EUROPEAN UNION HEALTH POLICY: THE GATE WITH NO FENCE

Summary: As the European Union (EU) institutions are gearing up to start a new legislative term, with new Commissioners, new European Parliamentarians and even some new governments, it is perhaps a good moment to remind us how EU health policy is developed and what the scope and constraints are of the health mandate that Member States have attributed to the EU level. This is exactly the idea behind a new publication – or rather a revised edition of a previous “best seller” – called Everything you always wanted to know about European Union health policy but were afraid to ask.

Keywords: Regulation, Internal Market, Fiscal Governance, Public Health, European Semester

Introduction

Picture this: a freestanding gate in a field with no fence on either side. It might be a good gate: solid, well-oiled, easy to open and sturdy when closed. But if there is no fencing on either side, people and animals can just go around it.

A gate with no fence on either side is an apt description of Article 168 of the Treaty on the Functioning of the European Union (TFEU) that lays out the European Union’s (EU) public health powers, as we argue in our new, completely revised edition of Everything you wanted to know about European Union health policy but were afraid to ask. Make no mistake, Article 168 is a gate that Member States intend to keep closed most of the time. The Article is a virtual lexicon of cautious phrases and exclusions that constrain, rather than foster, EU action in this field.

With such a legal base, it might almost seem miraculous that a considerable body of EU health policy has been developed over time. But all of these limiting phrases do not add up to a fence that keeps out EU public health action. Rather, they constitute a sturdy gate that can be opened when Member State governments choose. And they have on several occasions decided to open the sturdy gate, over time, with actions including the creation of the European Centre for Disease Prevention and Control and invocation of Article 168 in a variety of important pieces of legislation such as the General Food Law of 2002 (Regulation 178/2002) and the directive on cross-border patient mobility (Directive 2011/24).

But the gate of Article 168 that Member States so laboriously constructed stands alone in a field with no fence, and so other dimensions of EU health policy and integration can simply go around it.

Walking around the gate with internal market regulation

On one side, there is no fence keeping out the massive amount of internal...
The Union of their health services in cross-border areas... Member States shall... The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination... adopt incentive measures designed to protect and improve human health... excluding any harmonisation of the laws and regulations of the Member States... and adopt recommendations... The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them".

Source: Selected excerpts from Article 168(2); boldface added for emphasis.

Box 1: Article 168 of the Treaty on the Functioning of the European Union

"Union action, ... shall complement national policies... The Union shall complement the Member States’ action... The Union shall encourage cooperation ... and, if necessary, lend support ... improve the complementarity of their health services in cross-border areas... Member States shall, in liaison with the Commission, ... coordinate among themselves their policies and programmes ... The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination... adopt incentive measures designed to protect and improve human health... excluding any harmonisation of the laws and regulations of the Member States... and adopt recommendations... Union action... shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them".

Market regulation that is the traditional core of the EU. This is the legislation and policy involved in the ongoing EU project of unification through the market, promoting deregulation in Member States by removing policy that discriminates on the basis of Member State origin, and replacing it with regulatory floors at the EU level. The internal market is the basis of most EU law, and it certainly is in the case of health.

Consider the Directive on the application of patients’ rights in cross-border health care, a case of the EU simply walking around the gate on one side. The substantive policy impact involved was and remains minor, since people who are willing to pay out-of-pocket for health care services abroad and then claim reimbursement are not very numerous. For most cases, EU social security coordination rules, which organise the exportation of social security rights, including the European Health Insurance Card (EHIC), are able to solve the key problems of patient mobility. The whole issue of patient mobility is less consequential in substantive terms than the issue of health professionals’ mobility. None of that really matters, though, given that the issue of patient mobility in EU law and politics referred to the assimilation, by the European courts, of health care to internal market law starting with the 1998 Kohll and Decker decisions and the fallout from those cases. Over two decades, the European Court of Justice has learned more about health care, health care actors have learned more about operating in the EU, and the EU has passed legislation which accepts that health care is a service and regulates it as such. That legislation, the 2011 directive, uses internal market law as a jumping off point for cross-border health systems improvements, such as better interoperability of health information technology systems and a stronger EU role in health technology assessment (with internal market law now the basis for a proposed Regulation further enhancing it). The case of patient mobility showcases it all.

- how court rulings applying internal market law simply bypassed the careful constricting language of Article 168
- how the solution was to accept an EU role grounded in the internal market build better legislation on internal market treaty bases, and
- how the policies over time actually came to contain potentially valuable and supportive health systems policy.

Sidestepping the gate with fiscal governance

Next consider fiscal governance, a case of the EU walking around the gate on the other side. Fiscal governance refers to the rules binding Member States, especially Eurozone Member States, to avoid profligacy that might endanger the Euro. It was substantially strengthened in the aftermath of the 2008 financial crisis, which manifested in Europe as a series of sovereign debt crises starting at the end of 2009 and some highly controversial bailouts. The logic of fiscal governance is to both punish Member States that run excessive deficits or macroeconomic imbalances and to preemptively monitor and shape their policies in order to prevent such bad behaviour. There is an elaborate coercive set of mechanisms in EU law now, backed up by an intergovernmental treaty. There is also a complex mechanism designed to promote good policy and prevent bad policy, justified by fiscal governance legal bases, called the “European Semester.”

The European Semester is a year-long process of budgetary surveillance, with complex relationships between EU institutions’ evaluations of Member States and Member States’ contribution to broad EU goals. From its inception, the Semester took an interest in health simply because it is big, expensive and publicly funded, and it would be very strange for a procedure focused on preventing excessive deficits to ignore such a big and expensive public sector. This is irrespective of what Article 168 might say about Union action respecting the “responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care” (point 7). The result was a large number of recommendations about health services, not always with a coherent basis in good data or understanding of health policy, such as the puzzling 2015 recommendation.
that France should reconsider the *numerus clausus* (limiting the number of students) for health professional education. But again, over time and as with previous EU governance initiatives, the goals began to expand beyond simple budgetary control and to include an understanding of health as desirable in its own right and as a social investment. The number of Country-Specific Recommendations about health produced by the Semester increased, but also became more nuanced, sensitive, and potentially helpful for health. This reflected, in large part, health ministries, experts, Commission officials and advocates who engaged with the Semester and made clear the benefits of health, showing that it was not just a cost, and argued for subtler and more complex policy recommendations.

### Using market regulation and fiscal policy to promote health

In the cases of both market regulation and fiscal governance, the opportunity for health advocates, as well as the most effective defensive posture, has been to turn these policies and legal bases to ends that promote health. In the case of the internal market, much has been done to promote health on internal market bases. In the case of fiscal governance, what began as an often crude and austerity-minded intervention has increasingly become supportive of more egalitarian, higher quality, and even better funded health systems. The gate did not keep the EU out, but the entrance of the EU could be turned into something harmless or valuable to health.

That situation is even clearer when we remember that Article 168 is not even the only Treaty article that explicitly presents health as an EU goal. The Treaty chapters on Consumer Protection (Art. 169 TFEU), Environment (Art. 191 TFEU), and Social Policy (Arts. 151, 163, 156 TFEU) all call for health as a key goal, above and beyond the general call in Article 9 of TFEU for the EU to pursue a “high level of protection of human health.” It is almost certain that laws made under these legal bases have saved more lives than laws justified by Article 168. Workplace safety, work-life balance, and the control of potentially existential environmental risks, such as climate change, are all clearly contributors to health where the EU has often taken a leadership role.

The EU has, further, partially resiled from the austerity and economic focus that it adopted immediately after the debt crisis that focus had led to the explicit and effective devaluation of health in many EU policy areas (such as alcohol, diet, physical activity, and nutrition). The European Pillar of Social Rights enumerated 20 rights, including a right to health care and social care as well as rights with obvious health dimensions such as a right to adequate housing. The Commission adopted the United Nations’ Sustainable Development Goals as its own programme, bringing priorities such as health, climate change, and equalities into the Semester and other processes as EU goals. EU Presidencies have argued for a focus on well-being as an explicit goal. These initiatives and declarations mark a shift from the near-exclusive focus on markets and fiscal rigor of a decade ago. They reflect the work of advocates for a broader and healthier EU, and further empower them.

### Conclusions

Article 168 might be a beautifully constructed gate, but without a fence on either side, its well-oiled hinges and solid bars have failed to give Member States control over their health care systems or isolate them from EU policy and law. On one side, internal market legal bases underpin EU regulation of health care services as well as EU policies that affect health in many ways, often for the better. On the other side, fiscal governance mechanisms born in 2012—13 were by 2015 producing detailed recommendations about Member States’ health systems, and by 2019 were being mobilised to support good health policies in Member States. Given that the Juncker Commission did not prioritise health as a goal or a policy area, we might be impressed by the number of good things for health that happened even in years when the gate was rarely opened.

When we see a gate in a field with no fence, it usually means that somebody will come along and build the rest of the fence. There are good practical reasons for a farmer to build the gate before the fence. But the history of EU health policy tells us: there will be no fence. The challenge for everybody in health is to pay less attention to that beautiful, sturdy, defensive gate, and to pay more attention to the whole field and everything in it. There is much EU policy affecting health. The question is whether there will be EU policy for health.

### References

Everything you always wanted to know about European Union health policies but were afraid to ask (Second, revised edition)

By: SL Greer, N Fahy, S Rozenblum, H Jarman, W Palm, HA Elliott and M Wismar

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What does the European Union mean for health? What can it mean for health?

This comprehensively revised second edition answers these questions. It provides a comprehensive review and analysis of European Union (EU) public health policies to mid-2019. It covers the three faces of EU health policy. After explaining the basic politics of European integration and European policymaking in health, including the basic question of how the EU came to have a health policy and what it can do, it moves on to the three faces of EU health policy.

The first face is explicit health policy, both public health policy and policies to strengthen health services and systems in areas such as cancer, and communicable diseases. The second face is internal market building policies, which are often more consequential for health services but are not made with health as a core objective. These include professional and patient mobility, regulation of insurers and health care providers, competition in health care. They also include some of the policies through which the EU has had dramatic and positive health effects, namely environmental regulation, consumer protection and labor law. The third face is fiscal governance, in which the EU institutions police Member State decisions including health. Each face has different politics, law, policy, and health effects.

The book provides a synthesis with sources of the different faces and the different ways in which they have been used to strengthen or weaken public health and health systems in Europe. It shows the many ways that the EU has worked for health, often unappreciated, as well as the opportunities to further strengthen the EU’s positive impact on health. This book is aimed at policymakers and students of health systems in the EU who seek to understand how the influence of the EU on health policy affects those systems and their patients. To ensure that the EU’s impact on health is wholly positive, the wider health community must understand and engage with the EU in the future - something this book aims to encourage.

Contents: Introduction; The EU: institutions, processes and powers; EU action for health; The EU market shaping health; Fiscal governance of health; Conclusion; Appendices.

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