

The EU Healthcare Directive's impact on health services in Ireland

The proposed EU Health Services Directive has important and disturbing implications for the provision of health services in Ireland.

The directive risks removing the responsibility for health care provision from the hands of our democratically elected government and reducing it to a mere 'service provided' in terms of market rules set down by the EU.

Until now the approach of 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 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 major indication of this 'regulatory creep', relating to health care, came in 2006 in an extremely important ruling by the European Court of Justice (ECJ), which was made in the Watts case.

In the Watts case an osteoporosis sufferer who had travelled from the UK for treatment in France, without prior authorization from her local authority, to avoid a long wait in the UK, sought to recover the cost of her treatment from the NHS.

The ECJ ruled that the lack of an established NHS procedure to seek services abroad restricts the possibilities for patients to seek treatments outside the NHS system, and therefore is a restriction of their freedom to receive services.

The Court found that medical services are not exempt from the scope of EC Treaty law and that Mrs Watts was entitled to receive such a service and be reimbursed by the NHS.

The fact that in the UK the NHS is an entirely public body, funded by the State and providing health care free at the point of delivery, was irrelevant for 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 supremacy over national laws.

A country's actions tend to be assessed by the ECJ based on whether they help or hinder the move to a single EU superstate.

Free market, neo-liberal principles dominate ECJ rulings.

The ECJ's Watts ruling has established that Article 49 (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 in the EU.

The practical implications of the Watts case maybe limited at present because there is no easy route to access this option except through costly legal action, and the concept of "undue delay" is not defined.

However under the proposed Health Directive people will be able to gain access to treatment abroad much more easily. Local authorities will have to be more explicit about services that are available, and under what timescale people can expect to access them.

For non-hospital or daycare treatments under the directive patients will be able to get treated and be reimbursed up to the cost that their national health service would have paid for such a service.

Member states will not be in a position to insist that patients get prior authorization before going abroad or accessing treatment privately in this country for a daycare procedure.

Currently it is estimated that 75% of all medical procedures, that's diagnostic and treatment, carried out in Ireland are done on a day care bases.

For in-patient treatments people will be able to apply to a national "contact point" which will have to be widely advertised and according to the 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 outside the public sector either in the private sector in this country or in another EU country because unlike the current situation which involves legal action, asking will carry no financial cost.

The Commission argues that as a result of the Watts ruling it is necessary to "clarify" the altered role of the member states and it has proposed a directive that, according to the Commission, will do just that.

However, the proposed Directive is not just a "response" to the Watts ruling

The Directive will open up health services to free market competition.

In its explanation the Commission explicitly acknowledged that the Directive aims to fill a "hole" that has appeared in the Services Directive in the wake of the Watts ruling by the ECJ.

This 'hole' was created when health care was excluded from the scope of the Services Directive (2003). Following the Watts judgement however the proposed directive's legal basis is under the internal market rather than the health articles of the treaty.

Under the Lisbon Treaty national parliaments lost their veto on health so there fore the proposed Directive can be passed by a qualified majority vote.

The Commission's current 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', Treaty rules (Art 43 and 49) should apply. In other words, the actual provision or delivery of health care – as distinct from general policy making - is now subject to internal market rules.

Taking its lead from the ECJ, 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, whether public or private, from within the EU must be allowed to bid to provide the service.

In its 2006 policy Communication on Social Services of General Interest 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.

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 as “economic activities” within the meaning of Articles 43 and 49 of EC Treaty law even if paid for by the state.

It is therefore possible that over the coming years, in addition to health care services, the 'competency or authority' for regulating many more of the traditionally not-for-profit services such as education and social services will gradually be assumed by the EU.

There is no doubt that the principles established by the ECJ in the Watts case will remain as the legal framework for any EU legislation arising in a post-Lisbon Treaty scenario.

In 2006 the European Parliament had already made clear that it accepts the legal definitions and framework set out by the ECJ and the Commission.

In the same year a resolution from the Parliament declared that it does not matter whether public services are provided by the state or private operators; there must simply be 'fair' competition and adequate regulation..

Two features of the Health Directive - at least as currently drafted - are particularly problematic and would potentially favour higher income groups in Ireland:

Firstly that people would spend money on treatments abroad or in the private sector in this country and then be reimbursed by the HSE later, and Secondly, that the system would operate on a top-up basis - patients could get a certain proportion of the cost of a treatment reimbursed by the HSE, then make up the difference themselves.

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

The European Commission acknowledges concerns that the Directive may create pressure to move to a co-payments based system and thus reduce equality. The Commission has accepted and states that...

"Some stakeholders have raised concerns about the potential of cross-border health care to alter the overall choices of Member States with regard to their mechanisms for control of access to health care.

In particular, the Commission acknowledges that in so far as cross-border

health care provides a route for quicker care, this may provide an incentive for Member States who use waiting lists to manage demand (*as in Ireland*), to shift to other mechanisms such as co - payments, which could in consequence reduce the overall equity of their health system."

Co – payments is a mechanism where by the state pays a portion of the cost of treatment while the patient pays the balance. So, people who are wealthy enough could get their procedure and because the HSE has a fixed budget, that effectively means these patients would get first call on HSE resources.

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

We were led to believe that the essential role and wide discretion of national governments in providing, commissioning and organising non-economic services of general interest will be unaffected by the Lisbon Treaty.

But the key issue is that nothing in the Lisbon Treaty prevents services currently 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 fall under much greater EU control.

Other aspects of the proposed Directive also raise longer term questions about the role of the European Union in health policy, particularly: the proposal..

That the Commission should designate specialist centres for treatment;

The 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 suggest that the Commission sees a much greater role for itself in running health policy in the future.

The current status of the Directive is that in November 2009 nine EU countries managed to block the 'Patients without borders' directive. But as former Irish Commissioner Charlie Mc Creevy pointed out on the 'This Week' program, RTE, July 22, 2007 'In any bureaucracy, certainly a bureaucracy as big as the Commission, an idea never finally dies. It may be left aside for some time but it always comes back.'

IN CONCLUSION :

The current minister of health, Mary Harney, introduced the National Treatment Purchase Fund (NTPF) to help reduce waiting lists in the public health system by allowing public patients access treatment in private hospitals. Though the fund enabled some waiting lists to be reduced it was strongly criticised because it diverted much needed resources from the public health budget to the private sector.

Currently the NTPF is controlled and funded by the Irish government through the HSE. Under the proposed EU Health Service Directive patients' ability to travel abroad or move to the private sector for treatment will be greatly extended with the funding coming from the Irish health budget but the HSE will have little control over this area of expenditure.

Thus Irish taxes will be used not only to enhance the profit margins of private health care corporations but also to enhance the German, French, Dutch, British etc. health service while funding for chronic long term high intensity health care such as stroke and spinal units in Ireland will be depleted.

The proposed Directive serves to highlight a fundamental flaw embedded within the centralised bureaucracy that is the EU.

It is an attempt to fit 27 hugely diverging health care systems into one straight jacket. However, like most national institutions across 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 of health care provision in Ireland with a strong dependency on the private sector, Irish public health care will be particularly at risk under this Directive. The weak, the vulnerable and chronically ill will be further compromised. Social and community care, such as youth homelessness and drug addiction services, will be threatened as will financially non viable local hospitals.

The implications of these cut backs for local communities will not be considered. Under the Directive health care will become politically unaccountable. As democrats we can reject Mary Harney in the next general election for the debacle that is the HSE but who do we hold to account for the EU Health Service Directive and the budgetary implications there in?