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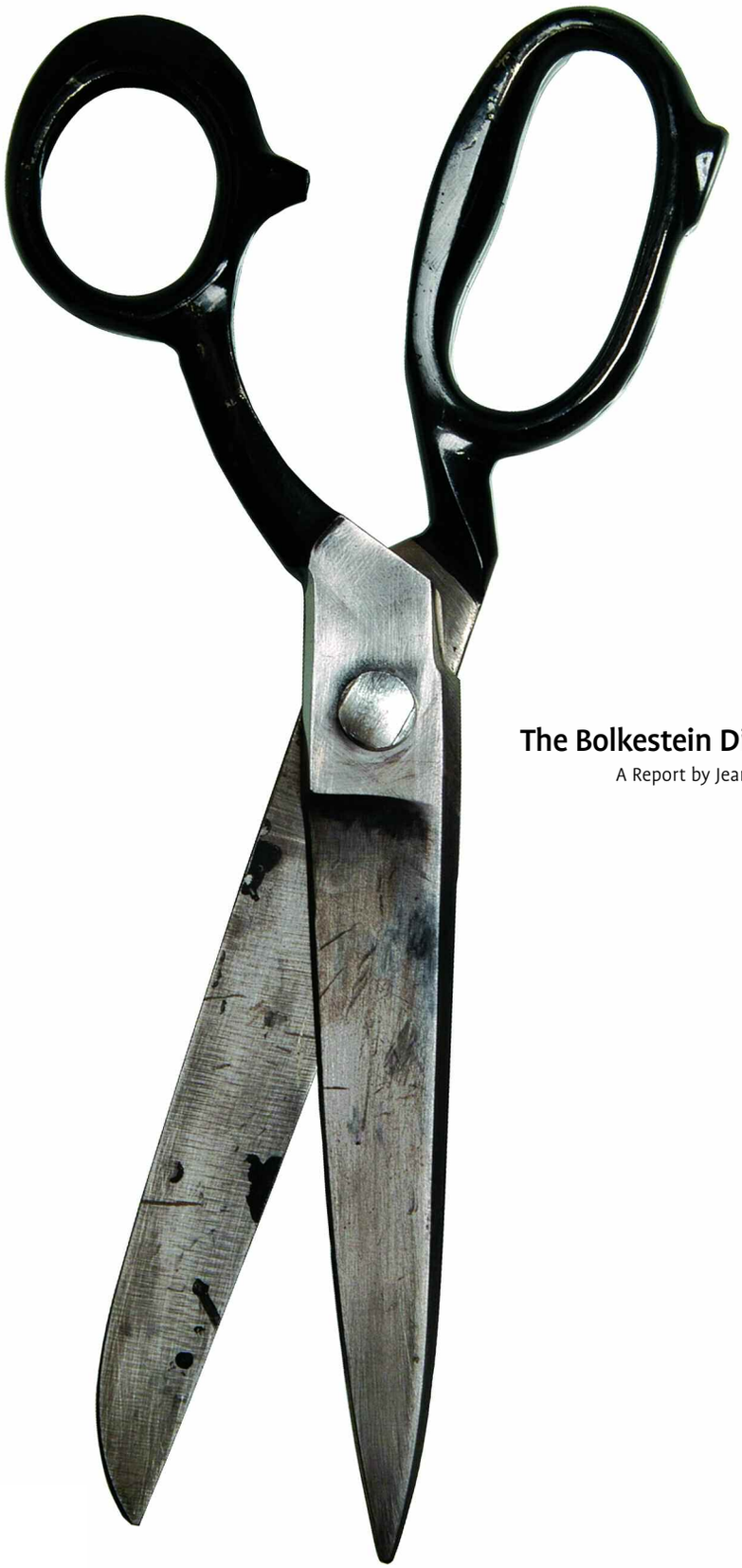
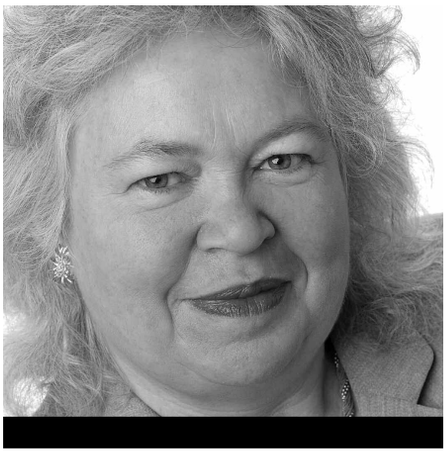


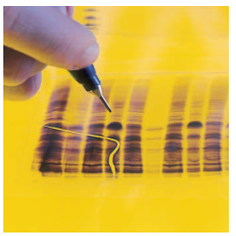
The Bolkestein Directive: Health Warning

A Report by Jean Lambert, Green Party MEP for London

The Greens | European Free Alliance
in the European Parliament



JEAN LAMBERT
MEP FOR LONDON



FOR MY PART, I BELIEVE THAT HEALTH IS NOT A COMMERCIAL SERVICE TO BE TRADED ACROSS BORDERS LIKE KITCHEN SINKS

This report aims to give an idea of why the Greens are opposing the inclusion of health in the Bolkestein Directive. We are campaigning to make sure that health is taken out of the Services Directive and we would like your help. If you think that health should be treated separately from commercial services such as estate agencies, recruitment consultancies and building then make your mark!

Visit www.jeanlambert.org.uk and register your views on the Directive. We've included interviews with three people who know what they are talking about when it comes to health and public services, all of whom have stringent and thoughtful criticism of the Directive as it stands today.

Kevin Doran speaks for the British Medical Association on European issues. Tim Curry is a policy adviser for the Royal College of Nursing. Penny Clarke is the policy officer for the Europeon Federation of Public Services Unions

And of course, it is not simply about health. Trade Unions and NGOs are rightly concerned about the possibility that construction companies will be able to ignore UK health and safety standards on site and there are numerous other examples.

The British Government has declared itself solidly in support of the whole Directive. I am convinced that supporting the Directive as it stands will leave the future of healthcare across Europe in very serious doubt. We can make the provision of services across borders easier. But we must not allow the safety of EU citizens to be put at risk and should continue to campaign for high-quality health and social care to be available for everyone.

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KEVIN DORAN
BRITSH MEDICAL ASSOCIATION

The Bolkestein Directive has, we believe, serious flaws at its heart. The BMA foresees real problems with the Directive as it stands. The assumption that health is a service, much like estate agency, recruitment or the installation of kitchens is the first and most serious mistake at the centre of the Services Directive. It assumes that harmonisation in the care system is already in place and the simple fact is that there is no such harmonisation which exists at present. We are more than happy to take part in the process towards harmonisation, but this completely leapfrogs over the process, assumes it has taken place, when in reality we have barely started.

The Services Directive, as the proposal stands at present, will undermine each country's right to run their own healthcare system as they see fit. There is a real risk that health services will be deregulated. Not only that but, contrary to what Commissioners hope will happen this Directive could cause a great deal of legal uncertainty. No serious legal impact study has been undertaken and there are some obvious incompatibilities in legislation; for example regarding contractual and non-contractual obligations.

Under the country of origin principle European healthcare providers would not be requires to meet existing British standards, only those of their own country. This could apply to any temporary health service provision from cleaning to radiography. We fear that unscrupulous operators could just use post office box addresses to operate under the easiest laws. Some qualifications are not recognised in the UK but would allow someone to practice here under country of origin principles. While doctors and nurses are covered by an existing system of mutually recognised qualifications, these are much less clear for other healthcare workers.

We already have a process in place for patient mobility – the E111. As most people know this allows people from member states to receive emergency or unplanned medical treatment abroad. We're also looking at a reworking of the less- well-known E112 which looks after people who seek medical help abroad by prior organisation. Ultimately there's nothing in this Directive which will genuinely ease cross border treatment. What we do have is a step into the unknown which has been insufficiently thought through and which leaves patients more at risk than they are today.

The BMA believes that it should be up to each member state to decide how their own health service is run and what regulations are in place. This is especially important, we believe, for Britain. If this Directive goes through unaltered, I can say with absolute certainty that the NHS will change irrevocably. These are uncharted waters.

We are aware that the Commission is fully committed to the EC Treaty, which provides for the free circulation of services, but we must reiterate that health is not and should not be defined as a commercial activity. Our position boils down to one simple truth – health services are not commodities to be traded indiscriminately across borders like any other. Health is and always has been a special case.

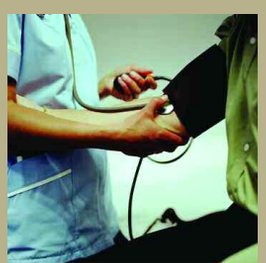
TIM CURRY
ROYAL COLLEGE OF NURSING

HEALTHCARE IS FAR TOO IMPORTANT TO BE LEFT TO THE VAGARIES OF THE MARKET. THIS IS CLEARLY ABOUT SOCIAL RESPONSIBILITY

Tim Curry Policy Advisor RCN

I think you can just make a straightforward moral case here. Health is not a service like any other. Providing care is not a service like any other. This is something that is provided not for the providers but to meet a social need.

This Directive seems to undermine that principle – a principle which is at the heart of how we provide heath and social care in Britain. I'm especially interested in the distinction between what a barrier is and what a safety net is. Especially around quality and experience of quality that is at the heart of the experience between a patient and their service provider – in our case the National Health Service.



For example in the National Health Service we have standards that include things like the provision of a minimum number of staff at any given time. Clearly this protects the safety of the patient and increases the quality and experience of their care. However under the Bolkestein Directive these safeguards, which protect the safety of patients using the NHS, will be seen as barriers – barriers which prevent a similar service being provided by a country or service provider where there are no minimum standards about how many people work ona ward. Suddenly a safety net which protects patient and staff has been reinterpreted as a barrier. And with the reinterpretation will come an immediate and serious lowering of standards and, ironically, service provision.

It certainly seems to undermine the unique quality of the NHS. In the UK health is overarched by a huge safety net – services just don't go bankrupt. The Services Directive assumes some kind of economic test. The danger here is that the Services Directive starts to lean too much in favour of the service provider and too far away from the rights and interests of the consumer. If this goes ahead we will almost undoubtedly see the NHS being taken over by a plurality of providers. It certainly won't just be the NHS providing services and information will be key. How will we choose who provides our healthcare? Where we will receive care?

Choice will become a fundamental principle underpinning public services. Which might be fine if you are an informed, educated, middle class client who has clear, well-researched ideas about her treatment. It might be a very different story for someone who is elderly, or has mental illness or who is from one of the many groups who traditionally don't engage in dialogue around healthcare.

We know already what the public wants from their health provider. They want good care delivered in a timely manner, close to where they live with a clear procedure for complaints. Healthcare is far too important to be left to the vagaries of the market. This is clearly about social responsibility.

SUDDENLY A SAFETY NET WHICH PROTECTS PATIENT AND STAFF HAS BEEN REINTERPRETED AS A BARRIER

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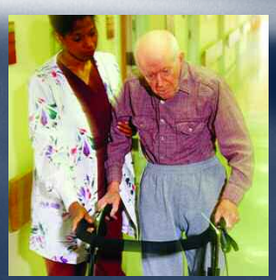
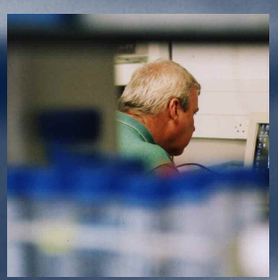
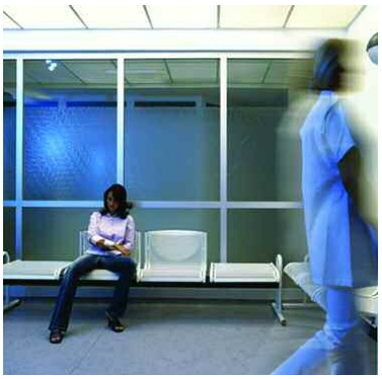
PENNY CLARKE
EUROPEAN FEDERATION OF
PUBLIC SERVICES UNIONS







THE DIRECTIVE WILL HAVE A HUGE IMPACT ON COLLECTIVE LABOUR ORGANISATION THROUGHOUT EUROPE, WHICH CONCERNS US ENORMOUSLY.

We have problems around the scope of the Directive and the main principle on which the Services Directive is based. The 'country of origin principle' is anti-European and it goes against the objective of (upwards) convergence and harmonization, of bringing the peoples of Europe closer together. The Directive will have a huge impact on collective labour organisation throughout Europe, which concerns us enormously. For example, collective agreements are seen as 'obstacles' to trade and service providers will argue that the working conditions applicable in the country where he or she comes from - not where he or she is actually providing the services - should apply. This is in direct contradiction to the Posted Workers Directive, but this only covers temporary (and not permanent) workers.

This Directive is hitting us at the same time as the revision of the Working Time Directive. They both represent a serious attempt to deregulate social standards, to try and liberalise everything and anything, and to attack collective organising.

For us, opposing the Services Directive is a number one priority, and we are not satisfied by recent statements from the Commission or the Council that they are prepared to make changes. The text is still in the Parliament, and that means that it is up to MEPs to sort out what the Commission has itself called "a politically and technically unworkable" piece of legislation.

The impact of the Directive on public services remains our concern. There have been comments from the Commission and some governments that publicly funded services of general interest are to be excluded. But is this assurance really any progress in comparison to the text of the draft Directive? We don't think so. Such a change would still mean that only services provided by the state, for no consideration, are excluded from the scope of the Directive. It still leaves us with the limbo of having to distinguish economic and non-economic public services, or SGI in EU-speak. The shifting boundaries between these makes an exemption rather unconvincing. Healthcare for instance is the prime example of a service that was deemed non-economic and has now been turned into an economic one. It is therefore not enough to exclude for example 'publicly funded' health care – to use McCreevy speak – from the Directive.

We need to ensure that the Directive does not have any negative effect on public services, or on social and labour standards. But at the same time an exemption strategy is not enough and does not provide a long-lasting solution. We need to develop common European principles for public services that go beyond the market rationale, principles relating to solidarity, equality, sustainability, risk sharing, territorial cohesion. Market rules are not an appropriate driver for public services. We need to press on with the follow-up to the White Paper on Services of General Interest to develop the necessary counterweight. A positive approach to public services and to public policy objectives is needed at EU level more than ever.

There are differences between the Member States in how they organise and pay for social and healthcare services. However, there are principles of solidarity and security that underpin all of them. There is no contradiction between strong economic growth and setting up fair systems of access to healthcare, we must combine both and keep working on the principles of solidarity, universality and equality.

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