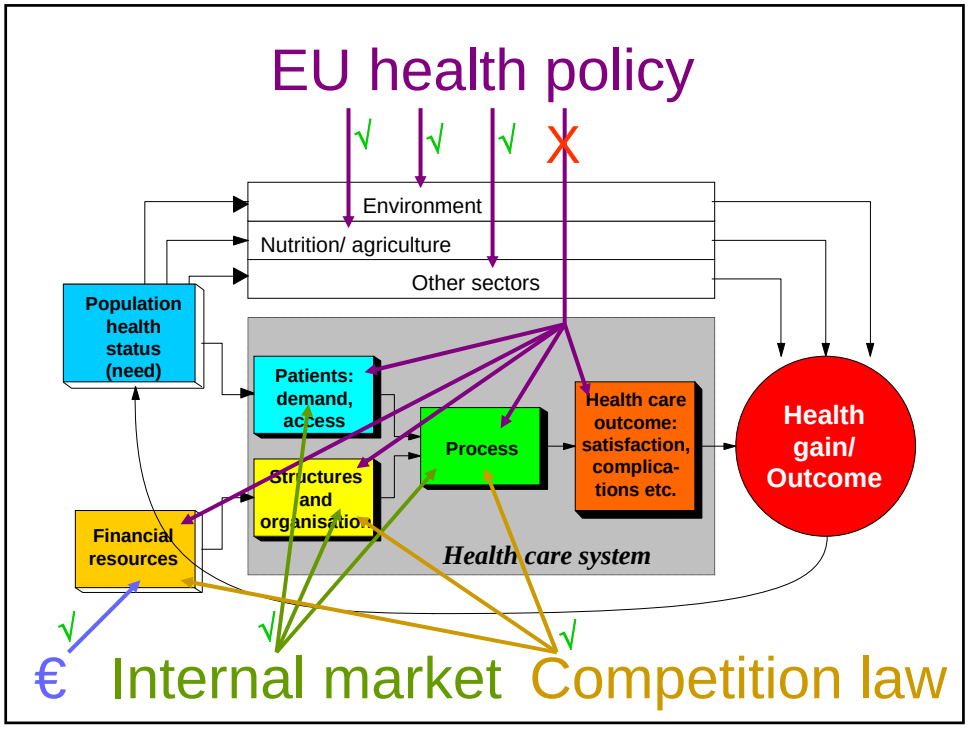
Basic principles of the latter ECJ rulings

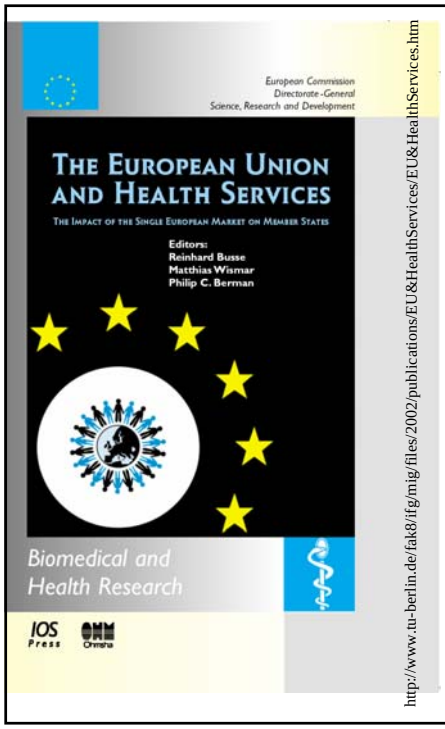
- Social security and health care are competence of Member States but does not preclude respecting Community law
- Free movement of goods and services applies to health care, regardless of the type of care (in- or outpatient) and the type of coverage (reimbursement – benefits in kind)
- Prior autorisation is an obstacle to free movement
- Can be justified to:
  1) Preserve the financial equilibrium of the social security system
  2) Maintain a balanced medical and hospital service and accessible to all
  3) Maintain medical capacity and expertise on the national territory, essential for public health
- As far as
  - necessary and proportional
  - criteria used are objective and non discriminatory

in-patient care	**out-patient care**
Smits-Peerbooms	***Kohll-Decker***
Van Riet	***Müller-Fauré***

- Prior authorisation is justified:
  - importance of hospital planning to guarantee rationalised, stable, balanced and accessible supply of quality care
- Can only be refused if same or equally effective treatment is available without undue delay in a contracted estalishment
- Undue delay: take into account actual medical condition (incl. degree of pain and nature of disability) and medical history
- Prior authorisation is not justified:
  - no spectacular increase of cross-border mobility to be expected
  - Cover remains subject to levels and conditions as defined by the home state
- Member States are allowed to fix reimbursement amounts to which cross-border patients are entitled

  (provided they are based on objective, non-discriminatory and transparent criteria)





http://www.tu-berlin.de/fak8/ifg/mig/files/2002/publications/EU&HealthServices/EU&HealthServices.htm

"At European level, health services have to adapt to market rules, while at national level, health services are seen as part of a social model.

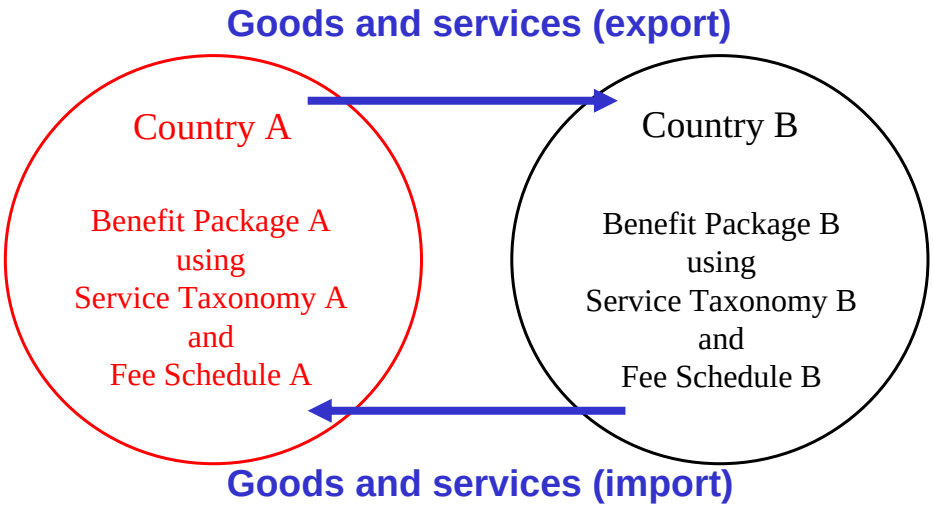
To overcome this situation and to ensure the social status of health services, we need – possibly paradoxically – to develop a European health policy."

If we accept that conclusion, the question is:

Should European health policy be based mainly on the "regular" instruments (regulations, directives etc.) or on the "open method of coordination" (OMC)?

4. The extent of patient mobility & open questions in this respect

Quantifying in- and exports of health goods and services in EU-member states



What do we know?

Trans-border care (here: imported goods and services in €/capita): negligible or under-counted?

Source: Palm et al. 2000

	1989	1993	1997	1998
Belgium	3.62	8.93	8.93	4.38
Denmark	-	0.16	0.83	0.63
France	0.79	1.87	1.21	1.05
Germany	1.77	1.83	2.08	2.21
Greece	0.95	2.51	2.68	3.15
Ireland	0.18	0.65	1.68	0.93
Italy	2.99	8.36	3.52	2.89
Luxembourg	58.01	149.55	135.29	116.00
Netherlands	1.95	0.26	1.98	2.85
Portugal	0.82	3.76	6.81	7.00
Spain	0.33	1.48	1.03	1.11
United Kingdom	0.33	1.61	1.92	0.36
Austria	-	-	0.48	1.87
Finland	-	-	0.49	0.52
Sweden	-	-	0.65	0.96
AVERAGE	1.31	2.95	2.37	1.99

Foreign EU patients treated annually in 2000/01: exports

	total invoice (€)	E112 persons	E111 persons
B	**168 790 871**	**14 061**	
DK		**2 401**	
E	**20 559 825**	**3 156**	**133 958**
F	**297 200 000**	**435 856**	
I		**1 022**	
IRL		**1 ?**	
L		**4 101**	**250**
NL		**3 316**	
AT	**5 160 000**	**1 000**	
FIN	**951 000**	**9**	**11 483**
SW	**9 504 411**		
UK	**8 720 428**	**871**	

No data: D, GR, P

Commission staff working paper, July 2003

Germany: Imported goods and services = best contained area of health expenditure!

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
SHI expenditure total in € bn	99	99	108	113	117	116	118	122	124	129	133
in % GDP	6.14	6.00	6.20	6.27	6.36	6.18	6.13	6.15	6.13	6.21	6.32
Outside the country in € bn	**0.36**	**0.35**	**0.33**	**0.36**	**0.40**	**0.35**	**0.34**	**0.35**	**0.37**	**0.37**	**0.41**
as % of SHI expenditure	**0.36**	**0.36**	**0.31**	**0.32**	**0.34**	**0.30**	**0.29**	**0.29**	**0.30**	**0.29**	**0.31**
as % of GDP	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**
Total expenditure in €bn	163	168	180	194	203	204	208	214	219	227	234
in % GDP	10.1	10.2	10.4	10.8	11.1	10.9	10.8	10.8	10.8	11.0	11.1
Outside the country in € bn	**0.38**	**0.37**	**0.35**	**0.38**	**0.42**	**0.37**	**0.37**	**0.38**	**0.40**	**0.41**	**0.44**
as % of total expenditure	**0.23**	**0.23**	**0.19**	**0.20**	**0.21**	**0.18**	**0.18**	**0.18**	**0.18**	**0.18**	**0.19**
as % of GDP	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**	**0.02**

Federal Statistical Office, 2004.

Ca. € 4.70/capita

Ca. € 5.40/capita

What is the money spent on? Ratios vs. overall expenditure (2002)

- Transport 1.3
- Physician services 1.25
- Goods 1.15
- Care/ accomodation 0.8
- Prevention 0.65

- Eye diseases 3.2
- Ear diseases 3.0
- Infections 2.0
- Injuries 1.3

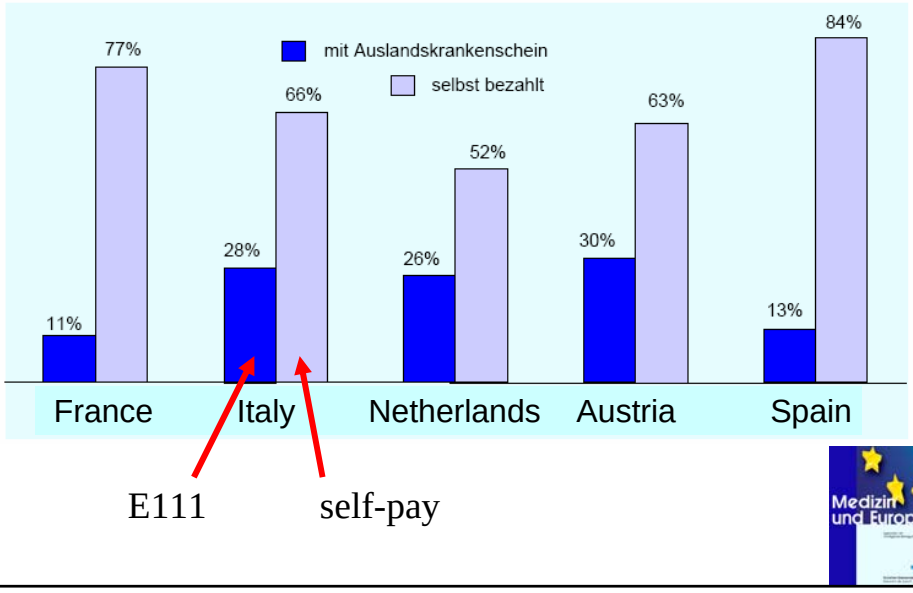
3x as often as within country

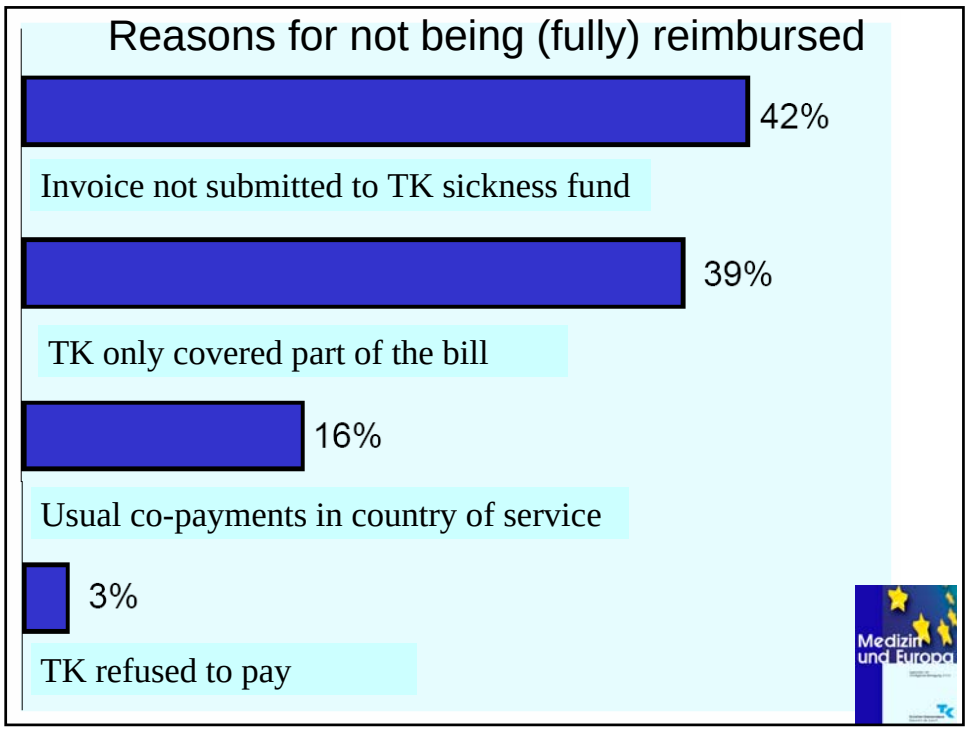
…

- Psychiatric diseases 0.4
- Pregnancy/ birth 0.4
- Cancer 0.35

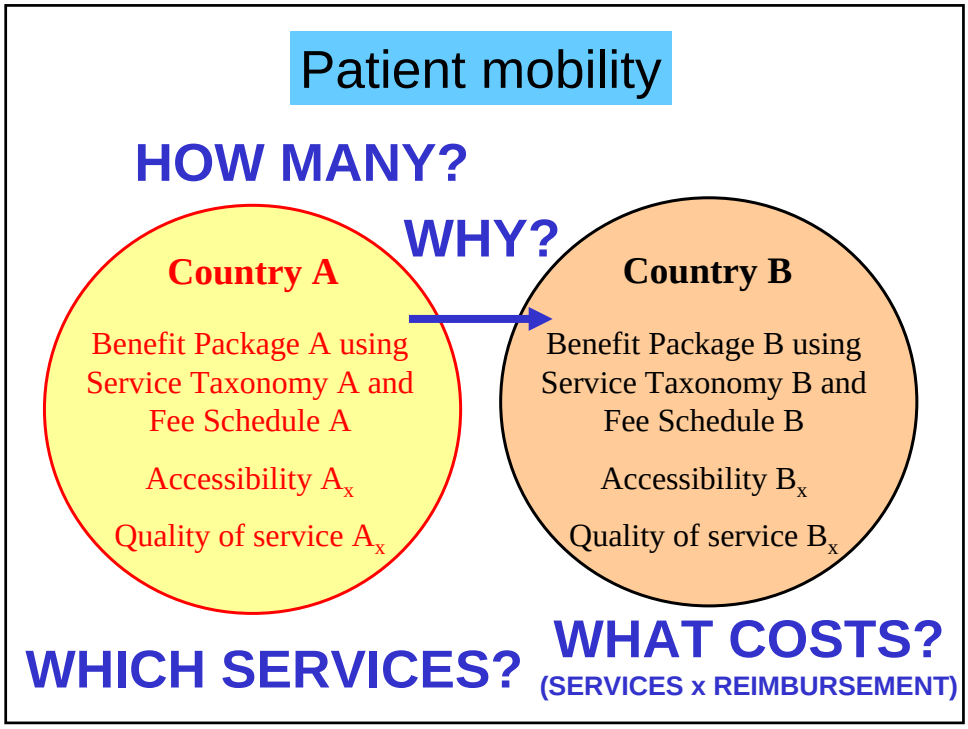
1/3x as often as within country

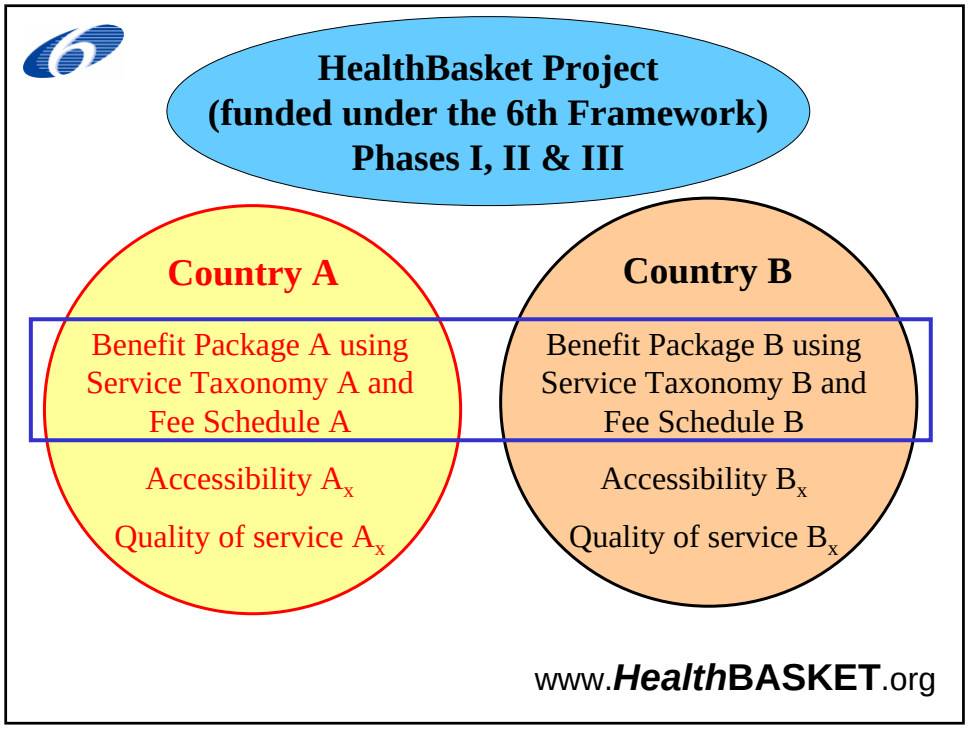
Is this the whole truth? Most likely not …





- Why do patients move? More push than pull *(difference to professionals!)* … and a lot of need arising when abroad.
- Has this led to unsustainable expenditure in the past? No, but there is probably a lot of expenditure not accounted for. Might this change? Not imminently …
- *Speculation:* The major reason for low volumes is that actors, policy makers and patients lack accurate information on …


Patient mobility
HOW MANY?
WHY?
Country A
Benefit Package A using Service Taxonomy A and Fee Schedule A
Accessibility A_x
Quality of service A_x
Country B
Benefit Package B using Service Taxonomy B and Fee Schedule B
Accessibility B_x
Quality of service B_x
WHICH SERVICES?
WHAT COSTS?
(SERVICES x REIMBURSEMENT)


HealthBasket Project
(funded under the 6th Framework)
Phases I, II & III
Country A
Benefit Package A using Service Taxonomy A and Fee Schedule A
Accessibility A_x
Quality of service A_x
Country B
Benefit Package B using Service Taxonomy B and Fee Schedule B
Accessibility B_x
Quality of service B_x
www.HealthBASKET.org

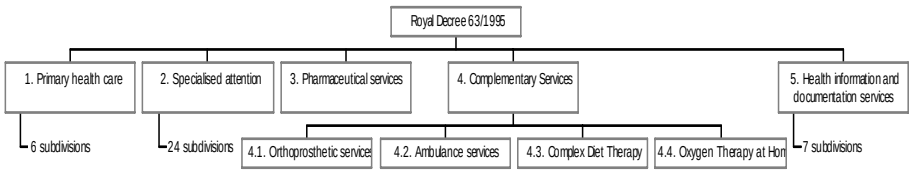
Taxonomy

theoretical study of classification,
including its basic principles,
procedures, and rules –
"the science of classification"

Diseases: ICD;
Functional impairments: ICF;
Health care providers: System of Health Accounts;
Health services and goods: ???

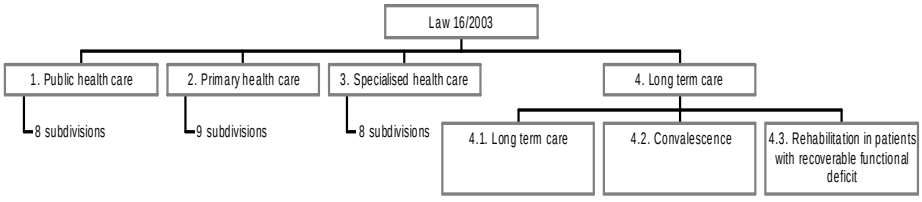
SPAIN

Figure 1: Taxonomy of the Royal Decree. 63/1995



Source: Own elaboration.

Figure 2: Taxonomy of LAW 16/2003



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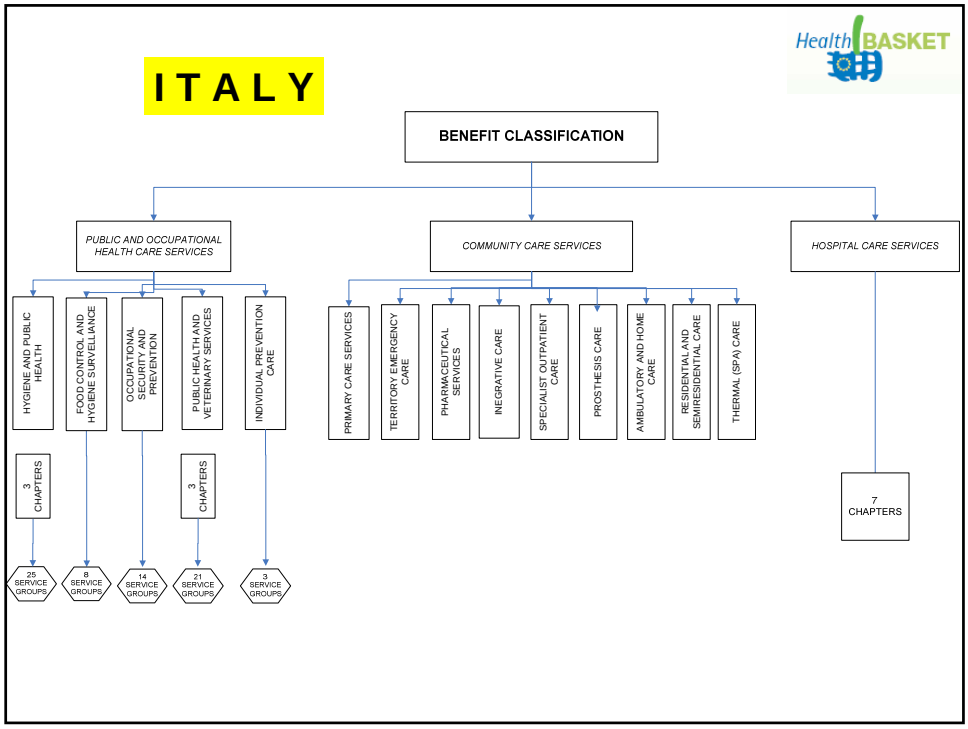


*Health*BASKET Phase I – How are benefit baskets determined and which services are included?

- Taxonomy differs largely from country to country – even if most tend to sort ambulatory care by physician specialty and inpatient care by diagnosis and procedure (DRGs/HRGs/DBCs …)
- No country has one uniform catalogue; it‘s rather a mixture of differently defined lists (entitlements, payment, guidelines …)

*Health*BASKET Phase I – How are benefit baskets determined and which services are included?

- Only small variation of provided benefits between countries – most countries exclude similar benefits: cosmetic surgery, vaccination for travelling purposes) and certain non-conventional treatments (e.g. acupuncture)
- variation might be even larger within countries due to decentralisation processes e.g. in Spain and Italy

*Health*BASKET Phases II & III

- How do countries fix/ negotiate reimbursement?
- How much do prices/ reimbursement rates really differ?
  Or are they rather explained by systematic differences (e.g. capital costs included/ not included)?
  Or by differences in service intensity (e.g. pre-operative tests)?

Methodology: Case vignettes

www.***Health*BASKET**.org

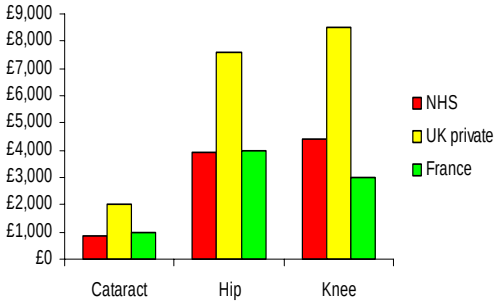
*Health*BASKET Phase III – Calculation of costs and prices for 10 case vignettes and analysis of differences

- 10 case vignettes ("service packages") are designed around episodes of care, e.g. hip replacement, cataract, coughing child
- To ensure comparability across vignettes, each is divided into detailed path components e.g. diagnostic procedures, care before operation etc.
- To ensure homogeneity within case vignettes, health status and indication of each patient is defined in detail for each vignette
- Partners in each country calculate costs and prices for case vignettes with data from at least 5 representative providers

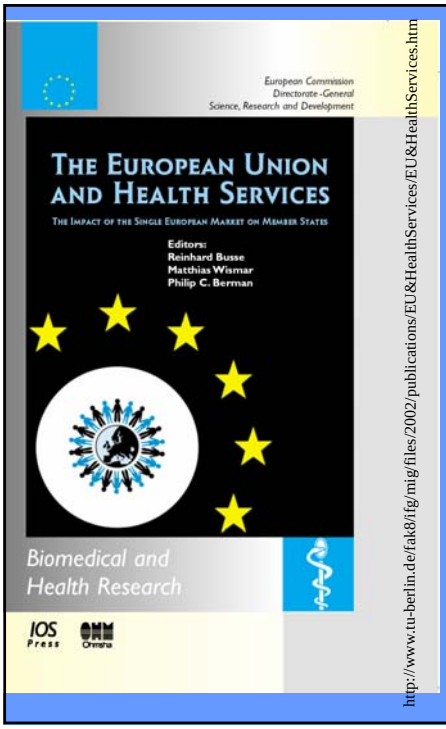
-> Finally costs and prices are compared and differences are analysed

The *Health*BASKET project is limited in scope – but important!

The first nine patients sent to France by the English NHS (not shown: the 40 journalists who accompanied them)



ARE THESE DATA REALISTIC?
ARE THEY REPRESENTATIVE?
HOW CAN THE DIFFERENCE BY EXPLAINED?



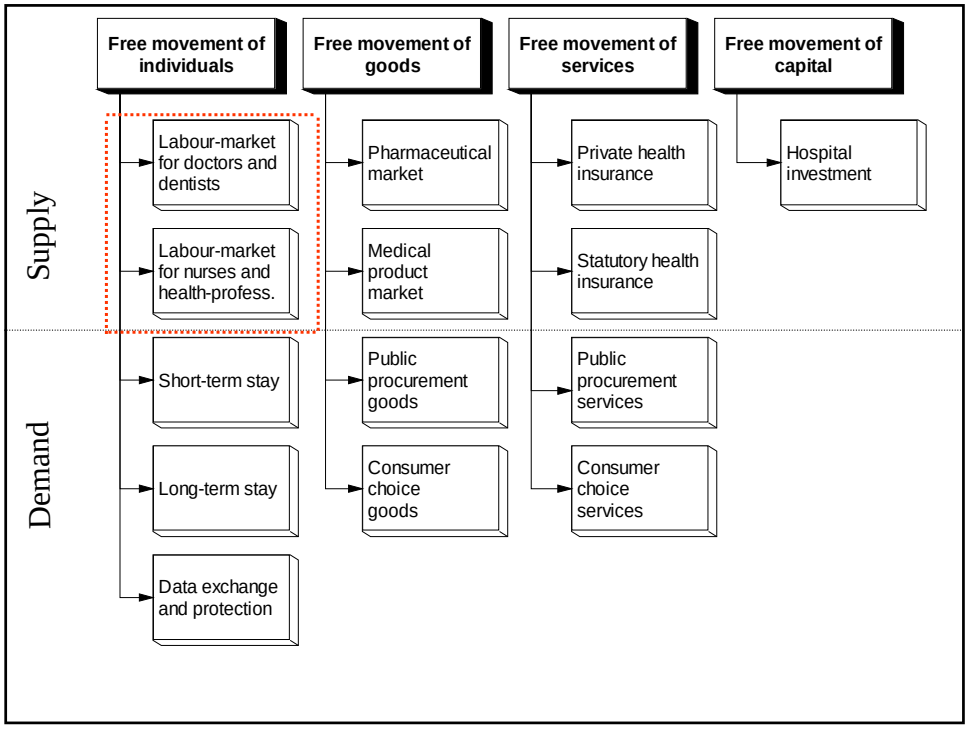
http://www.tu-berlin.de/fak8/ifg/mig/files/2002/publications/EU&HealthServices/EU&HealthServices.htm

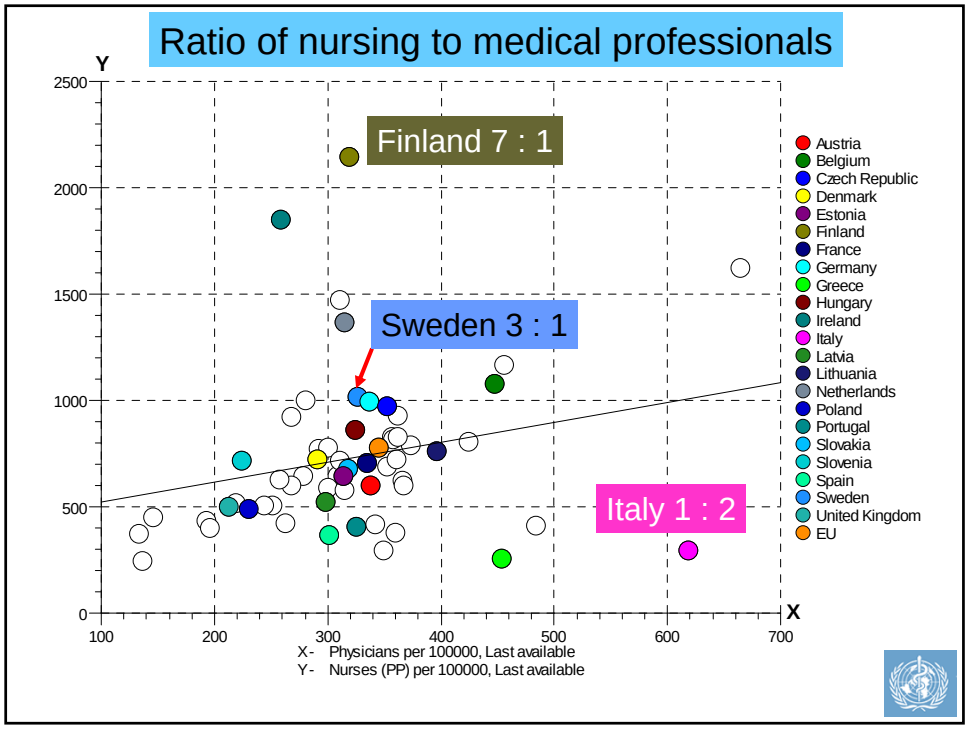
"At European level, health services have to adapt to market rules, while at national level, health services are seen as part of a social model.

To overcome this situation and to ensure the social status of health services, we need – possibly paradoxically – to develop a European health policy."

A core question to be solved for cross-border mobility (of patients, professionals, goods, services …)

- Who defines standards (for recognition of training, benefits covered, licensing, quality assurance etc.)?
- The country of origin?
- The country of work/ service delivery?
- Common rules? Based on bi-/tri-/multi-lateral agreements? Or based on EU law?


Free movement of individuals
Free movement of goods
Free movement of services
Free movement of capital
Supply
Demand
Labour-market for doctors and dentists
Labour-market for nurses and health-profess.
Short-term stay
Long-term stay
Data exchange and protection
Pharmaceutical market
Medical product market
Public procurement goods
Consumer choice goods
Private health insurance
Statutory health insurance
Public procurement services
Consumer choice services
Hospital investment


Ratio of nursing to medical professionals
Y
X
Finland 7 : 1
Sweden 3 : 1
Italy 1 : 2
2500
2000
1500
1000
500
0
100
200
300
400
500
600
700
X- Physicians per 100000, Last available
Y- Nurses (PP) per 100000, Last available
Austria
Belgium
Czech Republic
Denmark
Estonia
Finland
France
Germany
Greece
Hungary
Ireland
Italy
Latvia
Lithuania
Netherlands
Poland
Portugal
Slovakia
Slovenia
Spain
Sweden
United Kingdom
EU

Regulation facilitating cross-border mobility of health professionals I

- So called sectoral directives for physicians (inc. 52 specialties – those existing in at least 2 Member States), nurses, dentists, midwives ... regulate reciprocal recognition based on minimal standards (e.g. medical curriculum at least 5 years and 5500 hours)
  - *But: Instrument is relatively inflexible as changes in curriculum and new (sub-)specialties have to be included into directive*
- So called general directives (for all other professions) give several options for Member States: period for recognition, additional training or examination

Regulation facilitating cross-border mobility of health professionals II

- EU Commission has proposed a consolidated directive for health professionals which will reduce automatic recognition (e.g. only 17 medical specialties) but facilitate movement for short periods (up to 16 weeks: rules of country-of-origin apply – which was in line with the so-called services directive)
- *BUT: increasing common EU regulation of pharmaceutical licensing, medical devices …*

5. The Open Method of Coordination (OMC)

What is the Open Method of Coordination?

- Member States define – supported by the Commission – objectives and appropriate indicators for evaluation
- How to reach objectives is entirely up to Member States
- Member States have to regurarly provide data on progress; the worse should learn from the better („best practice“); non-achievement of objectives needs to be justified

COMMISSION OF THE EUROPEAN COMMUNITIES

Brussels, 20.4.2004
COM(2004) 304 final

COMMUNICATION FROM THE COMMISSION TO THE COUNCIL, THE EUROPEAN PARLIAMENT, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS

Modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care: support for the national strategies using the "open method of coordination"

How could the open method of coordination be applied to health care?

Objectives in Commission Communication 4/04:

- **Accessibility of care** for all, based on fairness and solidarity, taking into account the needs and difficulties of the most disadvantaged groups and individuals, as well as those requiring costly, long-term care;
- **High-quality care** for the population, which keeps up with medical advances and the emerging needs associated with ageing and is based on an assessment of their health benefits;
- Measures to ensure the long-term **financial sustainability** of this care and aiming to make the system as efficient as possible.

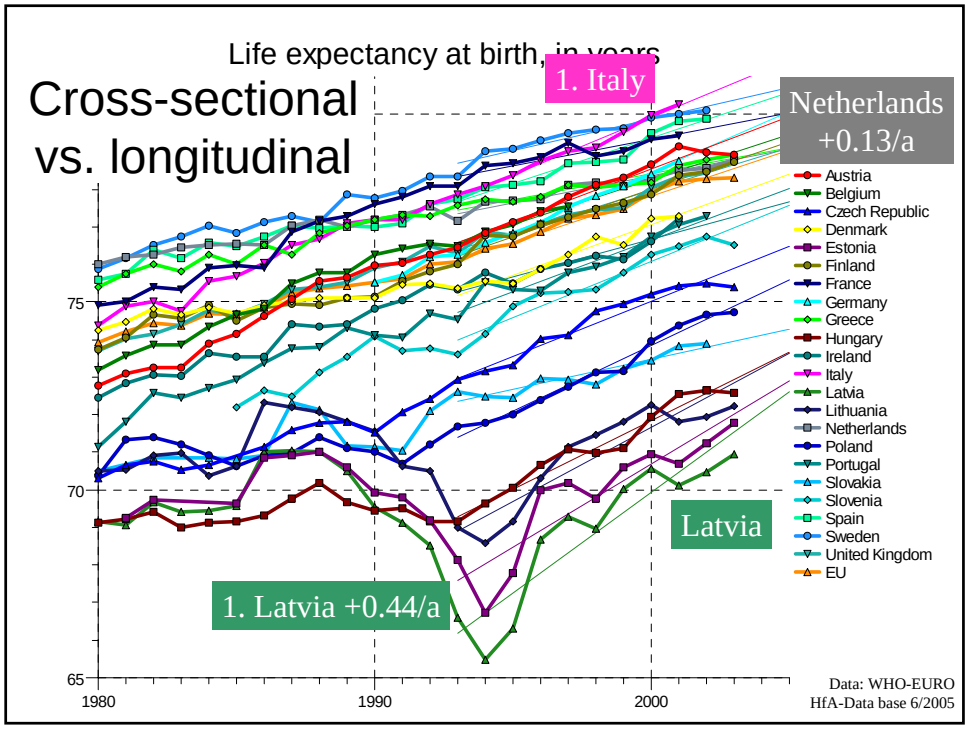
Which objectives are really relevant?

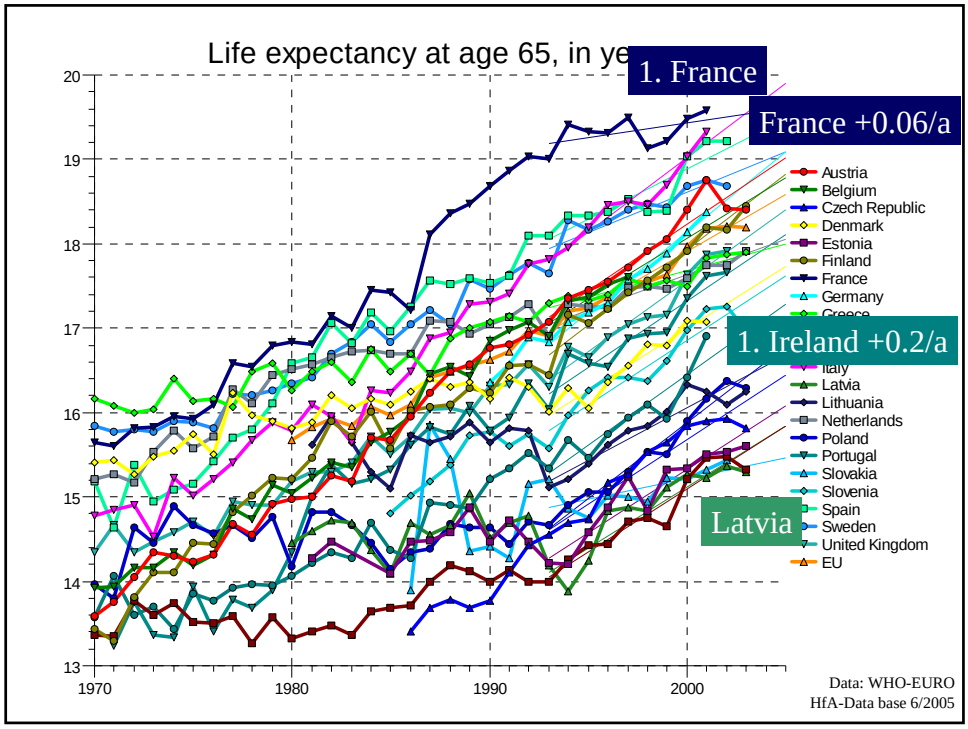
- to achieve a high population health status for the entire population (healthy life expectancy),
- to ensure access to needs-based and effective health technologies,
- to design health systems and make them function according to justified population health needs and expectations,
- assuring a fair *and* sustainable financing of health care.

What needs to be considered methodologically?

- Indicators need to be 1. based on data which – in all Member States – are collected *objectively*, are available in *good quality* and *timely*, and 2. *valid*.
- Data must *transnationally comparable*, which is not always the case (e.g. health expenditure as % of GDP).
- *Context* is relevant for interpretation, e.g.:
  Did expenditure only drop because certain services have been removed from the benefit catalogue?
- Emphasis on *health care outcomes* not inputs!
- *Indices* should *not* be used.

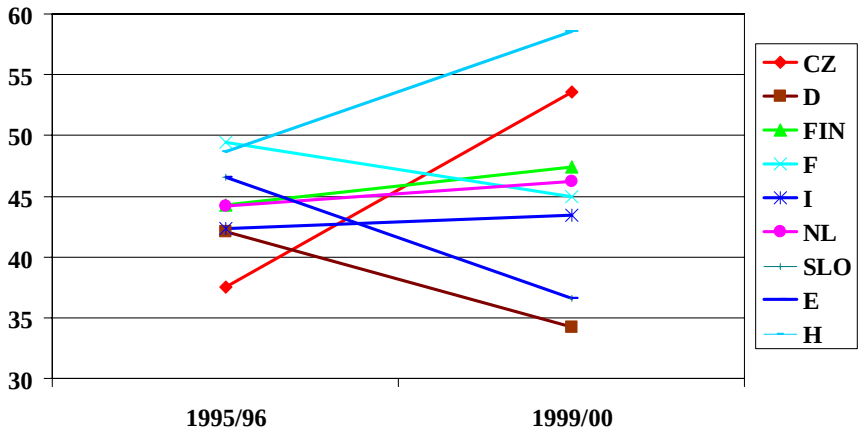
- to achieve a high population health status for the entire population (healthy life expectancy)





- to ensure access to needs-based and effective health technologies

Sufficient blood pressure control 6 months after a CHD hospitalisation



Daten: EUROASPIRE „Clinical reality of coronary prevention guidelines“, Lancet 2001; 357: 998

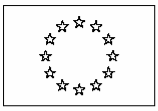
- assuring a fair *and* sustainable financing of health care

	Distribution: fairness in financial contribution (1.00 = max.)	Threshold	
		% of households with catastrophic payments (total expenditure)	% of households with catastrophic payments (out of pocket)
Slovakia	**0.941**	**0.00**	**0.00**
United Kingdom	**0.921**	0.33	0.04
Denmark	**0.920**	0.38	0.07
Sweden	0.920	0.39	0.18
Germany	0.913	0.54	**0.03**
Hungary	0.905	0.96	0.20
Czech Republic	0.904	**0.01**	0.00
Belgium	0.903	**0.23**	0.09
Finland	0.901	1.36	0.44
Spain	0.899	0.89	0.48
Slovenia	0.890	1.88	0.06
France	0.889	0.68	**0.01**
Lituania	0.875	1.68	1.34
Estonia	0.872	2.47	1.30
Greece	**0.858**	**3.29**	**2.17**
Portugal	**0.845**	**4.01**	**2.71**
Latvia	**0.828**	**4.05**	**2.75**

Data: Murray & Evans „Health Systems Performance Assessment: Debates, Methods and Empiricism“, WHO 2003: 525-6

6. Current and future developments

The health ministers have recognised the problem and look for ways to address (not yet: solve) it



COMMISSION OF THE EUROPEAN COMMUNITIES

Brussels, 20.04.2004
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COMMUNICATION FROM THE COMMISSION

Follow-up to the high level reflection process on patient mobility and healthcare developments in the European Union

The new Constitution?

current Article 152 EC Treaty

1. **A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities.**

   Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education.

   (…)

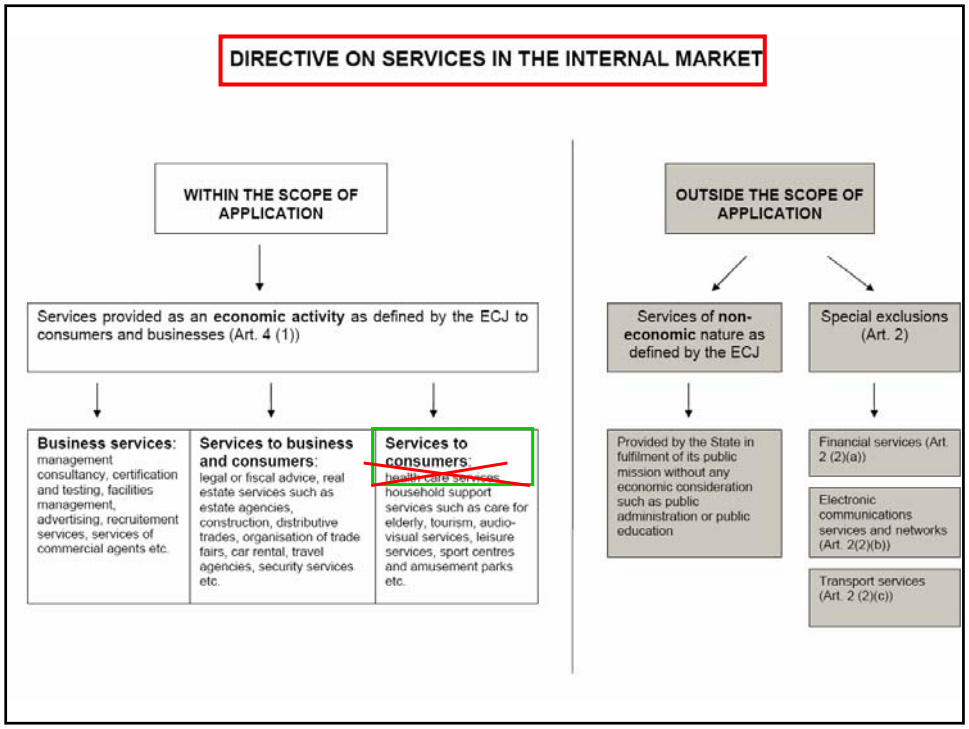
5. **Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care.**

Article III-278 draft Constitutional Treaty

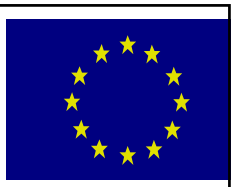
1. **A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities.**

2. **The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas.**

7. **Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them.**



How could the application of such developments influence European health systems? (1)



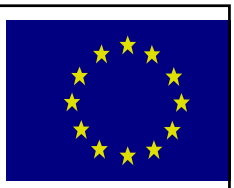
Initially probably not directly, but

- *Comparability* of services, their access and quality *will increase*,

and thereby contribute to the *Europeanisation of health care systems*, already on the way through

- mobility of short- and long-term tourists,
- cross-border contracts/ Euregios,
- ECJ rulings on Kohll/ Decker, Peerbooms etc.,
- the EU-health insurance card.

How could the application of such developments influence European health systems? (2)



This will in the medium-term probably lead to

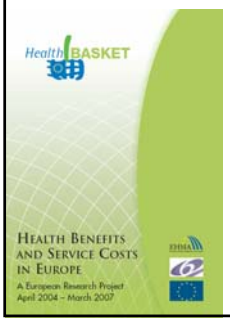
- a European *benefit catalogue* (but not equal prices),
- Europe-wide rules/ standards for *accreditation* and *quality assurance*,
- Europe-wide diagnosis/ treatment *guidelines*.

This could make *Europe more concrete for its citizens* and help to *remove the conflict between markets and the social model.*

Technische Universität Berlin

This presentation and more material can be found on the following websites:

http://mig.tu-berlin.de



www.***Health*BASKET**.org

European Observatory on Health Systems and Policies