

**THE RT HON LORD OWEN SPEAKING AT THE LAUNCH OF THE VOTE
LEAVE 'SAVE OUR NHS CAMPAIGN', WEDNESDAY 6 APRIL 2016**

Protecting our NHS from the EU

The EU could have been the champion of the social market and by including the term in its treaty structure I hoped it would be its prime exponent worldwide. Yet in 2016, for many millions of young people, the EU is indelibly linked to unemployment and 'austerity', not the social market. The fatal flaws in the design of the Eurozone have created a dysfunctional EU, united only in its incapacity to run a social market or a single currency.

Can anyone justify the appalling figures for unemployment – a direct result of the euro crisis - for the under 25s in Spain, that reached 54% and is expected to be between 18-19% in 2017 despite encouraging economic growth. In Greece, Portugal, Italy there is still savage unemployment, in Ireland many young people left to go abroad. Still the euro crisis persists; a dysfunctional EU cannot, it appears, make the structural reforms.

Can anyone justify the secret trade negotiations the Commission have signed up for in TTIP? Despite protests little has been done to redress its errors. No regard for the social purpose of healthcare and the erosion of health as a Member State responsibility. The EU/Eurozone from 1992, in marked contrast to the old European Community of 1975, creeps into every nook and cranny of our life. It is now becoming entrenched in the NHS and this June we have a once-in-a-lifetime opportunity to get it out.

The Second World War brought the Emergency Medical Service in the UK, the Beveridge report and the 1944 White Paper outlining the provisions of a UK-wide service. A cross-party resolve emerged in wartime within the British people that when peace came there would be a different and better system of healthcare for everyone. The result was the NHS of 1948. It lasted until 2002. In England it is no longer national in the sense of being comprehensive or planned.

Healthcare, in a very real sense, is infinite. The amount of money invested in the NHS is a democratic choice, relative to what we choose to spend on education, housing, welfare, defence. That rationing process within the 1948 design of the NHS was flexible, professional and democratically accountable. In England it is barely answerable to the Westminster Parliament. The Scottish Parliament, the Welsh and Northern Ireland Assemblies still run recognizable national health services. Different designs exist in many parts of the world but no system has been judged internationally as being able to match, for overall cost effectiveness, the 1948 UK design.

In this EU referendum, as in the September 2014 Scottish independence referendum, the design of the marketised English NHS promises to be a source of legitimate political division. Politics cannot be an ideology-free zone. The report released on Friday of the collapse of the Cambridgeshire and Peterborough contract calls for a review of "all

current and planned clinical commissioning groups and NHS England contracts of this sort as a matter of urgency, before entering into any new commitments.” That manifest failure is a dire warning about the massive extra costs of market structures and advisers.

We in the cross-party Vote Leave Campaign, however, share a common democratic commitment. We will restore legal powers and democratic control of the NHS to voters in the UK. If we vote Leave - we will be able to protect our NHS from EU interference.

We all need to respect and value, whatever political parties we support, those elements which bind the citizens of the UK together and the NHS is one of those. Now is the time to take back control from the EU and protect our NHS for future generations.

From 1973-2002 the European Commission, by and large, stayed out of interfering in the UK NHS. It was assumed that this was politically too sensitive and in those days the Commission was not obsessed with proposing market solutions to social policy. The EU social market was always open to exceptions, perhaps the most famous being the French railway system, where Paris has historically not accepted any EU intervention. Lately, however, on health it has been accepted in Brussels that for ‘consumer’ the Commission can read ‘patient’.

In 2006 the Labour government commissioned a legal opinion on the effect of EU legislation on the NHS. The Health Department’s then commercial director, Ken Anderson, who had been involved with independent surgical treatment centres (ISTCs), told the *Financial Times* in January 2007: ‘My personal conviction is that once you open up NHS services to competition, the ability to shut that down or call it back passes out of your hands. At some point European law will take over and prevail ... In my opinion, we are at that stage now.’¹ As if recognising the truth of this interpretation on 13 December 2007, with not much publicity, the Department of Health issued a document titled *Principles and Rules for Cooperation and Competition*, running through which are EU legal positions which have become the law that operates in the UK.

The advisory Co-operation and Competition Panel was reported in the *Financial Times* to have been applying its interpretation of the law since 2009 – by advising on NHS mergers and handling complaints about anti-competitive practices by hospitals and primary care trusts². In truth, since 2002 the Labour government, the Coalition government and now the Conservative government have accepted an EU market in health.

¹ *Financial Times*, 16 January 2007.

² *Financial Times*, 27 and 29 July 2011.

Personally I believe a ‘progressive alliance’ government supported by Labour, SNP, Green, Plaid Cymru and Northern Irish politicians from all parts of the UK will emerge within the next decade which will challenge that market consensus. As democrats we agree they must have the democratic right to reinstate the 1948 design.

Barbara Castle predicted in the 1975 referendum, against my view as the then Minister of Health, when she was Secretary of State for Health and Social Security, that the NHS would be challenged by Brussels. She has been proven right.

The NHS Operating Framework from the Department of Health for 2011 encouraged, for the first time, price competition below a maximum tariff. David Bennett, the current chief executive of Monitor, who had been a senior partner at McKinsey and head of the Downing Street policy directorate and strategy unit under Tony Blair, gave an interview to *The Times* in February 2011 which described the regulator’s new role in promoting competition. ‘We did it in gas, we did it in power, we did it in telecoms,’ he said. ‘We’ve done it in rail, we’ve done it in water. So there is actually twenty years’ experience of taking monopolistic, monolithic markets and providers and exposing them to economic regulation.’ It was, he declared, ‘too easy to say “How can you compare buying electricity with buying healthcare services?” Of course they are different. I would say ... there are important similarities and that’s what convinces me that choice and competition will work in the NHS as they did in those other sectors’³. This encouraged the Commission to apply competition rules.

Nigel Edwards, the acting chief executive of the NHS Confederation, underlined the degree to which under the 2012 legislation it was intended that the state would ‘be withdrawing from the day-to-day management of health care’, with the service becoming ‘like a regulated industry’ on the lines of telecommunications, water and the energy industries. It could, he warned, ‘trigger a major reshaping of the way care is delivered with services closing and changing’. ‘I do not think most people have grasped the scale of this change,’ he continued. ‘By 2014, the NHS will no longer be a system which still contains the characteristics of an organisation. Instead it will be a regulated industry in which that management chain no longer exists.’ Amid ‘any willing provider’, services would have to become more responsive to patients. But in a system with no real financial growth that would mean that new providers would have to replace existing ones. ‘There will have to be an element of Joseph Schumpeter’s “creative destruction”’.⁴ That too encouraged the Commission.

The campaigning group 38 Degrees commissioned an important legal opinion on the EU and the NHS. ‘It is likely that, even as matters stand, and in view in particular of recent non-statutory reforms which increase the involvement of the private and third

³ *The Times*, 25 February 2011.

⁴ *Financial Times*, 16 January 2011.

sector in health services provision, competition law already applies to PCTs and NHS providers.’ They concluded that the 2012 legislation reinforced that view, adding that there was ‘nothing in the Bill which has or can have the effect of preventing the application of competition law’ since prohibitions on anti-competitive conduct ‘gives rise to actionable claims in the High Court by any person affected’.⁵

The Dutch competition authority (the NMa) has had the effect of fragmenting service provision and impeding the provision of high-quality care.⁶ A €7.7 million fine levied on the Dutch GP association for a ‘bad case of anti-competitive behaviour’, which was the association’s efforts to ensure that all areas of the country were adequately provided with GP services. The Dutch Patients’ and Consumers’ Federation called for the involvement of competition in healthcare to be urgently reviewed.

The EU has deliberately obfuscated TTIP. The hugely experienced Pascal Lamay has rightly criticised the design of TTIP for it is not just a trade agreement, it is also a regulatory agreement. This always was an indefensible mixing up of what are two quite different legislative matters and all done with no reference whatever to the British Parliament.

In September 2014 in order to head off the growing opposition in the SPD and German trade unions to the ISDS terms, the Economic Affairs Ministry – headed by SPD leader Sigmar Gabriel – issued a joint position paper on the TTIP along with the DGB, Germany’s trade union confederation including the country’s largest trade unions like IG Metall and Ver.di.⁷ The paper, while praising elements of the TTIP, pledged on the ISDS: ‘Investment protection provisions are generally not required ... In any case, investor–state arbitration and unclear definitions of legal terms such as “fair and just treatment” or “indirect expropriation” must be rejected.’ The German government and the European Commission are at odds over whether national parliaments will need to ratify alongside the European Parliament. The Commission said no, but Berlin argued that a ‘mixed agreement’ with some of the issues, goods and services covered falling outside of the EU’s sole jurisdiction, the Bundestag and Bundesrat should also get to scrutinise the agreement and vote on it. The German government warned that it was willing to go all the way to the ECJ on this issue.

⁵ ‘In the Matter of the Health and Social Care Bill and the Application of Procurement and Competition Law’, available at http://38degrees.3cdn.net/b01df9f37ac81ffb2e_zhm6bnldz.pdf (accessed 5 November 2014).

⁶ Tony Sheldon, ‘Is Competition Law Bad for Patients?’, *British Medical Journal*, 20 July 2011; Tony Sheldon, ‘Dutch GP Association Is Fined €7.7m for Anticompetitive Behaviour’, *British Medical Journal*, 16 January 2012.

⁷ Bundesministerium für Wirtschaft und Energie / DGB: ‘Transatlantic Trade and Investment Partnership (TTIP): Anforderungen an Freihandelsgespräche zwischen der EU und den USA unter der Berücksichtigung von Nachhaltigkeit, Arbeitnehmerrechten und der Gewährleistung der Daseinsvorsorge’.

After having carefully considered the joint statements by the Commission and the United States government of 20 March 2015 and the defence of the present TTIP by the British government, the legal advice from Michael Bowsher QC, is very critical about its implications for the UK NHS [See Annex A]. He advised that despite the new right to regulate it was vague and subject to inherent uncertainties as to how it would be interpreted by arbitral tribunals and that the valid exercise of a right to regulate could, nonetheless, give rise to compensation even when there was no valid claim in domestic law.

We are agreed in Vote Leave, that whatever our political views on the present marketization of the NHS, decisions on the NHS should for the future be for the UK Parliament and devolved administrations to take. It should not be for the European Commission nor the European Parliament.

Our longstanding democracy has hitherto for a century and more accepted as a principle that the people through their vote in national elections should decide the policy and direction of health care.

If people Vote to Leave on 23 June – as I hope they will – it will automatically follow that no British government can ratify the present TTIP. Thereafter, UK legislation will govern the NHS in future and as a consequence we can take back control and protect the NHS from the EU. The NHS will not have to be part of any new UK-EU free trade agreement. There will no longer be competition and market led interference from the European Commission.

See Annex A attached with important quotes from the legal opinion on TTIP.

Bowsher argues crucially over TTIP⁸:

“The overarching approach of TTIP will be to open up these contracts to competition and to do so in circumstances which go beyond current interpretations of EU procurement law. The fact that such risks exist must raise concerns regarding the impact of TTIP upon UK governments’ freedom of choice in developing NHS arrangements.”

The legal advice goes on:

“As we have noted above, TTIP poses a real risk that if UK governments wished to change the arrangements for delivery of NHS services and either alter existing contractual arrangements, or seek to dispense with tendering for service contracts to do so, it may be exposed to a broader range of claims than the contracts would themselves afford. The level of compensation, while no doubt already high, may be significantly higher under TTIP.”

“Further, as seen above, even current arrangements in the NHS, and those of particular interest to the current government are already exposed to serious risk of challenge under TTIP. The very fact that these risks do not seem to have been identified demonstrates how TTIP can be expected to have a range of consequences and it will not be possible to anticipate all of them. Given the substantial risks involved we do not see why a well-advised negotiator would not seek to ensure that the position of the NHS was protected. The safest course would be for the NHS to be the subject of a specific exclusion contained within the main body of the TTIP text.”

“However, in the event that such an exclusion cannot be achieved, that there should be reservations within Annexes II and III provided for the benefit of the UK. This might be achieved with text along the following lines.

“The UK reserves the right to adopt or maintain any measure with regard to the organisation, the funding and the provision of the National Health Service in the UK as well as with regard to the public and/or the not for profit character of the National Health Service in the UK, where services may be provided by different companies and/or public or private entities involving competitive elements which are thus not “services carried out exclusively in the exercise of governmental authority”.

“We consider that without such reservations TTIP will pose a real and serious risk to the future ability of UK governments to regulate the NHS.”

⁸ ‘In the Matter of the Transatlantic Trade and Investment Partnership (“TTIP”) and Its Potential Impact upon the National Health Service’, Advice given by Michael Bowsher QC and Azeem Suterwalla, Monckton Chambers, Gray’s Inn, London.