



**The Social Insurers of Europe**

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***Proposal from the European Commission  
for a Directive on  
"Services in the Internal Market"  
dated 13 January 2004***

***Joint Position Paper  
of the European Social Insurance Partners***

***submitted in August 2004***

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**Foreword**

With the submission of a draft Directive on "Services in the Internal Market [COM/2004/2 final] the Commission has taken a further step towards completion of the internal market. The Directive is primarily aimed at services and activities of economic interest. However, this main thrust does not prevent services of "general non-economic interest" - in particular the social security systems and the social insurer- being affected directly and indirectly by the Directive.

In the opinion of the European Social Insurance Partners, the proposed Directive should be subjected to critical review, so that

- it is more in line with national social systems, whose design is a matter entirely for the member states to decide and
- it fits in better with the fabric of existing EU directives and regulations, particularly the Coordination Regulation No. EEC/1408/71.

The Commission may also take into account for their further debate that the complexity and sensitivity of the health care market make it inappropriate to apply the simple, horizontal approach taken by the draft Directive. Its limited focus on consumers and providers fails to recognise the involvement of a third important party, the social insurer. Indeed, it is the social insurer's role to bridge the gap between the economic interests of the providers, the socio-economic distinctions in the population and the individual medical demands of the patients. Therefore, ESIP calls on the Commission to revise the draft Directive in this context.

**Individual comments:**

**Article 4 no. 10 - Definition "Hospital care"**

The definition of "hospital treatment" given in Article 4 no. 10 attempts to introduce criteria to distinguish between "intramural care" and "extramural care", which has previously been left untouched by the case law of the European Court of Justice (ECJ). However, the chosen wording leaves open the question of whose law should be used to assess this type of treatment. So, for example, childbirth is considered in the Netherlands as an outpatient, non-

hospital related service, whereas in Belgium and Germany, in principle, it is considered a hospital service. Therefore, it is necessary to clarify which country is authoritative for the decision.

Taking into account that Article 152 of the Treaty [and Article III-179 of the Constitution] guarantees every Member State the right to define their health policy and to organise their health care system, the Directive must leave it up to the Member States to decide whether they link the definition of hospital care to the rules of the country of origin (in practice: the country of insurance) or to those of the country of destination. This would have the advantage that both patients and insurers have clear guidelines about what they can expect and in which circumstances they have to ask for / give permission for hospital treatment abroad. It also respects the freedom of Member States to organise their own systems.

The above principal should also be applied to long-term care in a nursing home.

Article 4 no. 10 should be supplemented as follows:

"Hospital care" means medical care which can **only** be provided within a medical infrastructure and which normally requires the accommodation therein of the person receiving the care. **The decisive factor in assessing whether this type of treatment is being given is the classification in the country of origin (read: country of insurance) of the patient or in the country of destination. The Member States have to declare which principle their health care system is following.** The name, organisation and financing of that infrastructure being irrelevant for the purposes of classifying such care as hospital care;

#### **Article 9, 10, 14 no. 5, 15 no. 2 a - Relationship between freedom of establishment and the quantitative management mechanisms of the social security system**

The European Social Insurance Partners assume that the quantitative management mechanisms in authorisation of medical service providers to treat patients at the expense of the social security insurance providers will be unaffected by the planned extensions to freedom to provide services, and will continue to be allowed. Should there be any doubt about this, the European Social Insurance Partners consider that an appropriate clarification is urgently required.

#### **Article 17 no. 9 - Precedence of the rules for coordination of the mandatory systems of social security**

Precisely for cases of secondment of workers (see Art. 24 and 25 of the draft Directive) a number of relevant rules are not contained in Regulation EEC/1408/71 itself, but in the implementing Regulation EEC/574/72. For example, Art. 11 onward lays down the obligation for the seconded worker to carry forms.

Therefore, Art. 17 no. 9 of the draft Directive should be supplemented as follows:

the provisions of Regulation EEC/1408/71, **574/72 and other provisions adopted at European level in this context concerning secondment of workers.**

#### **Article 23 paragraph 1 - Permissibility of management mechanisms**

Not only in the field of health insurance, but also in other branches of social security, the necessity may arise, for various reasons, to *restrict free choice of doctor*. For example, in the sphere of competence of the German accident insurance, to ensure early introduction of

rehabilitation measures in outpatient cases, a specialist is consulted at the beginning, known as the "transition doctor", who manages the subsequent course of treatment. The provision of optimal care as soon as possible has proven to be a significant curb on costs and has contributed to restricting the burden of contributions to be paid by businesses. The same applies to other procedures which require management mechanisms and the restriction of the free choice of doctor.

Therefore, the European Social Insurance Partners propose the following amendment to Article 23 para. 1 sentence 2:

The conditions and formalities to which the receipt of non-hospital care in their territory is made subject by Member States, such as **for example** the requirement that a general practitioner be consulted prior to consultation of a specialist, or the terms and conditions relating to the assumption of the costs of certain types of dental care, may be imposed on a patient who has received non-hospital care in another Member State. **These principles are also applicable to special requirements in other sectors of the social security system providing health services, such as the work and accident insurances.**

### **Article 23 paragraph 3 - reimbursement of treatment costs**

In Article 23, the Directive takes up the case law of the ECJ on cross-border use of health services outside the scope of Regulation EEC/ 1408/71. In the details, it must be ensured that the calculation of the amount of refund is not subject to misleading rules.

The wording used in Article 23 para. 3, "that the level of assumption... of the costs... is **not lower** than that... in respect of similar health care... in their territory", enables patients moving from a high-cost to a low-cost country to make a profit on the treatment. This contravenes the principle of solidarity on which social insurance is based and was never intended in the case law of the ECJ, not even in the Vanbraekel Judgement (C-368/98), which was issued in the special case of a refusal to authorise the costs of treatment.

Therefore, the European Social Insurance Partners urge that Article 23 para. 3 should be supplemented as follows:

Member States shall ensure that their social security system **reimburses** the **actual** costs of health care provided in another Member State **up to a maximum which is the limit payable for** similar health care provided in their territory.

### **Article 24 paragraph 1 c - Duty to appoint a representative**

The ban on imposing a requirement for the posting service provider to appoint a representative in the host country is in conflict with certain rules of the social security systems in the Member States, for example, rules governing enforcement measures in prevention, including fines, applicable in the field of accident insurance and those governing enforcement of payment of contributions in cases where a foreign seconding employer employs local workers, subject to local social security law, for whom social security contributions are obligatory .

For this reason, the European Social Insurance Partners propose that:

**the ban provided for in Article 24 letter 1 c) on imposing an obligation on the posting service provider to appoint a representative in the territory of the host member state should be deleted and not replaced.**

### **Article 24 paragraph 1 d - Production of social security documents**

The exemption of the seconded workers from the obligation to carry social security documents with them (e.g. Form E 101) raises the question of how the applicable legal rules or social security obligation can be determined without any doubt the host member state. In particular, considering Decision No. 181 of the Administration Commission which allows, controls to check the conditions of secondment, the provision in the Directive seems questionable on practical grounds.

The European Social Insurance Partners therefore consider it necessary that the ban

**foreseen on requiring posted workers to carry social security documents with them (Article 24 para. 1 d), should be deleted and not replaced.**

### **Article 29 - Commercial communications by the regulated professions**

The Social Insurers agree with the Commission proposal that the total prohibition of commercial communications for all regulated professions has to be reviewed. Nevertheless, in the sensitive area of health-care services the patient has to be protect from direct advertising and misleading information. Therefore, the European Social Insurance Partners urge the Commission to exclude the health-care professions from the proposed Article 29 of this Directive.

### **Article 31 - Quality Assurance measures**

The relaxation of the rules on establishment and free provision of services proposed in the Directive not only introduce additional possibilities of choice of provider for the consumer, but also additional risks with regard to the quality of care. In this regard, the idea put forward by the Commission of reducing quality risks through certificates and guidelines is to be welcomed.

The proposed voluntary procedure for the health services field are not adequate, however. Unlike "normal" goods and services, poor quality in services and goods in the health sector lead directly to impaired health or even death. Furthermore, consumer freedom is seriously restricted due to the urgency of treatment and the lack of comparability.

Therefore, it must be possible for the Member States, independently of initiatives at Community level, not only to introduce and monitor voluntary but also - provided that transparency and freedom from discrimination are guaranteed - mandatory quality criteria for the provision of health-related services delivered on their territory.

The European Social Insurance Partners therefore urge that Article 31 should be supplemented as follows:

**6. The member states may enact independent, for the purpose of maintaining and protecting public health, mandatory high quality criteria and treatment guidelines with respect to health-related services provided on their territory. The Commission supports the member states in the application of such high quality criteria in health-relevant services in the internal market.**

This position paper has the support of the following organisations:

AUSTRIA	HVSVT	Hauptverband der österreichischen Sozialversicherungsträger, Vienna
BELGIUM	ONP/RVP	Office National des Pensions/Rijksdienst voor Pensioenen, Brussels
CZECH REPUBLIC	CSSZ	Czech Social Security Administration, Prague
FINLAND	ETK	The Central Pension Security Institute of Finland, Helsinki
	FAII	Federation of Accident Insurance Institutions, Helsinki
FRANCE	FNMF	Fédération Nationale de la Mutualité Française, Paris
	CNAF	Caisse Nationale d'Allocations Familiales, Paris
	CNAM	Caisse Nationale d'Assurance Maladie
	CNAV	Caisse Nationale d'Assurance Vieillesse, Paris
	CCMSA	Caisse Centrale de la Mutualité Sociale Agricole, Paris
GERMANY	AOK-BV	AOK-Bundesverband, Bonn
	BKK-BV	Bundesverband der Betriebskrankenkassen, Essen
	IKK-BV	Bundesverband der Innungskrankenkassen, Bergisch Gladbach
	LKK-BV	Bundesverband der landwirtschaftlichen Krankenkassen, Kassel
	VdAK	Verband der Angestellten-Krankenkassen, Siegburg
	AEV	Arbeiter-Ersatzkassen-Verband, Siegburg
	Bkn	Bundesknappschaft, Bochum
	See-KK	See-Krankenkasse, Hamburg
	HVBG	Hauptverband der gewerblichen Berufsgenossenschaften, Sankt Augustin
	BLB	Bundesverband der landwirtschaftlichen Berufsgenossenschaften, Kassel
	BUK	Bundesverband der Unfallkassen, Munich
	VDR	Verband Deutscher Rentenversicherungsträger, Frankfurt/Main
	GLA	Gesamtverband der landwirtschaftlichen Alterskassen, Kassel
ITALY	INPDAP	Istituto Nazionale di Previdenza per i Dipendenti Dell' Amministrazione, Rome
	INPS	Istituto Nazionale della Previdenza Sociale, Rome
LUXEMBOURG	ALOSS	Association Luxembourgeoise des Organismes de Securite Sociale, Luxembourg
THE NETHERLANDS	SVB	Sociale Verzekeringsbank, Amstelveen
	CVZ	College voor Zorgverzekeringen, Amstelveen
POLAND	ZUS	The Social Insurance Institution of Poland, Warsaw
SWEDEN	FKF	Försäkringskassaförbundet, Stockholm
SWITZERLAND	SUVA	Schweizerische Unfallversicherungsanstalt, Lucerne