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European Distinctions between Private and Public Law in Health Care and the Emerging Influence of Private Lobbies

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4.1 INTRODUCTION

Private law plays an important, if not always recognized, role in European health law. It governs relationships between patients, health care professionals, and medical institutions they rely on for their care. Private law creates lines of accountability between manufacturers of medical devices and the end user. However, the legal landscape, regulatory frameworks, and academic literature are primarily premised on notions of care being a public good that falls under public law.[1] Nevertheless, there are important distinctions between the United States (US) and Europe, which this chapter highlights. Grasping these distinctions requires taking a step back from the sharp end of the law to understand important structural differences between the health systems and the influence of private entities that exist but which might not be the obvious first port of call for research.

The sections that follow examine three aspects of private health in Europe. First, this chapter explores the structural distinction between the health systems in the US and Europe. Public health is the predominant form of care in Europe, but that headline ignores the complex reality of a shared structure between public and private entities and the diversity of how those arrangements manifest between different European countries. Second, the chapter examines the extent and role of private law as a mechanism for governing health care disputes in Europe. While tort law is a given for resolving disputes, this chapter queries the extent to which contract law is used, finding that empirical evidence is limited.

Third, there is an examination of the influence of health care lobbies and private interests and how they can permeate all levels of governmental decision-making concerning health care down to decisions about commissioning services on the

[1] Constanze Semmelmann, Theoretical Reflections on the Public-Private Distinction and Their Traces in European Union Law, 2(4) Oñati Socio-Legal Ser. 25, 30 (2012).

ground. Public health has primacy in Europe, but that does not mean lobbyists do not constantly seek avenues to shape the policy and lawmaking environments to create new opportunities for funneling public funds toward their private services.

By highlighting these distinctions, this chapter provides a point of contrast to the US in other chapters of this volume, where private influences and private law are far more pervasive and a known part of the landscape. At the same time, the role of private influences and private law are less understood in Europe, and this chapter seeks to highlight their importance.

4.2 EUROPE DISTINGUISHED: THE STRUCTURE OF HEALTH SERVICES

There are four key distinctions between the US and Europe concerning the structure of health services that implicate the public and private distinction in health care.

First, the most pertinent distinction is that universal health care is a given in nearly every European country. In contrast, the US heavily relies on private health care to ensure that care is provided. In general, health care services in Europe are designated as public goods.[2] The form of public health coverage in Europe varies, but the underlying principles focusing on public universal health care are similar. For example, the United Kingdom (UK) has the National Health Service (NHS), Spain; the Sistema Nacional de Salud (SNS), and Italy; the Servizio Sanitario Nazionale (SSN), among others.[3] Of course, these are not absolutes. In the US, there are public hospitals, but these do not provide services for free, which precludes access to care for some. There are also elements of private care in Europe, but that does not preclude access to health.

Second, the role of government in providing health services and employing the health care workforce highlights another distinction. The UK is an extreme example because of its highly centralized nature, but it helps elucidate the government's role compared to the US. In the UK, policy is determined by the Executive (specifically, the Treasury headed by the Chancellor of the Exchequer), which moves money downwards to the Department of Health and Social Care (DHSC) for capital projects such as investment in buildings and equipment, salaries, medicines, vaccinations, and other public health programs.[4] The remaining money is trickled

[2] Id.

[3] Nigel Edwards, Why Has the NHS Not Been Copied? (Spoiler) It Has, Nuffield Trust (July 11, 2018), https://www.nuffieldtrust.org.uk/news-item/why-has-the-nhs-not-been-copied-spoiler-it-has.

[4] How Funding Flows in the NHS, The King's Fund (Apr. 2020), https://www.kingsfund.org.uk/sites/default/files/2020-04/NHS_Funding_Flow_April_2020.pdf.

down to NHS England (an executive non-departmental public body sponsored by the DHSC), which distributes that money further to various services and providers.[5]

In this manner, the government controls the NHS and is, therefore, the main employer of the health workforce and main provider of health services, whereas the US Government is not primarily a provider of health care services.

Third, health insurance is another significant difference. In the US, Medicaid and Medicare are public programs limited to specific individuals (such as low-income individuals, retirees, and disabled individuals). However, the predominant basis for coverage is through expensive private health insurance. In Europe, coverage is mainly provided by the state and is governed by public law. In some cases, coverage is provided by mandatory health insurance, such as in Germany, and supplemental private insurance is common in other cases, such as Belgium, Holland, and Slovenia.[6] Public coverage generally ensures that most individuals pay no (or nominal fees) at the point of service.

Where private providers exist, the cost of their services is usually paid by the national health insurance system or regulated social insurance schemes that coordinate the purchasing of such services.[7] How this plays out depends on the country. For hospital care, four approaches are pertinent in Europe. In one group (Belgium, Netherlands, Germany, and Norway), private hospital bed numbers are similar to those in the public sector, and the difference in services between public and private hospitals is minimal, with consumers and social health insurance payers deeming both functionally equivalent.[8] In a second group (Austria, France, Italy, and Portugal), private entities have increasingly offered lower-risk outpatient services for profit, offering fewer beds than the public system.[9] In the third group (Czechia, Estonia, Finland, Hungary, Latvia, and Poland), private providers offer a narrower range of short-stay services in specialized areas.[10] In the final group (Iceland, Ireland, the UK, and Lithuania), private facilities are in the minority.[11] Areas where private care tends to dominate in Europe include dental care. In most countries, 80 to 100 percent of dentists are private practitioners.[12] Further, primary

[5] Gov UK, NHS England, https://www.gov.uk/government/organisations/nhs-england#:~:text=NHS%20England%20is%20an%20executive,of%20Health%20and%20Social%20Care (last accessed Nov. 1, 2023).

[6] Dominic Montagu, The Provision of Private Healthcare Services in European Countries: Recent Data and Lessons for Universal Health Coverage in Other Settings, 9 Front Pub. Health 1, 2 (2021).

[7] Id. at 2.

[8] Id. at 4.

[9] Id.

[10] Id.

[11] Id. at 5.

[12] Id.

care tends to be provided in private settings,[13] and most pharmacies are privately owned and operated (although the state primarily pays for the medications).[14]

Fourth, the final difference between the US and Europe is the legal framework and the types of disputes that arise. There are disputes concerning health insurance coverage in the US, which are rarer in Europe. Health care fraud and antitrust rules also feature more prominently in the US. Disputes in Europe center on administrative decisions, quality of care, and access to care.

These distinctions highlight that private entities and private care in Europe fall within a broader public care matrix. The next query is the extent to which private law plays a role in this matrix.

4.3 THE ROLE OF PRIVATE LAW

While public law is of primary importance in Europe for regulating the relations between citizens and public authorities, private law can also regulate the medical field and ensure access to health.[15] One central area of law providing redress in Europe is tort law.[16] Similar underlying principles concerning duty, breach, and causation apply when compared to the US, but the application of those principles will likely differ between EU states. For contract law, contractual agreements can exist between medical institutions and doctors, between doctors and patients, and between insurance companies and hospitals.[17] It has been noted that the increased expansion and sophistication of regulations in Europe, such as consumer protections and anti-discrimination law in contractual relations, "amounts to an instrumentalisation of private law for political purposes."[18] However, as a legislative matter, there is no "health care" law basis in legislation for managing relationships between doctors and patients (although they can be regulated "through different modes of market regulations").[19]

While European countries primarily deal with malpractice cases through tort or contract law,[20] the number of private contracts governing such relationships and any disputes arising from them is unclear. In the UK, at least from a patient perspective, there are no contracts between patients and the NHS, so breach of contract cannot

[13] Id. at 6.
[14] Id.
[15] Anniek de Ruijter, EU Health Law & Policy: The Expansion of EU Power in Public Health and Health Care 52, 63 (2019).
[16] For broader analyses of tort law in Europe, see Athanasios Panagiotou, Medical Liability in Europe at the Dawn of Cross-border Healthcare, 23(4) Eur. J. Health L. 350, 350–72 (2016); Cees van Dam, Europe, in European Tort Law 23–50 (Cees van Dam ed., 2013).
[17] de Ruijter, supra note 15, at 63.
[18] Semmelmann, supra note 1, at 32.
[19] Id. (citing Tamara K. Hervey & Jean V. McHale, Health Law and the European Union (2004)).
[20] Kenneth Watson & Rob Kottenhagen, Patients' Rights, Medical Error and Harmonization of Compensation Mechanisms in Europe, 25(1) Eur. J. Health L. 1, 13 (2018).

be relied upon to sue health care institutions.[21] This is true not only for matters of care but also for the disclosure of confidential information. While the court may find an implied contract in such cases, it is thought to be unlikely.[22] A breach of contract claim may be more successful by the employer against their employee where the employee clinician divulges confidential patient information (thereby breaching the terms of the employment contract).[23] Linked to the legal pathway pursued is the concern about creating a compensation culture like in the US. A fear is that the slightest opportunity will be taken to make a "fast buck," and the ability to sue for breach of contract could contribute to that culture.[24] However, it has been determined that this concern is a myth.[25] Overall, empirical evidence is needed to determine how prevalent contractual disputes between patients, doctors, and health care institutions are in other European countries.

Another area of note is private litigation concerning access to health for individuals in the EU on the grounds of free movement of persons.[26] With citizens moving across borders for work, demands arose for access to health in other member states.[27] The courts also addressed specific issues like abortion. In the early 1990s, the Court of Justice of the European Union (CJEU) determined that Irish citizens had the right to access abortion services in other member states, and they could not be prohibited from doing so.[28] A line of case law raised the issue of whether the EU operates as a free market for health, whereby citizens can travel from their country to another country to receive care and then be reimbursed by their home country. Those cases determined that citizens could travel and be reimbursed for their care (although the home state could impose restrictions on the extent of this).[29]

Cohen has examined the intricacies of this paradigm, including the related case law, regulations, treaty provisions, and directives.[30] One major question has been whether patients are required to seek prior authorization from their home state for reimbursement of care in another EU member state. Case law has determined that prior authorization may constitute a restriction on the freedom to provide services,

[21] Jonathan Herring, Medical Law and Ethics 139 (9th ed. 2022).
[22] Id. at 306.
[23] Id. at 306 (citing X v. Y [1988] 2 All ER 649).
[24] Id. at 139.
[25] John Hyde, Compensation Culture Is 'Media-Created' Myth – Dyson, L. Soc'y Gazette (Mar. 25, 2013), https://www.lawgazette.co.uk/news/compensation-culture-is-media-created-myth-dyson/70091.article.
[26] de Ruijter, supra note 15, at 79.
[27] Id. at 80.
[28] Id. at 80 (citing Society for the Protection of Unborn Children Ireland Ltd v. Grogan [1991] ECR I-4685; for a discussion, see Stéphanie Hennette Vauchez, The Society for the Protection of Unborn Children v. Grogan: Rereading the Case and Retelling the Story of Reproductive Rights in Europe, in EU Law Stories: Contextual and Critical Histories of European Jurisprudence 393–417 (Fernanda Nicola & Bill Davies eds., 2017)).
[29] de Ruijter, supra note 15, at 82.
[30] I. Glenn Cohen, Patients with Passports: Medical Tourism, Law, and Ethics (2014).

and that prior authorization requirements may not be justified for outpatient care.[31] Requirements for prior authorization may be justified where the patient has access to treatment without undue delay, otherwise the ability of the patient's home country to "fund and organize its internal health care system" may become threatened.[32] If a patient is entitled to reimbursement, the level of reimbursement will depend on whether treaty or regulatory provisions apply. In some cases, where the level of reimbursement in their home country is lower than the cost of care they are seeking in another member state, the patient is entitled to be reimbursed for the additional costs they incur. In other cases, the patient will be required to make up the financial difference themselves.

Directive 2011/24[33] is also important in this area. It states that "decisions of refusal to grant prior authorisation, shall be restricted to what is necessary and proportionate to the objective to be achieved, and may not constitute a means of arbitrary discrimination or an unjustified obstacle to the free movement of patients."[34] Matters falling under the "necessary and proportionate" criteria include the "financial balance of a social security system" and "planning requirements" for ensuring access to high-quality treatments.[35] A significant concern during the negotiations of the Directive involved the movement of expatriate pensioners. For example, Spain was concerned that expats living there would return home for medical care, which would be charged back to Spain. To combat this, several countries agreed that patients entitled to receive a pension from their country (even where they are no longer resident there) would pay for the treatment of those patients returning home for care, as opposed to the expat's country of residence.[36] This would not apply to countries not on the list, or where the patient seeks treatment in a third country – in which case, the expat's resident country would be required to pay.[37]

Aside from medical tourism-type cases, there has also been a plethora of case law brought before the European Court of Human Rights (ECtHR) by individuals and groups concerning the right to "private or family life."[38] The cases do not involve contract law issues but illustrate how individuals have brought a range of matters to the courts concerning their care.

These involve medically assisted procreation, surrogacy, abortion, prenatal testing, informed consent, and end-of-life situations. They also cover the health of

[31] Id. at 184.
[32] Id.
[33] Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, OJ L 88, 4.4.2011.
[34] Id. at art. 8(1).
[35] Id. at recital (43).
[36] Cohen, supra note 30, at 193.
[37] Id.
[38] Council of Europe/European Court of Human Rights, Health-Related Issues in the Case-Law of the European Court of Human Rights (June 2015), http://www.antoniocasella.eu/salute/ECHR_health_2015.pdf.

detainees, health and immigration, health and the environment, health and the workplace, and the protection of medical data.[39]

For example, in surrogacy cases, the courts have had to navigate a complex terrain between adhering to public law prohibitions on commercial surrogacy and permitting private contractual surrogacy arrangements. In the UK, the Surrogacy Arrangements Act 1985 was passed to discourage surrogacy following a case involving a British woman being employed as a surrogate mother for a Swedish couple via a US agency.[40] It is illegal to negotiate or arrange surrogacy on a commercial basis under the Act.[41] However, surrogacy is legally permitted when organized by an individual or non-commercial body, and there is no payment.[42] In one case in the UK Supreme Court in 2020, the court rejected an argument that surrogacy was contrary to public policy and noted that it was not unlawful to enter into commercial surrogacy abroad.[43] In most cases, the courts will promote the child's welfare by determining what is in their best interests.

The particular arrangements and payments to the surrogate will not likely stand in the way of the courts giving a parental order because it will be in the child's best interests. This was seen in one case where a British couple paid a Ukrainian surrogate 235 Euros per month and 25,000 Euros upon birth (which she used to pay the deposit on her flat). A parental order was still given, with the judge holding that:

> The difficulty is that it is almost impossible to imagine a set of circumstances in which by the time the case comes to court, the welfare of any child (particularly a foreign child) would not be gravely compromised (at the very least) by a refusal to make an order.[44]

Thus, despite the restrictions in public law, the reality is that commercial surrogacy exists, and the courts will likely only refuse a parental order in the clearest cases of fraud and bad faith because the best interests of the child will usually be served by granting the order.[45]

Another area that intersects with private law is competition law. Increased competition may be seen as a solution to support the sustainability of public health care systems that are under strain. Yet, the applicability and scope of competition law is determined on a case-by-case basis, resulting in an inconsistent application of competition law to health care providers by the courts and the European

[39] Id.
[40] Herring, supra note 21, at 485.
[41] Surrogacy Arrangements Act, 1985, c. 49, § 2(1) (UK).
[42] Herring, supra note 21, at 485.
[43] Id. (citing XX v. Whittington Hospital NHS Trust [2020] UKSC 14 (appeal taken from [2018] EWCA (Civ) 2832)).
[44] Re X and Y (Parental Order: Foreign Surrogacy) [2008] EWHC 3030 (Fam) (Eng.).
[45] Re P-M [2013] EWHC 2328 (Fam) (Eng.).

Commission.[46] EU states do not favor introducing elements of competition law into the health care system because those systems are highly regulated, and it would increase the risk of conflicts between state interventions and EU law.[47] Exempting EU law from these realms could be an easier option in theory, but states cannot exempt health systems and the provision of care from competition law.[48] Consequently, there is limited scope for competition law to be adapted to enable more competition in health care in Europe.

Finally, it is worth noting developments concerning data. A survey by a European consumer organization finds that while Europeans are comfortable sharing their health data with doctors, they are not happy sharing that data with technology or insurance companies.[49] There is a particular reluctance to share health habits, genetic data, and sexual and reproductive data.[50] Some have called for protections for consumers to protect such data. The proposed European Health Data Space is a health-specific ecosystem designed to give individuals control over their health data while providing a consistent framework for using health data for research, innovation, policy, and regulatory activities.[51] There are already queries about how this space will intersect with contract law matters, such as whether data can be transmitted for research purposes based on contracts.[52]

4.4 THE INFLUENCE OF PRIVATE LOBBIES ON PRIVATE AVENUES OF CARE

The last area of examination pertains to lobbying. There has been a gradual creep of private health providers in Europe. The reason for this creep is multifaceted and complex, but much of it is enabled at the policy formulation level of government and even before that. The health care lobby is one of the most powerful in Europe.[53] Officially reported spending figures in the EU transparency register for pharmaceutical companies alone is 36 million Euros annually, but the figure is likely far higher

[46] Bruno Nikolić, Applicability of European Union Competition Law to Health Care Providers: The Dividing Line between Economic and Noneconomic Activities, 46(1) J. Health Pol. Pol'y & L. 49, 49 (2021).
[47] Id. at 51.
[48] Id. at 52.
[49] Consumers Uneasy Sharing Their Health Data, Survey Shows, BEUC (May 2, 2023), https://www.beuc.eu/press-releases/consumers-uneasy-sharing-their-health-data-survey-shows.
[50] Id.
[51] European Comm., European Health Data Space, https://health.ec.europa.eu/ehealth-digital-health-and-care/european-health-data-space_en (last accessed Dec. 23, 2023).
[52] Wenkai Li & Paul Quinn, The European Health Data Space: An Expanded Right to Data Portability?, 52 Comput. L. & Sec. Rev. 1, 4 (2024).
[53] Pharma Industry's EU Lobbying, Corp. Europe Observatory (May 31, 2021), https://corporateeurope.org/en/2021/05/big-pharmas-lobbying-firepower-brussels-least-eu36-million-year-and-likely-far-more.

owing to the voluntary nature of the EU's transparency register.[54] Even from the reported figures, those companies far outspend civil society actors (at a rate of 15 to 1).[55] The aims of lobbyists are broad, but in general, they seek to influence the formulation of laws that are favorable to them, delay and eventually remove bills from the legislative agenda that may be harmful to their profits, and seek lucrative contracts for providing health services to the public health system. Despite these aims, the results of their efforts reveal a nuanced picture.

The UK provides an illustrative case study of how lobbyists operate in this space.[56] Various avenues exist for lobbyists and citizens to get involved in policy development.[57] The most obvious route is influencing decision-makers in Government (the Executive), Parliament, and political parties on health care bills, policies, or legislation.[58] For political parties, the aim is to influence their internal policies and their manifesto. While party members have some influence, the greatest power may lie with a few vested interests. Think tanks such as the Institute of Economic Affairs for the Conservatives and Demos for Labour have been quite influential in this manner.[59] In Parliament, Members of Parliament (MPs) will scrutinize Government bills, and extra scrutiny is undertaken for different aspects of NHS performance by parliamentary committees, including the Health and Social Care Committee, the Public Accounts Committee, and the Public Administration and Constitutional Affairs Committee. For example, in 2017, the Health Committee considered the potential impact of Brexit on health and social care in the UK.[60]

For the Government, the DHSC is the ministerial department tasked with supporting and advising ministers, setting direction, and acting as "guardian" for the health and care framework.[61] It is chaired by the Secretary of State for Health and Social Care, whose responsibilities to Parliament are outlined under the National Health Service Act 2006. In practice, power is shared between ministers and civil servants, which will vary considerably depending on the personality and strength of the minister in charge.[62] The balance also depends on the quality of

[54] Id.

[55] Id.

[56] See generally, Barry Solaiman, Lobbying in the UK: Towards Robust Regulation, 76(2) Parliamentary Affs. 270 (2021) https://doi.org/10.1093/pa/gsab051; see also, Barry Solaiman, Evaluating Lobbying in the United Kingdom: Moving from a Corruption Framework to "Institutional Diversion" (Thesis, University of Cambridge, 2017) https://doi.org/10.17863/CAM.15615.

[57] I.e., identifying problems, recognizing issues, policy formulation, policy implementation and evaluation. See, K. Buse et al., Making Health Policy 13–14 (2d ed. 2012).

[58] Also, civil servants.

[59] Peter Dorey, Policy Making in Britain 48, 53 (2d ed. 2014).

[60] House of Commons Health Comm., Brexit and Health and Social Care – People & Process, 2016-17, HC 640, at 41 (UK).

[61] About Us, DHSC (Dec. 20, 2023), https://www.gov.uk/government/organisations/department-of-health-and-social-care/about.

[62] Christopher Ham, Health Policy in Britain 152 (6th ed. 2009).

advice given by civil servants, the weight given to the departmental view on an issue, and the commitment of a minister to the relevant matter.[63] Numerous conflicts of interest have been detailed concerning relationships between decision-makers and the private health sector.

This can be seen with the Health and Social Care Act (HSCA) 2012, which was created to restructure the NHS and encourage more private-sector competition. One report argued that many people involved in policy formulation had personal interests in private health companies.[64] Individuals with links to private health companies and think tanks had previously held positions as health ministers, members of the Cabinet, or MPs who had voted for the Bill,[65] which led to accusations of large-scale conflicts of interest.[66] These concerns should be understood in the context of a historical revolving door problem of former ministers being employed by private health companies as advisers.[67]

Another report revealed how McKinsey & Company (a management consulting firm that drew up many of the proposals for the Bill) had paid for the head of NHS regulator, Monitor, to attend an event with a banquet, five-star hotel, and first-class flights, which raised conflict of interest and undue influence concerns.[68] Finally, during the Bill stages, the Government "paused" the progression of the Bill to undertake a "listening exercise" after the proposals were subject to much criticism. During that period, the Government was accused of having private discussions with proponents of more privatization following a leaked document revealing that their purpose was to ensure that competition remained a core part of the Bill following the listening exercise.[69]

Despite all these efforts, the ultimate results of these efforts by private lobbyists paint a nuanced picture. The King's Fund (a health and social care charity) argued that the HSCA 2012 extended market-based principles and introduced more competition into the NHS, resulting in more contracts awarded to private

[63] Id.

[64] Tamasin Cave, The Health Industry Lobbying Tour, Alliance for Lobbying Transparency, Mancha Productions (Jan. 18, 2011), https://youtu.be/zrb3rJoLu9g?si = EvNDuUeI1fRcRF3w.

[65] Id.

[66] Adrian O'Dowd, Fifth of Coalition MPs Have Links to Private Healthcare Firms, 349 Brit. Med. J. 1 (2014), https://www.bmj.com/content/349/bmj.g6982.

[67] Cave, supra note 64; Hamid Sarwar, NHS Is Not Working 99–100 (2d ed. 2019).

[68] David Rose, The Firm That Hijacked the NHS, Daily Mail (Feb. 12, 2012), http://www.dailymail.co.uk/news/article-2099940/NHS-health-reforms-Extent-McKinsey–Companys-role-Andrew-Lansleys-proposals.html.

[69] Daniel Boffey, David Cameron Is Accused of a "Sham Listening Exercise" on NHS Reform after Links to Lobbyist Are Revealed, Observer (Nov. 25, 2012), http://www.theguardian.com/politics/2012/nov/25/sham-listening-exercise-nhs-reform; Unedited Document from NHS Private Healthcare Lobby Group Reveals Actions Taken to Ensure Competition Remained in Health Bill, Social Investigations (July 17, 2012), http://socialinvestigations.blogspot.co.uk/2012/07/unedited-document-from-nhs-private.html.

providers.[70] However, the overall proportion of the budget spent on private providers did not increase. The King's Fund also noted that the Health and Care Act 2022 removed the competition and market-based approaches introduced by the 2012 Act.[71] Other findings are far more critical. One study concluded that:

> The privatisation of the NHS in England, through the outsourcing of services to for-profit companies, consistently increased in 2013–20. Private sector outsourcing corresponded with significantly increased rates of treatable mortality, potentially as a result of a decline in the quality of health-care services.[72]

There was also criticism from the Deputy Chair of the British Medical Association (BMA), who argued that ministers were "throwing huge amounts of money at private firms rather than investing in rebuilding our health and care system."[73] However, other findings argue that the ability of private firms to make profit in this paradigm is limited by a top-down squeeze on prices, and the state's dominance of funding and provision.[74] Thus, while the result of private lobbying is contentious, the HSCA 2012 provides a useful case study for how private lobbyists can shape law and policy to encourage a shift toward greater marketization, creating more room for private entities to operate. Other European countries and the EU are not immune to the same influences.[75] Brussels is the world's second capital for lobbyists, followed by Washington, DC.[76] Following COVID-19, commentators highlighted a "frenzy"

[70] Charlotte Wickens, Health and Social Care in England: Tackling the Myths, The King's Fund (Mar. 15, 2023), https://www.kingsfund.org.uk/insight-and-analysis/long-reads/health-and-social-care-england-myths.

[71] Id.

[72] Benjamin Goodair & Aaron Reeves, Outsourcing Health-Care Services to the Private Sector and Treatable Mortality Rates in England, 2013–20: An Observational Study of NHS Privatisation, 7(7) Lancet Pub. Health e638–46 (2022).

[73] Andrew Gregory, NHS Privatisation Drive Linked to Rise in Avoidable Deaths, Study Suggests, The Guardian (June 19, 2022), https://www.theguardian.com/society/2022/jun/29/nhs-privatisation-drive-linked-to-rise-in-avoidable-deaths-study-suggests.

[74] Nick Krachler & Ian Greer, When Does Marketisation Lead to Privatisation? Profit-making in English Health Services after the 2012 Health and Social Care Act, 124 Soc. Sci. & Med. 215 (2015).

[75] For more detailed studies, see Scott L. Greer et al., Mobilizing Bias in Europe: Lobbies, Democracy and EU Health Policy-Making, 9 Eur. Union Pol. 403 (2008); Scott L. Greer, The Changing World of European Health Lobbies, in Lobbying the European Union: Institutions, Actors, and Issues 189–211 (David Coen & Jeremy Richardson eds., 2009); this phenomenon is also not limited to Europe and is likely a global problem. For example, on the influence of lobbyists in Africa, see Barry Solaiman, Lobbying in Tunisia: Developing a Transparency Regime to Tackle Perceptions of Corruption, in Deconstructing Corruption in Africa 104–27 (Inna Kubbe, Emmanuel Saffa Abdulai and Michael Johnston eds., 2024) https://doi.org/10.4324/9781003468608-8.

[76] Harry Cooper, Brussels Influence, Presented by EUI STG: EU-funded Fair Trade Campaign – Wealthy Lobbyists – Rise of the Robots, Politico (Feb. 2, 2018), https://www.politico.eu/newsletter/politico-eu-influence/politico-brussels-influence-presented-by-eui-stg-eu-funded-fair-trade-campaign-wealthy-lobbyists-rise-of-the-robots/.

of lobbying activity in the EU's health policy space.[77] In the future, systematic research concerning the actual health policies influenced by private entities in the EU would help delineate the extent to which laws are being shaped to benefit those interests.

4.5 CONCLUSION

While public law is predominant as a matter of legal governance for health care matters, the reality is somewhat more complex in Europe. This chapter has explored the topic from three lenses to provide points of contrast with the US. First, by examining the structure of health care services, we can see how private care fits into the overarching system of health care services.

Second, while contract law mechanisms exist to resolve disputes, there is little empirical evidence to analyze their implications where they exist. As the data regulation ecosystem develops, more avenues for private law may arise. Finally, the influence of private lobbyists in Europe highlights how laws and policies can be shaped to create new avenues for those entities to provide services.

[77] Helen Collis et al., Health Is Where the Money Is in Brussels and Disease Groups Are Circling, Politico (Nov. 30, 2021), https://www.politico.eu/article/health-where-money-is-brussels-disease-lobby-groups-eu-budget/; see also the concern that decision-making powers of doctors and patients where artificial intelligence is used in patient care may be ceded to private entities, Barry Solaiman and Abeer Malik, Regulating Algorithmic Care in the European Union: Evolving Doctor-Patient Models through the Artificial Intelligence Act (AI-Act) and the Liability Directives, Med. L. Rev. 1–22 (2024); see also, Barry Solaiman, From AI to Law in Healthcare: The Proliferation of Global Guidelines in a Void of Legal Uncertainty, 42(2) Med. L. 391–406 (2023).