

Recent rulings by the European Court of Justice (ECJ) have started the debate on the future perspectives of health care systems organised at a strictly national level. Political reaction throughout the Community has been largely calm with but a few exceptions, notably in Germany, where as a rule the price-level is among the highest. Irrespective of the basic economic principles of their health care systems, other countries with either insurance-based Bismarckian models or national Health Services, have up to now not reacted to these rulings in a similar fashion. This is no great surprise, since e.g. Austria has been well familiar with substantial parts of the Kohll and Decker ruling for many years without evident problems. A national health service used only to a sometimes want-driven mechanism of benefits in kind at a low price level may have to think twice about how such rulings could actually affect the own system. The interface between the confirmed national competence of the Member States to structure their systems of health care according to national preferences on one hand and the compliance with the principles of free movement of goods and services on the other is thus the centre of any future debate. The understanding of subsidiarity, economic logic, quality and general acceptance will define the future of the health care systems which goes beyond the scope of the recent and future rulings.

Subsidiarity is indispensable for the future in order to preserve functioning and economically sound statutory systems of health care. The national responsibility is at present without convincing alternatives. It does, however, call for precise definitions since pointless reforms and downgrading competitions among Member States keen on being the most attractive for investments are dangerous. Subsidiarity is just a means to provide economic logic and quality-based services, not a value in itself. The individualisation of risks in health care is favoured by some to serve their own interests rather than to solve the problem. It is as dangerous as any attempt to harmonise existing systems at the lowest common denominator of quality possible. New macro-economic structures, unknown 15 years ago, call for a refined understanding of subsidiarity with euro-compatibility of individual systems and social controlled market elements as a central feature. The billion dollar market of health care can hardly be fenced off against „foreign“, i.e. EU competitors. It must, however, not be directed against the patient as an incomplete market participant and thus the weakest part. A well-functioning national system has to solve economic contradictions, to establish new forms of co-operation among the actors and to demonstrate quality in order to be sure of sufficient political support at home. To achieve this, new solutions have to be found. The Kohll and Decker rulings, though raising more questions than answers, thus serve as a mirror for the macro economic status quo in many parts of the EC. Competence and responsibility may have to be re-allotted at national level in order to overcome a stalemate situation.

Some economic consequences of these rulings may be touched here. As far as the freedom of goods is concerned, the effects may be limited by a lack of market transparency. The patient will find it hard to compare the different prices, unless perhaps in border areas. There are, however, huge differences regarding e.g. many pharmaceutical products and medical devices and aids. With a little bit of organisation this may lead to savings, since prices in hitherto protected national high-level areas will be lowered. It is hard to see how this could endanger the national level of medical care available. The freedom of services will be more complex. A few natural restrictions apply, e.g. the language barriers and the legal role of the patient abroad, as well as quality assurance. Abroad the patient will be a private consumer quite unlike those seeking treatment under the Regulation 1408/71. With a few exceptions patients will hardly demand treatment in a foreign environment. These exceptions will largely

materialise where the national system already forces the patient to pay large amounts out of his or her private pocket.

The rulings have not touched the national choice of either following the benefits in kind principle or the reimbursement of costs. The first will be preferred since reimbursement will further weaken the influence of the purchasing collective of e.g. sickness funds on the market.

There are far greater challenges for the future of statutory and generally accessible health care than the rulings of the ECJ. With its many links to an economically important market the health care sector stands out. Contributions and taxes collected for this purpose have a double function: they are charges to employers and employees or tax-payers on the one hand but also reinvested into the macro-economic entity creating jobs, capacities, inventions, innovations, wealth and new contributions or taxes. Yet this seemingly well-functioning system might sooner or later reach its limits. New and central questions arise which go beyond the budget restrictions, co-payments and linear cuts of benefits. The latter are but one way to buy time for decision-making. Moreover one might ask if we are really concentrating our therapies of the great diseases of our civilisation at the proper period of time of a patient's career. The Monetary Union will bring more transparency and expose more contradictions. Economic aspects will be strengthened and our society will therefore need qualified socio-political elements to secure a desirable social reality and culture. Strengthening the economic logic and pushing forward with necessary and socially balanced reforms which touch existing contradictions is thus a promising way to preserve subsidiarity for times to come.