

SOCIAL SERVICES OF GENERAL INTEREST

UK RESPONSE TO QUESTIONNAIRE

We welcome the questionnaire as part of the preparatory work for the forthcoming Commission Communication.

The UK view is, however, that the range of the Questionnaire is too broad and would have been better focussed on points where there is known, with some degree of objectivity, to be a problem that needs to be addressed. So, as we take this debate forwards, we would strongly favour a more targeted approach – looking at issues known to need addressing (primarily health care in the light of various ECJ judgements) and avoiding issues where the SSGI dimension is not known to create any *appreciable* difficulties (eg in the UK context, at least, the provision of social housing, or public education services).

We would not wish to blur the boundaries between what is relevant to the work of this Committee and that which properly belongs to others; and by the same token, between areas of community competence and those areas which remain wholly or mainly the sole responsibility of individual member states.

In education and vocational training, for example, Articles 149 and 150 make it clear that the role of the community is to encourage and support member states whilst fully respecting the responsibility of member states for the content of teaching and organisation of education and training systems.

The new Constitution reinforces this.

We would emphasise that the development of the single market will itself support improvements in social protection and social inclusion. Openness to the economies of other Member States will generate economic growth and more jobs, which will in turn constitute the most effective anti-poverty strategy for people of working age.

So the work underway, most notably in the context of the draft Services Directive, to remove obstacles to the free movement of services must be supported. The United Kingdom, therefore, strongly endorses the key recommendation set out in the November 2004 High Level Group report chaired by Mr Wim Kok that obstacles to the free movement of services should be removed as soon as possible. We believe that agreement on the Services Directive is a priority as a means of achieving this aim.

We also don't think it appropriate for the Community to intervene in national social services provision given that the delivery, financing and organisation of public services are for Member States subject to compliance with existing

Community obligations. There is no need to expand the existing legislative framework

In order to provide the most useful contribution to the SPC's work, we have concentrated on those areas where we believe the impact of a single market in services will be felt most. We have also annexed a description of how our National Health Service is organised and paid for and how health services are delivered, to help highlight the real differences in service-provision that exist among member states and reinforce the difficulty of achieving 'one size fits all' solutions.

We agree with the authors that the Commission's Communication on Social Services of General Interest cannot and should not replace the work already going on in other fields. Work on the Services Directive is already ongoing in the relevant Council formation and, given the importance of liberalisation of this sector to achieving the Lisbon objectives, we must not delay or sidetrack this debate.

The same is true of State Aid rules and Public - Private – Partnership – Models which must be dealt with in the appropriate arenas.

Finally, we thank the authors for the preparatory work that has gone into this document and hope that our contribution will enable the Commission to produce a well-focused and relevant Communication in the Spring,

THE QUESTIONNAIRE

Field1

1. What are the general characteristics of the national social SGI with regard to e.g. the following points?

- **Organisation, design and structure (geographical, market structure, administrative level);**
- **financing (e.g. contributions, direct funding via government budget, payment of remuneration for the service, charity donations, mutualisation);**
- **service provider (e.g. state and local authorities, public enterprises, public-private partnership, voluntary non-profit organisations, role of volunteers, private enterprises);**
- **definition of tasks/obligations (what are these tasks/obligations and how are these laid down, i.e. contract, law or other);**
- **quality standards.**

There is no single model of social SGI within the UK. The area potentially covered by the term is so broad that provision is by a plethora of different models. Most of the variants discussed at question 1 are utilised somewhere across the range of social policy provision.

There is no commonly-agreed national definition of social (or any other) SGI, as the term arises primarily in the EU context. Similarly there is no set definition of "social services".

Pensions

The design and form of pension schemes and the nature of pensions provision is a matter of subsidiarity. This view was clearly reinforced at the recent presidency conference held in Amsterdam on 4th November. The UK and other Member States are clear that further legislation on pensions should only take place following a full cost-benefit analysis from the European Commission.

Healthcare

The NHS does not provide Treaty-regulated services when providing health care. Services of General *Economic* Interest are regulated by the rules in the Treaty. However, the UK considers that NHS bodies do not provide economic services within the definition of Article 50 of the Treaty nor are they undertakings within the meaning of article 48 of the Treaty, since they are engaged in activity aimed at social and health objectives which is carried out on a not-for-profit basis for no remuneration.

However, the questionnaire suggests that the concept of the SGI might be relevant to strategic questions arising relating to healthcare and the Internal Market, especially that the Member States' responsibility for the management and organisation of health systems should be respected. It would be helpful if

the Commission Communication contains a clear explanation of the impact of SGI on health. I attach a description of how the NHS is organised and funded to help with this (Annexe A).

2. Please indicate whether and if so how these characteristics are likely to develop and change in the coming years. This with a view of the modernisation of these services (taking into account developing users' needs, quality standards and (financial) efficiency).

There is a general drive to modernise and reform public services across the UK, including promotion of approaches to delivery that strengthen accountability, transparency, cost-effectiveness and responsiveness to customer need. But there is no one model applicable across the piece.

Field 2

1. Is there at national level a notion or definition of social SGI or social services generally?

There is no commonly-agreed national definition of social (or any other) SGI, as the term arises primarily in the EU context. Similarly there is no set definition of “social services”.

2. It has been argued that social SGI are different to other SGI – Do you agree with this? Is a more detailed analysis of these possible differences –especially in relation to networks industries¹ – a way forward to gain more certainty?

When addressing the status of different SGI's, we see little added value in specifically focussing on whether there is any ‘social’ dimension. What matters is to ascertain whether there is any significant public interest dimension, and – where there is – to ensure that these public policy objectives are upheld.

3. Which of the different sectors outlined under Field 1 should have priority for the examination at European level

Healthcare

It would be interesting to discuss how SGI might support a sustainable position between Internal Market objectives on one hand and the Member States' responsibilities and objectives in regulating health systems on the other hand. It would be useful to achieve clarity on the impact of SGI on

¹ In this context reference has to be made to the Commission Staff Working Paper “Horizontal Evaluation of the Performance of Network Industries providing Services of General Economic Interest” (SEC(2004) 866), which gives a good overview of the different aims and the performance of these services.

health. However, we refer to the UK position that the NHS does not provide services within the definition in Article 50 of the Treaty nor are NHS bodies undertakings within the meaning of Article 48 of the Treaty and any further work is in this context. Member States are responsible for the organisation and management of their own health systems. We understand that this encompasses how the system is financed, how money is allocated, the setting of national priorities, deciding access arrangements, and setting care standards.

Field 3

- 4. Please indicate for the services identified under question 7 with regard to the EC rules listed below (see also background document) whether:**
- a. it is established (in case-law or by way of Community law) that these services fall outside the scope of these rules**
 - b. it is established (in case-law or by way of Community law) that these services are falling within the scope of these rules**
 - c. it is unclear if these rules apply to these services, there is a need for clarification ("grey zone")**
- **Internal market rules;**
 - **Art. 81 and/or Art. 82 EC;**
 - **Art. 86 EC;**
 - **Art 87;**
 - **Public procurement rules;**
 - **External trade negotiations.**

Pensions

The EU's competence in this area is already clear. Private pensions are regulated under single market legislation in their role as a financial product which is bought and sold. Through the IORP Directive (2003/41/EC) there is also the potential for a single market on occupational pensions. As regards the wider social functions of private pensions, because they provide income in retirement, it is appropriate for the Social Protection Committee to facilitate the exchange of information about the solutions to problems which are common to all Member States.

Healthcare

It is important to recognise that the UK health system, is financed out of general taxation, compared to those health insurance systems on which the ECJ has issued rulings. See annexe A.

Article 86 of the Treaty provides that undertakings entrusted with the operation of services of general economic interest shall be subject to the rules contained in the Treaty. The Commission shall ensure the application

of this provision and shall, where necessary, address appropriate directives or decisions to Member States.

However, the Commission involvement in SGEI granted in Article 86 is incompatible with Article 152 and with the new Constitutional treaty, which both state that Member States are responsible for the organisation and management of their own healthcare systems. This is particularly true as health service providers are not considered to be undertakings: an undertaking is an entity which is engaged in economic activity and economic activity is anything which a private company could potentially perform for profit. The NHS does not provide Treaty services as there is no remuneration and NHS bodies are not-for-profit. Therefore NHS bodies are not SGEI, and the Commission is not able to use the Treaty base of Article 86 to legislate on them.

Field 4

5. Are there specific fields of European law and activities which necessitate further clarification with regard to their impact on social SGI (see also question 8), like e.g:

- **Internal market rules;**
- **Art. 81 and/or Art. 82 EC;**
- **Art. 86 EC;**
- **Art 87;**
- **Public procurement rules;**
- **External trade negotiations.**

We would like to see clarity on the impact of SGI on healthcare. It would be helpful if the Commission explicitly addressed this in their Communication.

What should be the concrete aim (especially concerning further steps) of the Communication of the Commission on social SGI including health services?

- The Commission Communication should provide useful clarity of the impact of SGI on certain, specified sectors (we suggest health as the key sector). We would not accept the list in this questionnaire as either accurate or focussed enough.
- It should reinforce that issues relating to the delivery, financing and organisation of public services are for individual Member States subject to compliance with existing Community rules (eg equal treatment).
- It should reflect the importance of liberalising the services market across Europe to help boost growth, competitiveness and employment in line with the Lisbon objectives

- It should ensure public policy objectives remain paramount and the sole concern of member states subject to compliance with existing Community rules; and that member states are free to fund, organise and deliver public services in line with these objectives
- It should **not** attempt a EU-wide definition of social services

6. Do you consider the use of the open method of co-ordination (existing or new) an appropriate means for further steps? If so, what should be the concrete task of this method? (e.g. common objectives, exchange of good practices, evaluation etc).

We would not wish to see the open method of co-operation extended beyond the current fields of employment, social exclusion and pensions. New methods of OMC such as in healthcare should be 'light touch' and only seek to use existing information within Member States

Could at some stage and without prejudging the right of initiative of the Commission, legislative acts be considered as an appropriate means for further steps (under the assumption that a valid legal base can be found), and if so what should be the concrete task of these instruments (Directives, Regulations, Recommendations)? The following additional questions seem to be possible:

- **Should these legal acts limit the scope of EU rules and their application to social services?**
- **Should these legal acts establish common standards for social services, allowing EU rules, like the Internal Market rules, to be applied while taking into account fully the social policy goals?**
- **Should there be legally defined criteria, e.g. criteria concerning quality, affordability, accessibility or solidarity at European level?**

It is not clear to us that there will be added value in addressing SSGI's as a whole when considering appropriate means for further steps. Where any issues arise, in practice, they tend to be sector-specific (for example health care, where the situation is significantly different to, say, education). We think that any response at the EU level needs to be similarly sector specific, although informed as necessary by any cross-cutting issues relevant to SSGI's.

As the Commission state in their White Paper on services of general interest (COM(2004) 374), the forthcoming Communication will take stock of the Community policies that are related to the provision of social and health services of general interest. In particular, it will set out a mechanism for a regular assessment and evaluation of the national frameworks for the provision of social services of general interest. The White Paper notes that existing open methods of coordination in the field of social inclusion and social

protection could be used to this effect and that the Commission has proposed an open method of coordination in the field of health care and long term care.

Where Open Methods of Coordination exist (such as social inclusion) and matters raised in this document fall within the scope of these processes, these should be addressed within the context of current mechanisms. Attempting to create new processes in these circumstances would run counter to both the generally accepted approach that our activity needs to be 'streamlined'.

More generally terms, the United Kingdom view is that 'social services of general interest' is too broad and uncertain a category to warrant a specific OMC. It would be possible, however, to raise SSGI issues within existing processes, where this is necessary to the delivery of the objectives of those OMCs.

The United Kingdom sees no case for legislative acts in the areas raised by the final question.

Annexe A: Summary of the United Kingdom National Health Service

Overview

The government is the dominant supplier of health care to the population of the UK, through the National Health Service (NHS) which provides comprehensive and universal coverage. Visits to the doctor and treatment at hospital are provided free of charge at the point of delivery. No one can opt out of the NHS. People can choose private health care, with or without private insurance, without affecting their access to NHS treatment.

How the system works

Responsibility for the UK NHS is devolved to the component countries, with England, Scotland, Northern Ireland and Wales each responsible for administering the NHS in their respective countries.

The Department of Health (DH) is responsible for setting health and social care policy in England. This Department, along with its counterparts in Scotland, Wales and Northern Ireland, agrees with the treasury how much money is to be allocated to the NHS on a three-or four-year cycle. The division of money throughout the United Kingdom is partly constrained by a formula designed to improve the geographic distribution of medical resources.

Funding and decision-making are increasingly devolved to a local level. In England the Department of Health allocates the money from the government health funds to 28 Strategic Health Authorities (SHAs) which look after the healthcare of their region. The SHAs are responsible for several functions: developing plans for improving health services in their local area; making sure local health services are of a high quality and performing well, and; increasing the capacity of local health services, so they can provide more services.

Each SHA is run by a board of executive and non-executive directors. The non-executive directors are appointed by the Government and the executive directors by the chairperson of the local authority. SHAs are accountable to the Secretary of State for Health, who is the government minister responsible for the NHS in England and answerable to Parliament for its work.

Health services are divided into 'primary' and 'secondary' and provided by smaller local NHS organisations called 'trusts'. Trusts are purchasing bodies. It is believed that because they are local organisations, they are in the best position to understand the needs of their community and to ensure that the organisations providing health and social care services work effectively. Trusts employ most of the NHS workforce, including nurses, doctors, dentists, pharmacists, midwives and health visitors, as well as allied health workers such as physiotherapists, radiographers, podiatrists, speech and language therapists, counsellors, occupational therapists and psychologists.

Primary care trusts

Primary care trusts (PCTs), of which there are 303, have been given a central role in the operation of the NHS. They are responsible for the provision and commission of services and now handle 80 % of the total NHS budget.

PCTs vary in size and population covered. They manage budgets for local services, and work with local authorities and other agencies that provide health and social care locally to make sure the community's needs are being met. They make sure there are enough services for people within their area and that these services are accessible. Their services commonly include the provision of GPs, dentists and health visitors and district nurses.

Primary care trusts are also responsible for secondary planning. They commission hospital care, and decide on the amount and quality of services provided by hospitals, dentists, patient transport and population screening.

A contracting prospective payments system which allows money to follow patients is been established. The PCTs pay hospitals and other providers on the basis of the number of treatments they carry out.

Acute trusts and public hospitals

NHS hospital services are run and managed by Acute Trusts, which are responsible for ensuring that hospitals provide high quality health care and that they spend their money efficiently. Acute Trusts also decide on a strategy for how the hospital will develop to achieve service improvement.

Hospital trusts report directly to the Secretary of State and are responsible for the service they provide to the public. They receive most of their income from service level agreements from Primary Care Trusts to provide services. The Secretary of State is the ultimate arbitrator of any disputes.

Foundation Trusts

Since April 2004, certain NHS trusts (the best performing hospitals with 3 star ratings) have been allowed to receive foundation status. The Secretary of State will no longer have any powers of direction over Foundation Trusts. Instead Foundation Trusts will operate as a not for profit Public Benefit Corporation under a licence (terms of authorisation). They will have an stakeholder board of Govenors with a majority of members elected. They will receive most of their income from legally binding contracts with Primary Care Trusts. The courts are the ultimate arbitrator of any contractual disputes.

This gives them much more financial and operational freedom than other NHS Trusts, and is paving the way for a new type of NHS hospital that is tailored to the needs of local populations and run by local managers, staff and members of the public.

Foundation hospitals have the power to manage their own budgets. They are able to borrow money privately and set their own financial and operational priorities. Foundation Trusts represent the Government's commitment to decentralising the control of public services and are viewed as the way to improve service responsiveness and the standards of care in the NHS. The government hopes that by 2008 all acute hospitals will be able to apply to become foundation trusts.

Star rating system

An independent health inspectorate, the Healthcare Commission, is responsible for inspecting the quality of hospitals and other NHS organisations. Star ratings are awarded depending on how a Trust has performed against a set of performance indicators set by the Healthcare Commission. Hospitals are rated as having zero to three stars - the more stars the better. The star ratings are said to provide an overview of how good the Trust's service is to its patients, i.e., how well it is run and whether it is performing well on important factors like reducing treatment waiting times. The Healthcare Commission publishes the results of the ratings process.

