Health Policy Regimes and the Single European Market

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Abstract I examine the potential effects of the creation of a single European market on the health policy regimes of the twelve member states of the European Community (EC), arguing that few changes can be expected in the basic nature of those regimes and that a Community-wide health policy regime is unlikely to emerge in the near future. Domestic health policy regimes and care systems will remain the dominant approach to health care delivery, and it is not likely that the American approach will be adopted. However, EC legislation designed to create favorable trade, economic, and fiscal conditions may affect key industries like pharmaceuticals and health insurance, with consequences for national health policy regimes. Patterns in Community-wide policy-making suggest that it will become increasingly difficult to define health issues in purely domestic or international terms.

In this paper, I discuss how the creation of a single European market and the freedom to move goods, services, people, and capital freely within the borders of the European Community (EC) will affect national health policy regimes in its twelve member states. I explore whether future developments will be determined by free-market forces and competition in health care services and prices, or whether the strong European social welfare tradition of granting universal access to health care,[1] regardless of economic means and social status, and the philosophy of solidarity between the sick and the healthy will be retained.

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1. The term *health care* is used interchangeably with *medical care*.

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Twelve countries belong to what is now called the European Community (see the Appendix for a summary of its legal and institutional framework). The original six—France, Italy, Germany,[2] Belgium, the Netherlands, and Luxembourg—signed the original Treaty of Rome to establish a common market in 1957. Britain joined in 1972, followed the same year by Denmark, and then by Ireland in 1973. Greece became a member in 1981, and Spain and Portugal joined in 1986. 344.5 million people live in the European Community, of whom 312 million are covered by a national health service (NHS) or compulsory national health insurance (NHI), 67 million carry voluntary, noncommercial health insurance, and almost 36 million carry private, commercial health insurance (PHI) (BASYS 1991: 11). The approximately 22 million Germans from the former German Democratic Republic are now covered by NHI, following the approach prevailing in the former Federal Republic of Germany.

The institutional arrangements adopted in the member states for the financing, control, and delivery of health care vary, but one important issue common to them all is the way in which employment, health protection, and welfare are contingent upon each other (Esping-Andersen 1987, 1990).

Despite the appearance of sweeping changes, there will be few fundamental changes in European health policy regimes after 1992. Rather, I predict, responses to demands for more, different, or better access to quality health care will be made within the confines of existing national policy regimes and the European Community's procedures for coordinating social security benefits and health care rights. National health policy regimes will continue to dominate the delivery of health care to European populations. Medical practice, health care organizations, and health care financing have strong cultural and political roots in every member state. As citizens remain firmly attached to the social security regimes of their nation state (Dogan 1988) and member governments are held accountable in national rather than European elections, the establishment of a European-wide health policy regime in the near future is just as unlikely as a European welfare state, a European social security system, or a unified European labor market (Lange 1992; Leibfried 1990; Garth 1986; Watson-Olivier forthcoming; Zacher and Kessler 1990). My argument is a structural one; its terms are those of the power structure and policy components

2. I have not discussed the merger of the two entirely different health policy regimes that existed before the former German Democratic Republic (East Germany) united with the Federal Republic of Germany.

that currently prevail in the health policy regimes under discussion. I do not exclude the possibility that budgetary pressures and changes in domestic politics may result in some changes in the content of health policy in the future.

A Comparison of Health Care in Europe and America

Like the United States, all twelve member states of the European Community have experienced escalating health care costs and rising demand for health care over the last two decades (OECD 1990). Yet in none of the twelve states, not even in Mrs. Thatcher's Britain, was there an attempt to fundamentally alter the health care system by restructuring its basic organization, delivery, and financing arrangements, or by moving in the direction of America. There has been an impressive continuity in rights to health care and the institutional arrangements that characterize national health policy regimes (Glaser 1980, 1991).

The effects of recent health reforms have been the subject of many studies (OECD 1985, 1987, 1990; Schieber and Poullier 1989, 1991; Poullier 1991; Hurst 1991; Alber and Bernardi-Schenkluhn 1992; Altenstetter and Haywood 1991). While differing in detail and orientation, all agree that health policy in these countries is still governed by a social welfare perspective. Rather than imposing constraints on access to health care, recent reforms almost exclusively imposed supply-side limitations. The Twelve have managed, individually, to stabilize the rise in health care expenditures without imposing sacrifices on their citizens. The United States has not been nearly as successful in this respect (see Table 1).

European health policymakers, who are familiar with the evidence from the United States and share a similar political and cultural background, tend to distrust the market as the optimal means of allocating resources and controlling health care spending. Nor do they share the conventional wisdom in the United States that "cost containment can be achieved via market reforms that rely heavily on direct consumer payments and cost sharing as instruments of financing" (Pfaff 1990: 21). For most European policymakers, coinsurance and deductibles are not feasible policy options for medical care, although they may be for dental care and prescription drugs. Where deductibles are used to discourage utilization, they are employed sparingly and are typically picked up by third-party payers rather than by the patient (BASYS 1991: 22, 25, 27).

From a comparative perspective, health care issues have long received

Table 1 Total Health Expenditures in the European Community and the United States, as a Percentage of Gross Domestic Product, 1970–1990

Country	1970	1975	1980	1985	1990
Belgium	4.1	5.9	6.3	6.9	7.2
Denmark	6.1	6.5	6.8	6.3	6.3
France	5.8	7.0	7.6	8.5	8.8
Germany	5.9	8.2	8.5	8.6	8.2
Greece	4.0	4.1	4.3	4.9	5.2
Ireland	5.6	7.6	9.0	8.3	7.1
Italy	5.2	6.1	6.8	7.0	7.6
Luxembourg	4.1	5.6	6.8	6.8	7.3
Netherlands	6.0	7.7	8.2	8.2	8.0
Portugal	—	6.4	5.9	7.0	6.4
Spain	3.7	4.8	5.6	5.7	6.6
United Kingdom	4.5	5.5	5.8	6.0	5.8
United States	7.4	8.4	9.3	10.6	11.8

Sources. Schieber and Poullier 1991: 109. Figures for the United States are for 1989. Figures for 1990 are from Poullier 1991: 5.

intense political attention in almost all countries of the European Community, irrespective of the governments in power, country-specific configurations of triage, and legal and political traditions. The extent to which America constitutes an exception is both surprising and unjustifiable.

It is particularly remarkable that although the United States spends more on health care than any other industrialized country, American citizens enjoy little financial or emotional security when illness strikes. From a European perspective, American society tolerates the intolerable: a system which is inhuman and penny-wise and pound-foolish. When the unexpected occurs, Americans face the loss of not only income but sometimes also their jobs (which almost always means the termination of insurance cover), and they are left with incomplete or no coverage to pay ever-rising doctor and hospital bills. There is hardly any safety net, and the sick and their families have to worry about financial ruin as well as physical recovery. Political discourse on health issues in the United States remains caught in a narrow ideological spectrum and has yet to debate health issues as ethical rather than exclusively partisan and economic questions.

The Persistence of the Social Welfare Tradition in National Health Policy Regimes and the European Community

We should anticipate continuity rather than change in the national health policy regimes of Europe. The existing regimes are rigorous, and national health care organizations dominate in the European Community, primarily because of the undiminished vitality of time-honored values, experience, and practice in health care in those countries. Other factors are the limited powers of the European Community in matters essential to health care and the reluctance of member states to transfer sovereign rights to the Community.

Social Welfare and the Social Market

Over the last hundred years the history of social security systems has demonstrated that a social welfare tradition, including health care, is compatible with a "social market" (Emerson and Dramais 1988). Although the particulars differ from country to country, this tradition has provided European citizens with basic social and economic rights. Likewise, the history of the European Economic Community since its inception in 1957 is living proof that competition is compatible with diverse social security systems and health policy regimes and that their unification is not a precondition for economic growth. This alone is a compelling reason for expecting that these traditional policy regimes will survive the globalizing forces of the international economy, worldwide competition, and attempts at deregulation (Tarullo 1991). A social market and social welfare can be consistent with global competition, if the political consensus and will are there.

Close Links between Policy Regimes

The argument that few changes are to be expected after 1992 also draws on the close links between the policy regimes of health, social security, labor markets, and industry, and the corresponding body of law in each member state and the Community. Social security rights are personal rights enforceable under Community and national law (Zacher and Kessler 1990; Schulte 1988). They cover maternity and sickness schemes, family allowances, unemployment, work injury and occupational disease, invalidity, old age, death, and dependents.

At the Community level, this intersection of important policy regimes is reproduced and reinforced in a variety of ways. Twenty-three international social conventions and the labor conventions of the International Labor Organization (ILO) have become Community law,[3] although they have not become domestic law in all twelve member states.

Additionally, a body of international law, the Social Charter of the Council of Europe, was adopted in 1965 by twenty-one European states, including the twelve states of the European Community. The Social Charter, now known as the European Convention on Human Rights, is binding on all the states which ratified it. It guarantees legal rights to individuals, secured by international law. The Social Charter should not be confused with the Community Charter of the Fundamental Social Rights of Workers, which had been on the agenda of the European Community for some time before it was adopted by eleven heads of state or government in 1989—the United Kingdom did not endorse it.

The rights granted under the Community Charter do not have the same legal standing as those guaranteed by the European Convention on Human Rights. Their enforcement depends not on law but on existing practices in the member states. Critics say that the Community Charter serves only a symbolic function, but symbols nonetheless mirror cherished values, policy preferences, and practice.

The value of the Community Charter does not lie in novelty or radicalism, but in what it reaffirms for the Community as a whole and the goals it sets for the future. It states:

> Every worker of the European Community shall have a right to adequate social protection and shall, whatever his status and whatever the size of the undertaking in which he is employed, enjoy an adequate level

3. The international conventions of the ILO include: labor clauses under public contracts (1972), collective bargaining agreements (1951), anti-discrimination in employment and occupation (1960), protection of workers against ionizing radiation (1962), guarding of machinery (1965), hygiene in commerce and offices (1966), minimum wage fixing (1972), annual paid holidays (revised) (1973), protection against benzine (1973), minimum age for admission to employment (1976), occupational cancer (1976), paid educational leave (1976), working environment, air pollution, noise, vibration (1979), nursing personnel (1979), conditions of employment in the public service (1981), promotion of collective bargaining (1983), safety and health of workers (1983), workers with family responsibilities (1983), maintenance of rights in social security (1986), termination of employment (1985), occupational readaptation and employment of handicapped persons (1985). Two conventions on health services (approved within ILO in 1985) and one convention concerning safety in the use of asbestos (1986) were pending as of 1 January 1986. But the proposals for improving the work environment and workers' health and safety, mentioned previously, may become European law before long (Commission 1988). The dates given in parentheses are the dates when the conventions became effective.

> of social security benefits. . . . Persons who have been unable either to enter or re-enter the labour market and have no means of subsistence must be able to receive sufficient resources and social assistance in keeping with their particular situation. (Commission 1990a: 15)

Social rights are guaranteed and implemented, in some cases at the level of the member states, in others at Community level, depending on the field of competence:

> whereas such implementation may take the form of laws, collective agreements or existing practices at the various appropriate levels and whereas it requires in many spheres the active involvement of the two sides of industries. (Commission 1990a: 11)

The Community Charter enjoys strong popular support. On an average, 70 percent of Europeans described the adoption of the charter as a "good thing," 7 percent considered it a "bad thing," 12 percent felt neither way strongly, and 12 percent did not respond (*Journal für Sozialforschung* 1990: 335).

The historical roots of the Community Charter trace back to the first regulations that implemented the intentions of the 1957 Treaty of Rome. These have evolved through five different phases from 1961 to the mid-1970s (AIM 1991: 9–11), when harmonization, or the "bringing in line," of social security regimes was a major goal. Community regulations were extended to more and different groups.[4] With the enlargement of the Community to twelve member states with very different social and economic circumstances, the goal of harmonizing social security regimes now appears a distant dream. In the 1990s, it has been replaced by the policy of convergence (Le Grand 1991), by which there are common goals for the Community, but each member state can move toward them at its own pace. Uniform Community measures are hardly reconcilable with this policy position.

4. The key provisions include: The freedom of movement for workers within the Community (Council Regulation EEC1612/68); the abolition of restrictions on movement and residence within the community for workers of member states and their families (Council Directive 68/360/EEC); the coordination of special measures concerning the movement and residence of foreign nationals, which are justified on grounds of public policy, public security, or public health (Council Directive 64/221/EEC); the right of workers to remain in the territory of a member state after having been employed in that state (Commission Regulation EEC 1251/70); extending to workers the right to remain in the territory of a member state after having been employed in that state (Council Directive 72/194/EEC—scope of Directive 64/221/EEC); the education of the children of migrant workers (Council Directive 77/486/EEC); the abolition of restrictions on movement and residence within the Community for nationals of member states with regard to establishment and provision of services (Council Directive 73/148/EEC) (Commission 1988).

In 1990, after the signing of the Community Charter, the Commission of the European Communities (see the Appendix) adopted a new social action program to guide the implementation of two main objectives: a convergence of the goals of national social security systems and the provision of a minimum subsistence level. As a next step, atypical workers and part-time and temporary workers are to receive benefits and legal protection in proportion to the legal protection and benefits available to full-time workers. Further, it is envisaged that the protection of pregnant and breast-feeding women, maternity leave, and the guarantee of a job upon return to work will be included in the regulation on the coordination of social security rights. These rights are realized in national schemes to varying degrees (see the section on national schemes below).[5] In signing a protocol on social policy of the new draft Treaty on European Union in Maastricht on 12 December 1991, the eleven heads of state or government who were signatories of the Community Charter expressed their intention "to continue along the path laid down in the Social Charter of 1989" (Belmont European Policy Centre 1991: 51). They also agreed that in social security and health care matters they would not move ahead without the United Kingdom.

The right of access to health benefits and care in the European Community is governed by Regulations 1408/71 and 574/72 of the Treaty of Rome that set up the EEC, and which apply to employed workers, self-employed people, and the unemployed, as well as to members of their families.[6] To qualify, one must also be the citizen of a member state and subscribe to a mandatory social security scheme or health care system (Schulte 1988). The Community regulation on coordinating security systems covers 95 percent of the Community population as reported in a study conducted by Henri Lewalle in collaboration with Murielle Lona under the direction of Jean Hermesse (AIM 1991: 165). Excluded from the scheme are civil servants, students, war victims, and those covered by nonmandatory complementary social security and health policy regimes (Pieters forthcoming).

5. For foreign companies wishing to do business in the European Community but operating under laws which do not require them to provide these benefits (like Americans and Japanese), this would mean that they would have to provide these rights.

6. Under the regulations on coordinating social security regimes, four administrative forms for different groups of eligible persons are used, E106, E121, E119, E109. To settle claims or obtain prior authorization for treatment abroad, different administrative procedures are used to prove eligibility by the member states and to authorize care abroad. Invoicing for cross-border care necessitates bilateral agreements among third-party payers. Practices diverge considerably (AIM. 1991). The Administrative Commission, which wields far-reaching powers in social security matters, was set up by the same regulations.

These regulations are extremely complex because they have to be applied to twelve different and highly differentiated health policy regimes and social security systems. In the final analysis national provisions are thought to carry the strongest weight (Schulte 1988; Pieters forthcoming; Watson-Olivier forthcoming), but it is important that Community-wide mechanisms to handle cross-border health care are in place and could be expanded if necessary.[7]

From the data available it is difficult to assess the significance of the flow of health care across borders as a part of all health care provided in the European Community. What we do know are which geographic areas see significant cross-border flow and which third-party payers in which member states are exchanging resources. A recent AIM study (1991: 103) has found that 90 percent of Community claims originate from France, Belgium, Italy, and Germany, with the remaining 10 percent divided between the other EC countries. Spain, Portugal, and Greece have few claims. In examining the total claims and debts within the Community, the study concluded that the five major creditors of the Community (France, Belgium, Italy, Germany, and the Netherlands) were also the countries with the highest debts. In the past, cross-border health care has been more significant in the countries which founded the Community than in later members (AIM 1991).

While mobility in Europe has been low in the past, there is a consensus that migration within the Community will intensify and that transborder health care issues will consequently become more significant in the future. Legal experts agree that Community regulations need revision and that all population groups should benefit from the scope of regulations (Watson-Olivier forthcoming; Pieters et al. 1990).

Preference for National Health Policy Regimes

To appreciate why there is little prospect of a Community-wide health policy regime or health care system emerging, one must also understand that health remains a popular issue with national electorates, who retain a firm loyalty to the welfare state. The popularity of welfare rights contrasts strikingly with the tenor of the debate about the limits to and the crisis of the welfare state (Dogan 1988; Flora 1988).

European publics still expect national governments to protect them

7. An alternative to a revision of the regulations is the Europe-wide social insurance system proposed by Pieters et al. (1990).

against adversity and health risks, and this expectation seems to override an otherwise pro-Europe attitude. In October 1989, one thousand citizens each from France, Spain, the United Kingdom, and the Federal Republic of Germany were polled on "Community-orientedness." They tended to prefer the retention of strong national responsibility for bread-and-butter issues like social security legislation, labor law, health protection, income tax, and school curricula, but the same individuals favored Community jurisdiction over defense, environmental protection, laws on foodstuffs, the quality of drinking water, and so on (*Süddeutsche Zeitung* 1989). If national electorates perceive that basic health rights are being negotiated or given away because of competition and unregulated health markets, governments are sure to see repercussions at the polls.

Support for Social Welfare Tradition

The social welfare tradition emphasizing work and welfare continues to enjoy wide support among core groups: governments, labor and business leaders, the public, providers of care, and health advocacy groups in every member state. Consequently, this tradition can be expected to guide both domestic politics (recent reforms confirm this) and future Community policy-making processes. The conflict surrounding the "social dimension" illustrates the vitality of belief in these established values and practices (Lange 1992; Rhodes 1991), as well as the differences which individual member states bring to the resolution of these conflicts (Baldwin-Edwards and Gough 1990/1991).

Some polarization has been observed in social policy on issues other than health care:

> Political parties and governments on the Left, as well as Christian Democrats with their traditions of social responsibility and close links to Catholic labor movements, national trade unions and the European Trade Union Confederation (ETUC), have favored the social-protectionist vision. Political parties and governments with a distinct neoliberal profile, national employers' associations and UNICE, the European employers' association, have favored the minimalist approach. (Lange 1992: 232)

But to expect a similar dichotomy of coalitions to emerge in health care policy—one pushing for a Community solution and the other for national solutions—would be to misread the diversity and complexity of political and professional forces traditionally mobilized around the key political

and health care institutions. These have spanned the entire political spectrum and controlled the allocation of resources, the price of health care, its provision in each country. National social security and health policy regimes still command strong political support from many different political camps, and we should not expect them to fade from sight in a single European market.

Decentralized Solutions Favored

Global and intra-European trade, competition, and investments may lead to greater mobility among Europeans after 1992. They would include not only migrant workers responding to work opportunities, as in the 1960s and 1970s, but also new groups like retirees and tourists, who are entitled to health and social security benefits.

To date, three types of cross-border flow in health care that require prior authorization have been identified (AIM 1991: 3). The first group is retirees and tourists, a flow which occurs along a north-south axis. The second is people seeking employment opportunities in a market without borders, who may invoke established rights of access to health care and treatment abroad. A new, third group is people seeking high-tech quality care in "centers of excellence." It is thought that this last group will grow in number, but the validity of speculations about patient mobility is beyond the scope of this paper.

Some call for an expansion of EC involvement in health matters beyond the scope of its current authority and request improved implementation of the Community policy of coordinating national social security systems. Others insist on the primacy and virtues of national, or even subnational, solutions. So far, the forces of decentralization—subsidiarity and decentralized collective bargaining (that is, solutions within a national context)[8]—are prevailing. "Think globally, act locally" has a strong parallel in "Think Community, act nationally."

Jacques Delors, president of the Commission of the European Communities, has summarized his view of the principle "that what can be done at

8. *Subsidiarity* in this context refers to a specific form of power sharing, in which subsidiary forces in society work both with and against *solidarity*. *Solidarity* refers to the forces of consolidation and centralization in society. The two concepts are closely linked insofar as they accept intervention from the center (the state) and the notion that society has a responsibility to provide for individuals and social groups the social and economic protection that they cannot provide on their own. Contrary to a widespread belief, the history of the Twelve indicates that solidarity and subsidiarity are not mutually exclusive. Subsidiarity is reconcilable with pluralism, state intervention, and solidarity.

the company level should not be done elsewhere, that what can be done at the regional level should not be done at the national level, and, finally, that what can be done in the member states should not be done in Brussels" (quoted in Tarullo 1991: 64).

The question remains why national forces are so strong. Historically, the rival political forces of a socialist, social-democratic, Christian democratic, and liberal orientation have driven the political dialectics supporting solidarity and/or subsidiarity. But neither solidarity nor subsidiarity has evolved as a unitary concept. Among the powerful members of the Community, political forces have pushed simultaneously for both solidarity and subsidiarity. These ideas are fully institutionalized and are most clearly manifest in the specific structures of national and voluntary insurance in the Netherlands, France, Belgium, Germany, and, until 1970, Italy. In these countries, insurance schemes are controlled by the social partners and other social groups, which are subsidiary to but separate from the state structure.

Subsidiarity has two other distinct manifestations. One is seen in the relationship between religion and society. Existing church-state relations in the member states are fundamental. For this reason, the forces of resistance to a Europeanized health policy scheme carry weight in many more member states than those mentioned above.

The second manifestation of subsidiarity is seen in the close involvement of regional and/or local governments with the central government of all member states in health policy regimes, regulating health and social care and providing the manpower to support them (Heidenheimer et al. 1990: 57–98). This form of power sharing is associated with what is best known in the United States as federalism, decentralization, and the sharing of power and authority among levels of government. However, the similarity with the United States of America ends there, in the sense that all twelve European states have accepted the necessity of a national solution to health and social protection, leaving the implementation of methods and means to decentralized units and/or subsidiary forces in society. The history of health policy in each member state could be written as a history of balancing centrifugal and centripetal forces. The same forces are now seeing a lively renaissance in the context of the new Community.

Powers of the European Community

The European Community has no explicit, treaty-based, legislative authority over health care, health care organizations, and social security

systems. Its regulations on the coordination of social security systems, including health care, fully respect national provisions. Community regulations are complementary to these provisions, and they were adopted specifically to handle cross-border health care issues and claims.

In areas where the Community does have explicit treaty-based authority, it has acted extensively. The Treaty of Rome covers the free mobility of labor, which entails the right to access to health benefits and care, environmental protection and health, and occupational health and safety (Commission 1990, 1990b, 1990d; Commission and MISSOC 1990).[9] The Single European Act of 1987 strengthened some of these rights. The new Treaty on European Union, signed in Maastricht on 12 December 1991 by all twelve heads of state or government will strengthen them further, after ratification.

A new Title X on public health in the newly amended treaty has strengthened the prohealth forces interested in a more health-conscious commission, which can now become more active in health and prevention, though not in social and health protection. The latter was explicitly excluded from Title X. Instead, Article 118 of the Treaty of Rome was not changed and hence remains pertinent for health care matters (Belmont European Policy Centre 1992).

Whatever the Community does, the original Treaty of Rome (as reconfirmed and expanded by the Single European Act and amended by the Maastricht Treaty) firmly states that the "choice of form and methods" for implementing EC initiatives, excluding EC regulations, is clearly a national responsibility (Article 189). If we focus on implementation rather than decision making when assessing future developments, it gives further reason to keep expectations moderate, even in the case of industries

9. The main social provisions of the Treaty of Rome (1957), which are binding, cover the following: (i) In a general way, Article 100 allows the approximation of "such provisions laid down by law, regulations or administrative action in Member States as directly affect the establishment or functioning of the common market"; (ii) freedom of movement for workers (Articles 48 and 49); (iii) social security for migrant workers (Article 51); (iv) freedom of establishment, i.e., the right to take up and pursue activities as self-employed persons (Articles 52 to 58); (v) equal pay for male and female workers (Article 119); and (vi) the European Social Fund.

Additional binding provisions introduced by the Single Act (1987) cover: (i) the approximation of national provisions relating to health, safety, environmental protection, and consumer protection (Article 100a); (ii) the working environment and the health and safety of workers (Article 118a); and (iii) the economic and social cohesion of the community (Articles 130a to 130e). Nonbinding provisions cover (i) the standard of living and working conditions and the social field in general (Articles 117 and 118); (ii) paid holiday schemes (Article 120); and (iii) a common vocational training policy (Article 128). A new provision of a nonbinding nature concerns a dialogue between management and labor which could lead to relations based on agreement (Article 128).

like insurance and pharmaceuticals, which will doubtless benefit from directives to facilitate trade and investment inside and outside of Europe.

In a comparative study of the licensing of pharmaceutical products in the early 1980s, Feick (1983: 204) drew a fundamental distinction between the driving forces which influence a "program context" and those which drive the "implementation context." This distinction offers a useful point of entry for reflection on the implementation of EC directives, decisions, and recommendations and how they militate against rapid change. The political-administrative traditions of the member states and their styles of intervention are becoming the determining factors in the implementation of Community directives, decisions, and recommendations. For example, national administrative culture and preferred implementation styles in individual countries were found to have made *the* difference in the "breadth, density and precision of substantial procedures" governing the licensing of pharmaceutical products (Feick 1983: 209–14).

National medical and licensing authorities are unlikely to relinquish their influence. In every country, domestic politics will have to balance not only the regular set of policy actors but also the diverse interests of a number of ministries (federal agencies) and their clienteles. Ministries of health concerned that drugs are safe and effective do not necessarily see eye to eye with finance ministries eager to control costs. The promotion of exports is of concern to ministries of economics or commerce, ministries of science and technology are interested in stimulating research and development, and ministries of labor have a keen eye on maintaining jobs, thus presenting the authorities with an internal dilemma (Kammradt 1989).

The Single European Act of 1987 introduced changes in the *modus procedendi* of Community policy-making. The replacement of voting by unanimity with voting by majority in the council of ministers (Commission et al. 1987) is expected to bring major change in many areas. Nonetheless, social security and health care issues still require unanimity—a strong indicator that national viewpoints and provisions will continue to carry weight. Other issues may be decided by majority voting.[10] But even here "difficulties in reaching agreement in the council on delegating implementing powers to the commission" have arisen. These include about fifty veterinary and phytosanitary controls, controls on foodstuffs, nutrition labeling, and directives on the insurance business, pharmaceuticals,

10. A qualified majority is obtained with 54 out of 76 votes. The votes are distributed in the following way: Germany, 10 votes; France, 10; Italy, 10; United Kingdom, 10; Spain, 8; Belgium, 5; Greece, 5; the Netherlands, 5; Portugal, 3; Denmark, 3; Ireland, 3; and Luxembourg, 2.

and high-technology medicines (Commission 1990c: Annex 2, 1–12). National interests and provisions remain tenacious.

Judicial Policy-making

A ruling of the European Court of Justice, rather than bilateral or multilateral agreements or a negotiated settlement among the Twelve, is the basis for the current practice of handling transborder health care protection and settling financial claims among health providers (individual and institutional) and a diverse third-party payers under each health policy regime. In an important case for health care (the Vasser Goppels case, number 61/65, of 30 June 1966) the Court distinguished between the receipt of benefits in kind and benefits in cash—a distinction prevalent in each national health policy regime. Benefits in cash cover loss of income due to illness or accident, while benefits in kind include medical and dental care, hospitalization, sickness/maternity insurance, and prescription drugs. "The Court judged that benefits in cash are to be paid directly by the competent institutions, whereas benefits in kind are to be provided by the institutions of the place of residence for the account of the competent institution" (AIM 1991: 29).

The Court reinforces the practice that persons covered under any one of the twelve health policy regimes are entitled to receive treatment abroad, provided it has been authorized by the competent health authority (article 22 of regulation 1408/71). Treatment is at the expense of this authority. But ter Kuile et al. (1989: 7) explain that "the power to refuse authorization was limited by the requirement that the insured person should be guaranteed the opportunity to receive a treatment appropriate to his state of health in any member state, whichever the member state of his residence or of the competent social security authority might be."

The European Court of Justice[11] serves as the ultimate interpreter of legal and political conflicts between Community and domestic law. Considered an activist court (Kommers and Waelbroeck 1986: 219), it has ruled on powers derived from the Treaty of Rome in a wide range of civil matters, including individual rights, environmental law, trade, and antitrust issues which are binding on the member states. The Court also has handed down over two hundred-fifty rulings concerning social secu-

11. Thirteen judges from the twelve member states sit on the Court. The court has ruled on constitutional issues and the enforcement of rights. To handle the Court's overload, a Court of First Instance was created in 1988.

rity rights and developments in national social security systems (Watson-Olivier forthcoming: 3). It has also ruled that benefits like social (medical) assistance that are outside social security systems fall within the scope of EC regulation (Pieters forthcoming: 4).[12]

Another ruling with important consequences for social security and health care rights is the Court's interpretation of the direct effect of the Treaty of Rome's provisions and, more importantly, of all Community regulations. "Direct effects means that any natural and legal person may invoke the rights deriving from these Community provisions before any national court. The national court is bound to protect these individual rights of the person concerned" (ter Kuile et al. 1989: 7).

In the opinion of several legal experts, however, judicial policy has served the interest of the European Community more than the interests of European citizens (Garth 1986; Kommers and Waelbroeck 1986). Kommers and Waelbroeck write that "there are a number of cases in which, either because of ignorance, intimidation or the expenses involved, parties renounce invoking their Community rights and prefer to settle on the basis of possibly infringing Member State statutes" (p. 225). Will the rights of European citizens to health care as patients, retirees, and travelers be compromised for the same reasons? The Court's past rulings on rights under social security suggest not, but the above arguments imply that it could happen.

The Court, therefore, has been a champion both of European integration and of individual rights, and not only for those in the labor force. Its ruling on treaty-based powers and social security–based rights are expected to constrain any future attempt by capitalist forces to sacrifice these rights for profit.

A Profile of National Health Policy Regimes

The shared social welfare traditions described above are all manifest in macrostructural features at the core of national health policy regimes. The twelve members are at different stages of development: the rich northern and western European countries have a long tradition of national health care organizations and universal access to health care, whereas the poorer Mediterranean countries only began to establish some kind of national

12. This article will not deal with the different meanings of the rule of law in the Anglo-Saxon and the Roman law traditions—a source of continuing disagreements which spill over into the political discourse.

health service ten or fifteen years ago (Portugal in 1976, Italy in 1978, Greece in 1982, and Spain in 1985).

Health policy regimes in the advanced industrialized societies can be classified under three historical prototypes (Pfaff 1990: 17):

1. The national health service (Beveridge) model, characterized by universal coverage, national general tax financing, and national ownership and/or control of the factors of production
2. The social insurance (Bismarck) model, characterized by compulsory universal coverage, generally within the framework of Social Security, and financed by employer and individual contributions through nonprofit insurance funds, and public and/or private ownership of factors of production
3. The private insurance (consumer sovereignty) model, characterized by employer-based or individual purchase of private health insurance coverage, financed by individual and/or employer contributions and private ownership of the factors of production

Prima facie, health policy regimes in Europe appear to be representatives of the first type (United Kingdom, Ireland, Denmark, Portugal, Spain, Italy, and Greece) and the second type (France, Germany, Belgium, Netherlands, and Luxembourg). But the political economy of health policy regimes is institutionally more differentiated and multifaceted. Looking solely at the sources of financing health care, four dominant approaches exist, as depicted in Figure 1.

Within each historical type there are further variations in the production, organization, and financing of health care (see Tables 4 and 5 below) and in the mix of public and private policy instruments used to steer and control health care organizations. Hurst (1991: 1–2) has identified seven subsystems governing the financing of health care and the payment of providers:

The public reimbursement model (with no connection between third parties and providers)

The public contract model (with contracts between third parties and providers)

The public integrated model (with vertical integration between third parties and providers)

Four voluntary subsystems supplement these three public schemes:

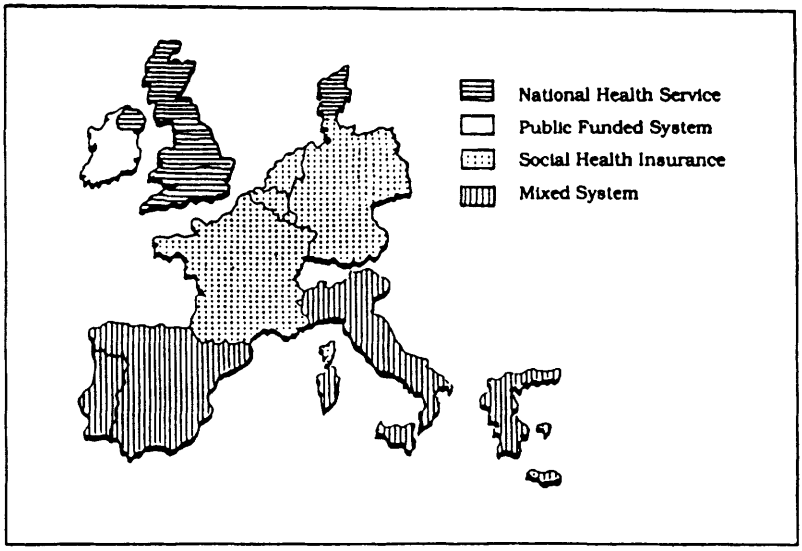

Figure 1 Health Care Systems in the Member States of the European Community

Source. BASYS 1991.

The voluntary out-of-pocket model

Three models involving voluntary third-party finance (private insurance) corresponding to the public insurance models above

To understand why there is such strong resistance to a Europeanization of health policy regimes and health care delivery systems, one must consider the strong political and cultural forces that supported voluntary organizations for medical care even before the rise of strong national welfare states in the late nineteenth century. Sickness funds, mutual aid funds, and other voluntary private groups were so powerful and entrenched that the founders of the welfare state had no choice but to integrate them into the compulsory social insurance system, and they have remained pillars of national health policy regimes ever since.

Health Care Benefits, Coverage, and Financing

In the European tradition, health protection for the majority of the population has been work-related, subject to an ever-rising income ceiling

(Glaser 1980, 1991).[13] The relative burden on employers and employees varies considerably between the twelve countries, as does the total percentage of gross salary spent on health care (see Table 2).

Almost 100 percent of the Community population is covered against illness through compulsory public and/or private insurance. Where less than 100 percent public coverage is provided, it is supplemented by complementary private, voluntary, and nonprofit insurance (through mutual aid funds) and commercial insurance. Table 3 shows the breakdown of coverage in the member states. Table 4 indicates the distribution of the dominant system types in health care and specifies the type of benefits available to most people. Income-related (not risk-based) contributions and taxes are the two dominant modes of financing health care.

In addition to inpatient and outpatient health services, dental care, and prescription drugs, every country also has an income-maintenance or cash component (see Table 6 below). These approaches to health care will continue to carry weight in the "new" Europe of the single market and multinational enterprises may find it difficult to disregard them.

The distribution of health care expenditures as a percentage of the gross national product (GNP) for different types of services or benefits shows a similar pattern in the twelve countries. Table 5 indicates expenditures for total benefits in kind as a percentage of GNP. In all member states, expenditures for hospital services exceed those for medical services and prescription drugs. However, the latter is not insignificant.

European employers (public and private) *nolens volens* have invested in the health of their workers and their dependents and have paid for income maintenance, apparently accepting a connection between these investments and worker productivity. In cases of temporary illness, full wages are paid for a week in Denmark, a month in Belgium and Luxembourg, six weeks in Germany and the Netherlands, and three months in Italy. When a temporary disability persists beyond the legal obligation of employers to make full wage payments, cash or sickness benefits are paid in all twelve member states. Cash benefits are typically less than full wages and are paid for between as few as twenty-eight weeks in the United Kingdom and 180 days in Italy to as long as two and a half years in Denmark or three years in Portugal. Benefit levels range from a low of between 50 percent

13. International comparisons usually rely on OECD data. In my own comparative work, I have found the data compiled by the BASYS group to be more reliable in reflecting country-specific circumstances.

Table 2 Type of Benefits and Contributions in the Member States of the European Community, as a Percentage of Gross Salary

		Contributions			
	Benefit	Employee	Employer	Total	Adjusted Total
Belgium	H	2.55	3.80		
	C	1.15	2.20	9.70	9.70
Denmark	C,H				
France	C,H	5.90	12.60	18.50	18.50
Germany	C,H	6.45	6.45	12.90	12.90
Greece	H	1.85	3.70		
	C	0.40	0.80	6.75	6.75
Ireland	H	1.00	(1.00)		
	C	5.50[a]	12.33[a]		2.81
Italy	C,H	1.30	9.65	10.95	10.95
Luxembourg	H	2.35	2.35		
	C	2.00[b]	2.00[b]	8.70	8.70
Netherlands	H	1.20	4.95		
	C	1.20	6.20	15.20	15.20
Portugal	C,H	11.00[a]	24.50		2.75
Spain	C,H	4.80[a]	25.80		8.90
United Kingdom	H				
	C	7.00[a]	7.00[a]		1.10

Notes: C = Cash benefits (sickness benefits and death benefits)
H = Health benefits (outpatient, inpatient etc.).
Data on Germany refer to the former Federal Republic of Germany only. The adjusted total for the tax-financed systems (Ireland, Portugal, Spain, and United Kingdom) gives a percentage for health benefits calculated on the basis of total social security taxes.
a. Not comparable, includes pensioners invalidity insurance.
b. Blue-collar workers only.
Source. Schneider et al. 1992: 17.

and 60 percent of previous wages in France, Portugal, Belgium, and Italy to 80 percent in Germany, 90 percent in Denmark, and 100 percent in Luxembourg (see Table 6).

Investment in health also rests on a broad social consensus that the extra expenditure to ensure the health of future generations is worthwhile. Health services are therefore provided not only to the labor force or to the

Table 3 Number and Percentage of People with Public and Private Coverage in the Member States of the European Community in 1990, by Type of Health Insurance

Country	Population	With Public Coverage	With Private Coverage	
			Mutual Aid Funds	Commercial Insurance
Number in Millions				
Belgium	9.9	9.9	5.9	1.4
Denmark	5.1	5.1	1.0	0.0
France	56.1	55.5	36.5	8.0
Germany[a]	62.0	54.7	6.4	5.6
Greece	10.1	10.1	0.3	0.2
Italy	57.4	57.4	2.9	6.0
Ireland	3.5	3.5	1.1	0.0
Luxembourg	0.4	0.4	0.2	0.1
Netherlands	14.8	10.4	8.1	5.9
Spain	39.2	37.9	1.2	2.3
Portugal	9.8	9.8	0.1	0.3
United Kingdom	57.2	57.2	3.0	5.7
Total	325.5	311.9	66.7	35.5
Number as Percentage of Population				
Belgium		100.0	59.6	14.1
Denmark		100.0	19.6	0.0
France		98.9	65.1	14.3
Germany		88.2	10.3	9.0
Greece		100.0	3.0	2.0
Italy		100.0	5.0	10.5
Ireland		100.0	30.0	0.0
Luxembourg		100.0	50.0	25.0
Netherlands		70.3	54.7	39.9
Portugal		100.0	1.0	3.1
Spain		96.7	3.1	5.9
United Kingdom		100.0	5.2	10.0
Total		95.8	20.5	10.9

Note. Data for Germany refer to the former Federal Republic of Germany only.
Source. BASYS 1991. Totals and percentages have been corrected.

Table 4 Financing Health Care in the Member States of the European Community

Country	Type of Health Care System	Type of Benefits	Financing	
			Contributions	Taxes
Belgium	NHI	in kind	X	
		cash	X	
Denmark	NHS	in kind		X
		cash		X
France	NHI	in kind and cash	X	
Germany	NHI	in kind and cash	X	
Greece	NHS/Mixed	in kind		X
		cash	X	
Italy	NHS/Mixed	in kind and cash	X	
Ireland	NHS	in kind		X
		cash	X	
Luxembourg	NHI	in kind and cash	X	
Netherlands	NHI	in kind and cash	X	
Portugal	NHS/Mixed	in kind and cash		X
Spain	NHS/Mixed	in kind and cash	X	
United Kingdom	NHS	in kind		X
		cash	X	

Notes. Data for Germany refer to the former Federal Republic of Germany only
In-kind benefits include outpatient and inpatient services; cash benefits include income maintenance or sickness benefits, maternity benefits, and death benefits.
Source. Schneider et al. 1992: 15.

elderly and poor, as in America, but also to children and young people. Coverage also provides for pregnancy and childbirth, and all twelve member states give maternity leave before and after childbirth, and maternity allowances, as indicated in Table 7.[14]

Finally, when choosing providers—general practitioners (GPs) and specialists—European patients face few restrictions (see Table 8). In those

14. For details on the remaining social security benefits, including family allowances, disability, employment injuries, and occupational disease, see Commission and MISSOC 1990.

Table 5 Health Care Expenditures as a Percentage of GDP of Member States of the European Community, by Type of Service, 1988

Country	Total Benefits in Kind	Hospital	Ambulatory Medical	Drugs	Long-Term Care
Belgium	7.35	2.60	1.55	1.19	0.63
Denmark	8.04	4.07	0.59	0.61	1.56
France	8.62	3.96	1.39	1.48	0.43
Germany	8.50	2.88	1.37	1.40	0.66
Greece	6.25	2.74	1.12	1.38	0.20
Italy	7.82	3.34	1.90	1.41	0.57
Ireland	8.42	4.14	1.23	0.99	1.03
Luxembourg	9.04	3.89	1.70	1.45	0.52
Netherlands	8.45	3.67	0.86	0.78	1.57
Portugal	6.52	2.30	1.30	1.28	0.35
Spain	7.10	3.23	1.15	1.30	0.51
United Kingdom	6.57	3.11	0.90	0.89	0.85
European Community	7.89	3.30	1.33	1.27	0.68

Note. Data for Germany refer to the former Federal Republic of Germany only.
Source. Schneider et al. 1992: 22.

countries where access to hospitals is limited, general practitioners serve as gatekeepers for referrals to hospitals.

Commercial Health Insurance and Prescription Drugs

After 1992, both industries expect to benefit from free access to an integrated European insurance and pharmaceutical market. By launching cross-border operations, they intend to expand both market volume and profits.

Commercial Health Insurance Industry. Since the mid-1970s, commercial health insurance has been growing (OECD 1987) as a result of increased demand for coverage and cost containment legislation and some privatization of health risks. In a few member states, minor cuts in public coverage have been offset by slight increases in household payments.

Table 3 showed the limited role played by commercial insurance in most member states, due to the existence of public regimes. In terms of volume, it has never exceeded 15 percent of total health expenditures in

Table 6 Duration of Sickness, Income Maintenance Benefits, and Sickness Benefits in Member States of the European Community

Country	Continued Payment by Employer of 100 % Wages	Deferral Period, in Days	Sickness Benefit, as % of Wages	Duration of Benefits
Belgium	30 (7[a]) days	0 (1[a])	60%	1 year
Denmark	1 week	0	90%	99 weeks
France	3 months	0 (3)[a]	50–67%	1 year
Germany	6 weeks	0	80%	1.5 (3 years)[a]
Greece	[b]	3	50–90%	360 days
Italy	3 months	3[a]	50%	180 days
			67% from 21st day	
Ireland	[b]	3	ECU 53 per week plus family allowance	1 year
Luxembourg	4 weeks	0	100%	1 year
Netherlands	6 weeks	2[c]	70%	1 year
Portugal	[b]	3	60%	3 years
Spain	[b]	3	60% up to 20th day	1 (1.5)[a] years
			75% from 21st day	
United Kingdom	[b]	3	ECU 52–74 per week	28 weeks

a. Blue-collar workers only.
b. Controlled by wage agreements.
c. "Man-valid" for some wage agreements.
Notes. Data for Germany refer to the former Federal Republic of Germany only. *ECU* stands for European Currency Unit.
Source. Schneider et al. 1992: 46.

Table 7 Maternity Benefits in the Member States of the European Community

Country	Maternity Leave in Weeks before and after Childbirth		Maternity Allowance as a Percentage of Salary
	Before	After	
Belgium	6	8	82%; 75%[a]
Denmark	4	24	90%
France	6 (10)[a]	10 (20)[a]	84%
Germany	6	8	100%; max. ECU 12 per day
Greece	7	7	100%
Italy	8	13	80% (30%)[a]
Ireland	6	8	70% respectively; ECU 54.7 per week
Luxembourg	8	12	100%
Netherlands	6	10	100%
Portugal	4	8	100%
Spain	6	10	75%
United Kingdom	11	7	ECU 48.8 per week

Notes. Data for Germany refer to the former Federal Republic of Germany only. *ECU* stands for European Currency Unit.

a. The source does not explain why sometimes a second figure is given. It may indicate a different arrangement for specific groups.

Source. Schneider et al. 1992: 48.

Table 8 Extent to Which Individuals Have Free Choice of Providers in Member States of the European Community

Country	GP	Specialist	Hospital
Belgium	yes	yes	yes
Denmark	limited	limited	limited
France	yes	yes	yes
Germany	yes	yes	yes
Greece	limited	limited	yes
Italy	limited	limited	limited
Ireland	yes	limited	limited
Luxembourg	yes	yes	yes
Netherlands	yes	yes	limited
Portugal	yes	limited	yes
Spain	limited	limited	yes
United Kingdom	limited	limited	limited

Note. Data for Germany refer to the former Federal Republic of Germany only.

Source. Schneider et al. 1992: 30, 35.

any country (Hurst 1991). Another indicator is the percentage of revenues raised for health insurance compared with the total contribution revenues of the commercial insurance industry. Except for the Netherlands (at 21.6 percent); Germany, where commercial insurance is the sole insurer of professional and civil service groups (13.2 percent); France (6.76 percent); and Spain (7.24 percent), commercial health insurance is insignificant and is below 2 percent in most member states (CEA 1990; n.p.).

Current evidence suggests that competition in commercial health insurance is unlikely to undermine public schemes. The changes in content between the first and second council directives on insurance other than life insurance and those currently being addressed in a draft for a third council directive are crucial pieces of evidence. National health policy regimes work through EC institutions, as do other vested interests. Van de Ven (1991: 2) suggests that the "time-bomb under solidarity" which seemed to be emerging two years ago has now been neutralized by the draft proposal for the third directive: "According to Art. 43 of this proposal, each member state is allowed to have specific regulations with respect to voluntary private insurance, for example, to preserve solidarity, and health insurers from other member states have to comply with the regulation of the state in which they sell health insurance policies."

If the Commission of the European Communities were to have its way, the protection of consumers in, for example, Germany and the Netherlands, who purchase commercial health insurance when they are young but rely on keeping their coverage until they are old, would be lost. The same consumers would pay lower premiums when young than they do today, but they would also run the risk of losing insurance cover when they are old or very sick. Calculating risk-based premiums over a life span, rather than over short periods of time, also reflects a welfare tradition which constrains even commercial health insurance.

The major bone of contention is the extent and range of controls that member states can retain over defining the terms of insurance, calculating risks and premiums, keeping reserves to pay for benefits, and investing fixed assets. In some countries, insurers are less restricted in operating and selling health insurance. Germany and the Netherlands—the only two countries where private health insurance has had a market share in the past—fear that consumers will lose protection. This claim may hide a protectionist argument, but consumer protection requires some restrictions on the insurance industry. To speculate more about the effects of the single market on commercial health insurance at this point is premature, because the Commission and the member states have not yet settled on the final policy terms.

Prescription Drugs Industry. Drug benefits are covered under the respective national health policy regimes. Coinsurance and deductibles seem to be policy options for prescription drugs more so than for medical and dental services (BASYS 1991: 22, 25, 27). But the consumption of prescription drugs is substantial in all member states (OECD 1990; BASYS 1991: 30–32). Germany, Luxembourg, the Netherlands, and the United Kingdom use *negative lists*, which enumerate the prescription drugs which will not be reimbursed. The remaining member states use a *positive list*, of all drugs which will be reimbursed.

There are also considerable national variations in taxes on pharmaceuticals paid by sickness funds or NHS organizations. A standard tax of 27 percent is levied on medication in Denmark, 14 percent in Germany, and 6 percent in Spain, while the remaining EC members use a reduced tax rate of 5 percent (Netherlands), 6 percent (Belgium and Luxembourg), 7 percent (France), and 8 percent (Italy) (*Arzt und Wirtschaft* 1988). The United Kingdom levies no tax, and the data on Ireland are said not to be comparable.

The elimination of the high nontariff barriers in the pharmaceutical industry (Commission 1990b) may increase intra-European competition, but competitive pricing of drugs should not be expected on a European-wide basis. Competition is expected to bring reductions in the price of pharmaceuticals in Denmark, Germany, and the Netherlands, while prices are expected to rise in France, Greece, Italy, Portugal, and Spain. Changes are not expected in the United Kingdom (Kammradt 1989: 11, 13).

There is little connection between price levels and the amount reimbursed by the system or paid by patients. These sums tend to be determined by entirely different processes, which are too complex to discuss here. Except for the Netherlands, Germany, and Ireland, where drug prices are among the highest in the Community, people pay between a fourth and a fifth of the cost of prescription drugs (see Table 9).

The evidence vividly illustrates the synchronization of benefits under national health policy regimes and national economic development.

Conclusion

I set out to show that few changes in the national health policy regimes of the twelve member states of the European Community should be expected in the new single Europe and, in health care at least, 1 January 1993 will not be a "magic" date heralding a new era.

The individual states that are members of the Community retain certain values and practices, which have shaped the social welfare tradition

Table 9 Ranking of the Member States of the Economic Community, by Total Price Levels of 125 Drugs

Country	Price Level	Percentage Reimbursed	Percentage Paid by Patient	Patient's Percentage Copayment for Nonreimbursed Drugs (at Retail Prices)
Portugal	100	77	23	23
France	111	66	34	34
Spain	112	68	32	32
Greece	115	80	20	20
Italy	127	62	18	18
Belgium	139	71	29	29
Luxembourg	155	86	14	14
United Kingdom	180	76	24	24
Ireland	193	—	1	1
Netherlands	214	92	8	8
Denmark	231	53	47	47
Germany	239	93	7	7
Average				33.1

Note. The data for Ireland are said not to be comparable.
Source. Sermeus and Adriaenssens 1989: 416, 425.

in each state; similar values and actions are also reflected in the historical record of the Community from 1958 to 1992. The national health policy and social security regimes are, as a result, widely supported within each nation and supplemented and reinforced internationally by labor and social conventions, the European Convention on Human Rights, and the Community Charter of the Fundamental Social Rights of Workers. The European Community's authority when it comes to health care defers to these national regimes and is designed to complement them, handling mostly cross-border health issues and claims, through such agencies as treaties and the European Court of Justice. Finally, an analysis of certain central macrostructural features of the national health policy regimes in the twelve member states supports the view that national regimes are firmly entrenched within the overall social welfare traditions and legal framework of the EC.

At the beginning of this article I asked whether the market approach to health services and prices would set the direction of future developments in national health policy regimes, or whether the philosophy of solidarity between the sick and the healthy would remain the dominant

credo in the new European Community. On the basis of the evidence presented, we can answer unequivocally that there will be no unregulated health policy regimes anywhere, at the national or Community level. The price of health services will continue to be socially and politically determined, and income-related contributions or taxes will remain the means of financing health care for the majority of Europeans.

The European social welfare tradition will remain an overarching and guiding principle in health policy-making in the future. The welfare state and its various social security regimes have been most effective in building loyalty to the nation-state and to these policy regimes. These institutions are likely to be the strongest bulwark against any assault on cherished benefits and rights. The welfare state is still alive and well in the minds of European citizens, and this is likely to be reflected in national elections.

A few other important conclusions can be drawn from this evidence. It shows that regulated national health policy and Community-wide health policy regimes are compatible with competition and economic growth, provided that there are close policy linkages between social security, health policy, labor markets, and industrial policy regimes at both national and Community level. This does not rule out the possibility of incremental changes within the existing mechanisms that link one regime to another nationally or Community-wide, but such changes will continue to entail more regulation and control, rather than less.

Where member states have policy responsibilities, they will keep and defend them, and where the Community has treaty-based powers, it will act. The new unconventional patterns of policy-making will merit attention in the future. We can predict that economic forces for integration will have only a limited impact on national health policy regimes, although some incremental change may result from an intensification of interpretative case adjudication by the Court of Justice. Some "safe" sovereign rights of the nation-state may turn out not to be so safe, after all. Negotiated agreements will remain a preferred policy approach among the Twelve. Other incremental changes may result from domestic circumstances and the ways in which the actors in public policy perceive and define the solution of health problems.

In the thirty-year history of Community policy-making, analytical concepts have spurred lively debates about the future of the European Community. Harmonization was one of them, but, along with other concepts (like synchronization, active policy, coordination, and concertation), it is misleading in the same way as talk about competition and deregulation can be. Concepts need to be examined to see whether they really reflect what

is happening on the ground, and, in the case of health policy regimes, they add little to our understanding of the intersection of Community and national policy-making. Many complex layers of international, Community, and domestic law combine to provide additional support for maintaining the existing social rights of Europeans to welfare, subsistence, and work. Harmonization has been replaced by convergence, which allows every member state to be under one common roof, while moving ahead as much and as fast as domestic politics will allow them to go.

Appendix

It may be useful to clarify the complexity of the legal and institutional framework of what is known today as the European Community and briefly trace its origins. The European Community traces back to the creation of the European Coal and Steel Community (ECSC) of 1952, the two Treaties of Rome that created the European Economic Community (EEC) (commonly referred to as the Common Market), and the European Atomic Energy Community (EAEC, or Euratom). These treaties, signed by the original six founding member states, constitute a first layer of the constitution of the European Community. New members committed themselves to this framework in the respective treaties of accession.

A second layer of complex legal provisions was added to the constitution in 1986 when the twelve member states signed the Single European Act (SEA) which became effective on 1 January 1987. The Single European Act amended and complemented the first layer of the constitution. More importantly, it outlined a number of objectives for the Community, like the creation of the single European market without frontiers.

A third layer of legal provisions emerged when the twelve heads of state or government signed the draft Treaty on European Union on 12 December 1991. The final text was signed on 7 February 1992 and is now awaiting ratification by referenda or parliamentary ratification in all member states.

References to treaty-based powers or authority and treaty-based rights of EC nationals rest on these complex layers of the constitution of the European Community.

The three European Communities—ECSC, EEC, and EAEC—are governed by common institutions. It is for this reason that references are now made in the singular to the "European Community." These institutions constitute the European Parliament, which at present is politically

the weakest body of the EC: the Council of Ministers, representing the member states and serving as the most important decision-making body of the Community; the Commission, the executive branch initiating proposals for Council decisions and implementing Council, i.e., Community, policies and programs; the Court of Justice; and the Court of Auditors.

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