The impact of the EU Health Care Directive on health services in Ireland

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THE proposed EU Directive on the Application of Patients' Rights in Cross-Border Health Care has important and disturbing implications for the provision of health services in Ireland. The directive risks removing the responsibility for the provision of health care from the hands of our own democratically elected Government and reducing it to a mere "service provided" in accordance with market rules laid down by the European Union.

For Ireland there is little doubt that, in a relatively brief period, this market-based approach would establish a health-care system that would favour the young, the mobile and the relatively affluent to the detriment of the weaker and more vulnerable members of society.

Until now the approach adopted in EU legislation has generally been to treat the provision of health care by individual member-states as a non-economic service. This has meant that national governments have had the authority (or, in EU-speak, "competency") over the provision of their own health services. However, typical of the "regulatory creep" that has resulted in the EU gaining authority over ever-increasing aspects of our daily lives, there is growing evidence that health care will not survive for much longer outside the authority of the EU.

A significant indication of this "regulatory creep" relating to health care came in 2006 in an extremely important ruling by the European Court of Justice, made in the Watts case. To avoid a long wait in Britain, a sufferer from osteoporosis had travelled for treatment in France, without prior authorisation from her local authority, and sought to recover the cost of her treatment from the National Health Service. The court ruled that the lack of an established NHS procedure for seeking services abroad restricted the possibilities for patients in seeking treatment outside the NHS system and was therefore a restriction of their freedom to receive services. It found that medical services are not exempt from the scope of the EC Treaty and that Mrs Watts was entitled to receive such a service and be reimbursed by the NHS.

The fact that in Britain the NHS is an entirely public body, funded by the state and providing health care free at the point of delivery, was irrelevant in determining whether the situation fell within the scope of the treaty.

The ECJ does not decide on matters of right or wrong: its job is merely to resolve any conflicts about the interpretation of European treaty law; and its judgements always take precedence over national laws. A country's actions tend to be assessed by the ECJ according to whether they help or hinder the move to a single EU superstate. Free-market, neo-liberal principles dominate its rulings.

The ruling in the Watts case has established that article 49 (the right to provide services) should apply in the provision of health services. At the time the Financial Times reported that the court's decision was a further step towards the establishment of a single market for health care within the European Union.

The practical implications of the Watts case may be limited at present, because there is no easy route to obtaining access to this option except through costly legal action, and the concept of "undue delay" is not defined. However, under the proposed Health Care Directive people would be able to obtain access to treatment abroad much more easily. Local authorities would have to be more explicit

about services that are available, and about the time limits within which people could expect to obtain them.

For non-hospital or day-care treatments, under the directive patients could be treated and be reimbursed up to the amount that their national health service would have paid for such a service. Member-states would not be in a position to insist that patients get prior authorisation before going abroad for a day-care procedure.

It is estimated that three-quarters of all medical procedures carried out in Ireland are done in day care. For in-patient treatments people would be able to apply to a national "contact point," which would have to be widely advertised; and, according to the draft directive, "it is appropriate that patients should normally have a decision regarding the cross-border health care within two weeks." This system is likely to encourage far more people to ask for treatment in other countries, because—unlike the present situation, which involves legal action—asking would carry no financial cost.

Following the Watts ruling there was widespread discussion within the Eurocracy about the uncertainty it had caused about determining who had jurisdiction over health care in the EU member-states: the individual member-governments or the European Union. The Commission argued that as a result of the ruling it was necessary to "clarify" the altered role of the member-states, and it has proposed a directive that, according to itself, will do just that.

However, the proposed directive is not just a "response" to the Watts ruling by the European Court of Justice[1]: it would open up health services to free-market competition. In its explanation the Commission explicitly acknowledges that the directive is intended to fill a "hole" that has appeared in the Services Directive in the wake of the Watts ruling. This was created when health care was excluded from the scope of the Services Directive. Following the Watts judgement, however, the legal basis of the proposed directive is under the internal market (article 95 of the treaty) rather than the health articles of the treaty.

Under the Lisbon Treaty, national parliaments lost their veto on health, and therefore the proposed directive can be passed by a qualified majority vote. The Commission's present policy is that member-states are free to define the "mission" of a public service, its "objectives and principles," but when "fixing the arrangements for implementation" the rules of the treaty should apply (articles 43 and 49). In other words, the actual provision of health care, as distinct from general policy-making, is now subject to internal market rules.

Taking its lead from the European Court of Justice, the Commission's view now is that any service for which payment is usually made is an "economic activity." As a result of this interpretation, any operator from within the European Union, whether public or private, must be allowed to bid for providing the service.

In its policy statement "Communication on Social Services of General Interest" (2006) the Commission declared: "With regard to the freedom to provide services and freedom of establishment, the Court has ruled that services provided generally for payment must be considered as economic activities within the meaning of the Treaty." However, the treaty does not require the service to be paid for directly by those benefiting from it.[2] This is a critically important interpretation of the EU's "new" position, as it follows that almost all services offered in the social field can be considered "economic activities" within the meaning of articles 43 and 49, even if paid for by the state. It is possible, therefore, that over the coming years, in addition to health services, the authority for regulating many more

1. www.openeurope.org.uk.

2. www.openeurope.org.uk.

of the traditionally non-profit services, such as education and social services, will gradually be assumed by the European Union.

There is no doubt that the principles established by the European Court of Justice in the Watts case will remain as the legal framework for any EU legislation arising in the post-Lisbon situation. In a speech expressing his concerns about the Lisbon Treaty in the House of Commons on 6 February 2008 the former Secretary of State for Health Frank Dobson (Labour Party) drew attention to the concern of many social democrats at these developments.

> Appearances would suggest that our National Health Service is and will remain the exclusive responsibility of the UK Government, but it is not, and under the Lisbon Treaty it will not. All the apparent protection for our sovereignty that was provided in the old and new treaties does not exist . . . In a recent ECJ decision, now followed up by the European Commission, the neo-liberals who hold powerful positions on the court and the Commission decided to open everything to do with health care up to internal market forces . . . I am very dubious about supporting a treaty that has not done something to set aside the Watts decision. I should warn the House that I think that there are very powerful forces at work behind the proposition, and they are in this country now. Those forces are the US health corporations . . .

Two years before Dobson made this comment the European Parliament had already made it clear that it accepts the legal definitions and framework set out by the European Court of Justice and the European Commission. In 2006 a resolution by the Parliament declared that it does not matter whether public services are provided by the state or by private operators: there must simply be "fair" competition and adequate regulation.[3]

The Lisbon Treaty and health care

THE provision of health and other services is subject to the rules of the internal market. Neither article 152 nor protocol 26 of the Lisbon Treaty excludes the provision of health services from market rules.

Ireland, Spain, Poland, Portugal, Greece, Hungary, Slovakia, Lithuania and Romania have stated that they are against the proposed Health Care Directive, because they think it would destroy their national health systems. Their biggest fear is that they are going to lose control over their health budget by not being able to predict how many claims might result from the proposed directive.

Two features of the directive—at least in the present draft—pose a particular problem and would potentially favour higher-income groups. Firstly, people would spend money on treatment abroad and would then be reimbursed later. Secondly, the system would operate on a top-up basis: patients could get a certain proportion of the cost of treatment reimbursed (say by the HSE), then make up the difference themselves.

One of the requirements of the directive is that member-states should refund to patients the same amount that would have been spent on the treatment in their own country. These features would lead to the diversion of resources towards higher-income groups.

The Commission acknowledges (but dismisses) concerns that the directive would create pressure to move to a "co-payments" system and reduce equality. Some stakeholders have raised concerns about the potential of cross-border health care to alter the general choices of member-states with regard to their mechanisms for control of access to health care. Cross-border health care certainly provides a

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3. www.openeurope.org.uk.

route for quicker care; but whether this provides an incentive for member-states that use waiting lists to manage demand to shift to other mechanisms, such as "co-payments," is open to question. Should they do so they would reduce the overall equity of their health systems.

"Co-payments" is a mechanism whereby the state pays a portion of the cost of treatment and the patient pays the balance. People who are wealthy enough and fit enough to travel could go abroad to have their procedure carried out; and, because the HSE has a fixed budget, this effectually means that those patients could get first call on the HSE's resources. It would establish a system that would favour the young, the mobile, and the relatively affluent.

Advocates of "patient choice" suggest that giving everyone equal choice about how and where they are treated would create greater equality. However, this argument doesn't work if patients must have enough money to exercise that choice in the first place, which would apply in the top-up-and-reimbursement model now being proposed by the Commission.

We have been led to believe that the essential role and wide discretion of national, regional and local government in providing, commissioning and organising non-economic services of general interest will be unaffected by the Lisbon Treaty. To this end the Lisbon Treaty contains a new protocol on services of general interest that says that the provisions of the EU treaties do not affect the "competency" (authority) of the member-states to "provide, commission and organise" non-economic services of general interest. However, the treaty does not make clear what member-states' authority to provide, commission and organise non-economic services actually means. Given the range of EU treaty provisions dealing with such services, it cannot mean that the EU has no influence whatsoever over them.

The likelihood that the EU is not completely excluded from these fields is implied in the statement produced by the summit meeting, which says that member-states have "wide discretion" in providing, commissioning and organising such services. It is significant that the summit statement does not say that individual states have complete freedom. The central issue is that nothing in the Lisbon Treaty prevents services now regarded as non-economic from being reclassified through ECJ case law as services of general economic interest. Once this has happened, services such as health and education would fall under much greater EU control.

It is important to recall that historically the Irish health service has been strongly dependent on a significant non-profit private hospital sector. One of the many dangers of this model is the ease with which private non-profit health care can be converted into private "for-profit" health care.

Ireland's pick-and-mix health service is unique within the European Union. The Government sponsors private health insurance by giving tax relief to subscribers; and nearly all public hospitals engage in commercial activities. Instead of a separate public hospital system we have a public-private mix, a two-tier hospital service, turning the health system into a "service of general economic interest." Since 1970 public hospitals have been permitted to charge fees to private health insurers. Beds have come to be regarded by hospital managements as money-making opportunities.[4] Marie O'Connor points out that we have a "mixed economy of care." Public patients are treated by a variety of providers, including national and foreign-owned private corporations. In this "mixed economy," clinical services are subcontracted to profit-making companies.

Privatisation has been brought into the heart of the system, and we now face a future where medical services that are paid for out of the public purse will increasingly be provided by profit-making operators. The new roles given to the profit-making sector include a wide array of services that were traditionally at the core of our public health service. They include the provision of beds for public

4. Marie O'Connor, *Emergency: Irish Hospitals in Chaos,* Dublin: Gill and Macmillan, 2007.

patients (under "co-location"), performing tens of thousands of procedures annually (under the National Treatment Purchase Fund), and implementing the golden formula of "design, build, maintain and operate" health facilities.[5] Generous tax incentives to encourage the construction of private hospitals and nursing homes were introduced in the 2002 budget. For every €100 million spent on hospital construction the exchequer gives €40 million in tax relief to the investors. Despite this form of Government funding, subsidised private hospitals will continue to cherry-pick while public hospitals will continue to provide more complex and costly services, including complicated surgical procedures and expensive but lifesaving rehabilitation treatment.[6]

Ireland's intertwined combination of private and public providers makes it more susceptible to EU regulatory creep, as the service is already partially monetarised. This makes it much easier for the EU to define our health service as being "of general economic interest," i.e. for profit.

An additional worry about the present Government's determination to promote its privatisation agenda is that it becomes increasingly likely that Irish health care will be subject not only to EU law but to international trade law, as determined by the World Trade Organisation. During the 1990s pressure built up to open public services, such as health, to international trade. American companies looked to other countries for boosting their income, especially those, like Ireland, that offered tax-funded schemes tailored to the needs of profit-making corporations. Through the World Bank, the OECD and the WTO these companies campaigned for the privatisation of all public services throughout the world.

The General Agreement on Trade in Services (GATS) was signed by Ireland on 1 January 1995. Article 1.3 states that the right to exempt public services from market forces did not apply if a service was provided on a "commercial basis," or if it was supplied "in competition with one or more service suppliers." By 1995 private health services were well established and integrated in the general health service in Ireland.[7]

In July 2008 the European Commission published the proposed Health Care Directive, setting out patients' rights to treatment in other EU countries, following a decade of ECJ rulings establishing that patients had a right to be reimbursed for treatment in other EU countries when facing lengthy delays for treatment at home. However, other aspects of the proposed directive raise long-term questions about the role of the European Union in health policy, particularly the proposal that the Commission should designate specialist centres for particular treatments, its proposal for a new EU health committee, chaired by the Commission, and the ending of the veto over public health issues in the Lisbon Treaty. All these proposals suggest that the Commission sees a much greater role for itself in running health policy in the future.

The present status of this "patients without borders" directive is that in November 2009 nine EU countries managed to block it. Pascal Garel, chief executive of the European Hospital and Healthcare Federation, said the failure to reach an agreement was a surprise, but he insisted that the issue has a future. He pointed out that the EU had had "a similar experience with the working time directive, when it took four years to get an agreement."[8] And, as the Irish commissioner Charlie McCreevy pointed out, "in any bureaucracy, certainly a bureaucracy as big as the Commission, an idea never

5. Marie O'Connor, *Emergency: Irish Hospitals in Chaos,* Dublin: Gill and Macmillan, 2007.

6. Sara Burke, "Addressing the health care crisis," ICTU, Congress Briefing Paper no. 10, 2007.

7. Marie O'Connor, *Emergency: Irish Hospitals in Chaos,* Dublin: Gill and Macmillan, 2007.

8. Jennifer Rankin, "Ministers reject proposal on cross-border healthcare," *European Voice,* 1 December 2009, at www.europeanvoice.com/article/2009/12/ministers-reject-proposal-on-cross-border-healthcare/66568.aspx.

finally dies. It may be left aside for some time, but it always comes back."[9]

The present Minister for Health, Mary Harney, introduced the National Treatment Purchase Fund to help reduce waiting lists in the public health system by allowing public patients to obtain access to treatment in private hospitals. Though the fund made it possible for waiting lists to be reduced, it was strongly criticised because it diverted much-needed resources from the public health budget. The fund is strictly controlled and funded by the Government through the HSE. Under the proposed Health Service Directive, patients' ability to travel abroad for treatment would be greatly extended, with the funding coming from the Irish health budget, but the HSE would have little control over this area of expenditure. Irish taxes, therefore, would be used not only to enhance the profit margins of private health corporations but also to enhance the German, French, Dutch, British and other health services, while funding for chronic and long-term health care in Ireland would be further depleted.

Under the directive, health care would become politically unaccountable. In response to issues such as overcrowding in hospital casualty departments and long waiting lists, as democrats we can reject Mary Harney at the next general election; but who do we hold to account for the Health Service Directive and its budgetary implications?

The proposed directive illustrates a fundamental flaw in the centralised bureaucracy that is the European Union. It is an attempt to fit twenty-seven hugely diverging health systems into one strait-jacket. However, as with most national institutions throughout Europe, one size does not fit all. The drive towards a market-based superstate will undoubtedly further undermine the development of a proper public health service in Ireland. Because of the peculiar features outlined above, Irish public health care would be particularly at risk under the directive, and the weak, the vulnerable and the chronically ill would be further compromised.

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9. "This Week", RTE Radio 1, 22 July 2007.