

Comment

Reflecting on ‘Supporting health systems in Europe: added value of EU actions?’

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Introduction

Many in the health policy community are highly critical of the European Union and its involvement in health. Clemens *et al.*'s paper is a refreshingly balanced analysis and assessment. It summarises the ‘standard narrative’ of the detrimental impacts of EU law and policy on national health systems. However, it also illuminates an important counterbalance of ‘hidden’ aspects of EU health policy. These have the potential to improve health across the EU, even in the post-crisis era of public spending austerity. The conclusion – that on balance ‘EU involvement can add biases and problems previously unknown at national levels’ (Clemens *et al.*, 2014) – is thus more persuasive than that in other analyses.

This commentary considers three inter-related aspects of Clemens *et al.*'s piece: the scope of enquiry; the multiple logics of EU health policy; and the Europeanisation of health, following the Eurozone crisis, which has had significant effects on health policies within the EU's Member States (Fahy, 2012; Kentikelenis and Papanicolas, 2012; Greer, 2014).

Core areas/scope of EU health policy

The paper's exploration of EU health policy rests on five selected EU policies with a health dimension. These are: patient and health professional mobility; ‘active ageing’; the public health ‘action programme’; EU structural funding for economic development; and ‘reflection processes’ among senior governmental actors. Implicitly, Clemens *et al.* claim that these are, if not the core of EU health policy, at least a sufficiently representative selection of examples from which to generalise about EU health policy.

Comparing this choice of examples (and claims) with the literature on EU health law and policy reveals that Clemens *et al.*'s choice departs from existing literature in several respects. Historically, public health policy enjoys a more important position

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than in Clemens' *et al.*'s piece, which covers only the EU public health programmes. General EU public health policy has a much wider meaning and significance. It interacts with the law of the internal market, as well as World Trade Organisation law about trade in products which are, or may be, harmful for health, such as tobacco or alcohol (Hervey and McHale, 2004; McKee *et al.*, 2010; Hervey and McHale, 2015). The role of food in public health, especially as Europe emerged from the starvation following World War II, means that the EU's common agricultural policy is an important site for its health policy. Food safety has become a vital part of the EU's health protection policy, especially following the BSE/vCJD affair of the 1990s (Grant, 2012). Early texts on EU health policy (such as McCarthy and Rees, 1992) are *only* on public health, and interest continues (Greer and Kurzer, 2013).

In addition, dating to the EU's foundational period, pharmaceutical policy continues to be central to EU health policy (Hermans *et al.*, 1992; Normand and Vaughan, 1993; Busse *et al.*, 2002; Hervey, 2002; McKee *et al.*, 2003; Mossialos and McKee, 2004; Hervey and McHale, 2004; Mossialos *et al.*, 2010; Hancher and Sauter, 2012; Greer and Kurzer, 2013). Recent developments in pharmaceuticals and medical devices technology (Flear *et al.*, 2013) mean that EU policy on human blood, tissue and organs is important (Hervey and Black, 2005; Lee, 2010; Altenstetter, 2011; Farrell, 2012; Stokes, 2013; Flear, 2015). In the post-crisis Europe, as Clemens *et al.* note, new health technologies are constructed as contributing to economic development and growth at least as much as to health *per se*. However, the regulation of the human body also has interactions with Europe's long-standing commitment to human rights (Hervey, 2003; McHale, 2010; Herrmann and Toebes, 2012; Harmon *et al.*, 2013; Peers *et al.*, 2014), a part of EU health policy not considered by Clemens *et al.*

There is general agreement that EU health policy includes mobility of patients and health care professionals, and the consequences of EU free movement and competition law for national health care systems (Mossialos *et al.*, 2002; Hervey and McHale, 2004; Nihoul and Simon, 2005; Thomson *et al.*, 2009; Mossialos *et al.*, 2010; Van de Gronden *et al.*, 2011; Hancher and Sauter, 2012; Greer and Kurzer, 2013; Hervey and McHale, 2015). A small, but growing, body of literature (Jarman, 2013, 2014; Hervey and McHale, 2015) is concerned with the *external* effects of the EU's health policy – how does mobility into and out of the EU of people and products related to health play out in the rest of the world? This latter aspect of the effects of trade and competition on EU health policy also falls outside the scope of Clemens *et al.*'s piece.

Although Clemens *et al.* do not adopt as wide a scope as sketched here, their focus, excluding areas such as human rights in health policies, public health protection and the EU's global health policies, is sufficiently wide for their conclusions to be persuasive nonetheless.

Multiple logics of EU health policy

Clemens *et al.* stress how their examples highlight multiple logics inherent in EU health policy. They note that – contrary to the general tenor of the health policy

community's views – no dominant narrative for discussing EU health policy has yet emerged. The discourse of 'constitutional asymmetry' (that the EU's powers to Europeanise economic policies are more complete than those for social policies) runs strong in EU health policy. However, other logics are also expressed. Furthermore, it is not clear whether 'health' counts as only 'social' or also as 'economic'.

In our forthcoming book (2015), McHale and I also approach EU health through multiple logics. We consider the themes of consumerism; (human) rights; interfaces between competition, solidarity and equality; and risk. We isolate, compare and contrast an individual perspective and a systemic or collective perspective, and we consider the EU's internal health law and its interactions with global health law. Like Clemens *et al.*, we find support for the standard narrative about EU health law and policy. We conclude that opportunities for EU health policy to improve health are missed. In Europe, the values of solidarity and equality of access according to medical need underpin health systems – and it follows that opposing values, such as mobility, consumer choice or competition, or risk within a market, sit ill with health policy communities. However, we also find – in common with Clemens *et al.* – that the dominant narrative is not the whole of the story. EU health policy *itself* expresses and embodies a range of values.

Europeanisation of health policy

Is health policy becoming 'Europeanised'? The answer depends upon how the scope of health policy is drawn. It is highly improbable that EU health policy will ever have the same substantive scope or dominant focus as national health policies. However, the EU at least touches upon virtually every aspect of such policies. In some areas (such as pharmaceuticals regulation), policies and laws are entirely EU-determined. By contrast, in others (such as end-of-life care), the EU (as opposed to the Council of Europe) barely has any influence at all. It is equally improbable that EU health policy will emerge as a simple regional variant of global health. A distinctively 'European' approach to the modification of liberal global trade involves conceptualising health as a productive factor in economic growth, but also embodies human-rights conditionality, elements of an ethic of equality and risk-based consumer protection, particular from products known to be dangerous to health and costly for national health systems.

Conclusion

Clemens *et al.* conclude that it is too soon to say whether the 'patchwork' of EU health policy is becoming ever more coherent, and we are seeing a process of Europeanisation, or whether the policy field will remain driven by multiple logics. I would say that the two are not mutually exclusive: we are seeing Europeanisation

of a policy area that is driven by one dominant (and other subsidiary) logics at national level, but by multiple equally dominant logics at the level of the European Union.

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