The hindering effect of EU VAT on the access to health care

9. Summary and conclusions

9.1. Introduction

This research started with the observation that, in relation to the taxation of health care services, in fact two 'forces' play a role. The first force is the application of the EU VAT, being a general tax on consumption and hence aiming to cover a large number of transactions within its scope. The other force is the right to health and, more in particular, access to health care. This force aims to keep health care accessible by trying to remove all kinds of burdens that could possibly hinder that access. The questions that play a role in this research relate to the interaction of these two forces with conflicting aims. As a starting point, I assumed that, under current positive EU VAT law, the application of those two forces has as a result that imposition of EU VAT on health care transactions hinders access to health care. I find support for his hypotheses in the case law on EU health care and in prior studies on the application of VAT exemptions and exclusions, in particular in relation to public sector activities. The hypothesis used in this research therefore is: the imposition of EU VAT on health care transactions hinders access to health care.

In my view, no extensive studies have been conducted so far on the interaction between the application of EU VAT on health care transactions and the application of the standard of access to health care. I believe that, at this point in time, a research on this interaction is useful and even perhaps indispensable for the improvement of EU VAT law and a more efficient levying of VAT that adheres to the current state of health care systems in the EU. Furthermore, the outcomes of such a research, in my view, would not only be relevant in relation to EU VAT but also for studies on the fiscal sustainability of health care systems in the EU.

The assessment of the hypothesis required, on the one hand, an understanding of the application of EU VAT law in relation to health care transactions and, on the other hand, the exploration of the principle of access to health care. In order to be able to weigh the two forces against each other and draw conclusions on the effects of my findings in relation to positive EU VAT law and to make recommendations for improvements to the current system, a research framework was required. By means of the two central research questions, formulated in section 1.3, I aimed to structure this research in a way that the hypothesis is tested and insights are provided on possible improvements to the EU VAT system as regards health care transactions.

9.2. Summary and conclusions

9.2.1. Conclusions as regards the principle of access to health as a standard

I established that the principle of access to health care is, in the context of human rights law, recognized as one of the interrelated essential elements that have been distinguished in the scope of the human *right to health*. A further breakdown of the human right to health even

revealed that accessibility also entails financial access to health care, which could explain the possible references to this human right by the CJEU in case law on the application of EU VAT on health care transactions. The human right to health is recognized in international human rights treaties and other legislative documents. It is included in the International Covenant on Economic, Social and Cultural Rights ('ICESCR'), which is considered the central instrument of protection for the right to health. The ICESCR is legally binding on the State Parties to the Covenant and they have the obligation to progressive realization and some other obligations with immediate effect. The EU, as such, was not a party although all of its Member States are. I concluded that the right to health — and hence, also the element concerning the accessibility of health care — has to be safeguarded while revising or drafting EU (VAT) legislation. I feel confirmed in this view, as the access to health care was explicitly recognized in 2006 as one of the overarching values of EU health care systems that has to be taken into account while drafting proposals concerning health services by the 25 Health Ministers of the EU. So far, I concluded that the access to health care, as part of the human right to health, serves as a valid standard for the application of EU VAT law.

9.2.2. Conclusions as regards EU health care systems in relation to this research

In chapter 2 definitions of *health care* have been explored. These proved to be very broad. Furthermore, as the EU health care systems are organized at the national level, no common definition of EU health care is available. Therefore, I explored definitions that are used by international organizations that conduct qualitative and quantitative research in the field of health care. I assumed that they would apply commonly accepted definitions as their research goals require them to make – often quantitative – comparisons of the functioning and funding of health care systems between EU Member States. The analysis of definitions provided insights into the common denominators of health care systems in the EU. The common denominators distinguished – i.e. common understandings of *health care supplies* and *health care suppliers* – have been used to come to a model EU health care system for the purpose of this research. To make sure that the EU model health care system would be reliable and able to provide information on the effect of the imposition of VAT on health care transactions and ultimately the effect on access to health care, certain requirements have been set. Next to the requirements that followed from the analysis of definitions, requirements derived from the VAT system were formulated. The requirements led to a multi-level and demand-driven model health care system, containing basic, parallel and successive transactions. An analysis of the Dutch health care system was carried out to ensure that the model has practical value and no essential elements have been overlooked. This analysis did not call for any alterations in respect of the model health care system.

9.2.3. Conclusions on the EU VAT perspective on health care transactions

So far, I explored the normative content of the right to health and concluded that it is a valid standard in relation to the application of EU VAT on health care transactions. In chapter 5,

explored the relationship between the principle of access to health care and EU VAT. I concluded, like the considerations of the CJEU suggest, that the principle of access to health care indeed has to be taken into account for the application of EU VAT on health care transactions.

Subsequently, with the establishment of the model health care system in chapter 2, it was established which kind of health care transactions potentially take place within the EU. The next step was the assessment of the VAT burden on health care transactions, which was undertaken in chapter 6. In that chapter, I concluded that the levying of EU VAT on health care transactions, by its nature, increases the cost price of health care transactions. Even if health care transactions are not taxed, as a result of the application of VAT exemptions or exclusions, the health care supplier incurs a substantial amount of input VAT, which he cannot deduct. As a result, the costs of the health care transaction to the health care consumer and hence access to health care is affected. The broad scope of both the subject (*taxable person*) and the object *(taxable transactions*) of the tax include a large part of transactions made in the health care sector within the scope of application of EU VAT. Furthermore, I have concluded that current mechanisms that are used for VAT relief of those transactions are not adequate. The application of VAT exemptions and exceptions form an infringement to the general character of the tax. Their application is distortive in many ways. This is already a direct consequence of their definition. The harmonized EU VAT system tends to subject health care transactions to VAT in a uniform manner, although health care systems in the EU are not harmonized. This leads to difficulties as regards the scope of application at the national level. Furthermore, this can lead to an unequal treatment of similar health care transactions in different Member States. This is a concern, as both the mobility of health care consumers and health care suppliers has increased during the last years. Difficulties as regards the scope of application also occur on a large scale in national situations. This leads to legal uncertainty and increased compliance costs. What makes it even more complicated is that the exemption for medical care in the EU VAT Directive is regulated by means of two different exemption provisions, i.e. one for intramural and one for extramural care. In order to improve legal certainty and reduce compliance costs, I would prefer an exemption for health care in a single exemption provision. As such, the legal uncertainty and increased compliance costs are factors that hinder the effective levying of the tax. They are a complicating factor in relation to the imposition of VAT on health care supplies. I concluded that this hindering effect in relation to access to health care cannot be justified by the aims, nor by the principles, of EU VAT law. I also concluded that the application of VAT exemptions and exclusions may force health care suppliers to make choices that are, from an economic point of view, perhaps less efficient. From a cost perspective, for health care suppliers it is in general not efficient to outsource services that are subject to VAT. This phenomenon is referred to as the bias towards insourcing. A similar effect occurs in cases of cooperation between health care suppliers. This also proves to lead to a substantial VAT burden in many cases.

Even though the CJEU seems to imply that VAT exemptions for health care transactions intend to facilitate access to health care, I demonstrated in chapter 6 that, from a conceptual point of view, exemptions are by definition distortive and are capable of hindering access to health care, in the worst case even with the accumulation of VAT. In conclusion, the levying of EU VAT on health care transactions would increase the costs price of health care transactions. As a result of the application of VAT exemptions and exclusions, a large number of health care transactions are not taxed with VAT. Nevertheless, these transactions are burdened to some extent with increased costs, either as a result of non-deductible input VAT or as a result if substantial compliance costs. The distortive effects of those mechanisms are often not justifiable on grounds of the aims or principles of EU VAT law.

9.2.4. Conclusions as regards the application of EU VAT in specific types of situations

In order to be able to answer the first research question completely, I aimed to demonstrate in which types of situations the application of exemption provisions hinders access to health care. In chapter 2, I already identified common types of transactions which typically occur in the health care sector.

It appeared in chapter 7 that the scope of application of health care exemptions differs depending on the situation and relationship in which the health care is provided. The scope of application in *basic situations* is different from the scope of application of health care exemptions in *parallel situations*. Furthermore, the scope of application in these two situations also differs from the scope of application in situations in which health care is supplied as a successive supply (*successive situations*). Therefore, I made a distinction between 'basic health care supplies', 'parallel health care supplies' and 'successive health care supplies'. In all three situations, I analysed both the application of the exemption provision for intramural care (Article 132(1)(b) of the EU VAT Directive), as well as the application of the exemption provision for extramural care (Article 132(1)(c) of the EU VAT Directive). The assessment of the basic health care supplies confirmed the findings in chapter 6. In my view, the application of Article 132(1)(c) of the EU VAT Directive results in more legal uncertainty for the health care suppliers supplying services in basic situations compared to the application of Article 132(1)(b) of the EU VAT Directive. This follows from the way the exemption provision is defined. The exemption provision for extramural care in Article 132 (1)(c) sets requirements as regards the professional qualifications of the providers and demands that the health care provided is within the area of expertise of the medical profession.

The hindering effect of VAT exemptions on access to health care in parallel health care supplies was analysed by distinguishing parallel one-on-one and parallel two-on-one situations. As regards the application of the exemption provision for extramural care, I concluded that the 'closely related test' that is necessary for the assessment of the application of the exemption provision for intramural care is superfluous in parallel one-on-

one situations. This is because the ‘closely related test’ requires the ancillary transaction to also be essential. On the other hand, the scope of application of the ‘closely related test’ appears broader. Where composite supplies can only be found in parallel one-on-one situations, closely related supplies can be found in parallel two-on-one situations and successive situations as well.