

Access to (almost) all areas: the implications of greater trade cooperation between the US and the EU for health care services in the Union Member States—the case of the NHS in England and Wales and Scotland

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1. Introduction

The current negotiations of the Transatlantic Trade and Investment Partnership Agreement have been welcome by many as another opportunity to boost economic growth on both sides of the Atlantic, by abolishing barriers to trade, enhancing regulatory convergence and fostering mutual trade flows. Others however have been far more sceptical: in the United Kingdom the debate has been particularly fierce and polarised, as the TTIP has increasingly been regarded as a factor potentially accelerating the process of ‘privatisation by stealth’ of the systems for the provision of state funded health care in the Member States. In the United Kingdom, the English NHS has already been opened up to significant private enterprise input with the 2012 Health and Social Care Act which has meant, among other outcomes, the applicability of competition principles to service provision and has conferred to Monitor, as sector regulator, competition enforcement powers. In Scotland, by contrast, the direction of travel has been substantially different, with the Parliament in Edinburgh being strongly committed to keeping health care provision ‘free at the point of need’ in the hands of the state.

But are these concerns justified? Or are there sufficiently strong safeguards, either in the Agreement itself or in the EU acquis, that will allow the UK, just as the other EU member states, to preserve the rich heritage of public health provision, and especially its continuity and reliability ‘free at the point of need’ in the face of an increasingly globalised world? This paper aims to consider these questions. After considering the scope and the limits of the EU mandate to negotiate TTIP it will investigate the role and the powers that the EU enjoys as an international actor, both generally and in the field of common commercial policy. In that context, it will be argued that although this is an area which falls within the exclusive powers of the Union, the exercise of powers in this field can only occur consistently with the overarching principles governing the EU action, namely the principle of conferral.

Thereafter the focus of the paper will turn to health care services provision. It will be argued that this is an area in which the EU only enjoys limited competences, of a “supporting and coordinating” nature. The paper will examine the key principles embedded in the EU acquis and developed, especially by the Court of Justice of the EU, mainly in the area of the free movement of services; on that basis it will be argued that member states remain “sovereign” over the way in which they decide to design their health care systems and to regulate these activities. Consequently, they are fully entitled to, inter alia, restrict market access vis-à-vis non-EU providers and more generally to limit the reach of the market economy and of the competition rules in respect to health care services. In this context, the paper will also examine the extent to which the meaning given to the notion of ‘undertaking’ has acted as a means of maintaining health service provision having a ‘mutualistic’ nature outwith free market principles.

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The paper will then consider the impact of the TTIP on public procurement: it will be reminded that this area has been significantly affected by EU legislation and is now governed by overarching principles of transparency and non-discrimination, in the interest of the good functioning of the internal market. Nonetheless, it will also be illustrated that the existing regime has been applied in a far more “lenient” manner to the award of contracts in a number of sectors, all of which are concerned with the “essential care of the person” and whose scope includes health care provided by state agencies. It will also be shown that the way in which these services are provided and in particular the extent to which they are placed under public control and oversight limits further the reach of the EU public procurement rules.

In its latter part the paper will address the question of whether TTIP may have any impact on the functioning of the National Health Service (NHS) in the United Kingdom. It will be shown that as a result of the 1997 Scotland Act, which has resulted in the devolution of significant powers to the Scottish Parliament from the Parliament in Westminster, considerable differences have emerged in the way in which state-funded healthcare services are provided, respectively, in England and Wales and in Scotland. Whereas the latter has elected to maintain public control on the provision of these services ‘free at the point of need’, the former has chosen to inject progressively a number of market based principles in the way in which the NHS commissions the supply of these services South-of-the-Border.

Against this background, this paper will argue that since the EU lacks the competence to act in the field of public health beyond the limited powers conferred to it by Article 168 TFEU, it cannot oblige the Member States to “open up” the market for health care services to greater rivalry and in particular to non-EU providers. It will be suggested that, on the one hand, the public interest goals of ensuring continuity of care and the demands arising from having to protect high levels of public health and even the survival of their populations are likely to provide the Member States with grounds for justifying restricting the freedom of movement of services that conform with the Treaty. And on the other hand, it will be illustrated that the “light touch” regime that EU public procurement legislation expressly allows for the award of public contracts concerning services of “essential care to the person” is very likely to allow awarding bodies to confine their selection of winning bids to undertakings chosen on the basis of “non-economic criteria”, including those inspired by geographical proximity.

In this specific respect, it will be submitted that even in a “neo-liberal” framework such as that provided by the 2012 Health and Social Care Act for England and Wales the notion of “patients’ interest” is going to allow awarding bodies to limit the reach of “value-for-money” considerations when it comes to identifying providers and at the same time remain compatible with competition law. It will also be shown that the commitment made by the EU Commission to excluding health care, as part of a “package” of essential services to the individual, from the TTIP reach reflects its concern for respecting the principles of conferral and of subsidiarity in this “sensitive area”. In light of the above, it will be concluded that the TTIP should not be regarded as a threat to public services and especially to the provision of health services ‘free at the point of need’, as alleged by several stakeholders. It will be illustrated that the choice between “opening up” to the market or maintaining public control over these activities remains firmly with the Member States, each according to their own institutional set up.

2. The EU as an international actor: of competences, powers and treaties...

2.1. General remarks—the Treaty-making powers of the EU before the TFEU

Since its inception, the European Economic Community, having been endowed with legal personality, has been able to enter into international agreements with non-Member States or international organisations for the purpose of furthering its objectives and in areas in which it had competence to act—whether exclusive or shared.¹ The original text of the EC Treaty only provided

¹ See chiefly case 22/70, Re: ERTA, [1971] ECR 263, para. 13.

for a few express treaty-making powers, most notably in the field of trade with non-Member countries.

The “list” of competences, however, was not limited to those expressly enshrined in the Treaty: as early as in 1970s the Court of Justice of the then EEC took the view that “(...) the system of internal Community measures may not (...) be separated from that of external relations”² and that its remit should be determined in light of the wider context of the scheme of the Treaty.³ Thus, it was held that external powers could also be “implied” in other Treaty provisions concerning “internal” competences in certain cases.⁴ In this respect, it was especially essential to consider whether the Community had already relied on its competences in order to enact common rules designed to regulate a specific area.⁵

In the Court’s view, “as and when” these “internal” powers were exercised only the Community could exercise the authority to enter into agreements with third countries or international bodies that affected the application of these common rules.⁶ Member States, on their part, were de facto “pre-empted” from negotiating international obligations, either unilaterally or jointly, in areas in which the Community enjoyed and has already exercised powers granted to it by the Treaty, even though no express mention was made that these powers also entail external action competence.⁷ In the words of the Court of Justice, “(...)to the extent to which Community rules are promulgated for the attainment of the objectives of the Treaty, the Member States cannot, outside the framework of the Community institutions, assume obligations which might affect those rules or alter their scope. (...)”.⁸

Later judgments, however, seemed to signal a gradual retreat from such a generous view of the Community/Union's external competences:⁹ thus, it was held that any implied authority to negotiate international treaties could only be advocated by the EC/EU if the corresponding internal power had already been deployed¹⁰ and consequently, the internal measures in issue should have “largely covered” the same policy area on which the proposed treaty had effect.¹¹ While this was not meant to require absolute correspondence between the latter and the EC/EU measures concerned, it was read as requiring an assessment of the “nature and content” of the EC/EU provisions”, of their “current state and (...) future [likely] development.”¹² On that basis, it was held that implied treaty making authority could only be justified if unilateral action on the part of the member states, with a view to negotiating an international agreement in a given area, was liable to endanger the integrity of existing internal EC/EU rules.¹³

The Court of Justice of the EU also clarified whether any implied authority to conclude international treaties, if it could be found, would be exclusive to the EC/EU or shared with the member states,¹⁴ by emphasising that this question only be addressed having regard to both the nature of the corresponding internal competence and to the extent to which the latter had already

² Id., para. 19.

³ Id., para. 15.

⁴ Case 22/70, Re: ERTA, [1971] ECR 263.

⁵ Id., para. 16.

⁶ Id., para. 17.

⁷ Id., para. 18.

⁸ Id., para. 22. See also e.g. Opinion 1/76, Re: Inland Waterway Vessels Convention, [1977] ECR 741. For commentary, see Emiliou, “Toward a clearer demarcation line?”, (1994) 19(1) ELRev 76 at 82-83; also Hartley, *The Foundations of European Union Law*, 8th Ed., 2014: OUP, pp. 180-181.

⁹ Opinion 1/94, [1994] ECR I-5267.

¹⁰ Id., para. 77; see also para. 85-86.

¹¹ Opinion 2/91, Re: ILO Convention No 170, [1993] ECR I-1061, para. 9-11.

¹² Opinion 1/2003, Re: Lugano Convention, [2006] ECR I-1145, para. 126-127. For comment, see Cremona, “Extending the reach of the AERT principle”, (2009) 34(5) ELRev 754 at 762-763.

¹³ Opinion 2/91, cit. (fn. 11), para. 26.

¹⁴ Case 22/70, cit. (fn. 4), para. 22.

been exercised:¹⁵ if the EC/EU had not taken any action, then, in the Court's view, the Member States remained jointly competent to negotiate and stipulate international agreements in this area in a unilateral fashion.¹⁶ Exclusive competence, instead, was reserved to cases in which the Treaty or a legislative act expressly recognised it or in which unilateral action on in the international plain, undertaken by the Member States, could have jeopardised the effectiveness of existing EU/EC measures.¹⁷ As to the manner in which treaty making powers should be exercised in areas of shared competence, the Court of Justice took the view that both the EC/EU institutions and the member states were subject to a duty of loyal cooperation and that, accordingly, negotiations should be conducted by the Union with the participation of the Member States; in addition, it was held that the resulting Treaty would be subjected to ratification at domestic level.¹⁸

In light of the forgoing analysis, it can be concluded that, largely thanks to the purposive interpretation adopted by the CJEU, the EC/EU has enjoyed increasingly significant treaty-making powers, both express and implied, in numerous areas encompassed by the Treaties: however, the Court has, especially of late, sought to establish more stringent criteria for the identification as well as the determination of the nature—whether exclusive or shared—of these unexpressed powers.

2.2. The Treaty of Lisbon and the system of EU competences: implications for the Union's external action

The previous section endeavoured to give an overview of some basic principles governing the EC/EU's treaty making powers and in that context emphasised the role of the principles of conferral and of the doctrine of "parallelism" to determine the scope of the Union's implied external authority. This section will focus on the question of whether the TFEU has had any consequences for the approaches identified so far. As is well known, the Treaty of Lisbon expressly recognises that the Union enjoyed legal personality, in Article 47 TEU. In addition it has resulted in a "wholesale reordering" of the Union's own competences: thus, the latter are in principle shared with the member states unless the Treaty itself explicitly states that they must be either exclusive to the Union or that the Union can only act to coordinate or support or "complement" national action, either individual or collective.

Consistently with these commitments, the TFEU aimed to "crystallise" the principles governing the recognition of "implied" external powers:¹⁹ according to Article 216(1) the EU enjoys the power to "conclude an agreement with one or more third countries (...) where the Treaties so provide or where the conclusion of an agreement is necessary in order to achieve, within the framework of the Union's policies, one of the objectives referred to in the Treaty (...)" ; it can also do so when stipulating an agreement with non-member countries is "provided for in a legally binding Union act" and where it is "likely to affect common rules or alter their scope".²⁰

Commentators suggested that this provision provided a legal basis for an unexpressed treaty-making power in very limited circumstances: such is the case, for instance, if an envisaged international treaty affects an area already "largely covered" by Union law, having regard to the Union measures' purpose, content and to the corresponding likelihood that the international commitments would encroach upon their integrity,²¹ clearly in order to maintain the coherence and

¹⁵ Opinion 2/91, cit. (fn. 11), para. 89-90; see also para. 104.

¹⁶ *Id.*, para. 105.

¹⁷ See e.g. *Commission v Luxembourg (Re: Open Skies agreement)*, [2002] ECR I-9741, para. 61-62 and 64-67; see also para. 84 and 87-88.

¹⁸ Opinion 1/94, cit. (fn. 9), para. 107-108. See also, inter alia, *Case C-431/05, Merck Genericos*, [2007] ECR I-7001, especially para. 31-35.

¹⁹ Kostadinides, "EU foreign policy under the doctrine of implied powers", (2014) 39(4) *ELRev* 511 at 512-513.

²⁰ See Opinion 1/2003, cit. (fn. 12), para. 132-133; for comment, see e.g. Hartley, *The Foundations of European Union Law*, 8th Ed., 2014: OUP, pp. 174 ff.; see especially p. 185-186.

²¹ See inter alia Opinion 1/2003, cit. (fn. 12), para. 126-128; for commentary, Kostadinides, cit. (fn. 19), p. 513.

effectiveness of existing Union rules.²² In any other case, however, external action on the part of the Union could only be justified in the silence of the Treaty if it could be shown that external commitments were "indispensable" for internal action to be taken and given effect to: this would be limited to cases where, having regard to the subject matter of the relevant internal measures, the latter could not effectively achieve their objectives without external action being adopted in the same field.²³ In the view of Advocate General Kokott, to hold that such implied external power could be exercised before adopting internal rules first would result, in the AG view, in the confines of the EU's treaty-making powers becoming "virtually indeterminate".²⁴

The Treaty of Lisbon also sought to shed more light on the question of how to determine the nature—whether shared or exclusive—of such unexpressed treaty making powers. According to Article 3(2) TFEU, exclusive external competence arises not only when EU law so provides (either in the Treaty itself or in a legislative act) but also when "an international agreement is "necessary" to enable the EU to exercise its internal powers or "insofar as its conclusion may affect common rules or alter their scope".²⁵ Commenting on this provision, it was suggested that as a result of the Treaty of Lisbon external powers whose existence is implied from corresponding internal powers²⁶ would only be exclusive if it could be shown, on the basis of a comprehensive analysis of the nature and content of any internal measures already adopted in the same area, that the agreement is going to affect a field "already covered to a large extent" by EU rules²⁷ and consequently, allowing the member states to negotiate the agreement independently undermined the full effectiveness of these internal EU rules.²⁸

In any other area, instead, the Union and the Member States would remain jointly competent to act on the international plain; as a result, any agreement stipulated in these fields would be a "mixed" one.²⁹ On this point, it was submitted that this is especially likely to occur in cases in which the Union enjoys competence to act internally which has not been exercised already in a field that an international agreement is going to influence³⁰ or when any internal competence is not "pre-emptive" in nature, e.g. if it only entails a power for the Union to enact measures laying down "minimum requirements", leaving the member states free to introduce more stringent legal standards.³¹ How are these principles likely to affect the EU's powers to negotiate and conclude TTIP? It is argued that this question must be answered on the basis of a careful reading of the rules governing external competence.

There is little doubt that the Union enjoys, in matters of "international trade", exclusive competence to act, in accordance with Article 3 TFEU. Nonetheless, it is undeniable that the scope of the proposed agreement encompasses matters going beyond "traditional" international trade issues. While the Treaty of Lisbon has altered and widened the scope of the "common commercial policy",³² TTIP has been envisaged as covering matters other than those now enshrined in Article 133 TFEU and therefore potentially falling within the shared competence of the EU and of the Member States.³³ Consequently, it is argued that since this agreement is going to affect areas in which

²² Ibid.

²³ Case C-81/13, *Commission v Council*, Opinion of AG Kokott of 17 July 2014, nyr, para. 54-55; see also para. 58, 70 and 74-81; para. 111-112. See also the judgment of the Court, para. 61-62.

²⁴ Id., para. 126-128; see also judgment of the Court of 18 December 2014, para. 62.

²⁵ Per AG Kokott, para. 132-33; for commentary see e.g. Konstadinides, cit. (fn. 19), p. 524.

²⁶ See Konstadinides, cit. (fn. 19), p. 524.

²⁷ Opinion 1/03, cit. (fn. 12), para. 126-127.

²⁸ Id., para. 132-133; see also para. 128.

²⁹ See Kostandinides, cit. (fn. 19), p. 524.

³⁰ See inter alia, Kostandinides, cit. (fn. 19), p. 526; also, mutatis mutandis, Cremona, "Balancing Union and member states interests", (2010) 35(5) *ELRev* 678 at 692.

³¹ Kostandinides, cit. (fn. 19), p. 526; see e.g. Opinion 1/94, cit. (fn. 9), para. 103-104.

³² Opinion 1/08, Re: GATS, [2009] ECR I-11129, para. 119-120.

³³ Mutatis mutandis, see id., para. 133-134.

member states retain the authority to act autonomously, TTIP is likely to be a “mixed agreement”.³⁴ On this point, it should be emphasised that in a letter dated 16 October 2014³⁵ and addressed to presidents and chairmen of parliaments and parliamentary committees of a number of member states the Commission seemed to suggest that the treaty would be of this nature; consequently, it was stated that it should be subjected to both the procedural requirements provided by the TFEU for the negotiation of international treaties and to the ratification processes in force in each domestic jurisdiction.³⁶

In the EU Commission’s view, the “interplay” between these two distinct sets of safeguards would be able to secure that the interests of the member states be protected and in particular that the “input” of their parliaments be maintained: in this specific respect, it was stated that the role of the Council (at the outset of the process as well as when the latter comes to its end and the Commission has drafted a proposal on the conclusion of the agreement, in light of the negotiations) and of the European Parliament which must be asked to consent to the agreement in the event of approval of the agreement would act as a sufficiently strong “check” on the Union’s action, in the spirit of openness and cooperation.³⁷ Thus, it could be argued that in this particular case the features and the nature of mixed agreements are likely to provide a significant degree of protection for the member states’ sovereignty by ensuring their participation, albeit in accordance with the duty of mutual cooperation and consequently their input in negotiations concerning, among others, the provision of certain types of services and other economic activities having implications for the public interest.³⁸

It is admittedly too early in the negotiations to speculate on what the “final deal” on TTIP is going to be and as a result, to assess, as required by the CJEU’s case law and also by the TFEU, its “content and purpose” in order to answer the questions on competence posed by the requirements contained in Articles 216(1) and 3(2). Nonetheless, it is argued that the exercise of these powers, even in an area in which international action is accepted as that of common commercial policy, cannot take place in a vacuum but must always conform to the principle of conferral: thus, regard must be had not only to the power to act on the international plain for the purpose of regulating trade with non-member states, but also to the question of whether such external action is likely to affect other policy areas in which the Union may only enjoy shared competence.³⁹

Having regard in particular to TTIP, even accepting that in principle its competence is exclusive in matters of “common commercial policy”, specific provisions of the proposed agreement, especially in respect of economic activities and sectors of “public interest significance” must be closely scrutinised and if they fall in areas of competence that are shared with the Member States, negotiations must be conducted in cooperation with national governments; furthermore, the resulting treaty is in all likelihood going to be a “mixed” instrument and as such is therefore going to be ratified at domestic level. As was forcefully held by the Court of Justice itself, it is only to the extent that these questions are addressed and the appropriate procedural and substantial requirements are fulfilled that the reciprocal limits existing, respectively, between the Member States and the Union’s competences can be secured.⁴⁰

In light of the forgoing analysis, it may be concluded that the EU can only rely on its external competence in accordance with the overarching requirements of the principle of conferral and in

³⁴ See e.g. *id.*, para. 133-135. See also, inter alia, Report to the House of Commons, “The Transatlantic Trade and Investment Partnership”, 18 December 2014, available at: www.parliament.uk/briefing-papers/sn06688.pdf

³⁵ C(2014) 7557 final, available at: <http://ec.europa.eu/transparency/regdoc/rep/3/2014/EN/3-2014-7557-EN-F1-1.Pdf>.

³⁶ *Id.*, p. 2.

³⁷ *Id.*, p. 3.

³⁸ See e.g., *mutatis mutandis*, opinion 1/08, cit. (fn. 32), para. 134.

³⁹ Opinion No 1/08, cit. (fn. 32), para.132.

⁴⁰ *Id.*, para. 133, 135-136.

that context in the full respect of the concurring powers of the member states. Thus, the answer to the question of whether the Union can, by entering into TTIP, impose an obligation on its members to introduce reforms in, inter alia, the area of public health services' provision can only be answered in light of the analysis of the more general question of whether the Union enjoys powers in this field and, if so, of which nature. These issues will be addressed in the following sections.

3. Public health care and the Single Market: a “special type” of services?

3.1. Healthcare provision and the single market: a “special type” of services?

The previous sections gave a brief account of the treaty-making powers enjoyed by the EU and attempted to place these powers in the wider context of the principle of conferral, which governs the exercise of the whole array of powers that the Member States have bestowed upon the Union. This section will consider the extent to which the Partnership agreement is likely to influence how the delivery of health care services may be provided within the Union after its stipulation in the Member States and especially the UK.

It was argued in section 2.2 that the exercise on the part of the EU of its treaty-making powers can legitimately occur only if it respects the principle of conferral: therefore, proposed international agreements must be scrutinised in their content and purpose with a view to determining whether such competence exists and whether all or any of their provisions may fall in fields of joint competence that require, therefore, the involvement of the member states in the negotiations and a separate ratification process in the respective jurisdictions. On this point, it was suggested that due to its wide remit, TTIP was most likely to be a “mixed agreement”, since its scope was likely to embrace not just “classical” commercial policy issues (such as among others the lowering or the elimination of custom duties) but also matters concerning, inter alia, services provision and even the settlement of investor-state disputes.⁴¹

In light of the forgoing, it is now legitimate to query what the position of healthcare services is vis-à-vis the TTIP negotiations: can the Union undertake international obligations affecting this policy area? In particular, can the Union mandate that the Member States grant “access to all areas” to non-EU companies when it comes to providing for the health of their citizens, as suggested by some stakeholders in the current debate? It is suggested that regard should be had to the existence and scope of any competence—whether internal or external—that the EU may claim in this field and especially to the extent to which the principles governing the single market and the rules on competition apply to the provision of health services on the part of domestic health authorities. In particular, it has been queried whether they can be regarded as an “economic activity” for the purpose of applying the free movement rules. It was further asked whether the manner in which individual EU nationals access these services in a different member state can affect their enjoyment of the right to move freely across the internal market and, if that is indeed the case, what is the scope of the power of a member state to, e.g. place conditions on that access and, more generally, lay down rules governing their cross-border provisions without infringing the Treaty rules.

According to consistent case law of the CJEU it is now established that health care services constitute “services” within the meaning of Article 56 TFEU: in *SPUC v Grogan* ruling, the Court made clear that in so far as a “(...) medical activity which is normally provided for remuneration (...) [is] carried out as part of a professional activity (...)” would be covered by the scope of the Treaty.⁴² As a result, “(...) persons receiving medical treatment (...) are to be regarded as recipients of

⁴¹ Id., para. 136.

⁴² Case 159/90, *SPUC v Grogan*, [1991] ECR I-4685, para. 18.

services”;⁴³ thus, the exercise on their part of the freedom to seek medical treatment that is publicly funded should not be unduly hampered by rules governing, for instance, the public funding of these services either in their own country or in the state where treatment is sought: as was forcefully stated in the *Kohll* judgment, while in the absence of harmonisation individual member states are allowed to set out rules governing the entitlement to healthcare benefits, these rules cannot contravene the requirements of the free movement of services.⁴⁴ In the CJEU’s view, the “special nature” of certain types of economic activity can “(...) not remove them from the ambit of the fundamental principle of freedom of movement (...)”.⁴⁵

As a result, it was held that “(...) the Treaty precludes the application of any national rules which have the effect of making the provision of services between Member States more difficult than the provision of services purely within one Member State (...)”.⁴⁶ Unless it could be shown that these domestic rules were “objectively justified” in light of “(...) an overriding reason of public interest”,⁴⁷ such as the concern for safeguarding a “balanced and open medical and hospital service open to all (...)”⁴⁸ Member States could not place conditions or limitations on the freedom of their nationals to obtain medical services elsewhere in the Union that made the exercise of their rights under the Treaty excessively difficult.⁴⁹

Thus, it was held in inter alia, the Geaets-Smits decision that Member States could establish rules designed to govern the reimbursement of medical expenses for services obtained by the patient in a different member state with a view to securing “(...) treatment capacity or medical competence on national territory” and, as a result, the attainment of high levels of public health in each member states that are necessary to guarantee the survival of the population.⁵⁰ Nonetheless, any such arrangement was only allowed within the limits enshrined in Article 56 TFEU: the Court took the view that since the rules governing access to cross-border medical services and in particular the reimbursement of expenses could discourage individuals from seeking medical care elsewhere in the internal market,⁵¹ they could only be justified if its rules were appropriate to attaining goals of “sufficient and permanent access to a range of high quality [medical] treatment” and to “prevent (...) any wastage of financial, technical and human resources”⁵² they were also “(...) based on objective, non-discriminatory criteria which are known in advance, in such a way as to circumscribe the exercise of the national authorities' discretion, so that it is not used arbitrarily (...)”.⁵³

In light of the forgoing analysis, it is submitted that Member States do not only remain “sovereign” in determining how to design and regulate their healthcare systems. They can also rely on Article 52(1) TFEU in order to introduce those restrictions on the right to freedom of movement of services that are regarded as being both “necessary” and “proportionate” for the attainment of such public interest goals such as preserving the accessibility of these “sensitive services” throughout the Union as well as protecting the financial stability of the authorities and bodies providing them. To this end, it is however indispensable to ensure that these national arrangements are both suitable for the attainment of an “overriding reason in the public interest” and conform with principles of predictability, non-discrimination and of certainty, as well as being applied in a non-arbitrary fashion.

⁴³ Cases 286/82 and 26/83, *Luisi and Carbone v Ministero del Tesoro*, [1984] ECR 377, para. 16.

⁴⁴ Case C-156/98, *Kohll*, [1998] ECR I-1931, para. 17-18.

⁴⁵ *Id.*, para. 20.

⁴⁶ *Id.*, para. 33.

⁴⁷ *Id.*, para. 36 and 41.

⁴⁸ Case C-158/99, *Geraets Smit*, [2001] ECR I-5473, para. 82.

⁴⁹ *Id.*, para. 72.

⁵⁰ *Id.*, para. 73-74.

⁵¹ *Id.*, para. 75.

⁵² *Id.*, para. 77-79.

⁵³ *Id.*, para. 90; see also para. 87-89.

It is added that how member states, in the exercise of their “sovereign powers” over their national healthcare systems, decide to design the latter can have a considerable impact on other single market principles such as the applicability of certain rules on competition. As is well known, one of the essential preconditions for the application of Articles 101 and 102 TFEU is that the entity prima facie responsible for allegedly anti-competitive behaviour be an “undertaking” i.e. a unit which, regardless of its legal status or the way in which it is financed, performs an economic activity, that is an activity involving the supply of goods or the provision of services in exchange for the payment of a price.⁵⁴ In *Fenin* the General Court drew a distinction between the performance of these activities for and according to purely solidarity-based principles and for the purpose of drawing a profit:⁵⁵ on that basis, it took the view that in so far as national health authorities, for instance, purchased large supplies of, e.g., medical equipment to be used to provide “universal” healthcare benefits to individuals, financed via social security contributions and supplied free-of-charge, they would not be acting as “undertakings” for competition law purposes.⁵⁶

In the Court’s view, while it was accepted that in these circumstances the health authorities were able to exert significant influence on the behaviour of their suppliers, their supply-side activity could not be separated from the fulfilment of their statutory mandate, for which these purchases were conducted.⁵⁷ It followed that since the provision of services to citizens was not of an “economic” nature, but rather, was based on principles of universality and of solidarity, the institution or body engaged in such purchasing practices, which, arguably, could in appropriate circumstances constitute the expression of the exercise of monopsony power, could not be subject to the application of the Treaty competition rules.⁵⁸

In light of the forgoing analysis, it may be concluded that healthcare services fall within the scope of the Founding Treaties and are therefore subject to the principles enshrined therein: although the CJEU has acknowledged their importance for the public interest they nonetheless represent “services” for the purpose of both Article 56 TFEU and, to the extent that they are supplied as part of an “economic activity”, also of Articles 101 and 102 TFEU. However, it is equally clear that member states enjoy extensive powers when it comes to designing and regulating the framework for their provision: in that context, they can choose to “take healthcare out of the market outright”, by providing these services to all individuals, free of charge and in accordance with principles of solidarity and universality. Furthermore they can lay down conditions and requirements that individuals affiliated to other EU countries must comply with in order to access health care services in their own territory; nonetheless, the exercise of this power is in any event confined and disciplined by the principles of “necessity” and “proportionality” and in that context if domestic authorities are recognised any discretion as to the application of these rules, the exercise of these powers must conform to canons of predictability, non-discrimination and non-arbitrariness. The next section will examine the other question of the extent to which the EU can act in the field of healthcare services and for that purpose will consider both the nature of the competence enjoyed by the Union and how this interacts with the “sovereignty” that member states retain vis-à-vis their healthcare services.

3.2. Healthcare services and the TFEU—between limited competences and the good functioning of the single market...

The previous section considered the question of the “nature” of state-funded health services in the context of the TFEU and argued that while these services remain subject to free movement and (in so far as they may be provided as part of an “economic activity”) competition principles, member

⁵⁴ See inter alia joined cases C-264/01 and others, *AOK Bundesverband and others*, [2004] ECR I-2493, para. 46.

⁵⁵ Case T-319/99, *FENIN v Commission*, [2003], ECR II-357, para. 35, 38.

⁵⁶ *Id.*, para. 36-37; see also para. 39-40.

⁵⁷ *Id.*, para. 36.

⁵⁸ *Id.*, para. 39; see also case C-205/03 P, *Fenin v Commission*, [2006] ECR I-6295, para. 25-27.

states retain a relatively significant power of appreciation in determining the way in which they should be provided, especially in “cross border” situations, albeit within the limits enshrined in Articles 49 and 56 of the Treaty.

But what are the implications of this approach for the EU’s own powers? In other words, can the Union adopt measures affecting the provision of healthcare services, including those that are publicly funded? According to Article 6 of the TFEU, public health is included among those areas of competence in which the Union enjoys limited powers of action, being allowed only to take measures designed to “support, coordinate and supplement” the action already adopted by the Member States. According to Article 168(7) TFEU the Union can only take action to complement domestic measures and policies, with a view to, inter alia, encouraging mutual coordination and in that context improving the “complementarity of their health services in cross border areas (...)”, for the purpose of ensuring a high level of human health protection.⁵⁹

Importantly, the last subsection of the same provision, consistently with the case law on free movement discussed in section 3.1, expressly states that the member states can therefore decide independently how to organise, design and finance healthcare provision within the respective jurisdictions.⁶⁰ The EU institutions, on their part, can only enact measures to encourage state coordination in, inter alia, the provision of health care services in cross-border situations so as to ensure that the sovereign powers enjoyed by the member states in this area do not unduly encroach upon the free movement of persons and of services’ rules.⁶¹ On this point, it is suggested that a good example of how this power is to be exercised is provided by the “Patients’ Directive”, i.e. Directive 2011/24/EU, laying down “(...)rules for facilitating access to safe and high-quality cross-border healthcare in the Union (...),[ensuring] patient mobility (...) and to promote cooperation on healthcare between Member States (...)”.⁶² For this purpose, the Directive crystallises⁶³ a number of rights that the CJEU had already been recognised for EU citizens enjoying their free movement rights vis-à-vis health authorities, including, for instance, the entitlement to the reimbursement of expenses incurred in seeking cross-border health services that are among the benefits to which they would have been entitled in their state of origin⁶⁴ and, after the provision of such services, to obtain any “follow-up” assistance in their home country that would have been offered to them had they been treated in their own country.⁶⁵

Thus, it is argued that in this area the “supporting competence” of the Union has been exercised in order to ensure that the functioning of the single market is not unduly impaired in the face of the significant autonomy enjoyed by the member states in respect of healthcare matters, especially by avoiding that the good functioning single market is unduly impaired as a result of state measures governing the provision of healthcare services according to the needs of their own populations.⁶⁶ In this context, it must also be emphasised that the choice of the extent to which these services are exposed to free market principles is for the member states to determine, in accordance with the principle of subsidiarity.⁶⁷

In light of the forgoing analysis, it is submitted that the answer to the question of whether the stipulation of TTIP could result in the EU member states being obliged to “open up” their health care

⁵⁹ See e.g. , *mutatis mutandis*, case C158/96, Kohll, [1998] ECR I-1931, para. 18.

⁶⁰ See e.g. case C372/04, Watts, [2006] ECR I-4325, para. 86 and 92; see also case C-385/99, Muller-Faure’, [2003] ECR I-270, para. 102-103.

⁶¹ See e.g. C-157/99, Geraets-Smits et al., [2001] ECR I-5473, para. 44-45.

⁶² Directive of the European Parliament and the Council of 9 March 2011 No 24 on the application of patients’ rights in cross-border healthcare, [2011] OJ L88/45, Preamble, Recital 10.

⁶³ *Id.*, recital 11.

⁶⁴ See Article 7 of Directive 2011/24.

⁶⁵ See Article 5(c).

⁶⁶ See e.g. Sauter, “The impact of EU Competition law on national healthcare services”, (2013) 28(4) *ELRev* 457 at 463-465.

⁶⁷ *Ibid.*; see also, *mutatis mutandis*, Opinion 1/08, cit. (fn. 32), para. 133, 136; also case C-385/99, Muller-Faure’, [2003] ECR I-270, para. 102-103; Fenin, cit. (fn. 55), para. 38-40.

services' markets to greater competition, especially from non-EU based firms,⁶⁸ appears to be largely negative. As was illustrated earlier although common commercial policy matters fall within the scope of the Union's exclusive competence, the latter can only be exercised within the scope of the principle of conferral.⁶⁹ It was illustrated earlier that health care provision is a field in which the EU only enjoys "coordinating" and "supporting" competence, that is the power only to ensure that the "sovereignty" maintained by the member states over publicly funded health care provision does not distort the functioning of the internal market. Member States, on their part, whilst remaining relatively autonomous in disciplining access to these services, can only introduce those domestic arrangements that are appropriate to the pursuit of the public interest to, e.g. the stability of their health systems and proportionate to the objective they seek to achieve.⁷⁰ Subject to these limits, they can therefore choose, for instance, to keep the provision of these services under state control and ownership or to limit the involvement of the private sector to a minimum; they can also introduce rules designed to regimenting access to these markets on the part of firms that are based outwith their territory if this is demonstrated to be both proportionate and necessary to the pursuit of goals of, e.g., continuity of care.⁷¹

Against this background, it is argued that the Union could not, via TTIP or indeed any other international trade instrument, oblige the member states to adopt a certain "model" for the provision of health care services or indeed to alter their choices as to whether to limit the space for the free movement of these services on the basis of public interest considerations, so long as they do not unduly interfere with the functioning of the internal market and especially with the smooth circulation of services. In this respect, it is suggested that it appears unlikely that the Union could advocate an unexpressed power to act on the international plain even by means of treaties concerning policy matters in respect of which it enjoys exclusive competence: it is submitted that measures such as the "patients Directive", far from seeking to harmonise the rules concerning the provision of these services, are carefully limited to smoothing out any national differences that may affect the functioning of the single market. As such, these powers would not therefore meet the requirements laid out by Articles 216 and 3(2) TFEU for the purpose of grounding "derived treaty making powers"⁷² on the ground that the internal competence could effectively be exercised without the need to adopt external measures concerning, e.g., the treatment of third country nationals.⁷³

In light of the forgoing, it is argued that the Union lacks the treaty-making powers that are required to enter into obligations with third countries affecting the area of health care, given the limited scope of the internal powers it enjoys in this field: it is suggested that since its competence under Article 168 TFEU is limited to ensuring the efficient circulation of services in cross border situation within the internal market and does not therefore affect the treatment of third country nationals,⁷⁴ its exercise in the form of internal measure does not require the EU to negotiate agreements with third countries.⁷⁵ Accordingly, it is argued that unless the member states were prepared to negotiate an amendment in the TFEU to confer on the EU more pervasive powers of regulation and harmonisation in this area, the Union could not, via the medium of TTIP or in other ways, mandate the member states to adopt a certain type of institutional framework for the

⁶⁸ Opinion 1/76, Re: Inland Waterway Vessels Convention, [1977] ECR 741.

⁶⁹ See also, e.g., Opinion 1/2003, Re: Lugano Convention, [2006] ECR I-1145, para. 126-128; see also para. 133.

⁷⁰ See inter alia case C-157/99, Geraets-Smits et al., [2001] ECR I-5473, para. 44-45; also case C-372/04, Watts, [2006] ECR I-4325, para. 86.

⁷¹ See e.g., mutatis mutandis, case C158/96, Kohll, [1998] ECR I-1931, para. 18.

⁷² See inter alia Opinion 1/03, cit. (fn. 12), para. 126-127; see also case C-81/13, cit. (fn 23), para. 57-59; see also AG Opinion, para. 102-104 and 106-107.

⁷³ Id., para. 106-107.

⁷⁴ See mutatis mutandis, id., para. 64-65; see also para. 78-80.

⁷⁵ Id., mutatis mutandis, para. 69-70; see also judgment of the Court of 18 December 2014, para. 44-46 and 52-55.

provision of publicly funded healthcare services that would allow, inter alia, for the extension of the free movement of services' rules to providers established in a third country.

On this point, it also appears unsurprising that according to a recent statement, the Commission has committed itself to keeping health care services outside the realm of the TTIP negotiations.⁷⁶ The memorandum published in July 2014 by DG Trade,⁷⁷ confirms that the partnership deal would preserve the power of EU Governments to limit the reach of the principle of "national treatment" and "market access" to healthcare provision, including the possibility of opening up health care markets to competition⁷⁸ and of reducing the scope for third country individuals and firms to enter and operate within the single market.⁷⁹

This commitment was also reiterated in communications occurring directly with the United Kingdom Parliament: in a letter dated 8 July 2014 and addressed to the Chair of the All-Party Parliamentary Group on TTIP, the Director for the USA and Canada division of the EU Commission's Directorate General for Trade. In the letter, Mr Garcia Bercero expressed the view that adhering to TTIP would not affect the "rights of the Member States to manage their own health systems according to their various needs".⁸⁰ To quote verbatim from the letter, "the EU does not intend to change its approach to health services in trade negotiations for TTIP"; consequently, Member States remain entitled to, inter alia, establish rules designed to "control access to their health services markets by foreign suppliers, without constraints under EU trade agreements."⁸¹

It is added that this position would likely not be affected by considerations concerning the nature of TTIP: as was also observed by DG Trade this treaty, despite being negotiated under the wide remit of the common commercial policy, i.e. an exclusive competence, is in all probability going to be a mixed agreement, in view of its remit and of the demands of the principle of conferral. It is acknowledged that this type of instrument is capable of allowing the Member States to "defend their sensitive interests".⁸² However, it is argued that the implications stemming from the nature of the agreement itself do not address the more general questions as to the allocation of powers of the Union vis-a-vis the Member States, which therefore remain the main obstacle vis-à-vis any action on the part of the Union affecting this area.⁸³ Thus, it is submitted that the partnership deal, even if concluded as a mixed agreement, could not go as far as to oblige domestic governments to reform their health systems so as, inter alia, inject "more market" into their functioning, on the ground that just as the EU does not enjoy sufficiently extensive internal powers in this area, it also lack the corresponding external authority to achieve these objectives.⁸⁴

It may be concluded that the principle of conferral precludes the EU from introducing measures resulting or encouraging the "privatisation by stealth" of national health care framework either via internal action or through the stipulation of international trade treaties. As was illustrated so far, the limited powers enjoyed by the Union in respect of health care matters would not, save for an amendment to Article 168 TFEU, allow it through TTIP to restrict the sovereignty that Member

⁷⁶ See: <http://trade.ec.europa.eu/doclib/press/index.cfm?id=918>. A text of the draft mandate was leaked in March 2013 to the "Inside US Trade" website; it was marked with the reference: COM(2013) 136 final; see also, mutatis mutandis, Article 14, General Agreement on Trade in Services, available via: http://www.wto.org/english/docs_e/legal_e/26-gats_01_e.htm#articleXIV; see also draft mandate, cit. (fn. 39), Annex, para. 6 and 14.

⁷⁷ See: <http://trade.ec.europa.eu/doclib/press/index.cfm?id=1115>.

⁷⁸ Ibid.

⁷⁹ Ibid.

⁸⁰ See the letter sent to John Healey MP (Chair, All Party Parliamentary Group on TTIP) by Ignacio Garcia-Bercero, DG Trade, EU Commission, on 8 July 2014, available at: http://trade.ec.europa.eu/doclib/docs/2014/july/tradoc_152665.pdf.

⁸¹ Ibid.

⁸² Opinion 1/08, cit. (fn. 32), para. 136.

⁸³ Id., para. 127.

⁸⁴ Ibid.; see also para. 128 and 132; see also para. 136.

States maintain over their publicly funded health systems and in particular to push them toward "market oriented models" when designing or reforming the relevant institutional frameworks.

3.3. "Contracting out" healthcare services in Europe: does TTIP de fact offer a "backdoor in" for third country providers?

The previous section discussed the nature of the competence enjoyed by the EU in the field of healthcare and showed that in accordance with Article 168 TFEU the Union can only act with a view to "supporting and coordinating" domestic action in this area and in particular to prevent the application of these domestic rules from fettering the functioning of the single market in cross border cases, with the Member States being fully "sovereign" over the provision of publicly funded health services.⁸⁵

It is however beyond doubt that private enterprise play a role (which is in some instances significant) in the delivery of these services, through the stipulation of contracts with the competent public authorities. The purpose of this section is therefore to address the question of whether TTIP is likely to increase the accessibility of public procurement markets for non-EU companies. As is well known, EU legislation has been introduced with a view to harmonising the principles and also the procedures according to which contracts whose monetary value is above a certain set of thresholds are assigned by public authorities:⁸⁶ at the core of these measures are a commitment to transparency and non-discrimination (especially on grounds of nationality) of potential contractors, so that equality of opportunity to secure these contracts is respected and the functioning of the single market is not adversely affected by making it more difficult from firms established in other member states to bid for selection.⁸⁷

Having regard in particular to non-EU firms, the current legislation expressly states that the Union is committed to guaranteeing to these would-be bidders conditions that are no less favourable than those enshrined in the WTO's Government Procurement Agreement, that is, the international law instrument negotiated and concluded within the framework of the World Trade Organisation with a view to ensuring the reciprocal opening up of the markets for public works and services to firms located in the territories of the Organisation's members. But, in view of the "sensitive" nature of healthcare services and of the correspondingly limited scope of the powers enjoyed by the EU in this field, to what extent can this commitment to mutual access to the respective markets be upheld?

The debate concerning the negotiations of TTIP has indicated since the very start that this is a "hard fought" field:⁸⁸ according to the EU Commission's Mandate, obtaining greater access to US public procurement, at least at Federal level, represented a key objective of the Union's negotiating position.⁸⁹ Several European stakeholders, on the other hand, claimed that if non-national or non-EU providers were allowed to bid for these contracts in conditions of non-discrimination, this would have resulted in public services (including health care) becoming more exposed to free market principles and in quality standards being lowered.⁹⁰ Having regard more specifically to the functioning of the NHS in the United Kingdom, it was claimed that the stipulation of TTIP could have

⁸⁵ Case C-372/04, cit. (fn. 70), para. 105.

⁸⁶ See chiefly Directive of the European Parliament and the Council 2004/18/EC, [2004] OJ L134/114.

⁸⁷ Id., see e.g. Preamble, Recitals 1-3.

⁸⁸ See e.g. House of Lords Select Committee on the EU, Sub-committee C, 14th Report, "The Transatlantic Trade and investment partnership agreement", session 2013-14, available at: <http://www.publications.parliament.uk/pa/ld201314/ldselect/ldeucom/179/179.pdf>, para. 131; see also EU Commission, Communications of 14 June 2013, available at: <http://trade.ec.europa.eu/doclib/press/index.cfm?id=918>.

⁸⁹ See e.g. State of Play of negotiations after 6th Round, July 2014, available at: http://trade.ec.europa.eu/doclib/docs/2014/july/tradoc_152699.pdf, p. 2.

⁹⁰ See e.g. John Hillary, "On TTIP and the NHS, they're trying to bamboozle us", 14 July 2014, available at: <https://www.opendemocracy.net/ournhs/john-hilary/on-ttip-and-nhs-they-are-trying-to-bamboozle-us>.

potentially wide-ranging and so far unclear consequences, due to the increasing push on the part of the Westminster Government especially to introduce "market based" principles in this sector,⁹¹ to which, it was often suggested, TTIP would contribute.⁹²

While, as will be illustrated later, these concerns have been felt especially in England and Wales⁹³ and less in Scotland where these services have excluded from the remit of free market principles,⁹⁴ questions remain as to the extent to which foreign and especially non-EU based firms may still bid for public contracts concerning healthcare provision both North- and South-of-the-Border.⁹⁵ In this respect, it may be queried whether Member States' health authorities can in some way limit access to the relevant bidding procedures on the basis of, e.g. geographical criteria associated with the localisation of service providers and aimed at pursuing non-economic goals such as, inter alia, maintaining continuity and quality of care for patients.⁹⁶

As a preliminary point, it must be noted that the current Directive concerning the award of public contracts appears to be consistent with the same principles underpinning Article 168 TFEU, namely that, in application of the principle of subsidiarity, "essential services to the person" and in particular health care falls within the power of the member states to decide how to organise their provision.⁹⁷ thus, its Preamble expressly acknowledges that the provision of these services takes place, within each member state, in a "(...)particular context that varies widely amongst Member States, due to different cultural traditions (...)".⁹⁸ Accordingly, domestic authorities retain significant discretion as to the manner in which these services should be supplied and in that context can "(...) organise the choice of the service providers in the way they consider most appropriate (...)".⁹⁹

National agencies responsible for the provision of publicly funded health care services can therefore opt for doing so "in-house", that is either directly or via entities that they themselves control;¹⁰⁰ they can also decide to grant licenses to outside bodies that meet objective selection criteria identified in advance.¹⁰¹ Alternatively, health authorities can decide to "contract out" specific services and select the firm or firms to which the relevant contracts should be awarded on the basis of criteria that are not solely based on the "value-for-money" principle but also on more quality-based requirements,¹⁰² such as, inter alia, a concern for ensuring the "continuity in the provision of public services" or for allowing organisations based on solidarity-led governance principles (such as, inter alia, workers' cooperatives or other organisations in which service users participate in the provision of the services) to bid for relevant contracts.¹⁰³

In light of the forgoing, it is argued that albeit within the constraints placed on their powers by principles of transparency and non-discrimination underpinning the award of any public contract, member States enjoy a power of appreciation in deciding whether to grant access to these procedure and in particular can opt for limiting the scope of application of criteria that are purely

⁹¹ See inter alia Curran and Albert, "It seemed a good idea at the time", (2014) 35(9) ECLR 419; see also Pownall, "Neoliberalism, austerity and the Health and Social Care Act 2012", (2013) 42(4) Industrial LJ 422 at 429-430.

⁹² See e.g.: <http://www.patients4nhs.org.uk/eu-us-free-trade-agreement-or-ttip/>.

⁹³ Ibid.

⁹⁴ See e.g. SPICe Briefing, "The National Health Service in Scotland", 21 June 2011, No 11/49, pp. 5-6.

⁹⁵ Ibid.

⁹⁶ See Directive of the European Parliament and the Council No 2014/24/EU, [2014] OJ L94/65, Preamble, Recital 118.

⁹⁷ See inter alia, mutatis mutandis, case C-300/07, H & C Oymanns GbR and others, [2009] ECR I-4779, para.51-56; see also para. 59.

⁹⁸ Directive of the European Parliament and the Council No 2014/24/EU, [2014] OJ L94/65, Preamble, Recital 114.

⁹⁹ Ibid.

¹⁰⁰ See e.g. case C-324/98, Telaustria, [2000] ECR I10745, para. 60-61.

¹⁰¹ Ibid., fn. 142. See also Directive 2004/18/EC, OJ 2004 L134/114, Annex II B.

¹⁰² Ibid.; Inter alia, see case C-321/03, Coname, ECR I-7287, para. 16-19.

¹⁰³ Id., fn. 142, Recital 118, Preamble.

economic in nature, such as those based on "value-for-money" in the selection of winning bids.¹⁰⁴ EU legislation, on its part, recognises and upholds the application of a "light touch regime" to healthcare as part of these sensitive services to the person and thus allows to the bodies responsible for the award of these contracts significant discretion in governing their provision.¹⁰⁵

Against this background it is suggested that applicability of the EU public procurement legislation can be severely restricted in its application to these activities. Thus, in *Teckal* the Court of Justice took the view that when a Member State opted for the "in-house" supply of these services, either directly or via controlled entities, the public procurement rules would not apply beyond the general principles of transparency and non-discrimination mentioned above.¹⁰⁶ In *Commission v Ireland* it was added that contracting authorities would not be obliged to "go out to tender" if services were entrusted with another public body and performed as part of their statutory duties.¹⁰⁷ More generally, the Court has recognised in several judgments that so long as they conform to principles of legal certainty and transparency and are not applied in an arbitrary or discriminatory fashion, the awarding bodies can identify and apply selection criteria that are not of a purely "economic" (i.e. value or price-based) nature even when, due to the manner in which services are provided, "going out to tender" is the only solution.¹⁰⁸

It is added that similar considerations would also likely allow the member states to regiment, in the context of the "light touch regime" described above, to exclude from public procurement procedures specific categories of undertakings, including those who are affiliated to third countries, on the ground that they would not satisfy requirements based on the need to ensure continuity and accessibility in public service provision that, in turn, may entail, inter alia, geographical proximity between their suppliers and those who benefit from them.¹⁰⁹ Having regard in particular to providers based outside the EU, it is acknowledged that as a result of the General Procurement Agreement, WTO members are under an obligation to respect the principle of non-discrimination and consequently must not make the entry into their public procurement markets for firms affiliated to fellow member states "unduly burdensome". Nonetheless, it should be emphasised that according to its Annex IV,¹¹⁰ "social and health services" are expressly excluded from the principle of equal treatment, thus allowing signatory states to restrict access to the market for the provision of these services to foreign suppliers if that is regarded as necessary to maintain high levels of health protection within their territories.¹¹¹

Having regard more specifically to trade deals involving the Union, a similar approach seems also to have emerged in the negotiations of the recent Trade Agreement concluded with Canada (CETA): its Annex II expressly states that the terms of the deal will not apply to certain "sensitive" types of public services, among which healthcare features prominently.¹¹² Thus, it is argued that publicly funded healthcare services are in all likelihood going to be excluded from the remit of any trade

¹⁰⁴ See e.g. Wiggins, "Public procurement rules and cooperation between public sector entities", (2011) 5 PPLR 157, especially pp. 158-159.

¹⁰⁵ See Directive of the European Parliament and the Council No 2014/24/EU, [2014] OJ L94/65, Preamble, Recital 118. For commentary, mutatis mutandis, inter alia, Brown, "Seeing through transparency", (2007) 1 PPLR 1, especially pp. 19-21.

¹⁰⁶ Case C-107/98, *Teckal Srl*, [1999] ECR I-8121, para. 49-51.

¹⁰⁷ Case C-532/03, *Commission v Ireland*, [2007] ECR I-801, para. 26-28; see also para. 35-36.

¹⁰⁸ See e.g. most recently, case C-568/13, *Azienda Ospedaliero-Universitaria di Careggi-Firenze v Data Medical Service Srl*, judgment of 18 December 2014, nyr, para. 32-35; see also, inter alia, case C-305/08, *CONISMA*, [2009] ECR I-12129, para. 37, 43.

¹⁰⁹ See e.g., mutatis mutandis, case C-160/08, *Commission v Germany*, judgment of 29 April 2010, para. 124 ff.

¹¹⁰ WTO, General Procurement Agreement, Appendices and Annexes, available at: http://www.wto.org/english/tratop_e/gproc_e/appendices_e.htm#ec.

¹¹¹ See e.g., in respect of pharmaceutical trade, Acquah, "Extending the limits of protection of pharmaceutical patents and data outside the EU", (2014) 45(3) IIC 256 at 268-269.

¹¹² See CETA—summary of the final negotiations, available at: http://trade.ec.europa.eu/doclib/docs/2014/december/tradoc_152982.pdf, pp. 10-11.

liberalisation deal involving the EU, including TTIP. This outcome appears particularly probable in light of the position expressed by the EU Commission in a recent letter. Writing to members of the UK Parliament, the erstwhile Director for Trade with responsibility for “Neighbouring countries—USA and Canada” expressed the view that the EU was not planning to change its position in this area; it was confirmed that EU member states retain “full policy space” in this field, and consequently remain competent to regiment—even to the point of negating it altogether—entry and participation within the market for healthcare services (including those that are publicly funded) for non-European providers.¹¹³ The EU for its part could only be bound by its obligations under the current WTO regime according to which, as illustrated earlier, these services would remain excluded from the remit of the principle of equal treatment.¹¹⁴

In light of the forgoing analysis, it may be concluded that while TTIP is likely to facilitate reciprocal access for EU and US based businesses in their respective procurement markets generally, it is not going to alter the “light touch nature” of the regime governing the award of contracts in the field of healthcare provision or of the supply of other “sensitive” services. But what about member states who have already decided to “inject free market principles” into healthcare provision? Is this domestic choice likely to alter this conclusion? The next sections will consider the framework for the provision of healthcare services respectively in Scotland and in England and Wales, with a view to assessing whether the obligations that TTIP is expected to involve are likely to facilitate the “internationalisation” of healthcare services’ provision and of public procurement when domestic legislation has already introduced a degree of “privatisation” in this area.

4. Healthcare services in the United Kingdom and the impact of the single market and of the common commercial policy at EU level: a tale of two nations?

4.1. The NHS in Scotland: relying on cooperation and state “control” and “ownership” as a means of seeking optimal provision of care

The previous sections analysed the scope of the competence enjoyed by the EU in the field of healthcare services and highlighted the very narrow contours designed for it by Article 168 TFEU and argued that unless the member states decided to amend the Treaty so as to confer on it more generous ability to take action, the Union would not be able to mandate, through an international instrument, any greater access of these markets to third-country providers than the one that domestic legislation and regulation currently allows in each jurisdiction.

It is however undeniable that, just as they retain the power to regiment entry into these economic areas vis-à-vis non-EU providers, member states can choose to adopt a “market oriented” approach to their provision, that may well involve allowing foreign providers into normally “national”, if not local, markets. It is submitted that a good example of the potentially divergent solutions that can be adopted to address this issue is the one offered by the National Health Service (NHS) in the United Kingdom: as is well known, the aim of the NHS is to provide medical care financed by the taxpayer “free at the point of need” to individuals resident within the UK. The Service enjoys high level of citizens’ trust and represents a key “cost component” in the British budget: according to data originating within the British Treasury, NHS costs in the years 2010/11 accounted for £121 bn or 8.2% of the country’s total GDP.¹¹⁵ In the years 2013/14 this figure was

¹¹³ See the letter sent to John Healey MP (Chair, All Party Parliamentary Group on TTIP) by Ignacio Garcia-Bercero, DG Trade, EU Commission, on 8 July 2014, available at: http://trade.ec.europa.eu/doclib/docs/2014/july/tradoc_152665.pdf.

¹¹⁴ *Supra*, this section, fn. 110 and 111 and accompanying text.

¹¹⁵ See e.g. House of Commons, Note: NHS funding and expenditure, SN/SG/724, 3 April 2012, available at: <http://www.nhshistory.net/parlymoney.pdf>, sect. 1.1-1.2.

approximating £114 bn—slightly lower, but still extremely significant and to date the highest single item of expenditure per function within the whole UK budget.¹¹⁶

Its structure has, however, been the target of significant reforms in the past 20 years, in response to concerns for its efficiency and financial sustainability. Demands for greater devolution of powers from the Westminster Parliament to the assemblies representing the population of the UK's nations and especially of Scotland have also been influential in this process which has resulted in the “Scottish arm” of the Service adopting a very different structure than the one characterising the NHS in England and Wales. The purpose of this section will be to provide a short overview of the NHS in Scotland and thereafter to attempt to gauge, however briefly, the extent to which the framework for healthcare provision in force North-of-the-Border is likely to be affected by the implementation of common commercial policy objectives affecting these services on the part of the EU.

As was anticipated, the power to legislate on the structure and functioning of the NHS in Scotland has represented a “devolved matter” to the Parliament in Holyrood since the 1997 Scotland Act: the Scottish Parliament has expressly maintained the NHS “in public hands”.¹¹⁷ Today, its running is devolved by the Government to a structure of fourteen area boards, responsible for the allocation of resources and the implementation of healthcare strategies via NHS Boards, Community Health Partnerships and Operating Divisions.¹¹⁸ These bodies operate according to principles of cooperation and are under direct control of the competent Minister.¹¹⁹ Performance objectives are set by the Scottish Government: NHS Boards are fully responsible for the implementation of the delivery plans that they sign with Government, by which they are also monitored and supported in the course of their activities.¹²⁰

Under the leadership of the Government's General Directorate for Health, the Boards, acting as “all-purpose organisations”, provide services to patients either directly or by commissioning them to independent contractors, such as, among others, GPs, dentists and pharmacies.¹²¹ Hospital care is provided under direct control of the Boards, organised on a territorial basis. NHS Boards also work in close cooperation with local authorities and communities, via local area partnerships. Overall quality of service and assurance of continuity of provision are guaranteed via specialised agencies, such as Healthcare Improvement Scotland.¹²² At the core of the Scottish NHS's strategy is a commitment to providing “(...) safe, high quality services that are as local as possible and as specialised as necessary”.¹²³ This objective is met in a variety of ways, ranging from the provision of services “in-house”—either directly or via bodies under the control of the NHS Scotland's Boards— or through the commissioning of these services in accordance with framework agreements that are negotiated on a UK wide basis.¹²⁴

Central to this activity is a strong emphasis on collaboration, partnership and the sharing of resources across the sector; in addition, the fact that there is often no “split” between purchaser and provider means that there is no such a thing as a “contract” for the supply of key services: this is the case for hospital care, which is managed “in-house” by a bespoke operating division within each Board.¹²⁵ Consequently, it is suggested that since these practices can be regarded as forms of

¹¹⁶ See e.g. the summary data available at: <http://www.nhsconfed.org/resources/key-statistics-on-the-nhs>.

¹¹⁷ See e.g. SPICe Briefing, “The National Health Service in Scotland”, 21 June 2011, No 11/49, pp. 5-6.

¹¹⁸ Ibid.

¹¹⁹ See e.g. <http://www.scotland.gov.uk/Topics/Health/About/NHS-Scotland>.

¹²⁰ See inter alia <http://www.ournhsscotland.com/our-nhs/nhsscotland-how-it-works>.

¹²¹ Ibid.

¹²² Ibid.

¹²³ See Kerr Report: Delivering for health, 2 November 2005, available at: <http://www.scotland.gov.uk/Publications/2005/11/02102635/26356>, Executive summary.

¹²⁴ See inter alia SPICe briefing, cit. (fn. 117), pp. 4 ff.

¹²⁵ See inter alia Timmins, “The four UK health systems”, paper produced for the King's Fund, in association with European Observatory, available at: <http://www.kingsfund.org.uk/publications/four-uk-health-systems-june-2013>, p. 4-5.

internal organisation within a "unitary structure", they are very likely to fall outside the scope of competition law scrutiny, just as any other form of "single firm conduct".¹²⁶

In light of the above it is argued that the choice of the Scottish Parliament has been very much in the sense of leaving publicly funded healthcare largely out of the market and under governmental control, by limiting the input of private providers in the provision of healthcare services, by maintaining key activities, such as the provision of hospital care, within NHS Boards and by managing significant areas of primary care, including GP services, under the strict supervision of local partnerships.¹²⁷ It is submitted that the emphasis on keeping taxpayer-funded healthcare under direct rule from Government may be regarded as instrumental to the attainment of non-economic goals such as continuity and accessibility of care and of overall stability (financial and institutional) of the overall NHS North-of-the-Border¹²⁸ and thus remains consistent with Article 168 TFEU.¹²⁹

It is argued that the choice of keeping the Scottish NHS "in public hands" has important consequences for the applicability of the EU rules on competition and on the free movement of services.¹³⁰ On this point, it is submitted that due to the Scottish Government's strong commitment to principles of universality and solidarity in the provision of publicly funded healthcare, the latter is unlikely to constitute an "economic activity" in the meaning conferred to this concept by the Court of Justice in, *inter alia*, the FENIN decision. Consequently, it is argued that arrangements aimed at ensuring cooperation and resource-sharing among different health boards and agencies within as well as outwith the Scottish NHS may escape the application of the Union competition principles.¹³¹

Having regard more specifically to the provision of services to patients, it is added that since these activities appear to be carried out mainly either "in-house" or via controlled entities, the contracts concluded for this purpose are very likely to be immune from the application of the "bulk" of the EU Public Procurement legislation.¹³² And finally, the circumstance that in any other case the award of these contracts, being concerned with "essential services to the person", is subject to a "light touch regime" under the relevant Union legislation is going to allow those Boards that may have to opt for "going out to tender" to regulate the access to the bidding process and to select the winning offers on the basis of criteria that are non-economic and thus not strictly based on the value-for-money principles: as was discussed above, this "lighter regime" would permit domestic agencies to subordinate their decision to the fulfilment of requirements based on other factors, such as geographic proximity or the extent to which the bidders may be non-profit organisations in which service users may also be involved.¹³³

It is concluded that the concerns that the Partnership agreement could affect the status quo characterising the functioning of the NHS in Scotland appear unjustified: not only does Article 168 TFEU protect the "sovereignty" of the Scottish Government and Parliament over regulation of and access to their taxpayer-funded health systems, albeit within the limits enshrined in the TFEU. The Scottish administration remains also entitled to rely on non-economic criteria in designing and regimenting the framework for the publicly funded provision of these services when the latter are supplied by private entities, thanks to the "light-touch regime" provided by the Public procurement legislation in this area.

4.2. State-funded healthcare in England and Wales—toward a "neoliberal" framework for the provision of these services... but what does this mean for market access?

¹²⁶ See e.g., *mutatis mutandis*, case C-73/95, *Viho Europe v Commission*, [1996] ECR I-465.

¹²⁷ *Id.*, see e.g. pp. 5-6 and 17-18.

¹²⁸ See e.g. case C372/04, *Watts*, [2006] ECR I-4325, para. 86 and 92; see also case C-385/99, *Muller-Faure*, [2003] ECR I-270, para. 102-103.

¹²⁹ *Ibid.*; see especially pp. 18-19.

¹³⁰ See e.g. C-157/99, *Geraets-Smits et al.*, [2001] ECR I-5473, para. 44-45.

¹³¹ Case T-319/99, *FENIN v Commission*, [2003], ECR II-357, para. 35-40.

¹³² See *inter alia*, case C-305/08, *CONiSMA*, [2009] ECR I-12129, para. 37, 43.

¹³³ *Ibid.*

The previous section briefly outlined the key principles governing the design and the functioning of the NHS in Scotland and in that context discussed the impact of these choices, which are strongly in the sense of maintaining this sector of the healthcare industry in Government's hands, on the applicability of the free movement of services and competition rules contained in the TFEU, as well as their implications for the continuing observance of the obligations enshrined in the current EU Public Procurement legislation.

The situation is, however, admittedly very different in England and Wales: as anticipated, whereas the Scottish Government, especially in the years between 1999 and 2007, "back-tracked" from a sustained move aimed at opening up these services to the free market forces, the solutions adopted by the Coalition Government in office since 2010 have aimed at resuscitating many of the ideas behind the objective of creating a "internal market" of health care services. The Health and Social Care Act 2012 was enacted for the purpose of "(...)promot[ing] competition amongst an increasingly diverse base of private, public and non-profit providers of public services, with the ultimate aim of raising the standards of service-provision and reducing its costs (...)".¹³⁴

To achieve these objectives, the Act abolished bodies such as the Primary Care Trusts and the strategic health authorities, along with the NHS executive, and replaced the former with Clinical Commissioning Groups (CCGs) and with a new NHS England commissioning board: CCGs are led by GPs and are responsible for the purchasing of medical services from third party providers, which in turn can either be publicly (e.g. NHS Foundation Trusts) or privately owned.¹³⁵ They act under the supervision of the commissioning board, which is also responsible for the direct purchasing of certain specialised services.¹³⁶ Thus, it is apparent that thanks to the 2012 Act the framework for the provision of healthcare services has gone back to relying on the "purchaser-provider" split and also to conforming to the idea of an "internal market" in services.¹³⁷ Importantly, the 2012 Act states that NHS commissioners must not engage in anti-competitive behaviour unless restrictive practices are justified "in the patients' interest".¹³⁸

To ensure the effective application of this principle, the Act has conferred to a sector regulator, Monitor, competition enforcement powers to be exercised in regime of concurrency with the Competition and Markets Authority (CMA).¹³⁹ Monitor is also responsible for authorising new entities wishing to start providing healthcare services and for regulating their activity. Having regard more specifically to its competition mandate, its role encompasses not only detecting and sanctioning anti-competitive behaviour but also the application of the competition rules in a way that contributes to the "patients' interests (...) by improving the quality of these services (...) and reducing inequalities in respect of both access to service and outcome of treatment."¹⁴⁰ It was suggested therefore that this aspect of Monitor's mandate allows it to authorise otherwise objectionable behaviour on the ground that the latter is regarded as justified and indispensable to secure "(...) seamless, well-coordinated and uninterrupted provision of health care services(...)" in accordance with clinical considerations.¹⁴¹ These decisions should be inspired by qualitative, clinically led considerations and should focus on striking an appropriate balance between the "costs" associated with a loss of competition (e.g. in terms of reduced incentives to innovate or to provide better "value-for-money" services for providers) and the benefits accruing to patients as a result of

¹³⁴ Sanchez-Graells, "New rules for healthcare procurement in the UK", (2015) 1 PPLR 16 at 19.

¹³⁵ See Timmins, cit. (fn. 125), pp. 3-4.

¹³⁶ Ibid.; see also p. 13.

¹³⁷ Id., p. 3-4.

¹³⁸ Sanchez-Graells, cit. (fn. 134), p. 20.

¹³⁹ See Timmins, cit. (fn. 125), p. 3.

¹⁴⁰ Sanchez-Graells, cit. (fn. 134), p. 20; see Article 62(4), Health and Social Care (England and Wales) Act 2012.

¹⁴¹ Ibid.

the practice: if the latter, on the whole, overcome the former, then the practice, albeit *prima facie* anti-competitive, will be deemed to be “in the interests of patients”.¹⁴²

The 2012 Act allows commissioners to exercise a widely discretionary power when it comes to identifying ways in which health services may be purchased. Nonetheless, when they “contract out” these activities, they are under a general obligation not to resort to procurement practices resulting in the “narrowing” of competition.¹⁴³ In addition, and consistently with the relevant legislation on Public procurement, they can “(...) take into account the need to ensure [inter alia] quality, continuity, accessibility, affordability, availability and comprehensiveness of the services, the specific needs of different categories of users, including disadvantaged and vulnerable groups (...)”¹⁴⁴ and therefore, in accordance with general principles of transparency and non-discrimination, remain entitled to establish and apply selection criteria for bids that are not exclusively economic in nature.¹⁴⁵ However, the application of these criteria must lead to outcomes that are at least “competition neutral”: in other words, any “reduction of potential competition for the contract [must be] clearly and soundly justified from the perspective of the clinical/medical needs to be satisfied” and no less restrictive alternative should have been available to the awarding body, especially in terms of allowing access to the process to all the potentially suitable candidate firms.¹⁴⁶

The above analysis suggests that the 2012 reforms have introduced a framework for the publicly funded provision of healthcare services inspired by “neoliberal”, relatively market-driven principles. However, in recognition of the “sensitive nature” of these services, the Act allows for inroads to be carved in the principle of “internal market for health services” if these restrictions are necessary in the patients’ interest. In addition, and consistently with the “light touch regime” applied to the award of contracts for essential services to the person, non-economic criteria, based, for instance, on quality and accessibility of services can be relied upon in selecting successful bids.

Having regard more specifically to the “patients’ interest” clause Guidance recently published by Monitor states that this justification is likely to apply to *prima facie* restrictive practices—i.e. to practices that “reduce the incentives on providers to provide high-quality services, provide value for money and/or improve services”—which nonetheless lead to (or are likely to do so) “improvements in quality through cooperation in the delivery of care” or in efficiency gains that result in better value for money, e.g. through the reduction of “duplication” in the supply of these services.¹⁴⁷ These benefits must be “material” to the practice, likely to be realised within a relatively short time and supported by appropriate scientific research; in addition, commissioning bodies should consider whether a “less restrictive alternative” exists, with a view to achieving these outcomes, *vis-à-vis* the arrangement in question.¹⁴⁸

The framework for assessment proposed in the Guidance can be usefully compared with the approach on which the EU Commission relies in its Guidance on Article 101(3); in a similar vein as the one adopted by Monitor, the Guidance states that those efficiency gains that stem from “technical and economic progress” will be regarded as relevant for the purpose of the application of the legal exception of Article 101(3).¹⁴⁹ They must be “objective”—that is, measurable and achievable—as well as linked by a nexus of causality to the practice.¹⁵⁰ While in principle “cost efficiencies” that can be readily quantified are ostensibly the “preferred type” of benefits,¹⁵¹ the Commission openly

¹⁴² Timmins, cit. (fn. 125), p. 21; see also Monitor, Substantive Guidance on procurement, patient choice and competition regulations, (2013), available at: <http://www.monitor-nhsft.gov.uk/s75>, pp. 61 ff.; see especially pp. 62-63.

¹⁴³ *Id.*, pp. 28-30; see also Sanchez-Graells, cit. (fn. 134), pp. 28-29.

¹⁴⁴ See Article 76(8), Directive of the Council and the European Parliament 2004/24/EU, [2014] OJ L94/65.

¹⁴⁵ See e.g. Monitor, Guidance, cit. (fn. 142), pp. 18-19; see also, *mutatis mutandis*, pp. 64-65.

¹⁴⁶ Sanchez-Graells, cit. (fn. 134), pp. 29-30.

¹⁴⁷ Monitor, Guidance, cit. (fn. 142), p. 63.

¹⁴⁸ *Ibid.*

¹⁴⁹ Commission Guidance on the application of Article 101(3) TFEU, [2004] OJ C101/97, para. 32-33.

¹⁵⁰ *Id.*, para. 48, 51-54.

¹⁵¹ *Id.*, para. 64.

accepts that “qualitative efficiencies (...) may be of equal or even greater importance” than cost reductions and can therefore justify the applicability of the legal exception.¹⁵² In this context, benefits such as “technological advances” or the supply of products or services that are better suited to the needs of their users may fall within the broad scope of Article 101(3)(a) TFEU.¹⁵³

As to the “negative” conditions, i.e. that the restraint be ‘necessary’ and not entail the elimination of competition from a substantial part of the relevant market, the Commission insists on the absence of a less restrictive alternative¹⁵⁴ as well as on proof that as a result of the agreement the “magnitude of the remaining sources of actual competition”¹⁵⁵ and of the threat if entry are not weakened to the point of allowing the parties to, e.g. impose sustained price increases.¹⁵⁶

This approach can be contrasted once again with the one adopted by Monitor: according to the Guidance, conduct that results in benefits being attained more quickly and cost-effectively than would have been the case without it and that does not, e.g., discourage new competitors from entering the market or expanding their share is likely to be in the patients’ interests, if the positive conditions just outlined are also fulfilled.¹⁵⁷ In light of the forgoing it can therefore be argued that, providing that the criteria set out in the Monitor Guidance are applied in a non-discriminatory and transparent manner, practices that, while being prima facie anti-competitive, are adjudged to be in the patients’ interests are not likely to be objectionable also under the generally applicable competition rules.¹⁵⁸

It should be noted, however, that as a result of the 2012 Act, the scope of involvement of commercial firms in the provision of healthcare has become potentially more considerable, thus calling into question the extent to which the “solidarity-based” nature of their activities can exempt them from the application of Article 101 TFEU, as posited in, inter alia, the *FENIN* judgment.¹⁵⁹ It is argued that the principle laid down by the CJEU in that decision is going to be applicable only if the act of “purchasing” these services is aimed at the later supply of healthcare free at the point of need.¹⁶⁰ It is undoubted that if both purchaser and supply act in a largely solidarity-led fashion, *FENIN* would provide them with a “defence” against any accusation of anti-competitive behaviour.¹⁶¹ What is uncertain, however, is whether the same outcome can be attained if one of the parties seeks to make a profit from healthcare provision, as may well be the case when private undertakings are involved.

In this specific respect, it was suggested that the solidarity-led, as opposed to profit-making, nature of the services should be taken into account not on its own, but as just one of the features of each case: for instance, Sauter argued that factors including the degree of control exercised on the providers of these services and on the services themselves by the State would be just as relevant.¹⁶² In other words, an assessment of the activity from a “functional standpoint”, as opposed to looking at each contract in a “granular fashion” should be carried out in order to answer the question of whether, in light of *FENIN*, a specific arrangement concerning healthcare provision and involving private providers may be falling within the scope of Article 101 TFEU.¹⁶³ In this context, a consideration of the ratio between the price charged to health authorities and the costs borne by the provider, of the manner in which these charges are determined and of how and by whom (i.e.

¹⁵² Id, para. 70-71.

¹⁵³ Id., para. 71-72.

¹⁵⁴ Id., para. 74.

¹⁵⁵ Id., para. 109.

¹⁵⁶ Id., para. 114.

¹⁵⁷ Monitor, Guidance, ci.t (fn. 142), p. 64-65.

¹⁵⁸ See e.g. id., p. 65.

¹⁵⁹ Case T-319/99, *FENIN*, cit. (fn. 55), para. 35-37.

¹⁶⁰ See inter alia Sinclair, “Undertakings in competition law at the public-private interface—an unhealthy situation”, (2014) 35(4) ECLR 167 at 168-169.

¹⁶¹ Ibid’; see e.g., mutatis mutandis, *Bettercare v DGFT*, [2003] ECC 40, especially, paras. 98-99 and 101-102.

¹⁶² Sauter, “The impact of EU competition law on national healthcare systems”, (2013) ELRev 457 at 465-466.

¹⁶³ Sinclair, cit. (fn. 160), p. 169.

whether these decisions are taken by the state authorities or are left to the parties' freedom to contract, for instance) the corresponding benefits for users of the services in issue are decided would be especially important.¹⁶⁴

It may therefore be suggested that the Health and Social Care Act has heralded numerous and very significant changes in the way in which state-funded health care is provided in England and Wales: while the "citizen-facing" aspects of these important public services remain unaltered, the Act has opened up this sector to greater private firms' involvement and thus paved the way to a degree of rivalry and to wider market access. However, as was illustrated above, this does not appear likely to lead to the full "marketization" of the NHS: it is argued that if, as a result of a careful analysis of the modes of provision of these services, it is clear that they retain a "solidarity-based" nature, even when they are supplied via a non-state actor, the rules on competition may not be applicable to the activities undertaken by the entities concerned.¹⁶⁵ It is added that, as was shown having regard to the role and approach adopted by Monitor in these matters, the notion of 'patients' interest' is likely to prove an effective instrument to introduce considerations of "public policy" in the assessment of *prima facie* anti-competitive conduct (such as, *inter alia*, cooperation arrangements), so as to promote objectives of continuity of care and, more generally, to ensure better, more integrated care provision.¹⁶⁶

It is argued that this approach is going to be unaffected in the event of the conclusion of TTIP. As was illustrated in respect to the position in Scotland, the Founding Treaties allow member states to rely on non-economic criteria, albeit subject to principles of non-discrimination, of necessity and of proportionality, in order to, *inter alia*, restrict the possibility for non-domestic, including non-EU, firms to access the single market in medical services: in this context, it could be argued that the very concept of 'patients' interest' represents the "shortcut" for the solution which the Westminster Parliament has chosen to adopt for this purpose, in accordance with the principle of subsidiarity enshrined in Article 168(7) TFEU.

It should be added that broadly similar principles are relevant when it comes to considering to what extent undertakings established outside the Union can be allowed to bid for contracts with commissioning bodies, in accordance with the public procurement rules: on this point, the Guidance published by Monitor identifies three goals for commissioning bodies seeking to procure services, namely "securing the needs of healthcare service users, improving the quality of services" and increasing their efficiency at the point of provision.¹⁶⁷ These objectives must be attained on the basis of a careful assessment of the healthcare needs existing in a certain area and also among each segment of the population affected.¹⁶⁸ In doing so, these bodies must act in a transparent, non-discriminatory and proportionate way and must seek to procure services from the entity that is "most capable" of securing the overarching procurement objectives while offering 'best value for money'.¹⁶⁹ To achieve these general objectives, commissioning bodies have a vast array of choices among the various procurement tools and procedures: Monitor takes the view that resorting to the publication of a contract notice is only one option open to them and that other alternatives can also be considered as equally appropriate in light of the framework of objectives outlined above and in the respect of criteria of transparency, non-discrimination and proportionality.¹⁷⁰

In particular, the Guidance once again emphasises that the ultimate objective of any such decision must be to secure "the needs of people who use the services and improve [their] quality and efficiency" to which other, more economic-based concerns can and in appropriate cases should

¹⁶⁴ Sauter, *cit.* (fn. 162), p. 466.

¹⁶⁵ See Monitor, *Guidance*, *cit.* (fn. 142), p. 62-63.

¹⁶⁶ *Ibid.*

¹⁶⁷ Monitor, *Guidance*, *cit.* (fn. 142), p. 18-19.

¹⁶⁸ *Id.*, p. 19-20.

¹⁶⁹ *Id.*, p. 21.

¹⁷⁰ *Id.*, p. 35-36.

be subordinate.¹⁷¹ Consequently, Monitor accepts that putting certain services “out to tender” may not always be the best option for commissioning bodies and that other, less competition-oriented options can be better suited to meeting these objectives.¹⁷² This may be the case, inter alia, when the commissioning body finds that for specific services there is only a “single capable provider”, on the ground that, for instance, that provider owns infrastructure that is essential to provide the service or when two or more services must be “co-located”, i.e. supplied in the same place for reasons of safety or to meet a clinical need.¹⁷³ Furthermore, in selecting the “best contractor”, they must consider “appropriate ways of improving services”, among the options of either allowing coordination and integration among providers or encouraging competition and patient choice.¹⁷⁴

Against this background, it is argued that when dealing with commissioning practices as well as with the public procurement of health services, commissioning bodies can, for instance, rely on criteria that are not economic in nature, such as, inter alia, those dependent on the geographic location of the provider vis-à-vis the territory for which the commissioning body is responsible, in order to identify suitable bidders, provided that general requirements of transparency, proportionality and non-discrimination are met.¹⁷⁵ So long as they act fairly and transparently, the awarding agencies can therefore subject the selection of both the most appropriate procurement framework and of criteria of selection for suppliers that are not solely tied to the concept of “best value for money”.¹⁷⁶ Consequently, it is suggested that the Guidance remains broadly consistent with the “light touch approach” that guides the application of the EU relevant legislation in the context of “essential services to the person”.¹⁷⁷

In light of the forgoing analysis, it may be concluded that the organisation of the NHS in England and Wales could not be made to morph into a “market-driven” framework through an international agreement stipulated jointly by the EU and the member states. As was illustrated so far, the parliament in Westminster remains the ultimate “custodian” of the NHS in those geographic areas in which it enjoys competence to legislate: in this context it remains entitled to rely on the “exceptions” to principles of competition law and to the single market rules that the Founding Treaties provide in order to restrict the reach of “possible providers” only to those, for instance, based in the EU or even in smaller, more local areas. Furthermore, commissioning bodies retain significant discretion when it comes to deciding whether services should be “put out to tender” and also to setting criteria for the selection of suitable bidders, albeit within the general framework of principles governing public procurement at Union level.

5. Tentative conclusions: TTIP and publicly funded health care in the United Kingdom—access (almost) denied?

The Transatlantic Trade and Investment Partnership represents a very promising but at the same time challenging trade deal, involving two among the largest world’s economies: it is undeniable that by reducing trade barriers in key economic areas the agreement is likely to lead to export increases from Union member states into the US and vice versa, thus encouraging economic growth. At the same time however, the significant differences existing between the two economic and legal systems are going to bring new challenges for policy makers at Union and at domestic level. This is especially clear in respect of public services’ provision and especially of healthcare services. Against this background, it is therefore not surprising that the debate has been so polarised, with many stakeholders, especially belonging to civil society, greatly concerned that TTIP could be used as some

¹⁷¹ Id., p. 38-39.

¹⁷² Id., p. 39.

¹⁷³ Id., p. 41.

¹⁷⁴ Id., p. 26.

¹⁷⁵ See e.g. id., p. 28.

¹⁷⁶ Id., pp. 45 ff.

¹⁷⁷ See e.g., *mutatis mutandis*, recital 114 of the Preamble to the Directive 2014/24, cit. (fn. 98).

form of “back door” for the “privatisation by stealth” of public services generally and healthcare specifically.

It is however clear from the forgoing analysis that this danger is more imagined than real: as was illustrated in section 2, the Union, in accordance with the principle of conferral, can only act in those policy areas in which it enjoys authority under the Treaty and can only do so to the exclusion of the Member States when the Treaty expressly provides it with sole competence. By contrast, all other policy areas are regarded as either shared with the member states or in several cases are only limited to the power to “support” domestic action, especially when the latter can affect “cross-border” situations. Thus, it was argued that even though the legal basis for the negotiation of TTIP can be found in Article 133, i.e. in the area of common commercial policy, which is exclusive in nature, the exercise of powers in this field cannot occur without ignoring the constraints that, due to the significant remit of the agreement, the framework of competences established by the Treaty imposes on the EU.

On that basis, it was therefore suggested that, first of all, to the extent that the envisaged deal affected areas in which competences remained shared, the agreement could only be concluded in conjunction with the member states, that is, in the form of a “mixed agreement” and after having allowed the national governments to represent their legitimate interests in the course of the negotiations. And second, the Union could not, via TTIP, alter the nature and order of the powers that the member states themselves had conferred upon it, by for instance mandating the member states to “open up to the market” their healthcare services, due to the limited powers enjoyed by the Union in this area, according to Article 168 TFEU.

On that basis, it was argued that neither TTIP nor any other international instrument is likely to threaten the power to design, regulate and finance health care services via the NHS in the way that is seen as “appropriate to the needs of [the] population” either in Scotland or in England and Wales. Article 168 TFEU is in fact going to preserve the UK nations’ “sovereignty” over health services without allowing the Union to instigate their “marketization. Thus, it was submitted that just as domestic authorities are allowed to carve exceptions, based on objective justifications in the public interest and within the constraints of the Treaty, into the principle of free movement of services, they remain competent to regiment access to their healthcare service markets to firms established in third countries. Similarly, it may be suggested that the light touch regime affecting the award of such contracts would entail scope for selection criteria to be based on “geographic proximity” of providers to users of services.

It is acknowledged that the 2012 reforms of the National Health Service in England and Wales have been very controversial and have resulted in gulf emerging between the nations North and South-of-the-Border. However, it is argued that since the Westminster and Holyrood parliaments remain “sovereign” over decisions in the area of healthcare, the stipulation of TTIP will not lead to any dramatic change in the status quo. As was shown in section 4, significant and effective checks are in place to allow for the scope of application of the competition and public procurement rules to be limited, if not altogether excluded. In this respect, it was suggested that the ‘patients’ interest’ exception enshrined in the Health and Social Care Act for England and Wales and the strong state control on healthcare provision which characterises the NHS in Scotland are likely to provide legal justifications for the limitation of the right to free movement of services and of equal treatment of foreign providers that remain in line with the Treaty’s own principles. Thus, it was argued that the stipulation of TTIP would not be capable of altering this position on the ground of the Union’s acknowledged lack of authority in this area and also in light of the widely held concern, which is manifested, inter alia, in the WTO acquis as well as, more recently, in the recently concluded Canada/EU trade arrangement CETA, that these activities should be maintained outside the remit of the principle of equal treatment for non-national firms.

In light of the forgoing analysis, it is concluded that while the proposed trade deal remains controversial for a number of reasons, ranging from the lack of transparency of the negotiations to the concerns arising from its proposed rules on investor-state dispute settlement, its scope is highly

unlikely to encompass much cherished public services such as healthcare, save for the Member States agreeing to a treaty amendment affecting the current dictum of Article 168 and thereafter accepting key changes in their own legal and institutional systems. The principles of conferral and subsidiarity represent key safeguards for the integrity of European tradition in public service delivery, which cannot change unless the member states as masters of the EU Treaties decide to do so. In this context, domestic governments can choose to open up healthcare and other “sensitive” services to competition; however, the EU cannot be held responsible if this indeed occurs.