

Controversial health services Directive shelved until after Lisbon Treaty referendum

The European Commission has temporarily shelved, until after the Irish referendum on the Lisbon Treaty, a controversial legislative proposal tackling patients' rights to receive medical treatment in another EU member state. This is a clear sign that the Commission is conspiring to keep citizens in the dark about contentious EU legislation on health which will have serious implications for the Irish taxpayer and have a damaging impact on our already beleaguered health system.

The official reason for withdrawing the Directive has been the Commission's heavy agenda, with the Commission's spokesperson saying on 7th February that the document was currently 'under further analysis [and] it will be scheduled at the appropriate time this year'. The fact that the EU Commission had put this legislation on temporary hold until after the Irish referendum would indicate that they want to avoid opening up an extremely controversial debate that could affect ratification of the Lisbon Treaty.

Several member states are also against the proposal because they think it would destroy their national health systems, with Denmark, Finland and the Netherlands being most vociferous. The feeling among its critics is that it goes much too far in giving total freedom of mobility and comes too close to 'health service shopping'. But member states' biggest fear is they are going to lose control over their health budget by not being able to predict how many claims might come in.

Following the exclusion of healthcare from the Services Directive, the European Commission had announced plans for a new separate Directive to open up health services to free market competition. Recent European Court of Justice rulings have assisted by using internal market arguments contained within the original Services Directive.

Two particular features of the Directive are problematic and would potentially favour higher income groups. Firstly, that people would spend money on treatments abroad, and then be reimbursed 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, but make up the difference themselves. These features would tend to lead to the diversion of resources towards higher income groups. Furthermore, the Commission acknowledges – but dismisses – concerns that the Directive will

create pressure to move to a co-payments based system and reduce equality.

So, people who are able to travel, can go and get their procedure and, because the HSE have a fixed budget, that effectively means they can get first call on the HSE resources. A major concern that has arisen concerns the impact that this would have on trying to run an equitable system. There could be an effect where those who are able to travel – and pay upfront – can to some extent push to the front of the queue. It would establish a system that would favour the young, mobile and relatively affluent. 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 the choice (i.e. the top-up-and-reimbursement based model now being proposed by the Commission).

Other aspects of the Directive also raise longer term questions about the role of the European Union in health policy. In particular proposals in the Directive that the Commission should designate specialist centres for particular treatments – an acceleration of the trend towards private provision; its proposal for a new EU health committee chaired by the Commission; and the end 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.

Where did this Directive come from?

The Commission argues that the Directive is necessary to put into practice principles which, it argues, were established by a controversial ruling of the European Court of Justice in 2006. In the Watts case an osteoporosis sufferer who had gone for treatment in France to avoid a long wait in the UK sought to recover the cost of her treatment from the NHS. The Court ruled that the lack of a NHS procedure to seek services abroad restricts the possibilities for patients to seek treatments outside the system, and therefore is a restriction of their freedom to receive services.

It also found that medical services are not exempt from the scope of the EC Treaty and that Mrs Watts received such a service in return for remuneration. The fact that 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. This decision was a further step towards the establishment of a single market for healthcare in the EU. So, the Watts judgment forces countries to pay for treatment in other states and represents the thin end of a very big wedge for introducing full-blown market mechanisms into healthcare provision.

The Commission argues that as a result of the rulings of the Court it is now necessary to 'clarify' the altered role of the member states:

'Given that Community law sets limits on the measures that Member States can take in these areas, it is essential for it to be clear what those rules and limits are, in order to provide certainty about the margin of manoeuvre

that Member States have to manage and steer their health systems effectively in order to meet their common objectives of universal access to high-quality healthcare on a financially sustainable basis.'

However, the Directive is not just a 'response' to the Watts ruling. In its explanation the Commission also explicitly acknowledges that the Directive aims to fill a 'hole' made in the Services Directive which was created when healthcare was excluded from its scope and its proposed legal basis is under the internal market (Article 95) rather than the health articles of the treaty. In its 2006 Communication (in the run up to the Directive) the Commission appeared to see a role for itself in generally increasing efficiency and cost control in member states' health systems:

'European action on health services will necessarily also contribute to the wider challenges facing health systems, beyond the specific case of cross-border healthcare itself. The cost of healthcare systems to public funds has risen significantly faster than inflation in recent years ... The key to sustainability for healthcare systems is therefore controlling costs and improving efficiency.'

However the practical implications of the Watts case are limited at present because there is no practical route to access this option except through costly legal action, and the concept of 'undue delay' is not defined. So despite the radical nature of the Watts ruling, without the proposed Directive it will have relatively little impact in practice.

But, under the new Directive people will be able to gain access to treatment abroad much more easily: The HSE will have to make much more explicit what services are available and under what timetable people can expect to access them. For non-hospital treatments people can simply get treated and be reimbursed up to the cost that their national health service would have been prepared to pay for such a service. Member states cannot insist that people get prior authorisation before going abroad.

For hospital treatments people will be able to apply to a national 'contact point' which will have to be widely advertised. According to the Directive:

'It is appropriate that patients should normally have a decision regarding the cross-border healthcare within two weeks.'

Even for hospital services the Directive also places limits on member states' right to insist on prior authorisation for overseas hospital treatment. For urgent cases prior authorisation will not be needed. Of course, the national authority making decisions about access to treatment will have to make its judgements in the knowledge that its decisions can then be appealed to a court, putting pressure on the authority to grant treatment. This system is likely to encourage far more people to ask for treatment in other countries (because, unlike legal action, asking will carry no financial cost). Therefore there are likely to be far more requests.

The Directive sets clear limits on a member states ability to say that it will not fund certain treatments. Article 21 of the draft says that:

'The requirement that Member States shall ensure that a patient may receive in another Member State and be reimbursed for healthcare appropriate to his state of health, which would have been assumed by his

statutory social security system had the same or similar healthcare been provided in their territory, covers also healthcare which is among the benefits provided for by the statutory social security system of the patient's Member State of affiliation, but which is not available in that Member State.'

For Ireland this is likely to be tricky, because the HSE – unlike insurance systems – does not provide a clear set of defined benefits and instead uses waiting lists to control costs. So it will be very difficult for the HSE to 'prove' that patients are not entitled to a particular service within a particular time.

Political context and future developments

The Directive is likely to be followed by further measures. The Directive mandates the creation of a new health Committee to be chaired by the Commission, and sets up a review of progress every five years. The Directive also proposes the harmonisation and mutual recognition of prescriptions.

It provides for the setting up of EU 'reference centres' – effectively specialist centres of excellence. In its proposal the Commission argues that 'European reference networks should provide healthcare to patients who have conditions requiring a particular concentration of resources or expertise.' While this may be harmless, it is unclear how it would work.

The idea of the Commission designating specialist centres for particular conditions takes the Commission a long way in the direction of setting clinical priorities, and for some conditions and treatments it might also lead to arguments for greater specialisation and rationalisation on an EU-wide basis in the long term.

The Commission clearly intends to play a greater role in running health policy in future. The Lisbon Treaty would give the EU a new competence in charge of public health, and ends the right of veto in this area. The EU would in future regulate medical standards. A new 'right to preventative healthcare' in the Treaty could potentially open the HSE up to court cases and legal challenges.

The well-off will be able to pay in advance and wait to be reimbursed – badly-off people will not be able to do any of those things.

Patrons: Robert Ballagh, Alderman Declan Bree, Raymond Deane, Tony Gregory TD, Prof. John Maguire, Terence P McCaughey, Finian McGrath TD, Patricia McKenna, Dervla Murphy.

25 Shanowen Crescent
Dublin 9
087-230 8330
post@people.ie