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The three faces of European Union health policy: Policy, markets, and austerity

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Abstract

European Union health policy has long had two faces. One face was its most visible: its support for data, networks, agencies and research that promoted shared practice and health objectives in fields such as cancer and communicable disease control. The impact the first face was striking mostly because the budget was so small. A second was long its most important: its courts' application of internal market law and regulation to health care services in pursuit of an integrated European market and freedom of movement of goods, capital, services and people. The impact of this face created EU health care politics, but ultimately had limited effects on health care systems. Since 2010, though, the reaction to financial crisis has given EU health policy a third face: a newly rigorous and intimate fiscal governance model in which member state policies and budgets will be under continuous review, and countries in extreme trouble will face elaborate loan conditions affecting health care in detail. The credibility and wisdom of these new policies is yet to be seen and will be contested, but in principle they commit member states to detailed EU oversight of their health care systems and priorities in pursuit of fiscal rigor.

1. Introduction

Traditionally, analysis of European Union (EU) health policies focuses on two aspects of European integration with consequences for health: its explicit health policies, most of which are to do with public health; and its health care services policies, most of which are driven by the imperatives of its single market. This paper argues that EU health policy has three faces: its generally benign health policies, its internal market law, which incorporates health systems into its broader system of market integrating law – and, since 2010, a much strengthened fiscal governance system which makes it a supervisor of member state policy and expenditure decisions.

In other words, we need to revise our textbooks. The effect of the EU on health care systems is not just networking and the compliance costs associated with the internal market law. It is also now about the extent of government expenditure and to a changing degree the specific health policies and priorities of member states. This paper first reviews the traditional understanding of the constitutional asymmetry between market and social concerns in the EU. It then introduces the new fiscal governance system and its implications for health, concluding that health care and policies in the EU are now incorporated into a new system of fiscal governance that is deliberately stacked in favor of fiscal objectives and finance ministries. At a minimum, this is a political change shaping access to decisions in favor of

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financial specialists and biasing decisions in favor of limited, procyclical policies, and at a maximum it means that the EU has taken on a role as a legislator determining priorities, including those in health. In some states it already has. Such a development is a major transformation in the EU, and presents challenges for health systems and advocates of better health policies as well as for the legitimacy of the EU in the eyes of the public.

2. Constitutional asymmetries and European policies

On one hand, the ''EU'' is like any democratic government; it does not act on its own. So EU policies are those decided by member states and their citizens. First, member states negotiate and ratify the Treaties that constitute the EU and authorize its actions. Second, member states and the directly elected European Parliament can amend and pass or not pass proposed EU legislation. Any given EU action therefore has the support of a qualified majority of member states and a majority of the parliamentarians that European citizens chose. Blaming ''Europe'' for policies is a longstanding tradition in member state politics, but European Union treaties are agreed by member states, and EU legislation and budgets are agreed by a majority or sometimes unanimous decision of member state governments and directly elected parliamentarians. The EU as of 2010–2013 had a clear majority among member states and the European Parliament on the right (e.g. liberals, Conservatives, and Christian Democrats), and it is a sign of its democracy that its policies tended to the right.

On the other hand, the real politics of the EU, like any political system mean that it has certain structural biases. In the case of the EU, these ''constitutional asymmetries'' (Scharpf, 2002) stem from the fact that the European Union is an essentially ''regulatory state'' with a powerfully developed legal system enforcing ''constitutional'' provisions focused on building its internal market. The EU is a regulatory state (Majone, 1994) par excellence: its budget, including agriculture and regional aid, is capped around 1% of EU GDP, which means that its spending powers are trivial compared to member states (EU member states, according to the OECD, spent around 9% of their budgets on health care alone in 2012). Its real tool is law – law that is frequently enforced and implemented by others. This makes it a very efficient system, able to influence most aspects of life across a continent with a relatively small budget and staff (Page, 2001). States pay the costs of carrying out EU laws, like any other laws, and also compensate any losers. EU law enforcement is also frequently cheap; while the European Commission, the EU's executive, can bring cases against member states that do not enforce law, EU law is also enforced by litigants who can bring cases under European law in member state courts to argue that they have rights under EU law (this latter route has been responsible for most EU health care litigation and case law) (Kelemen, 2011). As a regulatory state, the EU does not directly compensate losers, or use serious fiscal instruments such as taxes and transfers to address social problems.

The strongest principles in EU law, deemed ''constitutional'' ones by many legal scholars, include the ''four freedoms'' of the EU: the free movement of goods, services, capital and people. States that interfere with those freedoms have a hard legal task ahead of them. Given its near-exclusive regulatory toolkit and pro-market bias, any new social rights it produces are through more regulations (e.g. the Working Time Directive, on permissible working hours), and it also undermines forms of social protection that can seem discriminatory, directly (as with much Swedish labor law in the Viking and Laval decisions) or indirectly by promoting competition. The EU is by no means a deregulatory machine, but it is very much a regulatory, legalistic machine that scarcely compensates losers and imperfectly reregulates markets it creates.

In the context of this regulatory, asymmetrical, legalistic political system, it is unreasonable to expect some policies and unsurprising to see others. The rest of this section traces the EU's constitutional asymmetry and regulatory approach to health care. It identifies the two faces of EU health policy to 2010: weak and cheap but sometimes surprisingly effective public health interventions focused on networking and information; and powerful, if frequently unpopular extensions of internal market law to health care services.

3. Public health policies

It might seem natural to turn to the Treaties constituting the European Union to find out what it can do in health policy. The current (post-Lisbon) version of the Treaty on the Functioning of the European Union has a Public Health title, made up of a single Article, 168 (Articles 6 and 9 respectively allow and mandate that it attend to public health). Article 168 mandates that a ''high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities'' and states that ''Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action;'' it goes on to specify a variety of areas, including international organization and health services in border areas, for action. It concludes that ''Union action shall respect the