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COMMENTARY

A growing competence: The unfinished story of the European Union health policy

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A few months ago, the South Eastern European Journal of Public Health (SEEJPH) published a lengthy article by Hans Stein on the importance of the Maastricht Treaty of 1992 and how the European Union (EU) health policy has developed since then (1). Undoubtedly, Dr. Stein made a major contribution to this story himself and in his paper he sets out his own viewpoint on key events and trends, offering us a wealth of historical detail and many real insights. But, like all good commentators who try to condense and make sense of a tortuous and convoluted sequence of events spanning more than two decades and involving very many players, he inevitably omits parts of the story, and his interpretations can sometimes give rise to more questions than answers.

In this review, I will entirely leave aside his general discussion of the overall evolution of the EU and its future prospects, and instead concentrate on a few specific points about the development of EU health policy to date.

It is a truism, and the beginning of perceived wisdom on the history of EU Health policy, that the Maastricht Treaty introduced the first explicit EC (European Community) legal competence for public health, devoting an Article to it (Article 129). It is also true, as Dr. Stein mentions, that there was much health-related activity in the EC well before the advent of the Maastricht Treaty. Such actions, in fact, go back many years. For instance, there was an EC Directive on pharmaceuticals in 1971 and in the same year a Regulation on coordination of social security systems providing rights to health care to workers in other EC countries. Moreover, various public health programmes on cancer, AIDS and drugs also predate Maastricht. Yet, Article 129 represented the first explicit framework for public health.

However, Dr Stein makes the more interesting point that this competence was *"often but never substantially changed in the subsequent treaties"*. And, again, *"The main components of Article 129 were slightly reworded in the following treaties, but essentially are still valid"*. In saying this he is implying that it was and remains after several treaty changes, a very weak competence which results from the *"defensive and negative position of MS"* (EU Member States) and reflects their position *"to keep the EU as far away as possible from influencing their health policy"*.

There is no doubt that the health ministries of the older MS, and most, if not all, of the newer ones, have never wanted the EU to tell them how to run their healthcare systems, or to subsume their health policies into an EU-wide policy as has been done in areas such as trade or agriculture. And it is certainly the case, as Dr. Stein emphasizes, that the Article 129 competence is a weak one – as well as being very ill-defined.

But, this raises some further issues.

As he says, it was MS, not the Commission or the European Parliament, that dominated the process of negotiating and agreeing the Maastricht Treaty. The question then must arise of why did these very MS decide to put into the Treaty a new competence in public health at all if they did not want the EC (EU as it has become) to do anything of significance in this field?

Later in his paper, Dr. Stein quotes approvingly from an article by Scott Greer who says that Article 129 *"was the harbinger of more effective promotion of health issues within EU policy-making. In time, however, the Internal Market and the single currency have had the biggest health consequences"*. And then, Dr. Stein adds the interesting comment that: *"This was not really what the MS had in mind when they established a specific EU Public Health Mandate"*. Of course, in 1992, the MS could not really have been thinking about the impact of the single currency which was not introduced until 1999! It is true that the Treaty did set out some clear steps towards achieving an economic and monetary union. But, it seems far-

fetched, to say the least, to suppose that those involved in designing a new public health competence would have given any thought to the potential impact on health of such a theoretical eventuality.

Similarly, how likely is it that many of them were envisaging the creation of some kind of protective instrument to counter the single market's potential impact on public health? This may have been on the mind of one influential player: Hans Stein, at least according to what he wrote in an article some years later (2). In this he states that: *"Single market regulations are sure to have an impact on health and health policy.....The full consequences of the internal market in the field of health and health care are as yet unknown. To analyse, to support or to counteract them can be done effectively only on an EU scale"*.

But, it is doubtful that others were so far-sighted. Moreover, if MS had really wanted to establish a health competence that could act as a bastion to promote and defend the interests of public health against the possible negative consequences of the single market, why did they make the public health competence so feeble that it 'is the weakest legal base possible'? What seems more plausible is that MS (most of them in any case) saw some advantages in European cooperation in some health areas either where they faced common health problems such as AIDS, and tobacco, and on some apparently non-contentious topics, such as improving health information, and health education, where they could exchange experience and expertise. In doing so it is arguable that they were trying to achieve two objectives: first to show that the EC was not just about markets and economics but could play a valuable role in other policy spheres. This indeed was a general underlying thread of the Maastricht Treaty. It is noteworthy in this context that Article 129 is sandwiched by two rather similar Articles, 128 on Culture, and 129a on Consumer Protection. The second aim could be seen as being perhaps a more cynical one: it was to give the EC a formal competence to take some actions in health, which they had in any case been doing for some time in fields such as cancer, AIDS and drugs, while reducing the potential for any future action in areas where MS did not wish to see EC involvement by defining the scope of the EC's public health activities and explicitly limiting its competence in this field. This view was common among Commission officials involved in health policy, including this reviewer, who expressed it in an article in 1995 (3).

A second contestable point is the claim that the treaty competence on public health has remained essentially the same over the last two decades. On the face of it, this cannot really be the case. Indeed what is particularly striking about this competence is how greatly the legal provisions have changed from treaty to treaty. Unlike many other policy areas where the treaty provisions have remained largely unchanged, the wording about health has been greatly amended and the provisions have become more and more detailed.

In the Treaty of Amsterdam of 1997, for example, the public health article (Article 129 of the Maastricht Treaty) was significantly lengthened and the new article (Article 152), among other things, included for the first time the power to make binding EU legislation in a few specific areas, in relation to blood and organs, and in some veterinary and phytosanitary areas.

A quick look at the current health article, (Article 168 of the Lisbon Treaty) will show that it is again substantially different from the ones agreed in previous treaties, as well as being very much longer. The areas of binding legislative powers introduced in 1997 are retained and there is a further one: medicinal products and medical devices, Additionally, the scope for taking legal measures is increased, and now also includes cross-border threats to health,

tobacco and alcohol; and the article includes soft law provisions similar to those of the so-called 'open method of coordination' used in social and employment policy.

The Article also concedes for the first time that the EU in the framework of its public health competence may have a role in relation to health services, saying that the EU: *"shall in particular encourage co-operation between the MS to improve the complementarity of their health services in cross-border areas"*.

Finally, of course, in addition to Article 168, the Treaty of Lisbon also incorporates the Charter of Fundamental Rights of the EU. Article 35 of this promulgates a right in respect of Health care: *"Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities"*.

Hence, clearly, the EU's legal competence has considerably evolved since the Maastricht Treaty. But perhaps Dr. Stein is making a deeper point, that regardless of the specific textual amendments in successive treaties, the underlying scope of and limitations on the EU's public health competence have not fundamentally changed. There is some strength in this argument. But the position is not as clear-cut as he maintains.

The first point to be considered is similar to the one we have made in connection with the Article 129 of the Maastricht Treaty. If MS wanted to preserve the EU's public health power weak and nebulous, why did they not simply keep it as it was? Why did they keep changing it (and adding to it!) in each Treaty revision? We can advance several reasons. First, there was never unanimity among the MS about the extent of the EU's role in public health, and in fact a diminishing degree of consensus as more MS joined the EU. Some of them, notably the newer MS, actively welcomed a greater EU involvement not only in developing national public health policies but even in respect of the functioning of their health systems.

Second, the Treaty reformulations represent (to some extent) responses to developments in Europe and beyond. Gradually, even against their basic instincts, most, if not all, MS came to appreciate that the EU could be of use in helping tackle some health problems that would be difficult to deal with by individual countries acting separately. These include for example

- responding effectively to health threats from communicable diseases and man-made and natural disasters,
- tackling various health determinants,
- developing a framework for regulating health goods and related items that circulate in Europe, and
- responding to global health problems.

Thirdly, the MS were not negotiating in a vacuum; they had to take into account public opinion and, in particular, the views of the other EU Institutions, notably the European Parliament (EP) and the Commission which both pressed at various points for the EU to be given additional powers in particular health fields. In relation to the Maastricht Treaty, for example, the Commission may have had a limited role in the actual negotiations, but it made proposals for what it wanted to see, it liaised with MS about how texts were worded and certainly followed the negotiations extremely closely. The final draft of the new public health article therefore came as no surprise to the Commission. And directly after the Treaty had been ratified on 1 November 1993, it published a detailed communication setting out how it intended to implement the new provisions (4). Similarly the EP played a very forceful role in the BSE crisis which led both to a substantial shake–up in the organization of the Commission services to separate agriculture from food safety and also to pressure to

strengthen the Treaty provisions on the protection of public health. This resulted in the inclusion in Article 152 of the Amsterdam Treaty of provisions allowing for binding measures to be taken in the veterinary and phytosanitary fields in relation to public health, and the extension of the overall scope of EC public health action to "*preventing human illness and diseases, and obviating sources of danger to human health"*.

Certainly, Dr. Stein is right in his contention that the health ministries of many MS have never been the warmest advocates of increasing EU competence in health. Yet despite this the fact remains that it has increased, is increasing and seems likely to continue to increase. Paradoxically, it is arguable that the prime movers of this growth in EU power have not generally been those in the health field, but rather those in charge of other policy areas who have never been so zealous about national prerogatives in relation to health. Decades ago it was heads of government who pushed for action on the single market which led ultimately led to EU action on pharmaceuticals, mutual recognition of health professionals and reciprocity of health insurance coverage. Later those same heads of government called for EU action on cancer and AIDS. In the last few years it has again been heads of government and finance ministers who have set up a new EU system of economic governance which has led to direct interventions in MS's budgetary and economic policies and through those means intrusion into their national health care policies. Today, as part of this system, we have an EU instrument, the semester, which enables the EU to give every MS specific (non-binding but very influential) recommendations on the main issues confronting their healthcare systems, their health spending and the reforms they should make.

We have obviously travelled a very long way indeed from the arguments about whether the EU had a significant role in public health policy, let alone that it could have anything to do with the functioning of national health systems. Dr. Stein has written a thought-provoking article which helps us to trace the path that has been followed and offers us some pointers to what may come in the future for European Health Policy. As he wrote in 1995: "*It may take some time, but I have little doubt that when the range of possibilities inherent in the new treaty provisions are really used, their impact on public health will be greater than anybody expects today"* (5). Now, twenty years and several treaties later, we can see just how prescient he was.

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