

## The Health Services Directive

### Key points

- On 19 December the Commission announced for the second time that it will delay the publication of the Directive on Health Services.
- The UK Government absurdly claims "not to have seen" the Directive yet and says that it will make up its mind when it is published. In reality, behind the scenes a furious battle is going on with the UK trying to get controversial elements of the proposal deleted. However, because it is proposed under the internal market, the Directive can be passed by qualified majority vote, and the UK is seeking a compromise.
- The Directive would mean bigger changes in the UK than in any other member state because of its unique approach to funding healthcare.
- Discussion so far has been dominated by the fact that it will enable patients to seek private treatment in foreign hospitals, triggering an ideological clash between those who favour the greater involvement of the private sector and those who do not.
- Leaving this ideological debate aside, this paper argues that while quasi-markets in healthcare are a good thing, the specific proposal in the Health Directive is not the right way to go about introducing greater choice. Critics are indeed right to point out that the Directive is similar to the "patients passport" which the Conservatives proposed at the last election, and there are good reasons why the Conservatives have now moved away from that model with their current proposals on patient choice.
- Two particular features of the Directive - at least as currently drafted - 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 NHS, but make up the difference themselves. These features would tend to lead to the diversion of resources towards higher income groups.
- The Commission acknowledges - but dismisses - concerns that the Directive will create pressure to move to a co-payments based system and reduce equality:

*"Some stakeholders have raised concerns about the potential of cross-border healthcare to alter the overall choices of Member States with regard to their mechanisms for control of access to healthcare. In particular, in so far as cross-border healthcare provides a route for quicker care, whether this provides an incentive for Member States who use waiting lists to manage demand to shift to other mechanisms such as co-payments, which could in consequence reduce the overall equity of their health system."*

- Nigel Edwards, Policy Director of the NHS Confederation, says that, "the issue here is that people who are able to travel can go and get their procedure and because we have a fixed pot of money, that effectively means they can get first call on the NHS resources; one of the concerns that a number of people have - and not just in this country - is the impact that this has on trying to run an equitable system... there could be an effect here where those who are able to travel and pay upfront can to some extent push to the front of the queue... it has a potential differential effect that favours the young, mobile and relatively affluent." (Today Programme, 19 December)
- Confusingly, Health Secretary Dawn Primarolo has said that the Government is in favour of the Directive - but as long as it could "protect the basic principles of the NHS". She also said "What we won't accept is that wealthy patients go abroad and then hand the NHS the bill." She said, "We are quite clear that the NHS will decide what it pays for in terms of individual care." But this is the exact opposite of what the Directive proposes. This is essentially just an attempt to downplay the radical implications of the proposal. (*BBC News*, 19 December)
- Regardless of whether we think that insurance based systems are better or worse than the NHS, trying to retro-fit aspects of a continental insurance based system onto what remains fundamentally the 1945-model NHS is likely to create an incoherent system and unfair outcomes. It will not transform the system as a whole, but will allow large numbers of people to exit from it based on their ability to argue their case.
- This is the opposite outcome from that hoped for by advocates of quasi-markets. One of the clinching arguments for quasi-markets in healthcare - particularly for Blairites - is that as well as increasing the productivity of the system overall, they can potentially increase equity compared to a rationing / command and control system (the basic NHS model). Julian Le Grand and others have convincingly argued that under rationing systems high income groups are better at getting the treatments they want in a rationing system because of greater knowledge and pushiness. (This is visible in statistics showing, for example, that middle class people will tend to spend more time with a GP for the same complaint than people from lower income groups).

- Advocates of patient choice suggest that giving everyone *equal choice* about how and where they are treated will create greater equality. Introducing his own reforms Tony Blair said: "We should give poorer patients ... the same range of choices the rich have always enjoyed." John Reid said that "choices will be there for everybody.... Not just for a few that know their way around the system. Not just for those who know someone "in the loop" - but for everybody with every referral."
- 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; 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.
- Several principles were established by the defeat of the UK Government in the *Watts* case in 2006. As the Commission explains in its communication:

*"Two clarifications were provided by the Watts judgement on 16 May 2006. First, some Member States with systems based on integrated public funding and provision of health services had argued that the Treaty provisions on the freedom to provide services did not apply to them; the Watts judgement confirmed that they do.*

*"Second, some Member States have argued that the requirement in Article 152, paragraph five of the Treaty to "fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care" prevented binding obligations under Community law regarding health systems. In the judgement, the Court stated that this provision does not exclude the possibility that the Member States may be required under other Treaty provisions, such as Article 49 EC, or Community measures adopted on the basis of other Treaty provisions, such*

*as Article 22 of Regulation (EC) 1408/71, to make adjustments to their national systems of social security."*

- The Commission now 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 the Socialist group in the Parliament insisted that healthcare was excluded from its scope. Interestingly, its proposed legal basis is under the internal market (article 95) rather than the health articles of the treaty.

- In its Communication making the case for the Directive the Commission makes a wide-ranging and more political argument. It argues that:

*"Cross-border care can provide an additional choice that allows all citizens to 'exit', which for cross-border care will be particularly relevant for specialised services that otherwise have low domestic contestability. By doing so, this can provide an additional signal of patient dissatisfaction, which may bring about improvements in quality of the care concerned that would also benefit patients who do not move."*

- 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, and is projected to rise by one to two percent of GDP in most Member States between now and 2050 as a direct result of ageing populations. However, these projections of future costs are very sensitive to changes in costs of providing a given package of care. The key to sustainability for healthcare systems is therefore controlling costs and improving efficiency."*

- The country which is likely to see the biggest changes as a result of the Directive is the UK - which has a system based on integrated public funding and provision of health services, as opposed to an insurance / reimbursement system of the kind that prevails in most other member states. For example, 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. But the recently introduced NHS "tariff" does not even yet cover all forms of treatment (e.g. not mental health services) and so further development of the internal market will be necessary to bring it into line with the Directive.

### How would it actually work in practice?

- The *Watts* case established the principle that individuals have a right to seek treatment and be reimbursed if there is a risk of "undue delay" to their treatment nationally.
- However the practical implications of these cases 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. Indeed, according to BBC reports ministers are discussing further watering down the requirement to prove undue delay (Mark Mardell 19 December).
- So despite the radical nature of the Watts ruling, without the proposed Directive it will have relatively little impact in practice.
- However, under the new Directive people will be able to gain access to treatment abroad much more easily:
- The NHS 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.<sup>1</sup> 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.
- 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. Moreover the

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<sup>1</sup> Article 11 of the proposed Directive states that "Member States shall clearly designate and make easily accessible national contact points for cross-border healthcare. The national contact point in the Member State of affiliation shall, [...] provide and disseminate information to patients in particular on their rights related to cross-border healthcare..." It is unclear whether LHAs or PCTs or a new national body would be put in charge of such decisions in the UK.

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.

- The approach described by the Directive certainly cuts clearly across the UK approach of trying to impose a cost/benefit analysis on treatments through the National Institute of Clinical Excellence.
- Article 7 of the draft Directive states simply that: *"The treatment shall be considered to be appropriate if the expected health benefit exceeds the expected negative consequences by a sufficiently wide margin that the treatment is medically worth doing, exclusive of costs."*
- The Directive sets clear limits on a member state's 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 the UK this is likely to be tricky, because the NHS - 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 NHS to "prove" that patients are not entitled to a particular service within a particular time.

### Political context and future developments

- The Directive is also 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.
- The Directive also 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 revived Constitutional Treaty, now known as 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 NHS up to further court cases and legal challenges.