European health policies – moving towards markets in health?

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The future of European national health systems is currently at a critical juncture. In the European Union, health issues tend to be discussed in non-health arenas while at the same time in many Member States health care systems face increasing pressures and demands in terms of universal access to services, cost-containment and the sustainability of health care financing. In this respect it is important to draw attention to five interlinked processes:

1. The impact of internal market regulations on the financial sustainability and functioning of national health care systems.

2. The negotiation process concerning the General Agreement on Trade in Services (GATS),

3. The European Commission's Green paper on Services of General Economic Interest.

4. How current processes within the health sector are geared towards accommodating patient mobility and the open-method coordination in health services.

5. How the proposed draft Constitutional Treaty may raise challenges for national health systems.

Internal market regulations

The impact of the internal market on health care systems has been raised in the context of European Court of Justice decisions and European policies towards health.[1,2] The relevance of these decisions seems to be greater than the existing size of patient mobility or services in Europe and thus relates more to policy priorities and the legitimacy of imposing structural change.

There is little, if any, evidence that commercialisation of service provision leads to improved, lower cost and better quality health care systems for all citizens. However, more evidence exists of the problems and problematic incentives that health service commercialisation brings in terms of cost-containment and equity considerations. Choice is typically linked to responsibility. Enabling choice in health care is costly and has broad-based implications for equity of access amongst those who are less able to choose.

These issues are already problematic within current European health care systems, making it unlikely that commercialisation will be part of a solution to cost-containment and ensuring of equity in access to services. There is also a fundamental problem in priorities if in European Community policy the rights of service providers to establish services take precedence over European citizen's rights of access to high quality health services according to need, independent of the ability to pay.

It is necessary to acknowledge the known information asymmetries and market failures in health care. It is also important to understand that quality of care in health has broader aspects than easily measurable issues of staff requirements, equipment levels and cleanliness. While it is unlikely that health systems will collapse due to one major regulatory move, it is much more likely that incremental changes and measures may culminate in vicious cycles and compromises in the longer-term, leading slowly to malfunctioning and decay. In this context the proposal for a directive on services in the internal market merits detailed analysis.[3] The directive is clearly based on the assumption that health services are part of the broader internal market of services and thus need to be included in the regulatory framework. However, it is likely that this framework may become deeply problematic for European health care systems. Problematic issues extend from authorisation and country of origin principles to the restrictiveness of exceptions allowing little leeway for governments in regulation of services. In this context it is important to emphasise again that while the regulatory proposals may not directly imply harmonisation of health care systems, it is clear that they can provide indirect pressure towards

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this end and more importantly limit the ways in which Member States can ensure cost-containment, quality of services, cross-subsidisation and access to services within the scope of national health care systems. While European health care systems may not be harmonised into one similar system, they may each become commercialised in different ways.

The impact of GAT negotiationss

Negotiations concerning the General Agreement on Trade in Services are continuing under the auspices of the World Trade Organisation. In the European Community trade policy is determined by the Article 133 Committee named after the relevant article in the EC Treaty. The Committee is technically a Working Group of the Council where 133 European decisions are made on the basis of the trade and foreign policy expertise. Consultations, if they take place, occur at the national level and often within very short time frames. It is not evident to what extent European Union trade related views on necessity tests, subsidies and other aspects of domestic regulation may be serving the ends and needs of Member States or the regional and local entitities accountable for service provision in practice. It would, for example, be problematic if European proposals on subsidies in the context of GATS would suggest obligatory use of competitive bidding in service contracts if these would otherwise be considered as potentially inappropriate subsidies to local providers.

It is known that many aspects of the GATS negotiations have both direct and indirect implications for European health care systems and their regulation. Legal analyses suggest that most European health care systems would not be covered by the current WTO exemption for public services and that GATS would have significant implications for health care systems.[4–6]The European Community has taken a specific horizontal commitment on mode 3 in market access, however, it is not clear how this relates to other areas of the agreement and their impact on service provision. The flexibility in GATS rests in a government's ability to decide the level of commitment, but the general emphasis and context of the negotiations aims to promote the liberalisation of service provision and when committments are made it is difficult to change them subsequently. As liberalisation of service provision is possible without GATS committments this implies that it is wiser to take a cautionary approach within the GATS negotiations. The strong emphasis on effectiveness in promotion of majority voting, and no exceptions in the context of commercial policies, thus needs be challenged by requirements for caution and better understanding of the implications of negotiated committments in all service sectors.

Green paper on Services of General Economic Interest

It is important to draw attention to the Green Paper on Services of General Economic Interest as it proposes a definition for the scope and nature of these services.[7] The Green Paper places services of general interest and those of general economic interest in separate categories. This is important as competition and internal market rules would not apply to the former, but only to the latter category. The problematic aspect for health, social and education services is that they are defined as being part of services of general economic interest. This means that the narrowest interpretation of exclusion would include only those services provided directly and without charge in the category of services of general interests and that all other provision would be subject to internal market rules and regulations in the context of the European Union.

The Green Paper also points out that the European Community has freely decided to undertake binding commitments in respect to certain services of general economic interest already open to competition within the internal market.[7] This implies that this would also be likely with respect to other services that are also subject to internal market rules and regulations. While so far Member States have the right to schedule services and decide on scheduled services, it should be noted that when scheduled in the context of the GATS these services sectors are subject to requirements in relation to domestic regulation, including requirements about least trade restriction of government policies and regulatory measures. The issue is thus not so much about changing the aims of service provision or public policies, but rather of how and in what kind of a regulatory context this is done.

Patient mobility

In European health policy substantial attention has been drawn to the mobility of patients and the implications of European Court of Justice judgements for national health care systems. The aims of current

efforts and the proposed mechanisms for the open method of coordination are unclear. These activities seem to be more focused on forcing European health care systems to adopt a more commercial framework of operation rather than ensuring that they can have the necessary scope and regulatory freedom to ensure their commitments on provision of health services for all of their citizens. In this light it is worrying that the proposed regulation on internal markets in services states that it consistent with work on patient mobility.[1] Increasing cooperation and mutual learning between Member States is easy to support. However, if the mechanism of open method of coordination becomes a soft mechanism of governance and a means to adjust Member States health systems to fit with the requirements of an internal market and competitiveness within the European Union, this activity becomes problematic.

This is important also within the context of the forthcoming enlargement of the European Union, which will bring even more diversity of health systems and underlying values into the European Union. It is clear that action at the European level in terms of health will be required. However, there is a danger of merely increasing the European level competence without an increase in the capacity to ensure health policy and public interests at the European level. The danger of is that this will lead to a greater emphasis on the interests of industrial and interest group aims rather than the the interests of citizens; an outcome that is all to apparent in the context of pharmaceutical policies.

Draft Constitution

The proposed draft constitutional Treaty provides both threats and opportunities for European health systems. In this context it is necessary to emphasise that the actual details of the Treaty may not as yet have attracted sufficient attention, especially part III. Even though it would be unrealistic to assume that health would be a central objective of the EU, it is clear that a European social model can exist only if social and health policy priorities and commitments are considered to be of equal relevance with the free movement of goods, people, capital and services and the right of establishment. At the moment no such clear recognition exists in a Treaty that instead seems to enhance the economic aspects of the EU at the expense of social goals in the context of the 'hard' legal framework of aims and priority commitments.

In this context it is necessary to ensure that definitions of competence do not end up leaving Member States with residual powers where EU activities would in practice define competence. On the other hand, the draft constitutional Treaty is weak in terms of European competence in the area of public health, health promotion and in broad fields that would improve European level regulatory functions for health promotion (e.g. alcohol, tobacco policies) or help ensure high levels of health protection. Commitments to EU citizens in terms of access to health services and the provision of care remain with Member States. This is to be expected, but it does not provide grounds for further changing a situation that is already problematic. There is thus a danger that current problems with respect to internal markets and health may become further enhanced through a new Treaty. In order to ensure that access to health services and social security are not compromised by commitments to fundamental freedoms, (free movement of goods, people, capital, services and freedom of establishment) and that public health issues receive higher priority within all policy areas, additions and changes would need to be proposed. In practice proposals to address the problem of internal markets and health services and other health-related matters have already taken place, having been put forward by Member States. The challenge is to ensure that obtain sufficient priority in future rounds of negotiation.

The current negotiation process, in the context of the WTO, raises concern with respect to EU competence in the negotiation of international Treaties. This is particularly true in respect of EU competence and common commercial policies as stated in the draft Constitutional Treaty. In the current version of the constitution the only exclusion from majority voting in commercial policies is made for audiovisual services. In comparison to the Treaty of Nice, the current draft constitutional Treaty clearly expands EU competence in relation to commercial policies. Majority voting is promoted on the basis of increasing the effectiveness of trade negotiations and decision-making, yet there is often a trade-off between the more shortsighted efficiency aims and democratic processes and accountability. If the Member States, or in many cases their regional or local authorities, are held accountable for service provision, it is problematic to treat health, social and educational services simply as part of

the general Community approach to trade negotiations. The Assembly of European regions has drawn attention to this problem with respect to stipulations in commercial policy in the draft Constitutional Treaty.[8] If the stance on common commercial policies remains unchanged, there is a high risk that European Community trade policies will compromise the capacities of Member States to ensure the financial sustainability of their health systems and social rights of their citizens. European citizens have the right to expect that decisions concerning the organisation of their health systems and the delivery of health care will be made on the basis of health policy priorities and interests, rather than on the basis of equal treatment of service providers or the priorities of commercial actors.

European health policies have reached a critical juncture. It is clear that the profile of health and concerns over health systems capacities, resources and functions need to be raised at European level. It is not though clear whether this automatically means increasing EU competence over health. It is in the interests of European citizens to ensure that health and the sustainability of European health care systems are given a higher priority at a European level and that this is recognised both within the context of internal market, trade and competition policies, and within the further negotiation process for the draft constitutional Treaty.

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