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Opredelitev slovenskega dopolnilnega zdravstvenega zavarovanja kot storitev splošnega gospodarskega pomena

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IZVLEČEK

Dopolnilno zdravstveno zavarovanje je v slovenski zakonodaji opredeljeno kot dejavnost v javnem interesu, ki je neločljiv in bistven element sistema socialne varnosti ter kot tak uresničuje identične cilje kot obvezno zdravstveno zavarovanje – finančno varnost prebivalstva pred visokimi zdravstvenimi izdatki ter primeren in pravičen dostop do učinkovite in kakovostne zdravstvene oskrbe. Države članice EU pogosto uvajajo različne regulatorne ukrepe, s katerimi varujejo javni interes na področju gospodarskih dejavnosti. Ti ukrepi so pogosto v nasprotju s pravnim redom EU (pravili o delovanju notranjega trga in konkurenčno zakonodajo), kar je z vidika EU načeloma nedopustno. Cilj članka je opredelitev slovenskega dopolnilnega zdravstvenega zavarovanja kot storitev splošnega gospodarskega pomena, ki državam članicam širi meje avtonomnega urejanja oziroma omogoča sprejem regulatornih ukrepov, ki niso skladni s pravili o delovanju notranjega trga in konkurenčno zakonodajo EU.

Ključne besede: *financiranje zdravstvenega varstva, dopolnilno zdravstveno zavarovanje, storitev splošnega gospodarskega pomena, javni interes*

JEL: K32

1 Uvod

Zdravstveno zavarovanje je zavarovanje za izgubo, ki nastane zavarovancu v primeru bolezni, poškodbe, poroda ali smrti. Posameznikom, ki so vključeni v sistem zdravstvenega zavarovanja, zagotavlja socialno varnost pred negotovostjo, ki jih lahko doleti ob nastanku zavarovalnega dogodka. Nekatere države uporabljajo zdravstveno zavarovanje na sistematski ravni in prek predplačniških prispevkov financirajo sistem zdravstvenega varstva. V to skupino uvrščamo tudi Slovenijo, kjer se sistem zdravstvenega varstva financira iz dveh virov, to je iz javnih in zasebnih sredstev. Levji delež javnih sredstev, okoli 75 %, znaša socialno oziroma obvezno zdravstveno zavarovanje.[1] Največji vir zasebnega financiranja pa so prostovoljna zdravstvena zavarovanja (nekaj več kot 50 % zasebnih sredstev), katerih več kot 90 % obsega dopolnilno zdravstveno zavarovanje (ZZZS, 2013, str. 144; SURS, 2013).[2]

Zdravstveno varstvo je temeljni element evropske socialne države. Kljub temu da države članice EU različno urejajo to področje, je skupna značilnost vseh ureditev zasledovanje univerzalnega dostopa, ki temelji na načelu solidarnosti. Države članice z vstopom v EU nanjo prenesejo izvrševanje dela suverenih pravic, kar z drugimi besedami pomeni, da se odrečejo delu svojih pristojnosti in jih v večji ali manjši meri prenesejo na institucije EU. Področje zdravstvenega varstva je na začetku razvoja Evropske gospodarske skupnosti spadalo povsem v pristojnost držav članic. Rimska pogodba, ki je stopila v veljavo leta 1958, ni vidneje posegala na področje zdravstva.[3] Razvoj Evropske gospodarske skupnosti in kasneje EU je skozi čas na številnih področjih dodobra zabrisal meje med pravnim redom držav članic in pravom EU. To se odraža tudi na področju zdravstvenega varstva. Zdravstveno varstvo je postajalo vse pomembnejši interes EU, kar je dobro razvidno iz erozije pristojnosti držav članic na tem področju.[4] Glavno vlogo pri tem imajo reforme ustanovitvenih pogodb, sekundarni pravni viri, razvoj interpretacije temeljnih načel in progresivna vloga Sodišča EU.[5] Tudi pri organiziranju sistema financiranja zdravstvenega varstva, države članice niso povsem avtonomne. Njihova avtonomija je v največji meri odvisna od načina organizacije sistema financiranja in njegove pravne ureditve. Države članice pogosto uvajajo različne regulatorne ukrepe, s katerimi varujejo javni interes na področju financiranja in izvajanja sistema zdravstvenega varstva. Ti ukrepi pogosto prestopijo prag avtonomnosti, ki jim ga dopušča evropska zakonodaja, kar pa je z vidika EU nedopustno.[6]

1 Preostali javni viri so proračunska sredstva države in občin.

2 Preostali zasebni viri so neposredna plačila prebivalstva za zdravstvene storitve (okoli 45 % zasebnih sredstev) ter donacije raznih dobrodelnih ustanov in drugih donatorjev.

3 Zdravstvo in zdravje, predvsem glede njegove zaščite, so omenjali zgolj trije členi: 36, 48(3) in 56(1).

4 Van de Gronden (2013, str. 128) piše o evropeizaciji na področju zagotavljanja in organiziranja socialnih storitev v splošnem interesu. Izraz evropeizacija uporablja tudi Szyszczak (2013, str. 321), s katerim pojasnjuje nastanek mreže uveljavljenih in novih akterjev, ki ustvarjajo koncept socialnih storitev splošnega pomena, ter nove pristojnosti Evropske komisije v obliki nezavezujoče zakonodaje in »mehkega« upravljanja (angl. *soft governance*).

5 Za podrobnejšo razpravo o razvoju vpliva pravnega reda EU na socialne storitve od začetka integracij do Lizbonske pogodbe glej Damjanovic & de Witte (2009).

6 Slovensko dopolnilno zdravstveno zavarovanje se je že znašlo pred Sodiščem EU. Evropska komisija je v tožbi Sloveniji očitala neizpolnitev obveznosti iz člena 8(3) Prve direktive o neživljenjskem zavarovanju ter iz členov 29 in 39 Tretje direktive o neživljenjskem zavarovanju ter tudi iz členov 56 in 63 PDEU (Sodba SEU C-185/11 z dne 26. januarja 2012, odst. 19). Glede očitka v zvezi s kršitvijo člena 8(3) Prve direktive o neživljenjskem zavarovanju ter 29. in 39. člena Tretje direktive o neživljenjskem zavarovanju je Sodišče EU ugotovilo, da Republika Slovenija z nepravilno in nepopolno implementacijo Prve in Tretje direktive o neživljenjskem zavarovanju ni izpolnila obveznosti iz člena 8(3) Prve direktive o neživljenjskem zavarovanju ter iz členov 29 in 39 Tretje direktive o neživljenjskem zavarovanju (Sodba SEU C-185/11 z dne 26. januarja 2012, odst. 27). Očitek v zvezi s kršitvijo členov 56 in 63 PDEU je Sodišče EU zavrglo na podlagi ugotovitev, da v obravnavani zadevi ni koherentnosti med povzetkom očitka, da Republika Slovenija krši člena 56 in 63 PDEU, ter tožbenim predlogom, v okviru katerega Evropska komisija Sloveniji očita nepravilen in nepopoln prenos Prve in Tretje direktive o neživljenjskem zavarovanju (Sodba SEU C-185/11 z dne 26. januarja 2012, odst. 30). Sodišče je tožbeni zahtevek zavrglo kot nedopusten, kar pomeni, da o zadevi ni odločalo meritorno.

Na pravno ureditev zdravstvenega varstva, kamor spada tudi sistem financiranja zdravstvenega varstva, ima v smislu pravnega reda EU izredno velik vpliv koncept *storitve splošnega pomena* (angl. *Service of General Interest – SGI*). Opredelitev posameznih segmentov zdravstvenega varstva v kontekstu storitve splošnega pomena pod določenimi pogoji izključuje domet pravil notranjega trga in konkurenčne zakonodaje EU (*negospodarske storitve splošnega pomena*) oziroma upravičuje regulatorne posege držav članic, ki niso skladni s pravili o delovanju notranjega trga in konkurenčno zakonodajo EU (*storitve splošnega gospodarskega pomena*). Cilj prispevka je opredelitev slovenskega dopolnilnega zdravstvenega zavarovanja kot storitev splošnega gospodarskega pomena, ki državam članicam širi meje avtonomnega urejanja oziroma omogoča sprejem regulatornih ukrepov, ki niso skladni s pravili o delovanju notranjega trga in konkurenčno zakonodajo EU. Takšna opredelitev nacionalnemu zakonodajalcu omogoča sprejem regulatornih ukrepov v javnem interesu, ki krepijo socialno dimenzijo na področju financiranja zdravstvenega varstva.

2 Koncept storitve splošnega pomena

2.1 Storitve splošnega pomena

Storitve splošnega pomena oziroma javne službe, kot jih tudi imenujemo, so pravni koncept, ki zajema vrsto različnih dejavnosti. Mednje uvrščamo obsežne mrežne gospodarske panoge, kot so energetika, telekomunikacije, promet, avdiovizualne in poštne storitve, izobraževanje, oskrbo z vodo, ravnanje z odpadki ter ne nazadnje tudi zdravstvene in socialne storitve. Te storitve imajo pomembno vlogo pri zagotavljanju socialne, ekonomske in ozemeljske kohezije celotne EU ter so bistvene za njen trajnostni razvoj glede višje stopnje zaposlenosti, socialne vključenosti, ekonomske rasti in kakovosti okolja (Evropska komisija, 2007, str. 3). Storitve splošnega pomena lahko nadalje opredelimo kot storitve gospodarske narave – storitve splošnega gospodarskega pomena in kot storitve negospodarske narave – negospodarske storitve splošnega pomena.

2.2 Negospodarske storitve splošnega pomena

Med negospodarske storitve splošnega pomena (negospodarske javne službe) uvrščamo naslednje dejavnosti: davčni sistem, policijo, sodstvo, sisteme socialne varnosti ipd. Za te dejavnosti velja, da spadajo v izključno pristojnost držav članic, kar v smislu pravnega reda EU pomeni, da niso predmet konkurenčne zakonodaje EU in pravil, ki urejajo delovanje notranjega trga (Evropska komisija, 2007, 4; 2. člen Protokola št. 26 o storitvah splošnega pomena, ki je dodan Lizbonski pogodbi (2007/C 306/01)). Obseg dejavnosti, ki so opredeljene kot negospodarske storitve splošnega pomena, se v pravnem

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Glede na zapisano lahko Evropska komisija ponovno vloži tožbo zoper Slovenijo in ob ustrezni dopolnitvi tožbenega zahtevka doseže meritorno obravnavo zadeve.

redu EU skozi čas vztrajno krči, kar hkrati zmanjšuje avtonomijo držav članic na tem področju. Pri tem igra poglavitno vlogo Evropska komisija, ki z »mehkim pristopom« (nezavezujočimi pravnimi akti) širi domet evropske zakonodaje (Neergard, 2013, 209).

2.3 Storitve splošnega gospodarskega pomena

Koncept storitve splošnega gospodarskega pomena se nanaša na tržne storitve, za katere države članice zaradi splošnega pomena določijo posebne obveznosti zagotavljanja javnih storitev. Mednje uvrščamo dejavnosti, ki jih zagotavljajo velike mrežne gospodarske panoge (telekomunikacije, poštne storitve, elektrika, plin, promet itd.) in druge storitve splošnega gospodarskega pomena (upravljanje z odpadki, oskrba s pitno vodo, RTV itd.) (Pečarič in Bugarič, 2011, 166). Storitve splošnega gospodarskega pomena obravnavajo domala vsi segmenti pravnega reda EU. Njihovo opredelitev zasledimo v primarni zakonodaji, natančneje v Pogodbi o delovanju Evropske unije (v nadaljevanju PDEU) in Protokolu št. 26 o storitvah splošnega pomena, ki je priložen Lizbonski pogodbi. PDEU v členu 106(2) navaja, da morajo podjetja, pooblaščena za opravljanje storitev splošnega gospodarskega pomena, oziroma podjetja, ki imajo značaj dohodkovnega monopola, ravnati po pravilih o delovanju notranjega trga in konkurenčni zakonodaji EU. Vendar pa ta člen določa tudi izjeme od tega pravila v primeru, če bi uporaba pravil o delovanju notranjega trga in konkurenci pravno ali dejansko ovirala izvajanje nalog, ki so takim podjetjem dodeljene. Ta izjema se uporabi le, kadar ni vpliva na razvoj trgovine v obsegu, ki bi bil v nasprotju z interesi EU (Evropska komisija, 2011, 3. odstavek).

Poleg primarne zakonodaje urejajo storitve splošnega gospodarskega pomena tudi sekundarni pravni viri. Najpomembnejši med njimi je *Direktiva o storitvah na notranjem trgu*.[7] Večina sekundarnih pravnih virov s področja storitev splošnega gospodarskega pomena je odraz liberalizacijske politike EU, ki je potekala po tako imenovanem sektorskem pristopu, v sklopu katerega je Evropska komisija z različnimi sekundarnimi zakonodajnimi akti uredila posebnosti izvajanja posameznih storitev splošnega gospodarskega pomena (področje energetike, telekomunikacij, transporta in drugih, na omrežje vezanih gospodarskih dejavnosti) (Brezovnik, 2008, 40).[8]

7 Direktiva 2006/123/ES Evropskega parlamenta in Sveta z dne 12. decembra 2006 o storitvah na notranjem trgu (Uradni list L 376/37, 27. 12. 2006).

8 Direktiva 96/92/ES Evropskega parlamenta in Sveta z dne 19. 6. 1996 o skupnih pravilih notranjega trga z električno energijo (Uradni list L 027, 30. 1. 1997); Direktiva 97/67/ES Evropskega parlamenta in Sveta z dne 15. decembra 1997 o skupnih pravilih za razvoj notranjega trga poštnih storitev v Skupnosti in za izboljšanje kakovosti storitve (Uradni list L 15, 21. 1. 1998); Direktiva 2002/22/ES Evropskega parlamenta in Sveta z dne 7. marca 2002 o univerzalnih storitvah in pravicah uporabnikov v zvezi z elektronskimi komunikacijskimi omrežji in storitvami (Direktiva o univerzalni storitvi) (Uradni list EU L 108, 24. 4. 2002); Direktiva 97/33/ES Evropskega parlamenta in Sveta z dne 30. junija 1997 o medomrežnem povezovanju v telekomunikacijah glede zagotavljanja univerzalnih storitev in interoperabilnosti z uporabo načel zagotavljanja odprtosti omrežij (Uradni list EU L 199, 26. 7. 1997) itd.

Poleg primarne in sekundarne zakonodaje lahko zasledimo tudi druge oblike zavezujočih in nezavezujočih pravnih aktov, s katerimi institucije in drugi organi EU posegajo na področje storitev splošnega gospodarskega pomena.[9]

Kljub obsežni literaturi, ki obravnava storitve splošnega gospodarskega pomena, in velikemu prizadevanju vseh treh vej oblasti EU za njihovo natančno opredelitev , kar se odraža na številnih aktih s tega področja, še zmeraj ni bila izoblikovana povsem jasna pravna definicija tega koncepta.

2.4 Socialne storitve splošnega pomena

Za področje zdravstvenega varstva je pomemben tudi koncept *socialnih storitev splošnega pomena* (angl. *social service of general interest – SSGI*).[10] Tako primarna kot sekundarna zakonodaja tega pojma ne opredeljujeta. Gre za novejši koncept v družini storitev splošnega pomena, ki ga v zavezujočih pravnih aktih EU ne zasledimo. V politični agendi EU se prvič pojavi v Poročilu Evropske komisije o zasedanju Evropskega sveta v Laeknu – Storitve splošnega pomena iz leta 2001. V pravnem kontekstu pa ga prvič zasledimo v nezavezujočem sporočilu Evropske komisije z naslovom *Izvajanje programa Skupnosti iz Lizbone: Socialne storitve splošnega pomena v Evropski uniji*,[11] ki poleg storitev zdravstvenega varstva v ožjem smislu[12] opredeljuje tudi dve veliki skupini socialnih storitev, kamor uvrščamo obvezna in dopolnilna zdravstvena zavarovanja.[13]

Sporočilo nadalje pojasnjuje, da socialne storitve splošnega pomena v pravu EU ne predstavljajo samostojne pravne kategorije.[14] Socialne storitve splošnega pomena v pravnem smislu uvrščamo, odvisno od njihove narave dejavnosti, med storitve splošnega gospodarskega pomena ali pa med negospodarske storitve splošnega pomena. Samo dejstvo, da je dejavnost označena kot socialna dejavnost, še ne pomeni, da je hkrati ni mogoče označiti kot gospodarsko dejavnost. Socialne storitve splošnega pomena, ki imajo gospodarsko naravo, uvrščamo med storitve splošnega gospodarskega pomena (Evropska komisija, 2010, str. 17). Zanje velja, da mora biti zagotovljena

9 Za ponazoritev navajamo le nekaj primerov: Komisija EU: Zelena knjiga o storitvah splošnega pomena, Bruselj, 21. 5. 2003, COM(2003) 270 končno; Sporočilo Komisije: Bela knjiga o storitvah splošnega pomena, Bruselj, 12. 5. 2004, COM (2004) 374 končno; Resolucija Evropskega parlamenta z dne 5. julija 2011 o prihodnosti socialnih storitev splošnega pomena (2009/2222(INI)); Resolucija Evropskega parlamenta z dne 14. marca 2007 o socialnih storitvah splošnega pomena v Evropski uniji (2006/2134(INI)); Primeri: zadeva C-393/92, Almelo, [1993], zadeva C-320/91, Corbeau, [1993], zadeva C-340/99, TNT Traco, [2001], zadeva C-393/92, Almelo, [1993], zadeva C-475/99, Ambulanz Glöckner, [2001], zadeva C-41/90, Höfner and Elser, [1991], zadeva C-266/96, Corsica Ferries, [1998]…

10 Za razvoj in boljše razumevanje ter razlikovanje vseh konceptov splošnega pomena glej Neergaard (2013).

11 Sporočilo Komisije: Izvajanje programa Skupnosti iz Lizbone: Socialne storitve splošnega pomena v Evropski uniji (COM(2006) 177, z dne 26. 4. 2006).

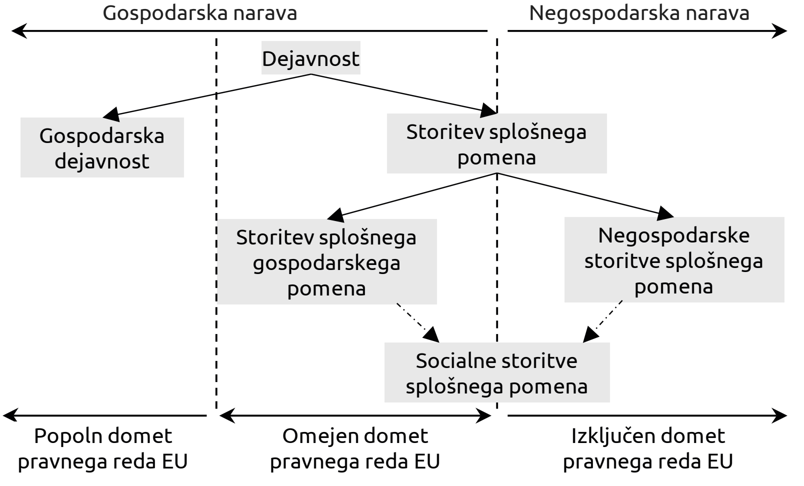
12 Te niso zajete s tem Sporočilom Komisije.

13 Natančneje v prvo skupino: »zakonsko določene in komplementarne oziroma dopolnilne sisteme socialne varnosti v različnih organizacijskih oblikah (vzajemni ali poklicni), ki zajemajo temeljna življenjska tveganja, povezana z zdravjem, starostjo, nesrečami pri delu, brezposelnostjo, upokojitvijo in invalidnostjo«.

14 Tako meni tudi Szyszczak (2013).

skladnost njihovega načina organizacije in delovanja s pravili notranjega trga in konkurenčno zakonodajo EU.[15]

Slika 1: Domet pravnega reda EU



Vir: prirejeno po Hatzopoulos (2011, str.12).

3 Pristojnosti in pogoji opredeljevanja dejavnosti dopolnilnega zdravstvenega zavarovanja kot storitve splošnega gospodarskega pomena

Storitve splošnega gospodarskega pomena se razlikujejo od običajnih gospodarskih storitev, saj država meni, da jih je treba opravljati tudi v primeru nezadostne tržne spodbude. S tem se ne zanika, da je trg v nekaterih primerih najboljši mehanizem zagotavljanja teh storitev, temveč državam zgolj dopušča, da v primeru, če menijo, da so nekatere storitve v splošnem interesu in jih tržne sile ne zmorejo uspešno zadovoljiti, poskrbijo za zagotovitev teh storitev pod posebnimi pogoji v obliki obveznosti zagotavljanja storitve splošnega pomena (Evropska komisije, 2001, točka 14).

Prvi pogoj za opredelitev dejavnosti kot storitve splošnega gospodarskega pomena je, da ima dejavnost gospodarsko naravo. Drugi pogoj za opredelitev zahteva, da se z dejavnostjo zagotavljajo za družbo eksistenčno pomembne storitve (dobrine), zato družba upošteva, da je preskrba s temi storitvami (dobrinami) v javnem interesu in jih podvrže posebnemu pravnemu režimu.

Pri opredeljevanju dejavnosti kot storitve splošnega gospodarskega pomena z vidika evropske zakonodaje je pomembno vprašanje distribucije kompetenc med državami članicami in EU. Države članice imajo pri opredeljevanju

15 Neergardova (2013, str. 207–210) ponazarja razmerje med storitvami splošnega pomena, storitvami splošnega gospodarskega pomena (oziroma negospodarskimi storitvami splošnega pomena) in socialnimi storitvami splošnega pomena s sorodstvenim razmerjem med staro mamo, mamo in vnukinjo.

storitve splošnega gospodarskega pomena široko diskrecijo, kar podpirajo tako primarna in sekundarna zakonodaja EU kot tudi sodna praksa Sodišča EU. V pravnem redu EU ne zasledimo natančne opredelitve pojma storitev splošnega gospodarskega pomena, niti pogojev, ki morajo biti izpolnjeni, da bi se lahko država članica sklicevala na obstoj in varstvo posebnega pravnega režima storitve splošnega gospodarskega pomena.[16] Evropski zakonodaja tudi ne podeljuje EU posebnih pristojnosti glede storitev splošnega gospodarskega pomena. Na podlagi teh argumentov je Sodišče EU v primeru BUPA zavzelo stališče, da je opredelitev dejavnosti kot storitve splošnega gospodarskega pomena v pristojnosti držav članic.[17] Na področju storitev splošnega gospodarskega pomena, ki imajo naravo socialnih oziroma zdravstvenih storitev, je takšno stališče še toliko močnejše, saj imajo države članice na tem področju skoraj izključno pristojnost.[18] Države članice so na podlagi člena 168(7) PDEU odgovorne za opredelitev zdravstvene politike ter organiziranje in zagotavljanje zdravstvenih storitev in zdravstvene oskrbe. Iz tega sledi, da so tudi za opredelitev obveznosti storitve splošnega gospodarskega pomena v tem okviru najprej pristojne države članice. Enako opredelitev pristojnosti na splošni ravni izraža tudi člen 14 PDEU, v skladu s katerim ob upoštevanju položaja, ki ga imajo storitve splošnega gospodarskega pomena v okviru skupnih vrednot in vloge, ki jo imajo pri pospeševanju socialne in teritorialne kohezije v EU, EU in države članice v mejah svojih pristojnosti skrbijo, da takšne službe delujejo na podlagi načel in pogojev, ki jim omogočajo izpolnjevanje njihovih nalog.[19] Sodišče EU je v zadevah FFSA proti Komisiji [C-174/97, 100], Olsen proti Komisiji [T-17/02, 216] in BUPA [T-289/03, 169] zavzelo stališče, da je pristojnost EU pri opredeljevanju storitev splošnega gospodarskega pomena zelo omejena in se nanaša zgolj na iskanje očitnih napak pri presoji držav članic.[20]

Kljub široki diskreciji držav članic morajo biti te pri tem vseeno pazljive, da dejavnost v okoliščinah danega primera izpolnjuje v sodni praksi Sodišča EU opredeljena najnižja merila, skupna vsaki storitvi splošnega gospodarskega pomena. Ta merila od držav članic terjajo, da pri opredeljevanju dokažejo (i) gospodarsko naravo zadevne dejavnosti, (ii) da se dejavnost izvaja

16 Zadeva BUPA [T-289/03, 165].

17 Široko diskrecijsko pravico držav članic pri opredeljevanju je Sodišče EU potrdilo tudi v zadevi FFSA in drugi proti Komisiji [T 106/95, 99]. Takšno stališče zasledimo tudi v Direktivi o storitvah 1(3) in številnih dokumentih Evropske komisije: Sporočilo Komisije o uporabi pravil Evropske unije o državni pomoči za nadomestilo, dodeljeno za opravljanje storitev splošnega gospodarskega pomena, 2012/C 8/02, točka 46; Sporočilo Komisije: Storitve splošnega pomena v Evropi (96/C281/03), OJ C 281/3, sekcija 26; Sporočilo Komisije: Bela knjiga o storitvah splošnega pomena, Bruselj, 12. 5. 2004, COM (2004) 374 končno, str. 5–6; Zelena knjiga o storitvah splošnega pomena, COM(2003) 270, sekcija 30–32, itd.

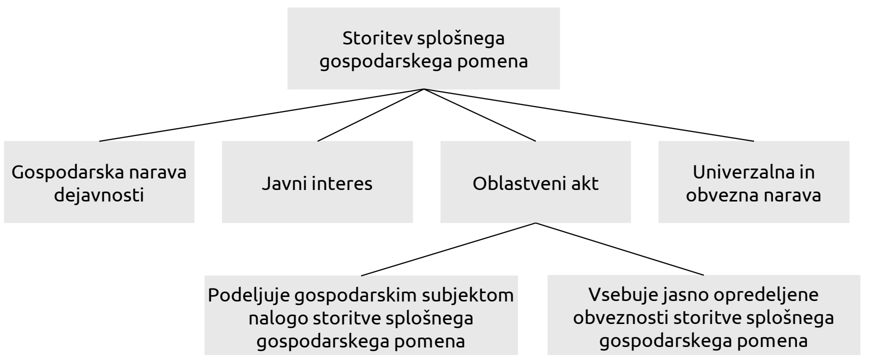
18 Glej člene 2(5), 6, 153 in168(1), (7) PDEU.

19 Zadeva BUPA [T-289/03, 167].

20 Takšno stališče je zavzela tudi Evropska komisija v Sporočilu Komisije o uporabi pravil Evropske unije o državni pomoči za nadomestilo, dodeljeno za opravljanje storitev splošnega gospodarskega pomena, 2012/C 8/02, točka 46.

v javnem interesu,[21] (iii) obstoj oblastvenega akta, s katerim je zadevnemu gospodarskemu subjektu podeljena naloga storitve splošnega gospodarskega pomena (oblastveni akt mora vsebovati jasno opredelitev obveznosti storitve splošnega gospodarskega pomena) ter (iv) univerzalno in obvezno naravo podeljene naloge. Če država tega ne stori, lahko to pomeni očitno napako, ki jo Evropska komisija mora sankcionirati. V nadaljevanju razčlenjujemo merila za opredeljevanje storitve splošnega gospodarskega pomena in v tej luči presojamo slovensko dopolnilno zdravstveno zavarovanje.

Slika 2: Merila za opredelitev dejavnosti kot storitve splošnega gospodarskega pomena



Vir: lasten.

4 Ali slovensko dopolnilno zdravstveno zavarovanje izpolnjuje merila za opredelitev dejavnosti kot storitve splošnega gospodarskega pomena

Če želimo opredeliti slovensko dopolnilno zdravstveno zavarovanje kot storitev splošnega gospodarskega pomena, moramo dokazati, da zavarovanje izpolnjuje merila iz slike 2.

a) Gospodarska narava dejavnosti

Iz ustaljene sodne prakse Sodišča EU izhaja, da ima dejavnost gospodarsko naravo, če izpolnjuje dva kriterija: v okviru te dejavnosti se na trgu ponujajo izdelki ali storitve[22] in finančno tveganje pri opravljanju dejavnosti nosi subjekt, ki to dejavnost opravlja (ponuja na trgu izdelke ali storitve).[23] To ne pomeni,

21 Država ima dolžnost navesti razloge, zaradi katerih meni, da je treba zadevno storitev zaradi njenega posebnega pomena opredeliti kot storitev splošnega gospodarskega pomena in jo tako ločiti od drugih gospodarskih dejavnosti. Glej Zadevo BUPA [T-289/03, 172] in zadevo Merci Convenzionali Porto di Genova [C-179/90, 27].

22 Zadeva Cisal in INAIL [C 218/00, 23].
Nakup dobrin ali storitev na trgu ne opredeljuje (gospodarske) narave te dejavnosti per se. Za namen presoje narave dejavnosti je treba upoštevati tudi poznejšo uporabo kupljenega proizvoda, saj gospodarska ali negospodarska narava poznejše uporabe proizvoda opredeljuje tudi naravo dejavnosti nakupa (FENIN [C-205/03, 26]).

23 Zadeva Wouters C-309/99, 48-49].

da mora subjekt opravljati dejavnost na dobičkonosen način,[24] temveč zadostuje že to, da jo lahko vsaj načeloma izvaja na takšen način (Hatzopoulos, 2011, str. 18–19).[25] Slovenski sistem dopolnilnega zdravstvenega zavarovanja je dejavnost, ki jo izvajajo zdravstvene zavarovalnice po tržnih zakonitostih in s pridobitnim namenom. Dejavnost izpolnjuje oba kriterija, saj zdravstvene zavarovalnice ponujajo dopolnilno zdravstveno zavarovanje na trgu in hkrati nosijo finančno tveganje pri opravljanju te dejavnosti. Glede na oba izpolnjena kriterija lahko nedvomno potrdimo gospodarsko naravo dopolnilnega zdravstvenega zavarovanja.

b) Splošni pomen oziroma javni interes

Za opredelitev dejavnosti kot storitve splošnega gospodarskega pomena je treba dokazati, da je ponudba oziroma opravljanje storitve v splošnem oziroma javnem interesu. Zakonodajalec je v členu 62 Zakona o zdravstvenem varstvu in zdravstvenem zavarovanju (v nadaljevanju ZZVZZ)[26] opredelil, da pomeni dopolnilno zdravstveno zavarovanje javni interes Republike Slovenije, saj skupaj z obveznim zdravstvenim zavarovanjem tvori sistem socialne varnosti. Samo dejstvo, da nacionalni zakonodajalec v splošnem interesu v širšem smislu določi poseben pravni režim izvajanja določene dejavnosti, načeloma ni bistveno za obstoj storitve splošnega gospodarskega pomena.[27] Treba je tudi dejansko dokazati, da je izvajanje dejavnosti v javnem interesu.

Dopolnilno zdravstveno zavarovanje ni le sestavni del sistema socialne varnosti, temveč njegov neločljiv in bistven element ter kot tak uresničuje identične cilje kot obvezno zdravstveno zavarovanje – finančna varnost prebivalstva pred visokimi zdravstvenimi izdatki ter primeren in pravičen dostop do učinkovite in kakovostne zdravstvene oskrbe. Brez vključitve v dopolnilno zdravstveno zavarovanje se zdita finančna varnost pred visokimi zdravstvenimi izdatki ter primeren dostop do učinkovite in kakovostne zdravstvene oskrbe, nedosegljiva ideala. Javni interes dopolnilnega zdravstvenega zavarovanja potrjuje tudi njegova močna socialna funkcija, ki se odraža s pomočjo naslednjih argumentov:

(i) dopolnilno zdravstveno zavarovanje je pomemben in nepogrešljiv vir financiranja sistema zdravstvenega varstva;
(ii) visoka pokritost prebivalstva z dopolnilnim zdravstvenim zavarovanjem;
(iii) namen ustanovitve in narava dopolnilnega zdravstvenega zavarovanja.

24 Zadeva FFSA [C-244/94, 21].
25 Zadeva SAT Fluggesellschaft mbH v. Eurocontrol [C-364/92, 9]. Za več o razlagi drugega kriterija, ki je izredno široka (ne zahteva se dejanska konkurenca, temveč zadostuje že domnevna konkurenca), glej Sauter W. in Schapel H.: State and Market in EU Law: The Public and Private Spheres of the Internal Market before the EU Courts (Cambridge: CUP, 2009), stran 82.
26 Zakon o zdravstvenem varstvu in zdravstvenem zavarovanju (ZZVZZ), Uradni list RS, št. 9/1992.
27 Glej zadevo BUPA [T-289/03, 178].

i) Dopolnilno zdravstveno zavarovanje kot pomemben in nepogrešljiv vir financiranja zdravstvenega varstva

Zasebna sredstva pri financiranju zdravstvenega varstva so v leta 2011 znašala 841.743.000 evrov, kar znaša 26,3 % vseh izdatkov za zdravstveno varstvo. Sredstva iz prostovoljnih zdravstvenih zavarovanj so v istem letu znašala okoli 422.000.000 evrov, kar je nekaj več kot 50 % vseh zasebnih sredstev (ZZZS, 2013, 144). Levji delež teh sredstev predstavljajo sredstva dopolnilnega zdravstvenega zavarovanja, ki so leta 2010 znašala okoli 400.000.000 evrov, to je krepko čez 90 % vseh sredstev prostovoljnih zdravstvenih zavarovanj (Šik, 2011, str. 41).[28] Tako velik delež prostovoljnih oziroma dopolnilnih zdravstvenih zavarovanj v financiranju zdravstvenega varstva najdemo v EU le še v Franciji. Poleg znatnega deleža sredstev (okoli 13 % vseh izdatkov za zdravstveno varstvo), ki kaže na izredno pomembno vlogo dopolnilnega zdravstvenega zavarovanja v sistemu zdravstvenega varstva, nosi to zavarovanje tudi breme kritja stroškov medicinske inflacije in neučinkovitosti javnega financiranja zdravstvenega varstva.

Na prevalitev bremena medicinske inflacije na dopolnilno zdravstveno zavarovanje kaže dejstvo, da se skupna prispevna stopnja obveznega zdravstvenega zavarovanja ni spremenila vse od leta 2002. Medicinska inflacija je praviloma nad stopnjo splošne inflacije, ki je v obdobju od januarja 2003 do marca 2014 znašala 34,2 %. Na kritje bremena medicinske inflacije nakazuje tudi poslovanje zdravstvenih zavarovalnic, ki izvajajo dopolnilno zdravstveno zavarovanje.[29] Triglav je v obdobju 2007–2014 dvignil premije dopolnilnega zdravstvenega zavarovanja iz 20,61 evra na 29,42 evra, kar pomeni 42,7-odstotno povišanje. Adriatic Slovenica je v obdobju 2006–2014 dvignila premije iz 20,71 evra na 29,38 evra, kar pomeni 41,8-odstotno povišanje.[30] Čeprav v Sloveniji podatki o medicinski inflaciji za to obdobje niso dostopni, se dvigi premij ujemajo oziroma, tako kot je pričakovati, presegajo stopnjo splošne inflacije. Obe zdravstveni zavarovalnici sta po večini opravičevali postopno dvigovanje premij z rastjo stroškov zdravstvenih storitev in spreminjanjem deležev kritja pravic iz obveznega zdravstvenega zavarovanja. Prevalitev stroškov medicinske inflacije povečuje pomen dopolnilnega zdravstvenega zavarovanja in skladno s tem uresničevanje socialnega cilja, saj na ta način država ohranja obstojnost financiranja obveznega zdravstvenega zavarovanja ter dostopnost in kakovost zdravstvenih storitev, ki so del obveznega zdravstvenega zavarovanja.

Gospodarska kriza in recesija, ki je krizi sledila, sta prinesli vidne spremembe na področju financiranja zdravstvenega varstva. Zakonodajalec in Zavod

28 V tem letu so iz naslova dopolnilnega zdravstvenega zavarovanja obračunali skoraj 370.000.000 evrov odhodkov za škodne dogodke. Za več o visokem škodnem količniku dopolnilnega zavarovanja, ki je znašal leta 2006 kar 88 %, glej Milenkovič Kramer (2009).

29 Ne moremo trditi, da je dopolnilno zdravstveno zavarovanje nosilo celotno breme medicinske inflacije, saj sta se na ta račun povečevala tudi luknja v zdravstveni blagajni in obseg sredstev neposrednih plačil uporabnikov zdravstvenih storitev.

30 Splošna inflacija je v obdobju 2006–2014 znašala 20,4 %.

za zdravstveno zavarovanje Slovenije (v nadaljevanju ZZZS) kot nosilec obveznega zdravstvenega zavarovanja sta pri reševanju finančnih težav zdravstvene blagajne posegla po kratkoročni strategiji, ki ne odpravlja strukturnih pomanjkljivosti, temveč zgolj blaži bolezenske znake in hkrati poglablja razsežnost pomanjkljivosti. Varčevalni ukrepi, ki so odraz prezadolženosti države in zdravstvene blagajne, ter prenos finančnega bremena iz javnih virov financiranja na zasebne predstavljajo osrednji del strategije, katere cilj je zagotavljanje finančne vzdržnosti sistema zdravstvenega varstva. Prenos finančnega bremena prezadolžene zdravstvene blagajne na zasebne vire financiranja oziroma v največji meri na dopolnilno zdravstveno zavarovanje je posledica znižanja odstotnega deleža plačil zdravstvenih storitev, ki je krit iz naslova obveznega zdravstvenega zavarovanja (zviševanje doplačil).[31] Na ta način je država kratkoročno prenesla del finančnega bremena in družbene odgovornosti na zdravstvene zavarovalnice, ki pa so s hitrim odzivom in dvigom zavarovalnih premij breme nadalje prevalile na prebivalstvo.[32] Država s povečevanjem odstotnega deleža kritja zdravstvenih storitev iz naslova dopolnilnega zdravstvenega zavarovanja dodatno povečuje njegovo vlogo in pomen v sistemu zdravstvenega varstva.

ii) Visoka pokritost prebivalstva z dopolnilnim zdravstvenim zavarovanjem

Konec leta 2012 je bilo v obvezno zdravstveno zavarovanje vključenih 2.076.273 zavarovanih oseb, od tega 1.536.876 zavarovancev in 539.397 družinskih članov (ZZZS, 2013, str. 18).[33] Dopolnilno zdravstveno zavarovanje je imelo leta 2012 v povprečju sklenjenih 1.431.951 zavarovancev (Gracar, 2014, str. 14). Ker se nekaterim posameznikom ni treba vključiti v dopolnilno zdravstveno zavarovanje, saj imajo doplačila zdravstvenih storitev krita iz drugih naslovov (državnega proračuna,[34] obveznega zdravstvenega zavarovanja[35]), je pokritost z dopolnilnim zdravstvenim

31 Za več o spremembah zakonodaje in ukrepih, ki jih je ZZZS sprejel na podlagi zakonodajnih sprememb; glej ZZZS (2012, str. 20–21).

32 Odličen primer takšne prakse je sprejem Zakona o uravnoteženju javnih financ (ZUJF) (Uradni list RS, št. 40/12). Zaradi zniževanja deleža kritja zdravstvenih storitev iz obveznega zdravstvenega zavarovanja, ki je bilo posledica sprejetja tega zakona, se je mesečna premija s 1. 7. 2012 pri vseh treh zdravstvenih zavarovalnicah dvignila za 15–20 %.

33 Po podatkih SURS je imela Slovenija 1. oktobra 2012 2.058.123 prebivalcev. To potrjuje skoraj popolno pokritost prebivalstva z obveznim zdravstvenim zavarovanjem.

34 Iz tega naslova imajo krita doplačila (24. in 25. ZZVZZ):
- priporniki, ki niso zavarovanci iz drugega naslova, obsojenci na prestajanju kazni zapora in mladoletniškega zapora, mladoletniki na prestajanju vzgojnega ukrepa oddaje v prevzgojni dom, osebe, ki jim je bil izrečen varnostni ukrep obveznega psihiatričnega zdravljenja in varstva v zdravstvenem zavodu ter obveznega zdravljenja odvisnosti od alkohola in drog;
- zavarovanci in po njih zavarovani družinski člani, ki nimajo zagotovljenega plačila zdravstvenih storitev v celoti iz obveznega zdravstvenega zavarovanja, če izpolnjujejo pogoje za pridobitev denarne socialne pomoči, kar ugotavlja center za socialno delo;
- vojni invalidi;
- vojni veterani;
- žrtve vojnega nasilja.

35 Iz tega naslova imajo krita doplačila:
- otroci, učenci in študenti, ki se redno šolajo (posamezniki do dopolnjenega osemnajstega leta starosti oziroma v primeru rednega šolanja do šestindvajsetega leta starosti);
- otroci in mladostniki z motnjami v telesnem in duševnem razvoju;

zavarovanjem ogromna. O tem priča tudi majhna razlika med obveznim in dopolnilnim zdravstvenim zavarovanjem (približno 105.000 oseb). Oktobra 2012 je po podatkih SURS in Ministrstva za delo, družino, socialne zadeve in enake možnosti v Sloveniji prebivalo 363.442 oseb, mlajših od osemnajst let, in 45.734 prejemnikov socialne pomoči. Seštevek mladoletnih oseb in prejemnikov socialne pomoči, ki mu prištejemo zavarovance, ki imajo sklenjeno dopolnilno zavarovanje, znaša več kot 1.800.000 oseb. Če temu prištejemo še dijake in študente, stare med osemnajst in šestindvajset let, ki se redno šolajo,[36] ter druge skupine prebivalstva, ki jim krije doplačila državni proračun, se močno približamo pokritosti z obveznim zdravstvenim zavarovanjem. S tem dokazujemo, da je v dopolnilno zdravstveno zavarovanje vključeno skoraj celotno prebivalstvo Slovenije. Izjemno velika pokritost z dopolnilnim zdravstvenim zavarovanjem je značilna za vse države, ki imajo dopolnilno zdravstveno zavarovanje za doplačila uporabnikov (Francija, Belgija, Luksemburg) (Mossialos & Thomson, 2009, str. 27). Tako velika pokritost dodatno potrjuje pomembno vlogo dopolnilnega zdravstvenega zavarovanja v sistemu socialne varnosti in hkrati dokazuje njegovo močno socialno funkcijo.

iii) Namen ustanovitve in narava dopolnilnega zdravstvenega zavarovanja

Namen ustanovitve in narava dopolnilnega zdravstvenega zavarovanja sta prežeta z močno socialno konotacijo. Sistem financiranja zdravstvenega varstva temelji na obveznem zdravstvenem zavarovanju, ki pa ne krije vseh zdravstvenih storitev, temveč zgolj tiste, ki so določene z zakonom.[37] Tudi delež kritja obveznega zdravstvenega zavarovanja se razlikuje glede na skupino, v katero je razvrščena posamezna storitev. V celotni vrednosti krije le peščico zdravstvenih storitev, pri vseh drugih pa mora razliko do polne vrednosti doplačati zavarovanec neposredno ponudniku storitev. Višina doplačil variira med 10 in 90 % vrednosti zdravstvene storitve. Določena doplačila so zaradi visoke cene zdravstvenih storitev tako visoka, da jih lahko uvrstimo v kategorijo »katastrofalnih« zdravstvenih izdatkov. Po podatkih Vzajemne so zneski nekaterih doplačil v prvi polovici leta 2013 dosegli naslednje vrednosti: najvišje doplačilo za zdravilo iz vmesne liste (90 % vrednosti tega zdravila krije dopolnilno zdravstveno zavarovanje) je znašalo 9.579,11 evrov; povprečno doplačilo za zdraviliško zdravljenje je znašalo 832 evrov, medtem ko je znašalo najdražje kar 4.560 evrov; najvišje enkratno doplačilo za najzahtevnejše bolniške storitve, ki jih je potrebovalo več kot 8.000 zavarovancev (dopolnilno zdravstveno zavarovanje krije 10 % njihove vrednosti), je znašalo 21.560 evrov (Mikeln, 2014).[38] Posledica

- otroci in mladostniki z nezgodno poškodbo glave in okvaro možganov.

36 V študijskem letu 2011/2012 je bilo v Sloveniji v visokošolske študijske programe na univerzah in samostojnih visokošolskih zavodih vpisanih 89.600 študentov (SURS).

37 Glej 23. člen ZZVZZ.

38 Za boljšo predstavo o višini doplačil in finančnem tveganju, ki ga prinašajo, navajamo povprečno mesečno plačo in časovno obdobje, v katerem posameznik za zdravstveno varstvo nameni znesek v višini najvišjega enkratnega doplačila za najzahtevnejše bolniške storitve: posameznik, ki je v delovnem razmerju in prejema povprečno mesečno plačo (povprečna bruto plača je februarja 2014 znašala 1.520,88 evra), bi potreboval dobrih štirinajst let, da

uvedbe doplačil oziroma tako visokih doplačil in velikega finančnega tveganja, ki ga doplačila prinašajo v primeru potrebe po zdravstvenih storitvah, je nastanek trga dopolnilnega zdravstvenega zavarovanja oziroma njegov razcvet. Posamezniki so zaradi izjemno visokih doplačil, z izjemo tistih, ki so nagnjeni k tveganju, prisiljeni skleniti dopolnilno zdravstveno zavarovanje, saj drugače tvegajo nastanek »katastrofalnih« zdravstvenih izdatkov. Iz narave dopolnilnega zdravstvenega zavarovanja in ureditve sistema doplačil izhaja, da dopolnilno zdravstveno zavarovanje nima vloge nadgradnje socialne oziroma zdravstvene varnosti, temveč je njen sestavni in bistveni element. Prav tako težko trdimo, da je vključitev v zavarovanje posledica avtonomne odločitve posameznika, saj višina doplačil skoraj onemogoča posameznikovo svobodno voljo. To potrjuje tudi izjemno visoka pokritost prebivalstva z zavarovanjem.

Glede na močno socialno funkcijo dopolnilnega zdravstvenega zavarovanja ter njegovo vlogo in pomen v sistemu zdravstvenega varstva in socialne varnosti lahko sklepamo, da je izvajanje te dejavnosti v javnem interesu.

c) Oblastveni akt, s katerim je gospodarskim subjektom podeljena naloga storitve splošnega gospodarskega pomena z jasno opredeljenimi obveznostmi te naloge

Podelitev naloge storitve splošnega gospodarskega pomena ne pomeni, da mora gospodarski subjekt nujno pridobiti za njeno izpolnjevanje izključno oziroma posebno pravico. Treba je razlikovati med posebno oziroma izključno pravico, podeljeno gospodarskemu subjektu za izvajanje določene storitve, in nalogo storitve splošnega gospodarskega pomena, ki ji je v okoliščinah posameznega primera lahko pripeta tudi izključna pravica. Izključna pravica služi gospodarskemu subjektu zgolj kot orodje, ki mu omogoča izpolnjevanje naloge storitve splošnega gospodarskega pomena.[39] Za dodelitev naloge splošnega gospodarskega pomena se tako ne zahteva podelitev posebne oziroma izključne pravice, temveč zadostuje že oblastveni akt, s katerim se enemu ali celo vsem gospodarskim subjektom, ki izvajajo določeno storitev, dodeljujejo jasno opredeljene obveznosti.[40] Takšen oblastveni akt predstavlja ZZVZZ, s katerim je bila ustanovljena in opredeljena storitev dopolnilnega zdravstvenega zavarovanja. Gospodarski subjekti morajo izvajati storitve ob spoštovanju posebnih obveznosti, ki so opredeljene v členih 62–62c ZZVZZ (enotno ocenjevanje oziroma enotna premija, odprti pristop in doživljenjsko kritje). Četrta točka prvega odstavka 62.b člena ZZVZZ nadalje opredeljuje predmet oziroma pravice iz dopolnilnega zdravstvenega zavarovanja, ki obsegajo kritje razlike med vrednostjo zdravstvenih storitev v skladu s členom 23 ZZVZZ in deležem te vrednosti, ki ga v skladu z istim členom krije

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bi za zdravstveno varstvo (obvezno in dopolnilno zdravstveno zavarovanje – upoštevali smo višino zavarovalne premije Vzajemne, ki je marca 2014 znašala 27,62 evrov) porabil sredstva v višini 21.560 evrov. V tem izračunu je upoštevan samo prispevek obveznega zdravstvenega zavarovanja, ki bremeni neposredno delavca (6,36 % bruto plače). Če pa pri izračunu upoštevamo tudi prispevek delodajalca, bi se časovno obdobje skrajšalo na slabih osem let.

39 Glej zadevo BUPA [T-289/03, 179].

40 Glej zadevi Almelo [C-393/92, 47] in BUPA [T-289/03, 179].

obvezno zdravstveno zavarovanje, oziroma del te razlike, ko se doplačilo nanaša na pravico do zdravil z najvišjo priznano vrednostjo in medicinskih pripomočkov. Zakonodajalec tako ne določa zgolj obveznosti najosnovnejših storitev, ki bi zagotavljale, da bi storitve spoštovale najnižje standarde, temveč v celoti opredeli predmet dopolnilnega zdravstvenega zavarovanja oziroma zavarovalne proizvode, saj dopolnilno zdravstveno zavarovanje po zakonu ne sme vsebovati dodatnih storitev oziroma pravic.[41] Za ta namen lahko zdravstvena zavarovalnica ustanovi dodatno zdravstveno zavarovanje, ki je ločena kategorija prostovoljnih zdravstvenih zavarovanj. Poleg navedenega je zakonodajalec izvajalcem dopolnilnega zdravstvenega zavarovanja v drugi točki člena 62(1) ZZVZZ naložil, da se morajo vključiti v izravnalno shemo dopolnilnega zavarovanja, s katero se med njimi izravnavajo razlike v stroških zdravstvenih storitev, ki izhajajo iz različnih struktur zavarovancev glede na starost in spol.

Sodišče je v zadevi BUPA odločalo o vprašanju, ali lahko štejemo *Health Insurance Acts*, ki podrobno opredeljujejo obveznosti zasebnega zdravstvenega zavarovanja (enotno ocenjevanje, odprti pristop, doživljenjsko kritje in najosnovnejše storitve, ki jih morajo spoštovati vsi izvajalci zasebnega zdravstvenega zavarovanja) kot oblastveni akt, s katerim je gospodarskim subjektom podeljena naloga storitve splošnega gospodarskega pomena z jasno opredeljenimi obveznostmi te naloge. Sodišče je na to vprašanje odgovorilo pritrdilno.[42] Izhajajoč iz primerjave irske ureditve zasebnega zdravstvenega zavarovanja (*Health Insurance Acts*) in slovenske ureditve dopolnilnega zdravstvenega zavarovanja (ZZVZZ) lahko z gotovostjo trdimo, da tudi slovensko dopolnilno zdravstveno zavarovanje izpolnjuje kriterij oblastvenega akta, s katerim je gospodarskim subjektom podeljena naloga storitve splošnega gospodarskega pomena z jasno opredeljenimi obveznostmi te naloge. Ureditvi v obeh državah se namreč v smislu obveznosti, ki jih nalaga proučevana zakonodaja, skoraj povsem ujemata: enotno ocenjevanje, odprti pristop, doživljenjsko kritje in obseg storitev, ki jih morajo spoštovati vsi izvajalci zasebnega zdravstvenega zavarovanja, pri čemer je slovenska ureditev strožja, saj ne določa zgolj najosnovnejših storitev, temveč celoten obseg storitev oziroma pravic dopolnilnega zdravstvenega zavarovanja. Glede na zapisano lahko sklepamo, da je v primeru slovenskega dopolnilnega zdravstvenega zavarovanja podan oblastveni akt (ZZVZZ), s katerim je gospodarskim subjektom podeljena naloga storitve splošnega gospodarskega pomena z jasno opredeljenimi obveznostmi te naloge.

d) Univerzalna in obvezna narava naloge storitve splošnega gospodarskega pomena

Univerzalna narava storitve ne zahteva, da je storitev univerzalna v ožjem pomenu.[43] Dejstvo, da ima od storitve korist le relativno omejena skupina

41 Irska zakonodaja nalaga gospodarskim subjektom, ki izvajajo zasebna zdravstvena zavarovanja, obveznost najosnovnejših storitev.

42 Glej zadevo BUPA [T-289/03, 174–176 in 182].

43 Značilno za obvezno zdravstveno zavarovanje.

uporabnikov, ne postavlja nujno pod vprašaj univerzalne narave naloge te storitve (v našem primeru dopolnilnega zdravstvenega zavarovanja).[44] Univerzalna narava tudi ne zahteva, da je dopolnilno zdravstveno zavarovanje brezplačno, oziroma ga je treba ponujati ne glede na ekonomsko donosnost. Nevključevanje prebivalstva zaradi nezadostnosti finančnih sredstev oziroma finančne nedostopnosti zavarovalnih premij ne spodkopava njegove univerzalne narave. Za to zadostuje, da se storitev ponuja vsem prebivalcem po enotnih in nediskriminatornih cenah ter pod enakimi pogoji in enake kakovosti. Univerzalna narava prav tako ni v nasprotju s svobodnim določanjem višine zavarovalnih premij izvajalcev dopolnilnega zdravstvenega zavarovanja. V Sloveniji določajo višino zavarovalne premije dopolnilnega zdravstvenega zavarovanja zdravstvene zavarovalnice (tržne sile), kar lahko ob pomanjkanju regulacije vodi v visoke premije. Tveganje visokih premij, ki bi presegale finančne zmožnosti določenih skupin prebivalstva, je zaradi obveznosti enotnega ocenjevanja oziroma enotne cene premije ne glede na starost, spol in zdravstveno stanje zavarovancev ter konkurence med zavarovatelji v praksi zelo omejeno.[45] Kljub omejenemu tveganju so cene zavarovalnih premij v zadnjih letih močno porastle.[46] Predstavniki zdravstvenih zavarovalnic opozarjajo, da se cene nevarno približuje psihološko najvišji sprejemljivi vrednosti, ki naj bi znašala okoli 30 evrov. Porast cene zavarovalnih premij pa ni posledica »nedelovanja« tržnih mehanizmov in obveznosti storitve splošnega gospodarskega pomena, temveč državne politike, ki z namenom razbremenitve javnih sredstev prelaga finančno breme na zasebne vire financiranja.

Obvezna narava dopolnilnega zdravstvenega zavarovanja je prav tako bistveni pogoj za obstoj naloge storitve splošnega gospodarskega pomena. Obvezno naravo je treba razumeti tako, da morajo gospodarski subjekti, ki jim je z oblastvenim aktom zaupana naloga storitve splošnega gospodarskega pomena, to storitev načeloma ponujati na trgu ob spoštovanju posebnih obveznosti storitve splošnega gospodarskega pomena. Gospodarskim subjektom, ki izvajajo storitev dopolnilnega zdravstvenega zavarovanja, ni podeljena posebna oziroma izključna pravica, ki bi jim nalagala izvajanje te storitve ne glede na stroške, povezane z njenim izvajanjem. Kljub temu pa ZZVZZ, ki gospodarskim subjektom poverja izvajanje dejavnosti dopolnilnega zdravstvenega zavarovanja, določa dolžnost, da subjekti ponujajo to storitev vsem, ki zanjo zaprosijo. Sodišče EU je v zadevi BUPA zavzelo stališče, da sta obvezna narava storitve in posledično naloga storitve splošnega gospodarskega pomena podani, če mora ponudnik sklepati pogodbe pod določenimi pogoji, ki mu preprečujejo zavrnitev sopogodbenikov.[47] Za izpolnitev pogoja obvezne narave storitve dopolnilnega zdravstvenega zavarovanja zadostuje že obveznost odprtega pristopa, ki je podana v členu 62.b(1) ZZVZZ. Obvezno

44 Takšno stališče je potrdilo Sodišče EU v zadevi BUPA [T-289/03, 187].

45 Tako je odločilo tudi Sodišče EU v zadevi BUPA [T-289/03, 202–203].

46 Z izjemo leta 2014, ko so vse tri zdravstvene zavarovalnice znižale premije: Vzajemna iz 27,76 € na 26,79 €, Triglav iz 28,54 € na 27,51 € in Adriatic Slovenica iz 28,34 € na 27,49 €.

47 Glej zadevo BUPA [T-289/03, 186–190].

naravo storitve dodatno utrjujejo tudi druge obveznosti dopolnilnega zdravstvenega zavarovanja, ki omejujejo diskrecijo zdravstvenih zavarovalnic: obveznost enotnega ocenjevanja, obveznost doživljenjskega kritja in opredelitev pravic iz naslova dopolnilnega zdravstvenega zavarovanja.[48]

Prostovoljna narava dopolnilnega zdravstvenega zavarovanja v smislu, da je vključitev v zavarovanje prepuščena svobodni izbiri zavarovancev, ni v nasprotju z univerzalno in obvezno naravo storitve. Univerzalna in obvezna narava nista pogojeni z obligatorno vključitvijo v dopolnilno zdravstveno zavarovanje.[49] Dodatno dejstvo, ki govori v prid univerzalni in obvezni naravi dopolnilnega zdravstvenega zavarovanja, je tudi visoka pokritost prebivalstva z zavarovanjem. V zavarovanje je vključenih neposredno prek pogodbenega razmerja z zavarovateljem okoli 70 % prebivalstva, če pa k temu prištejemo še prebivalstvo, ki ima kritje dopolnilnega zdravstvenega zavarovanja iz drugega, z zakonom določenega naslova, se delež močno približa pokritosti obveznega zdravstvenega zavarovanja.

Sodišče EU je v zadevi BUPA v kontekstu univerzalne in obvezne narave storitve presojalo tudi začetno čakalno dobo za vključitev v zavarovanje, ki je sestavni del slovenske ureditve dopolnilnega zdravstvenega zavarovanja (peta točka 62.b(1) člena ZZVZZ). Pri tem je zavzelo stališče, da so čakalne dobe za vključitev v dopolnilno zdravstveno zavarovanje bistveni element prostovoljnih zdravstvenih zavarovanj, ki temeljijo na obveznosti odprtega pristopa in enotnega ocenjevanja. Kljub temu da so čakalne dobe omejitev pri sklepanju zavarovanj, je to primerno sredstvo za usklajevanje dostopnosti in univerzalnosti storitve dopolnilnega zdravstvenega zavarovanja, saj onemogoča izkoriščanje medgeneracijske solidarnosti na način zlorab osebam, ki z vključitvijo v zavarovanje odlašajo, dokler nimajo precejšnje potrebe po zdravstvenih storitvah.[50]

Glede na stališče Sodišča EU v zadevi BUPA, kjer je odločilo, da je v primeru irskega zasebnega zdravstvenega zavarovanja podana univerzalna in obvezna narava naloge storitve splošnega gospodarskega pomena,[51] ter analize slovenske ureditve dopolnilnega zdravstvenega zavarovanja lahko sklepamo, da je tudi v primeru slovenskega dopolnilnega zdravstvenega zavarovanja podana univerzalna in obvezna narava naloge storitve splošnega gospodarskega pomena.

5 Zaključek

Iz presoje slovenskega dopolnilnega zdravstvenega zavarovanja v luči meril za opredelitev dejavnosti kot storitve splošnega gospodarskega pomena, ki jih je izoblikovalo Sodišče EU, izhaja, da dopolnilno zdravstveno zavarovanje

48 Glej zadevo BUPA [T-289/03, 191–192].
49 Glej zadevo BUPA [T-289/03, 190–195] in pripadajočo sodno prakso.
50 Glej zadevo BUPA [T-289/03, 195–200].
51 Glej zadevo BUPA [T-289/03, 205–207].

izpolnjuje vsa zahtevana merila. Dopolnilno zdravstveno zavarovanje ima gospodarsko naravo dejavnosti in se izvaja v javnem interesu kot nepogrešljiv del sistema zdravstvenega varstva (socialne varnosti). Analiza nadalje potrjuje tako podanost oblastvenega akta, s katerim je gospodarskim subjektom podeljena naloga storitve splošnega gospodarskega pomena z jasno opredeljenimi obveznostmi (ZZVZZ), kot tudi obvezno in univerzalno naravo dopolnilnega zdravstvenega zavarovanja. Glede na zapisano lahko zaključimo, da je slovensko dopolnilno zdravstveno zavarovanje storitev splošnega gospodarskega pomena, za katero velja omejen domet pravnega reda EU (pravil notranjega trga in konkurenčne zakonodaje). Takšna opredelitev pa ne upravičuje vsakršnih državnih regulatornih posegov v to dejavnost (npr. neposredno ali posredno dodeljevanje državnih sredstev subjektom, ki opravljajo storitve splošnega gospodarskega pomena – nadomestila za izvajanje javne storitve, različne obveznosti dopolnilnega zdravstvenega zavarovanja, pravila, ki zagotavljajo solventnost izvajalcev zdravstvenega zavarovanja itd.) temveč zgolj omogoča možnost za njihovo upravičevanje, ki je naslednji korak na poti presoje skladnosti pravne ureditve slovenskega dopolnilnega zdravstvenega zavarovanja s pravnim redom EU.

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Slovenian Complementary Health Insurance as a Service of General Economic Interest

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ABSTRACT

Slovenian legislation defines complementary health insurance as an activity of the public interest, which represents an inseparable and essential element of healthcare system and as such pursues objectives identical to those of compulsory health insurance – financial security of population against high healthcare expenses and appropriate and fair access to efficient and quality healthcare. EU Member States often introduce different regulatory measures to safeguard the public interest in the field of economic activities. These measures often contravene the Union acquis (the rules on the functioning of the internal market and competition law), which is in principle unacceptable. This article aims to define Slovenian complementary health insurance as a service of general economic interest, which opens up new prospects for the Member States' adoption of the regulatory measures that are not compliant with the rules on the functioning of the internal market and EU competition law.

Keywords: *financing of healthcare, complementary health insurance, service of general economic interest (SGEI), public interest*

JEL: K32

1 Introduction

Health insurance is insurance against financial loss which is incurred by illness, body injury and birth or death of the insured person. Individuals with health insurance are provided with social security against uncertainty that may befall them if an insured event occurs. Some countries organize health insurance at a systemic - national level and finance their healthcare system through pre-paid Health insurance contributions. Such a system can be found in Slovenia, where healthcare system is financed by two sources, that is public and private funds. The lion's share, around 75% of these funds, represents social or compulsory health insurance.[1] The largest source of private financing represents voluntary health insurance (a little above 50% of private funds),

1 The remaining public sources are budgetary resources of the state and the municipalities.

of which complementary health insurance represents more than 90% (ZZZS, 2013, 144; SURS, 2013).[2]

Healthcare is a fundamental component of European welfare state. Although EU Member States regulate this area differently, all regulations have a common feature of pursuing the universal access to healthcare, which is based on the principle of solidarity. When Member States join the EU, they confer the exercising of a part of their sovereign rights to the EU. In other words, they renounce a part of their competences and pass them, to a greater or lesser extent, on the EU institutions. In the early period of the development of the European Economic Community, the field of healthcare fell within the exclusive competence of the Member States. The Treaty of Rome, which entered into force in 1958, did not visibly affect the field of healthcare.[3] Development of the European Economic Community and later the EU has, over time, thoroughly blurred the lines between national legal systems of Member States and EU law. This is reflected in the area of healthcare as well. EU's interest in healthcare has been on the increase, which is evident from the erosion of Member States' competence in this field.[4] The leading role in this have the reforms of the Founding Treaties, secondary legislation, the development of interpretation of fundamental principles and progressive role of the Court of Justice of the European Union.[5] Member States also do not have complete autonomy in organizing the healthcare financing system. Their autonomy mainly depends on the organizational structure of financing system and on its legal regime. Member States often introduce different regulatory measures in order to protect the public interest regarding financing of healthcare system and provisions of medical services. These measures often cross the autonomy threshold admissible by EU law, which classifies as an infringement of Union acquis.[6]

2 The remaining private sources are direct payments for health services made by individuals (around 44% of private funds) and donations of various charities and other donors.

3 Healthcare and health, especially in terms of its protection, were mentioned only by three Articles: 36, 48(3) and 56(1).

4 Van de Gronden (2013, p. 128) writes about Europeanisation in the field of providing and organizing social services of general interest. The term Europeanisation is also used by Szyszczak (2013, p. 321) in order to explain the emergence of new networks of established, and new players, creating the concept of social services of general interest and the emergence of the Commission with a new governance competence and capacity in the form of soft law and soft governance processes.

5 For detailed discussion on the development of EU law influence on social services from the beginning of integration until the Lisbon Treaty see Damjanovic & de Witte B. (2009).

6 Slovenian complementary health insurance has already been a subject of infringement proceedings before the Court of Justice of the European Union. In its action against the Republic of Slovenia, the European Commission accused it of Infringement of Article 8(3) of First Council Directive 73/239/EEC (First non-life insurance Directive) and of Articles 29 and 39 of Council Directive 92/49/EEC (Third non-life insurance Directive) – Infringement of Articles 56 and 63 of TFEU (Judgement of the CJEU case C-185/11 of 26 January 2012, Par. 19). With regard to the infringement of Article 8(3) of First non-life insurance Directive and Articles 29 and 39 of Third non-life insurance Directive, the Court of Justice of the European Union ruled that, by incorrect and incomplete transposition of First and Third non-life insurance Directive into national law, the Republic of Slovenia has failed to fulfil its obligations under Article 8(3) of First non-life insurance Directive and Articles 29 and 39 od Third non-life insurance Directive (Judgement of the CJEU case C-185/11 of 26 January 2012, Par. 27). With regard to the infringement of Articles 56 and 63 of TFEU, the Court of Justice of the European Union

Legal regulation of healthcare, including the healthcare financing system, is, within the meaning of the Union acquis, substantially influenced by the concept of *Service of General Interest – SGI*. Definition of individual segments of healthcare in the context of service of general interest under certain conditions excludes the scope of the internal market rules and EU competition law (non-economic services of general interest) or justifies the Member States' regulatory measures that do not comply with the rules on the functioning of the internal market and EU competition law (services of general economic interest). This article aims to define Slovenian complementary health insurance as a service of general economic interest, which opens up new prospects for the Member States' autonomous regulation and allows the adoption of the regulatory measures that are not compliant with the rules on the functioning of the internal market and EU competition law. Such definition enables national legislature to adopt regulatory measures in the public interest, which reinforce the social dimension of healthcare financing.

2 The Concept of Service of General Interest

2.1 Services of General Interest

Services of general interest, also known as *public services*, are legal concept covering a series of different activities. These include large network industries, such as energy industry, telecommunications, traffic, audio-visual and postal services, education, water supply, waste management and, last but not least, healthcare and social services. These services are essential for the daily life of citizens and enterprises, and reflect Europe's model of society. They play a major role in ensuring social, economic and territorial cohesion throughout the Union and are vital for the sustainable development of the EU in terms of higher levels of employment, social inclusion, economic growth and environmental quality (European Commission, 2007, p. 3). Services of general economic interest can be further defined as services of an economic nature – services of general economic interest and services of a non-economic nature – non-economic services of general interest.

2.2 Non-Economic Services of General Interest

Non-economic services of general interest (non-economic public services) include the following activities: tax system, the police, the judiciary, social security systems etc. Member States have exclusive competence over these

dismissed the action. Its decision is based on the finding that there is no coherency between the summary of allegations claiming that the Republic of Slovenia violates Articles 56 and 63 of TEFU and the statement of claim in the context of which the European Commission accuses Slovenia of incorrect and incomplete transposing of First and Third non-life insurance Directive (Judgement of the ECJ case C-185/11 of 26 January 2012, Par. 30). The Court of Justice of the European Union rejected the complaint as inadmissible, meaning that it did not decide on the merits of the case. This means that the European Commission can once again bring an action against Slovenia and with appropriate supplement of the complaint achieve hearing on the merits of the case.

activities, which are not, within the meaning of the Union acquis, subject to EU competition law and the rules governing the functioning of the internal market (European Commission, 2007, 4; Article 2 of the Protocol No. 26 on services of general economic interest, annexed to the Lisbon Treaty (2007/C 306/01)). Over time, the scope of activities defined as non-economic services of general interest has been constantly diminishing and thus simultaneously reducing Member States' autonomy in this field. European Commission plays a key role in this, as its "soft law" approach (non-binding legal acts) broadens the scope of European legislation (Neergaard, 2013, p. 209).

2.3 Services of General Economic Interest

The concept of services of general economic interest refers to market services for which the Member States, for general interest reasons, determine special obligations for providing public services. These include activities provided by large network industries (telecommunications, postal services, electricity, gas, traffic etc.) and other services of general economic interest (waste management, drinking water supply, radio and television broadcasting service etc.) (Pečarič & Bugarič, 2011, p. 166). Services of general economic interest are considered in nearly every segment of the Union acquis. Their definition is to be found in primary legislation, specifically in the Treaty on the Functioning of the European Union (hereinafter referred to as TFEU) and Protocol No. 26 on services of general interest, annexed to the Treaty of Lisbon. Article 106(2) of the Treaty states that undertakings entrusted with the operation of services of general economic interest or having the character of a revenue-producing monopoly are subject to the rules contained in the Treaty, in particular to the rules on competition, in so far as the application of these rules does not obstruct, in law or in fact, the performance of the tasks entrusted. This should however not affect the development of trade to such an extent as would be contrary to the interests of the Union (European Commission, 2011, Par. 3).

Beside primary legislation, services of general economic interest are regulated also by secondary legislation. The most important of them is *Directive on Services in the internal market*.[7] The majority of secondary legal sources concerning the field of services of general economic interest is the reflection of the liberalisation policy of the EU, which was implemented by a so-called sectoral approach. It enabled the European Commission to regulate the specifications of individual services of general economic interest (the fields of energy industry, telecommunications, traffic and other network–bound economic activities) by means of various secondary legislative acts (Brezovnik, 2008, p. 40).[8]

7 Directive 2006/123/EC of the European Parliament and of the Council of 12 December 2006 on services in the internal market (OG L 376/37, 27 December 2006).

8 Directive 96/92/EC of the European Parliament and of the Council of 19 June 1996 concerning common rules for the internal market in electricity (OG L 027, 30 January 1997); Directive 97/67/EC of the European Parliament and of the Council of 15 December 1997 on common rules for the development of the internal market of Community postal services and the improvement of quality of service (OG L 15, 21 January 1998); Directive 2002/22/EC of the

In addition to primary and secondary law, the institutions and other EU bodies influence services of general economic interest also through other forms of binding and non-binding legal acts.[9]

Despite the extensive literature concerning services of general economic interest and considerable efforts for their exact definition by all three EU branches of government, which is reflected in numerous acts from this field, a clear-cut legal definition of this concept has yet to be determined.

2.4 Social Services of General Interest

Another important concept in the field of healthcare is the concept of *social services of general interest – SSGI*.[10] This term is not defined by neither primary nor secondary law. It is the latest concept in the group of services of general interest which cannot be found in binding European legislation. The political agenda first mentions it in the European Commission's report on the European Council session in Laeken – Services of General Interest from 2001. In legal context it is first found in a non-binding Commission communication titled *Implementing the Community Lisbon programme: Social Services of General Interest in the European Union*,[11] which in addition to health services in narrower sense[12] defines two main categories of social services (included compulsory and complementary health insurances).[13]

This Communication further states that social services of general interest do not constitute a legally distinct category within EU law.[14] Social services of general interest in legal terms qualify as, depending on the nature of their activity, services of general economic interest or non-economic services of general interest. The mere fact that the activity is considered a social activity does not mean that it cannot be simultaneously considered as an economic

European Parliament and of the Council of 7 March 2002 on universal service and users' rights relating to electronic communications networks and services (Universal Service Directive) (EU Official Journal L 108 of 24 April 2002); Directive 97/33/EC of the European Parliament and of the Council of 30 June 1997 on interconnection in Telecommunications with regard to ensuring universal service and interoperability through application of the principles of Open Network Provision (EU Official Journal L 199 of 26 July 1997) etc.

9 To illustrate, here are a few examples: Commission Green Paper on Services of General Interest, Brussels, 21 May 2003, COM(2003) 270 final; Communication from the Commission: White Paper on Services of General Interest, Brussels, 12 May 2004, COM(2004) 374 final; European Parliament Resolution of 5 July 2011 on the future of social services of general interest (2009/2222(INI)); European Parliament Resolution of 14 March 2007 on social services of general interest in the European Union (2006/2134(INI)); Examples: case C-393/92, Almelo, [1993], case C-320/91, Corbeau, [1993], case C-340/99, TNT Traco, [2001], case C-393/92, Almelo, [1993], case C-475/99, Ambulanz Glöckner, [2001], case C-41/90, Höfner and Elser, [1991], case C-266/96, Corsica Ferries, [1998]…

10 For detailed development and better understanding and differentiation of all concepts of general interest see Neergaard (2013).

11 Communication of the Commission: Implementing the Community Lisbon programme: Social Services of General Interest in the European Union (COM(2006) 177 of 26 April 2006).

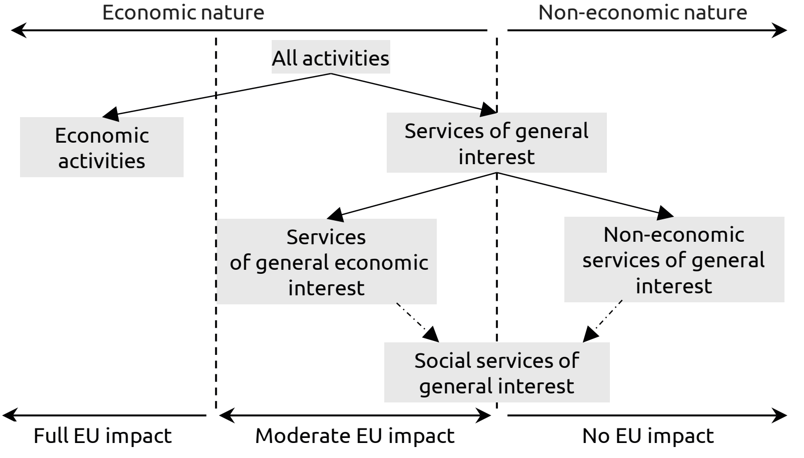
12 They are not covered by this Communication.

13 More precisely in the first category: "statutory and complementary social security schemes, organised in various ways (mutual or occupational organisations), covering the main risks of life, such as those linked to health, ageing, occupational accidents, unemployment, retirement and disability".

14 This view is shared by Szyszczak (2013).

activity. Social services of general interest, which have an economic nature, are classified as services of general economic interest (European Commission, 2010, p. 17). They have to assure the compatibility of their organisational arrangements with rules on the internal market and EU competition law.[15]

Figure 1: The scope of EU law



Source: adapted from Hatzopoulos (2011, p.12).

3 Competences and Criteria for Defining the Activity of Complementary Health Insurance as a Service of General Economic Interest

Services of general economic interest are different from ordinary services in that public authorities consider that they need to be provided even where the market may not have sufficient incentives to do so. This is not to deny that in many cases the market will be the best mechanism for providing such services. However, if the public authorities consider that certain services are in the general interest and market forces may not result in a satisfactory provision, they can lay down a number of specific service provisions to meet these needs in the form of service of general interest obligations (European Commission, 2001, point 14).

The first condition for defining an activity as a service of general economic interest is its economic nature. The second condition requires that the activity provides services (goods) that are of existential importance for the society, which therefore considers that provision of these services (goods) is of general interest and subjects them to a special legal regime.

15 Neergaard (2013, pp. 207–210) illustrates the relations between services of general interest, services of general economic interest (or non-economic services of general interest) and social services of general interest with family ties between grandmother, mother and granddaughter.

When defining an activity as a service of general ecoomic interest within the meaning of European legislation, an important question should be considered, namely that of distribution of competences between Member States and the EU. When defining a service of general economic interest, Member States have a wide discretion, which is supported by both, primary and secondary EU law, as well as the Court of justice of the European Union case-law. Nowhere in the Union acquis a specific definition of the term services of general economic interest can be found, nor the conditions that need to be fulfilled so that a Member State could refer to the existence and protection of a special legal regime of service of general economic interest.[16] Beside the absence of the definition, EU law does not grant any special powers to the EU regarding the services of general economic interest. Thus in the case BUPA the Court of justice of the European Union took a position that defining an activity as a service of general economic interest falls under Member States' competence.[17] This refers even more for services of general economic interest which have the nature of social or healthcare services, as Member States have almost exclusive competence in this area.[18] Pursuant to Article 168(7) of TFEU, Member States are responsible for defining health policy and organizing and providing health services and healthcare. In this context, the determination of obligations of a service of general economic interest is firstly a matter of the Member States. The same definition of competences on a general level can be found in Article 14 of TFEU which provides that, given the place occupied by services of general economic interest in the shared values of the Union as well as their role in promoting social and territorial cohesion, the EU and the Member States, each within their respective powers and within the scope of application of the Treaty, are to take care that such services operate on the basis of principles and conditions which enable them to fulfil their missions.[19] In cases *FFSA vs. Commission* [C-174/97, 100], *Olsen vs. Commission* [T-17/02, 216] and *BUPA* [T-289/03, 169] the Court of justice of the European Union has taken the standpoint that its competence in defining services of general economic interest is limited to checking whether the Member State has made a manifest error when defining the service as an service of general economic interest.[20]

16 Case BUPA [T-289/03, 165].

17 Member States' wide margin of discretion in defining the activities was confirmed also by the Court of Justice of the European Union in the case of *FFSA and others vs. Commission* [T 106/95, 99]. This standpoint may also be found in the Services Directive 1(3) and numerous European Commission documents: Communication from the Commission on the application of the European Union State aid rules to compensation granted for the provision of services of general economic interest, 2012/C 8/02, Point 46; Communication from the Commission: Services of General Interest in Europe (96/C281/03) OJ C 281/3, section 26; Communication from the Commission: White Paper on Services of General Interest, Brussels, 12 May 2004, COM(2004) 374 final, pp. 5–6; Green Paper on Services of General Interest, COM(2003) 270, section 30–32, etc.

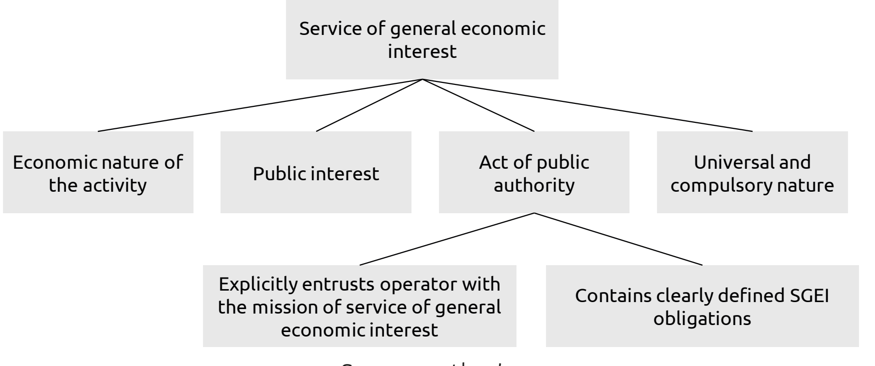
18 See Articles 2(5), 6, 153 and 168(1), (7) TFEU.

19 Case BUPA [T-289/03, 167].

20 Such standpoint was also taken by the European Commission in Communication from the Commission on the application of the European Union State aid rules to compensation granted for the provision of services of general economic interest, 2012/C 8/02, point 46.

Despite the fact that Member States have wide discretion, they need to be vigilant and ensure that the activity in circumstances of a given case fulfils the lowest criteria determined by the case-law of the Court of justice of the European Union, which are common to all services of general economic interest. When Member States wish to define an activity as service of general economic interest, they need to demonstrate: (i) economic nature of the activity, (ii) activity is carried out in the public interest[21] , (iii) the existence of the act of public authority which explicitly entrusts operator with the mission of service of general economic interest (act of public authority must contain a clear definition of SGEI obligations) and (iv) universal and compulsory nature of the entrusted mission. If the state fails do so, this may present a manifest error that has to be sanctioned by the European Commission. Further on we analyse the criteria for defining a service of general economic interest and in this perspective assess Slovenian complementary health insurance.

Figure 2: Criteria for defining an activity as service of general economic interest



Source: author's.

4 Does Slovenian Complementary Health Insurance Meet the Criteria for the Definition of the Activity as a Service of General Economic Interest?

In order to define Slovenian complementary health insurance as a service of general economic interest, one has to demonstrate that the activity meets the criteria presented in Figure 2.

a) Economic nature of the activity

The Court of Justice of the European Union defines the nature of activity as economic, if it meets two criteria: first, the activity offers goods and

21 The state is obliged to set out the reasons why it considers that the service in question should be, due to its particular significance, defined as a service of general economic interest and thus separated from other economic activities. See Case BUPA [T-289/03, 172] and Case Merci Convenzionali Porto di Genova [C-179/90, 27].

services on the market[22], and second, financial risk in performing the activity is borne by the subject that carries out the activity (offers goods or services on the market).[23] This is not to say that the subject is obliged to carry out the activity in a profitable manner,[24] but the fact that it can be carried out in such manner, at least on principle, suffices (Hatzopoulos, 2011, pp. 18–19).[25] Slovenian complementary health insurance system is an activity carried out by health insurance companies on commercial principles and for the purposes of profit. This activity meets both criteria as health insurance companies offer complementary health insurance on market and at the same time bear financial risk in performing this activity. By both criteria being met, we can undoubtedly confirm that complementary health insurance is of economic nature.

b) General or public interest

In order to define the activity as a service of general economic interest, it has to be demonstrated that offering or carrying out the service is in the general or public interest. In Article 62 of Zakon o zdravstvenem varstvu in zdravstvenem zavarovanju (hereinafter ZZVZZ)[26] the legislator defined that complementary health insurance represents the public interest of the Republic of Slovenia as it, together with compulsory health insurance, forms a social security system. The mere fact that national legislator in the general interest and within the broader sense defines a special legal regime for carrying out a certain activity, is in principle not imperative for the existence of service of general economic interest.[27] It needs to be demonstrated in fact that carrying out of the activity is in the public interest.

Complementary health insurance is inseparable and essential element of social security system and it, as such, pursues identical objectives as compulsory health insurance does – financial security of the population against high healthcare expenses and appropriate and fair access to efficient and quality medical services. Without complementary health insurance, financial security against high healthcare expense and appropriate access to efficient and quality medical services seem an unattainable ideal. Public interest

22 Case Cisal and INAIL [C 218/00, 23].
Purchase of goods or services on the market does not define the (economic) nature of this activity per se. For the purpose of determination of the activity, account should be taken of the subsequent use of the purchased goods as the nature of the purchasing activity is determined also according to the economic or non-economic nature of subsequent use (FENIN [C-205/03, 26]).

23 Case Wouters [C-309/99, 48-49].

24 Case FFSA [C-244/94, 21].

25 Case SAT Fluggesellschaft mbH vs. Eurocontrol [C-364/92, 9]. For more information on interpretation of the second criterion, which is very extensive (actual competition is not required as alleged competition is sufficient in itself) see Sauter W. and Schapel H.: State and Market in EU Law: The Public and Private Spheres of the Internal Market before the EU Courts (Cambridge: CUP, 2009), p. 82.

26 Zakon o zdravstvenem varstvu in zdravstvenem zavarovanju (Health Care and Health Insurance Act) (ZZVZZ), Official Gazette of the RS, no. 9/1992.

27 See case BUPA [T-289/03, 178].

of complementary health insurance is affirmed also by its strong social function, which is reflected through the following arguments:

(i) complementary health insurance is an important and indispensable source of financing of healthcare system;

(ii) high level of complementary health insurance population coverage;

(iii) purpose of creation and nature of complementary health insurance.

i) Complementary health insurance as an important and indispensable source of financing of healthcare system

In 2011, private resources in financing of healthcare system amounted to €841.743.000, representing 26.3% of total healthcare expenditure. In the same year, resources from voluntary health insurances amounted to €422.000.000, representing a little over 50% of all private resources (ZZZS 2013, 144). The lion's share of these resources represent resources from complementary health insurance, which in 2010 accounted for about €400.000.000, representing well beyond 90% of all resources from voluntary health insurances (Šik, 2011, p. 41).[28] Within the EU, such a large share of voluntary or complementary health insurances in financing of healthcare can be found only in France. Alongside considerable share of funds (around 13% of all healthcare expenditure), which indicates an exceptionally important role of complementary health insurance in the healthcare system, this insurance also bears the burden of covering expenses of medical inflation and inefficacy of public financing of healthcare.

The fact that the total contribution rate of compulsory health insurance has not changed since 2002 shows that the cost of medical inflation has been passed on to complementary health insurance. Medical inflation rate is normally above the percentage point of general inflation. In the period between January 2003 and March 2014 the general inflation was 34.2%. Management decisions of insurance undertakings which provide complementary health insurance additionally point to the compensation of medical inflation.[29] Between 2007 and 2014, Zavarovalnica Triglav raised the complementary health insurance premium from €20.61 to €29.42, which represents an increase of 42.7%. Between 2006 and 2014 Adriatic Slovenica raised premiums from €20.71 to €29.38, representing an increase of 41.8%.[30] Although in Slovenia data on medical inflation are not available for this period, the raises in premiums are consistent and, as is to be expected, exceed the general inflation rate. Both health insurance companies justified the gradual raising of premiums mainly by increasing

28 In the same year complementary health insurance covered loss events amounting to almost €370.000.000. For more information on high claims percentage of complementary health insurance, which in 2006 amounted around 88%, see Milenkovič Kramer, 2009.

29 We cannot claim that complementary health insurance bore the entire burden of medical inflation, as the latter caused also negative profits of health insurance fund and increase of out-of-pocket payments of health service users.

30 General inflation between 2006 and 2014 was 20.4%.

health services costs and changing the coverage ratio of compulsory health insurance benefits. Absorbing the costs of medical inflation is increasing the importance of complementary health insurance and, in line with this, achieving the social objective – it helps to maintain viability of compulsory health insurance financing as well as efficiency and quality of medical services which are covered by compulsory health insurance.

Economic crisis and recession that followed brought visible changes to the field of healthcare financing. The legislator and Zavod za zdravstveno zavarovanje Slovenije (*Health Insurance Institute of Slovenia*; hereinafter ZZZS) – provider of compulsory health insurance have reached for a short-term strategy in order to solve financial problems of health insurance fund, which does not eliminate structural deficiencies but only mitigates the pathological problems and simultaneously deepens the scope of the deficiencies. Austerity measures, which reflect over-indebtedness of the country and health insurance fund alongside with passing the financial burden from public sources of financing to private ones both represent the central part of the strategy, the objective of which is ensuring financial sustainability of the healthcare system. Passing on the financial burden of over-indebted health insurance fund onto the private financing sources, mainly onto the complementary health insurance, is a consequence of increasing statutory user charges for benefits covered by compulsory health insurance.[31] In doing so the state in the short term passed on financial burden and social responsibility on health insurance companies, which by a quick increase of insurance premiums passed them on the population.[32] By increasing statutory user charges covered by complementary health insurance, the state additionally amplifies its role and significance in healthcare system.

ii) High level of complementary health insurance population coverage

At the end of 2012, 2,076,273 insured persons were provided with compulsory health insurance, 1,536,876 of which were insured persons and 539,397 their dependent family members (ZZZS, 2013, p. 18).[33] In 2012, complementary health insurance was on average taken out by 1,431,951 insured persons (Gracar, 2014, p. 14). Because some individuals do not need to obtain a complementary health insurance as they have statutory user charges for benefits covered by compulsory health insurance covered by other sources

31 For additional information on changes in legislation and measures taken by ZZZS on the basis of the legislative reforms see ZZZS (2012, pp. 20–21).

32 An excellent example of such practice is adoption of a Fiscal Balance Act (ZUJF) (OG RS, No. 40/12). Because of the reduction of percentage share of benefits covered by compulsory health insurance, which was a consequence of the adoption of the above mentioned Act, a monthly premium of all three insurance companies were increased on 1 July 2012 by 15–20%.

33 According to Statistical Office of Republic of Slovenia (SURS), on 1 October 2012 Slovenia had a total population of 2,058,123. This confirms almost complete compulsory health insurance population coverage.

(state budget,[34] compulsory health insurance[35]), the complementary health insurance coverage is very large. A good evidence of this is also the small difference between compulsory and complementary health insurance (approximately 105,000 persons). According to SURS and Ministry of Labour, Family, Social Affairs and Equal Opportunities in October 2012 Slovenia had 363,442 inhabitants under the age of 18 and 45,734 recipients of social assistance. The sum of minors, social assistance recipients and persons with complementary insurance amounts to more than 1,800,000 persons. If we add pupils and students in regular education between the ages of 18 and 26[36] and other sectors of the population which have statutory user charges covered by the state budget, we come fairly close to compulsory health insurance coverage. Thus we substantiate the claim that complementary health insurance covers almost all population of Slovenia. Extremely high complementary health insurance coverage is characteristic for all states in which users can take out complementary health insurance for statutory user charges (France, Belgium, Luxembourg) (Mossialos & Thomson, 2009, p. 27). Very large coverage additionally confirms its important role in the social security system and at the same time demonstrates its strong social function.

iii) Purpose of creation and nature of complementary health insurance

Purpose of creation and nature of complementary health insurance have a strong social connotation. Healthcare financing system is based on compulsory health insurance, which does not cover all medical services.[37] The compulsory health insurance coverage ratio also differs according to the group of services to which individual service belongs. Only a handful of medical services are fully covered, for all other services the insured person has to go directly to the service provider. Statutory user charge rate varies between 10 and 90% of medical service value. Due to the high prices of medical services, some statutory user charges may be so high that can be classified as “catastrophic” health expenditure. According to *Vzajemna*, amounts of some statutory user charge in the first half of 2013 reached the following values: the highest

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34 This title covers the statutory user charges for (Articles 24 and 25 of ZZVZZ):
- pre-trial prisoners not insured under other title, convicts serving a prison sentence and juvenile detention, minors awarded into a re-education facility, persons with imposed security measures of compulsory psychiatric treatment and care in a health establishment and compulsory treatment of alcoholism and drug addiction;
- insured persons and covered family members who do not have full compulsory health insurance coverage for payment of medical services if they fulfil the conditions for granting financial social assistance, which is determined by Social Work Centre;
- war disabled;
- war veterans;
- victims of war violence.

35 This title covers the surcharge for:
- children, pupils and students in regular education (until the individual reaches the age of 18 or in case of regular education the age of 26);
- children and adolescents with physical and mental health disabilities;
- children and adolescents with accident-related head injury and brain injury.

36 In academic year 2011/2012 in Slovenia there were 89,600 students enrolled in higher education study programmes at universities and independent higher education institutions (SURS).

37 For covered medical services see Article 23 of ZZVZZ.

statutory user charge for the medicine from the intermediate list (90% of this medicine's value is covered by statutory user charge) was €9,579.11; average statutory user charge for treatment at a health resort was €832 while the most expensive amounted to €4,560; the highest single statutory user charge for most demanding medical services, needed by more than 8,000 insured persons (complementary statutory user charge covers 10% of their value), was €21.560 (Mikeln, 2014).[38] Introduction of high statutory user charge and large financial risk that they bring in cases of healthcare needs, resulted in the creation of complementary health insurance market and its flourishing. Due to extremely high statutory user charge the individuals, except for those more susceptible to health risk, are compelled to take out complementary health insurance, as they otherwise run the risk of "catastrophic" health expenditure. The nature of complementary health insurance and regulation of statutory user charge make clear that complementary health insurance does not have a role of upgrading social and health security but it represents integral and key element of Slovenian social security system. It is also difficult to claim that taking out complementary health insurance is a consequence of autonomous individual's decision, as the height of statutory user charge renders individual's free will almost impossible. This is also supported by high level of insurance coverage of the population.

Given a strong social function of complementary health insurance, its role and importance in the healthcare and social security system, one can conclude that performance of this activity is in the public interest.

c) Act of public authority that explicitly entrusts operator with the mission of service of general economic interest and clearly defines service of general economic interest obligations

Recognition of service of general economic interest mission does not necessarily presume that the operator entrusted with that mission will be given an exclusive or special right to carry it out. There is a distinction between a special or exclusive right conferred on an operator and the service of general economic interest mission which, where appropriate, is attached to that right. The grant of a special or exclusive right to an operator is merely the instrument, possibly justified, which allows that operator to perform service of general economic interest mission.[39] Assigning the mission of general economic interest thus does not demand granting a special or exclusive

38 For illustration of the height of statutory user charges and financial risk they bring along, we present an example of an average monthly salary and time period in which an individual dedicates the amount of the highest single statutory user charges for most demanding medical services to healthcare: employed individual who receives an average monthly salary (in February 2014 average gross salary was €1,520.88), would need a little more than 14 years to spent €21,560 on healthcare (compulsory and complementary health insurance contributions – we considered Vzajemna's insurance premium value, which in March 2014 totalled €27.62). This calculation takes into account only the contribution of compulsory health insurance, which is charged to the employee directly (6.36% of gross salary). If the calculation considers also the employer's contribution, the time period would be reduced to a little less than 8 years.

39 See case BUPA [T-289/03, 179].

right because an act of public authority, which clearly defines obligations to one or even all operators who perform certain service, suffices.[40] ZZVZZ represents such an act of public authority. It created and defined a service of complementary health insurance. Economic operators have to perform services while respecting the special obligations laid down in the Articles 62–62c ZZZVZ (community rating, open enrolment and lifetime cover). Article 62.b, Par. 1, Point 4 of ZZVZZ further defines the subject and health care benefits covered by complementary health insurance which is difference between the value of health services in accordance with Article 23 of ZZVZZ and the share of these value covered by compulsory health insurance under the same Article, or a part of this difference, when statutory user charges refer to the right to medications with the highest recognised efficacy and medicinal devices. Legislator does not define only obligations for minimum benefits ensured that the products proposed would respect certain minimum quality standards, but defines the subject of complementary health insurance and its benefits entirely, as complementary health insurance by the law may not include additional services or benefits.[41] For this purpose a health insurance company may create a supplementary health insurance which represents a separate category of voluntary insurances. Furthermore, Point 2 of Article 62(1) of ZZVZZ obliges the complementary health insurance providers to participate in the equalization scheme for complementary health insurance, which distributes fairly some of the differences that arise in insurers' costs due to the differences in age and gender of the insured persons.

In case BUPA the Court of Justice of European Union was deciding whether Health Insurance Acts, which specify obligations of a private health insurance (community rating, open enrolment, lifetime cover and minimum benefits), could be considered as an act of public authority that explicitly entrusts operator with the mission of service of general economic interest with clearly defined obligations. The answer of the Court was affirmative.[42] Drawing on the basis of the comparison between the Irish regulation of private health insurance (Health Insurance Acts) and Slovenian regulation of complementary health insurance (ZZVZZ) we may conclude that Slovenian complementary health insurance also meets required criterion. Regulation of both countries, within the meaning of obligations imposed by Irish Health Insurance Acts and Slovenian ZZZV, coincide almost entirely: community rating, open enrolment, lifetime cover and level of benefits received by insured people, where the Slovenian regulation is even stricter, because it does not define only minimum level of benefits, but a complete extent of benefits provided by complementary health insurance. In view of the above, it can be concluded that in case of Slovenian complementary health insurance an act of public

40 See cases Almelo [C-393/92, 47] and BUPA [T-289/03, 179–182].

41 Irish legislation imposes on the operators who provide private health insurance the obligation of minimum benefits.

42 See case BUPA [T-289/03, 174–176 and 182].

authority – ZZVZZ which explicitly entrusts operator with the mission of service of general economic interest with clearly defined obligations is presented.

d) Universal and compulsory nature of the service of general interest mission

Universal nature of the service does not demand that the service is universal in narrow meaning.[43] The fact that only relatively limited group of users benefits from the service does not necessarily call into question the universal nature of the service's mission (in our case complementary health insurance).[44] The universal nature also does not require that complementary health insurance is free of charge and it has to be offered irrespective of economic profitability. Population's not covered by this service due to the insufficiency of financial means does not undermine its universal nature. It suffices that the service is offered to the entire population at an affordable price and on similar quality conditions.[45] Likewise, universal nature does not oppose free fixing of the amount of insurance premiums. Insurance premiums are in Slovenia determined by the health insurance companies (market forces), which might lead to high premiums and diminished accessibility of health care. Due to the obligations of community rating, and competition between the providers of complementary health insurance, the risk of high premiums is very limited.[46] Despite the limited risk, the prices of premiums have increased sharply during the last years in Slovenia.[47] The representatives of health insurance companies point out that the prices are dangerously approaching the psychologically highest acceptable amount of €30. However, the increase of insurance premiums is not a consequence of "non-functioning" market mechanisms or even service of general economic interest obligations, but of the state policy which aims to relieve public sources of funding by passing financial burden of financing health care to private sources (complementary health insurance).

Compulsory nature of complementary health insurance is a prerequisite for the existence of a mission of service of general economic interest as well. That compulsory nature must be understood as meaning that the operators entrusted with the service of general economic interest mission by an act of a public authority are, in principle, required to offer the service in question on the market in compliance with the service of general economic interest obligations which govern the supply of that service. Operators who perform service of complementary health insurance in Slovenia are not entitled to any special or exclusive right which would impose performing of this service irrespective of the costs of performing it. Nevertheless, the ZZVZZ, which explicitly entrusts the operators with the mission of service of general

43 Characteristic for compulsory health insurance.

44 The Court of Justice of the European Union confirmed this view in case BUPA [T-289/03, 187].

45 See case BUPA [T-289/03, 206].

46 See case BUPA [T-289/03, 202–203].

47 With the exception of 2014 when all three health insurance companies lowered their premiums: *Vzajemna* from €27.76 to €26.79, *Triglav* from €28.54 to €27.51 and *Adriatic Slovenica* from €28.34 to €27.49.

economic interest, also establishes the subject's obligation to offer the service to everyone upon their request. In case BUPA the Court of Justice of the European Union took a position that compulsory nature of the service and subsequently the mission of service of general economic interest exist, if the service-provider is obliged to contract, on consistent conditions, without being able to reject the other contracting party.[48] To confirm the condition of compulsory nature of service of general economic interest, the obligation of open enrolment given in Article 62.b(1) of ZZVZZ suffices. Compulsory nature of the service is additionally supported by other complementary health insurance obligations which limit the discretion of health insurance companies: community rating, lifetime cover and level of benefits provided by complementary health insurance.[49]

Voluntary nature of complementary health insurance, in the meaning that the decision for taking out insurance is left to the insurer's freedom of choice, is not contrary to the universal and compulsory nature of the service.[50] Furthermore, in favour of universal and compulsory nature of complementary health insurance implies also high insurance coverage of the population. Around 70% of the population takes out the insurance directly through contractual relation with one of the insurers. Adding the rest of population which has complementary health insurance covered by other statutory source, the percentage share is almost the same as the share of compulsory health insurance coverage.

In case BUPA the Court of Justice of the European Union was also evaluating, in the context of universal and compulsory nature of the service, the initial waiting period after which the insurance enters into force, which is an integral part of the Slovenian complementary health insurance regulation (Article 62.b(1), Point 5 of ZZVZZ). The Court took the view that the waiting periods present an essential element of voluntary health insurance based on the obligation of community rating and open enrolment. Despite the fact that waiting periods impose a restriction on taking out insurance, they are essential and lawful measures designed to prevent abuse consisting in obtaining purely temporary cover in order to obtain treatment rapidly without having contributed beforehand, by paying premiums.[51]

On the basis of Court of Justice of the European Union, which in the case of an Irish private health insurance (case BUPA) decided that the universal and compulsory natures of the mission of service of general economic interest exists[52], and on the basis of comparative analysis of Slovenian complementary health insurance regulation it can be concluded that in the latter case universal

48 See case BUPA [T-289/03, 186–190].
49 See case BUPA [T-289/03, 191–192].
50 See case BUPA [T-289/03, 190–195] and related case law.
51 See case BUPA [T-289/03, 195–200].
52 See case BUPA [T-289/03, 205–207].

and compulsory natures of the mission of service of general economic interest exist as well.

5 Conclusion

In light of criteria for defining an activity as a service of general economic interest, laid down by the Court of Justice of the European Union, the assessment of Slovenian complementary health insurance demonstrates compliance with all criteria required. Complementary health insurance has an economic nature and is performed in the public interest as an indispensable part of healthcare system (social security). Further analysis confirms both, existence of the act of public authority which explicitly entrusts operator with the mission of service of general economic interest whose obligations are clearly defined (ZZVZZ) and compulsory and universal nature of complementary health insurance. It can be concluded that Slovenian complementary health insurance is a service of general economic interest which falls under a limited scope of the Union acquis (rules on internal market and competition law). This definition does not justify any regulatory state intervention regarding this activity (e.g. direct or indirect allocation of state resources to subjects providing services of general economic interest – compensation for public services, different obligations of complementary health insurance, rules providing solvency of health insurance providers etc.) but only provides an opportunity for their justification, which is the next step in the assessment of compatibility between statutory rules of Slovenian complementary health insurance and the EU acquis.

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