European Public Services Briefings 3

A Single European Market in Healthcare: The impact of European Union policy on national healthcare provision

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The member states of the European Union (EU) never intended EU law to get anywhere close to domestic policy concerning the organisation of national healthcare systems like Britain's NHS. Until recently there was a clear division of labour in this area with member states reserving responsibilities for the provision and organisation of healthcare. Since the 1990's this slowly started to change due the quiet activism of the European Court of Justice (ECJ). This culminated in the Cross-Border Healthcare Directive recently agreed in Brussels. The introduction of EU law into this area presents many problems. The most pressing being that EU institutions have sought to apply the 'economic' rights enshrined in the EU Treaty's free movement law to national healthcare systems, like Britain's NHS, that are essentially 'social' in purpose and aims. Expanding the 'choices' of users and providers of cross-border European healthcare is a further indulgence of the choice agenda that we've seen in Britain. This will only serve to further undermine social healthcare provision in the UK and the rest of Europe.

1. Introduction: Issues in Cross-Border healthcare in the European Union

Most informed observers in the UK would not have thought that the EU had much bearing on how the NHS was run and organised. This impression would also have been common amongst most other Europeans in regards to their own healthcare systems.

Even if you asked most UK civil servants and government ministers fifteen years ago you might get a few references to EU State Aid rules and their impact on NHS funding; but that would be about it. Throughout the history of European integration EU member state governments have intended that national healthcare systems were to remain a national affair. This was the settled division of competence in this area.

In the last fifteen years however developments at the European level have breached this settlement. EU law and policy has been introduced into the realm of healthcare policy, organisation and provision by the back door by a number of means all initiated by EU institutions.

There have long been cross-border issues relating to a country's EU membership and the social services it provides within its borders. The issue of access to cross-

border *healthcare*[1] more specifically has a broad set of issues connected to it. This includes those of tourists (covered under the European Health Insurance Card (EHIC) scheme[2]) and ex-patriots.

However, what has defined the problems of *cross-border healthcare* in recent years and concerns the choice of both *patients* and *providers* to leave their own member state and go to another to receive or provide healthcare and the priority placed on these mobility rights by EU institutions.

Cross-border healthcare currently only consists 1% of national healthcare budgets. So where's the threat to national healthcare systems?

Observers of the UK's recent NHS reforms have witnessed a number of changes which have sought to expand the use of private healthcare options, either through direct 'choice' of patients or by the awarding of contracts to private providers.

Cross-border healthcare users and providers taking up these opportunities in Europe have created a complex set of issues and problems. The overarching problem created is that the principle of individual cross-border choice inherent in European free movement rights and the principles of solidarity that define national systems of healthcare in EU countries are in conflict and that the former is being prioritised over the latter.

The conflict between the application of European rules and national prerogatives in social security was for along time regulated by European Regulation 1408/71 (now 883/2004) and its interpretation has been the trigger of many battles between the ECJ seeking to expand *European* cross-border rights and member states seeking to protect *national* powers in the area of social security and policy.

The EU's four economic freedoms[3] that constitute the Single European Market have been used to expand market integration between European states by facilitating the European mobility rights and opportunities of citizens and firms. The ECJ, through delivering the famous and foundational *Dassonville* and *Cassis de Dijon* cases, has been the primary driver of this process.

The ECJ in the 1990's, in the tradition of these famous cases, started to open up questions of national social healthcare provision to the market-making imperatives of the Single European Market. This was despite there being no treaty basis for this encroachment and certainly not for the application of the *economic* four freedoms law into questions of sensitive national questions *social* policy.

Therefore two settlements of legal division have been breached: the division of competence between member states and the EU institutions and between economic principles of the Single Market and social policy concerns underpinned by the ideal of the European Social Model.

[1] 'Healthcare' refers to policies, principles, institutions in providing and organising a system of national
[2] Strictly speaking this is a European Economic Area (EEA) scheme
[3] The phrase 'four economic freedoms' pertain to the free movement of persons, goods, services and capital which constitute the Single European Market. 'four freedoms', 'free movement law/provisions' will be used interchangeably throughout.

In February the EU Council of Ministers and the European Parliament agreed text for the ***Cross-Border Healthcare Directive*** (thereafter CBHD). This is the culmination of years of uncertainty surrounding the EU's nascent role in healthcare policy and amidst fears that this could create a ***Single European Market in healthcare***. The directive, the ECJ case law that preceded it and the controversial issues that surround it are addressed below.

2. Background of EU law in healthcare.

2.1 The EU Treaty and healthcare policy and organisation.

Before its ratification in Lisbon, the EU treaty said very little on the issue of healthcare. What it did say made clear that "organisation and delivery of health services and medical care"[4] was the responsibility of member states. The Lisbon treaty brought with it some additional clauses which would appear to offer a more expansionary role for the EU in healthcare.

These new clauses do point to a facilitator role for EU institutions and demands that member states engage in greater "cooperation" in the field of health and in particular in "cross-border areas"[5]. However this still leaves member states with the role of initiative in organising and providing healthcare in their own countries.

Moreover, in the new wordier healthcare provisions of the Lisbon Treaty there are ***no*** references to single market law being applied to questions of healthcare policy & provision. Yet, this is what's happened: free movement law has been pushed into the realm of national healthcare provision which could have a considerable impact on member states' ability to organise these regimes.

How did it we get here?

To understand how the Single Market's four freedoms have infiltrated national policy concerning member states' healthcare systems one must appreciate the ECJ's role in this, in European integration as a whole and the enormous power the Single (formerly 'common') market has had on nearly all areas of national policy.

The ECJ's role as primary motor in the 'Europeanisation of healthcare' mirrors its motor role in European integration as a whole. In the 1960s and 70s the ECJ was solely responsible for creating the doctrines providing for the supremacy of EC law and also the direct effect of EC law and did this with no treaty basis or mandate from member states. The ECJ then used this foundation to drive the four freedoms law into national systems of policy making and regulation. Again, the Court expansively interpreted its mandate beyond that that member states envisaged.

The *Dassonville* and *Cassis de Dijon* cases are the foundational cases upon which the Single Market we see today is built. In both of these cases the ECJ struck down national regulations deemed to be unfairly impeding the "intra-community" trade

[4] Article 152 subsection 7 in the EC Treaty (pre-Lisbon)
[5] Article 168 of the Lisbon Treaty, the current EC Treaty. (note* with the Lisbon Treaty the phrase 'EC Treaty' can be replaced by the phrase 'EU Treaty' due to the abolition of the EU's three pillars.

in goods between two member states. This created the principle of mutual recognition.

These cases were the first of many examples of an activist, supranational Court using the market-making tools of the Single Market's four freedoms to integrate the countries of Europe. The spillovers from this, coupled with codifying secondary legislation and treaty changes[6] at the European level, have created a Single European Market that affects so much of national domestic policy making.

2.2 The European Court of Justice and the 'Europeanisation of Healthcare'.

In the 1980s and most of the 90s the ECJ's activism in forging a Single European Market in the trading of goods was continued in regards to the free movement of *persons*[7] but not the free movement of services. Concerted attempts at the European level to create a single market in services were to come later.

This was to emerge in the 1990s and 2000s as the ECJ sought to apply free movement of services law to many areas of national social policy like healthcare. This was controversial in areas such as healthcare and labour law as it altered existing EU law in the area and angered Europeans who championed the European Social Model in the European project.

From 1998 to 2003 the ECJ delivered the *Köhll, Decker, Vanbraekel, Garaets-Smits and Peerbooms*, *Watts* and *Muller Fauré*[8] cases. In these cases the ECJ managed to bring the different forms of European healthcare system under the ambit of four freedoms law including those like the NHS despite the absence of any Treaty provision allowing this.

More importantly the challenge posed by the ECJ to national prerogatives in these cases, and to the (formerly) settled division of competence that placed healthcare as the responsibility of member states, came in the form of challenges to national *Prior Authorisation* rules.

Prior authorisation rules regulated both the opportunities of *Entry* and *Exit* to their healthcare system open to both *providers* and *patients*. In regards to *exiting* patients such authorisation was marked by the issue of reimbursement. This is exemplified in the *Watts* case below.

The ECJ undermined national means to use these rules by placing national healthcare under Article 49 (now 56) of the Treaty providing for the free movement of services. This was despite protestations of defendant member states,

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[6] In particular regard to the Single European Act (1985) and the Maastricht Treaty (1993)

[7] See the *Bosman case 415-93 (1995).*

[8] *Köhll case-158/96 and Decker case -120/95 (1998), Vanbraekel case -368/98 and Garaets-Smits and Peerbooms case -157/99 (2001), case -372/04 Watts (2003), case -385/99 Muller-Faure.(2003)*

particularly in the *Garaets-Smits and Peerbooms* case, of the 'special' and non-commercial nature of health services.

Relying on the ECJ's reasoning in the earlier *Humbel*[9] case, where it deemed education services as *non-commercial and therefore 'special'* in character, member states tried to argue that healthcare provision should also be regarded as such therefore exempt from EU four freedoms law. The ECJ bizarrely rejected this and consolidated its decisions made in *Köhll* and *Decker*.

Among the problems the ECJ's new case law created was the impact it had on the variety of different means of *funding* healthcare systems in the EU. These comprise of social insurance type 'Bismarckian' systems like in France, Holland and Germany and the 'Beveridgean' tax-funded model seen in the UK and throughout most of the EU.

The ECJ clearly put concerns of free movement rights above considerations of the way member states can fund and organise their healthcare systems. This was brought into sharp focus in relation to the NHS in the 2003 *Watts* case.

Mrs. Yvonne Watts was on the NHS waiting list for a hip operation. She was given a three to four month wait for the procedure but she chose to go to France to have the operation. She was charged £3900 for the operation in France and she returned to the UK and asked for reimbursement.

Mrs Watts was refused this and took legal proceedings against her local Primary Care Trust which eventually reached the ECJ. In line with its recent prior case law the ECJ decided that Mrs. Watts' free movement rights were paramount and placed above the rights of the UK government to use prior authorisation rules organise its healthcare system, the NHS. This was also despite the fact Mrs Watts only requested authorisation once she had returned from France.

One of the 'organisational' problems here is that the NHS did not have a mechanism for reimbursement as would be the case with the refund-based systems found in France.

More crucially however member states organise their systems based on national needs and priorities and factoring questions of patients travelling to receive healthcare elsewhere and entering from elsewhere makes such tasks of organisation impractical.

The ECJ's selection of article 49(56) indicated the ECJ's intent to frame questions of healthcare in commercial & economic terms. If it insisted on bringing internal market law into questions and issues of healthcare, it could have introduced article 39 providing for the free movement of *persons*.

The free movement rights of *patients* were not the only concern of the ECJ. In the *Köhll* case the ECJ judged the cross-border rights of a dentist to provide his services in another member state as 'services' as defined under article 49 (56).

[9] *Humbel case 263/86 (1986)*

Therefore, the cross-border rights of *providers* as well as *patients* have been enforced by the ECJ under article 49 at the expense of national regulations.

The expansion of free movement rights to healthcare *providers* is potentially the most damaging development in the EU's entrance into healthcare policy. Increasing the rights and market opportunities of private providers will aid the creation and expansion of a Single European Healthcare Market. This in turn will only undermine systems of social provision.

This has meant that issue of healthcare choice in Europe is framed by economic not social objectives despite all European healthcare systems being defined by the former. This has also been applied to both hospital and non-hospital care.

It may also seem odd to some to equate national policy with the preservation of social healthcare provision. Particularly as many member state governments have embarked upon various healthcare liberalisation programmes and many countries *social* systems including formidable private, for-profit elements.

However, national social healthcare systems in Europe, in all their different guises, are defined by national boundaries. There is no 'European health service' of any kind. The introduction of the EU and its four economic freedoms into this area can only point to further pressure toward liberalisation.

There is no doubt there is a need to clarify EU law in this area and serious questions need to be asked. In particular, why on earth did the ECJ apply four freedoms law to such sensitive issues of social policy like healthcare provision when there is no legal basis for this in the treaty? The issue of prior authorisation would also form a crucial battleground in the Cross-Border Healthcare Directive.

However, a more infamous attempt to codify the ECJ's case came first.

3. The Cross-Border Healthcare Directive

3.1. Background: A Directive to regulate Cross-Border Healthcare.

In 2004 the European Commission unveiled a proposal for a directive in the field of services. The Services Directive, as originally proposed, was as radical as it was controversial. Its contents were vehemently opposed by trade unions and the centre-left and left blocs in the European Parliament. This was due to the presence in the proposal of the Country-of-origin principle in regards to labour rights and to other provisions like that pertaining to healthcare.

The directive attempted to codify the ECJ's above case law in a bizarre fashion. It sought to squeeze all of the contents and principles of the ECJ's case law into *a single* article[10]. This attempt, if successful would have placed healthcare under article 49(56) in unvarnished form as the ECJ had done.

[10] Article 23 of the original draft of the directive.

Cramming all the rules governing the complex issues of cross-border health care and the different forms of national healthcare organisation into a single article is self-evidently ridiculous. Furthermore, this would mean questions of interpretation would once again be left to the ECJ.

Thankfully the Commission had to retreat and the provision was gutted, along with the country-of-origin-principle, from the directive courtesy of an alliance between national governments in the Council and the European Parliament.

The European Commission was however asked to return to the issue of cross-border healthcare in an entirely new and separate directive. It did this in 2008 and proposed a *Cross-border Healthcare Directive* (thereafter 'CBHD').

From its chastening and embarrassing experience with the Services Directive the Commission embarked on a new strategy of smoke-screening to implement the principles of the ECJ's case law.

The Commission couched the proposal in language of 'consumer rights' and to underline the point gave responsibility for the draft proposal to the Directorate General[11] for Health and Consumer Affairs (DG SANCO) rather than the Directorate General for the Internal Market (DG MARKT) which was responsible for the now ratified Services Directive[12].

The language also gave the impression that this Directive was merely a technical, tidying-up exercise that was based on providing clarity and making information easier to obtain for EU citizens seeking cross-border healthcare.

This attempt at deception notwithstanding the goal of the Commission's remained the same: to codify as much of the ECJ's aggressive application of European economic rights to national social institutions of healthcare provision.

This is made clear by its choice of legal base for the proposed directive. The legal base of the CBHD was still the single market provisions in the EC Treaty but instead used article 94 (now 114 post-Lisbon) instead of article 49(56). Article 114 is the article used so that harmonization measures of general application relating to any of the four freedoms of the single market can be implemented.

In light of this radical move to apply four freedoms law to questions of healthcare a pertinent question remained: 'if this is really a technical tidy-up of issues pertaining to consumer rights and not an attempt to push free market principles into healthcare, why *again* has the single market provisions been used as the legal base for this proposed directive on cross-border healthcare?'

More importantly the same social democratic/socialist bloc in the European Parliament and the European trade union movement (that successfully lobbied for

[11] 'Directorates Generals' are the different policy-area departments of the European Commission and are referred to as 'DG's' followed by an official acronym such as DG MARKT, DG SANCO, DG COMP (competition)

[12] The Commission was advised down this route by Conservative MEP John Bowis who was the Rapporteur in the European Parliament for the CBHD.

the watering down of the Services Directive) were not fooled. These forces demanded that public health concerns were heeded and appropriate Treaty provisions be used as the CBHD's legal base.

This issue of legal base would define the CBHD's negotiations. By the end of the first reading and with the guidance of the CBHD-sceptical Spanish presidency article 168 (which outlines the EU's respect for member state prerogatives in the field of healthcare) was successfully added to the CBHD as its joint legal base alongside article 114.

This represented a partial success but also some complex questions. Which Treaty base will an individual provision in the CBHD be based upon? How will this relate to the crucial questions of **Prior Authorisation**, **reimbursement** and to **hospital and non-hospital care**?

3.2. The final text as agreed by the Council and the Parliament

The questions above needed answering in the European Parliament's second reading of the CBHD in January 2011. The Parliament's amendments to the CBHD of January 15th were officially accepted by the Council of Ministers on February 28th[13]. The adopted CBHD has partially mended some of the problems of the original Commission proposal but most of these remain.

In particular, ambiguity in key areas will mean member states will be left to interpret them when they transpose the CBHD in to national law. But one member state cannot control how another will do this and one member states goes for the liberalisation-*plus* route of transposition this will only increase the level of competition in any future Single European Market in healthcare that all member states will be subject to.

Of course the ECJ will also be able to interpret the CBHD, and national measures transposing it, when later cases in cross-border healthcare reach it.

Ambiguity on the issues of ***prior authorisation*** and ***reimbursement*** are made clear by two separate provisions.

> *"The sole objective of the provisions regarding prior authorisation and reimbursement of healthcare provided in another Member State should be to enable freedom to provide healthcare for patients and to remove unjustified obstacles to that fundamental freedom within the patient's Member State of affiliation…"*
>
> Paragraph 35, CBHD.

This would point to the more liberal interpretation given by the ECJ which underwrites for mobility rights for healthcare providers as well as patients.

> *"According to the constant case law of the Court of Justice, Member States may make the assumption of costs by the national system of*

[13] 'Directive on Cross-Border Healthcare Adopted' Press release of the Council of the European Union 7056/11. Presse 40. Brussels, February 28th 2011.

hospital care provided in another Member State subject to prior authorisation. The Court of Justice has judged that this requirement is both necessary and reasonable, since the number of hospitals, their geographical distribution, the way in which they are organised and the facilities with which they are equipped, and even the nature of the medical services which they are able to offer, are all matters for which planning, generally designed to satisfy various needs, must be possible…"

Paragraph 40, CBHD.

This amendment, put into the Directive by the Council and Parliament, clearly reinstates much of the prior authorisation prerogatives of member states, specifically concerning overnight hospital stays and specialised care. It is however clearly contradicted by that highlighted above in paragraph 35.

The reference in paragraph 40 to ECJ jurisprudence is also a curious one. Its case law on the subject of prior authorisation is contradictory[14] but crucially struck down national prior authorisation rules more often than not. Directives, in light of ECJ jurisprudence in a given area, are meant to provide clarity and legal certainty to issues like this. The final CBHD text has failed to do this.

It should be noted that many national pieces of legislation are not immune from such contradictions. This is however more common in European legislation due to the much more elaborate, and continent-wide, bargaining process that must precede the passage of most of its legislation. This bargaining process is also why a lowest common denominator outcome often results in European legislation.

This leaves open important questions of interpretation. If member states choose to transpose this directive with greater emphasis on paragraph 40 providing for stronger prior authorisation powers above this could be challenged by a citizen whose lawyer has read paragraph 35.

If this goes to the ECJ what will happen? Based on the majority of the ECJ's case law it is likely to side with the economic European rights of citizens than the social rights they enjoy at home.

Perhaps the more concerning element of the EU's encroachment into national healthcare has less to do with the mobility rights of patients and more to do with providers. The latter could seek to pursue overseas market opportunities.

In light of growing private healthcare sectors within member states the developments in EU law present legal underpinning to firms seeking to penetrate 'healthcare markets' in another member state other than that which they are established. This can only add to liberalisation pressures already palpable throughout many EU countries.

[14] Despite examples from its case law looked at earlier in the *Inizan* case, and others concerning broader social insurance programmes found in Bismarckian countries, the ECJ did up hold a member states' right to impose prior authorisation requirements.

Most references to providers in the CBHD are wrapped around other seemingly harmless references to transparent information being provided to patients. Some crucial references however underline the mobility rights apply to providers of healthcare as well as users albeit not too clearly.

> *"This Directive should apply to individual patients who decide to seek healthcare in a Member State other than the Member State of affiliation* ***As confirmed by the Court of Justice, neither its special nature nor the way in which it is organised or financed removes healthcare from the ambit of the fundamental principle of the freedom to provide services****. However, the Member State of affiliation may choose to limit the reimbursement of cross-border healthcare for reasons relating to the quality and safety of the healthcare provided, where this can be justified by overriding reasons of general interest relating to public health. The Member State of affiliation may also take further measures on other grounds where this can be justified by such overriding reasons of general interest. Indeed, the Court of Justice has laid down that public health protection is among the overriding reasons of general interest that can justify restrictions to the freedom of movement envisaged in the Treaties."*
>
> Paragraph 11, CBHD.

The paragraph 11 sought, rather messily, to deal with a number of different issues. These included those of individual patients, exceptions for overriding reasons of general interest and reimbursement.) This may look like a mistaken attempt to deal with these different issues.

However, given the key sentence (highlighted) buried within it pertaining to the controversial mobility rights of providers one is left to wonder. The presence of this key provision thrown into the middle of a much larger, almost garbled paragraph does look like an attempt to hide was made. It does make the Commission's claim that the directive was directed at *patients* seem rather hollow.

The directive does make some things clear however: firstly, the CBHD does state that *all* forms of healthcare, in the cross-border context, are covered in the directive although subject to some prior authorisation rules.

On reimbursement, the CBHD also states that EU citizens cannot claim for healthcare costs above that available within their own country. It doesn't however make reference to additional costs such as travel and non-hospital accommodation. This is important.

In 2008, when the CBHD was first proposed, there were claims form some that this would amount to a rich patient's charter as only the well-off would be able to afford these additional costs. This has not bean dealt with in the CBHD.

4. Conclusions: Toward a Single European Market in healthcare

The ECJ's case law and the CBHD will not create a Single Market in health. It does however open a door. Reframing social rights to healthcare around the economic principles of the market will only serve to further undermine social healthcare provision and the systems that preserve them.

There are, again, however issues of cross-border healthcare that do need to be clarified at the European level; especially in light of the ECJ's worrisome case law. However, indulging the liberal choice agenda as the CBHD has done will only serve the liberalisation of healthcare cause further.

The CBHD does not provide enough legal certainty. This is perhaps deliberate on the part of Commission. Therefore it does not provide enough protection for national prerogatives to organise social healthcare provision even if there are some improvements compared to the ECJ's case law. The EU certainly has no prerogatives to organise social healthcare provision.

What is the game plan of EU institutions here? Is it to galvanise member states into greater cooperation in the field of healthcare? If so there were ways of doing this without bringing the single markets four freedoms into it. The four economic freedoms were designed for the market integration not for undermining national welfare institutions.

Trade union campaigners and left groupings in the European Parliament succeeded in watering down the CBHD a little. Unfortunately, the necessary removal of the Treaty's single market provisions didn't happen. Therefore a door has been opened and will be very difficult to close.

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KEY

EU – European Union
EC – European Community
ECJ - European Court of Justice
CBHD – Cross-Border Healthcare Directive
EHIC – European Health Insurance Card
NHS – National Health Service

LIST OF CASES

- ***Humbel*** *case - 263/86 (1986)*
- ***Köhll*** *case - 158/96 (1998)*
- ***Decker*** *case -120/95 (1998)*
- ***Vanbraekel*** *case - 368/98 (2001)*
- ***Garaets-Smits and Peerbooms*** *case - 157/99 (2001)*
- ***Watts*** *case - 372/04 (2003),*
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- ***Inizan*** *case - 56/01 (2003)*
- ***Bosman*** *case 415-93 (1995).*

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