The Europeanization of Health Policy

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Four Points

1. Concepts, paradoxes
2. Free market and health in the Treaties
3. The Europeanization process, in two selected fields:
   - Public health (transmittable disease)
   - Health care
4. Explaining the complex process
A European Health Policy?

A series of paradoxes:

• Limited EU role, but growing EU impact
• No specific treaty provision (until 1992), but involvement since the first treaty (Rome 1957)
• No neat body of legislation, but many goals, instruments, Directives
• “Health” is the biggest single heading within EU Research funding...
The EU... what is it?

• Less than a State (unlike the USA or Brazil)
• More than an intergovernmental organization (unlike Mercosul or ASEAN)
• Conceptualized as “Regulatory State” (G. Majone 1994)

An economic union composed of national Welfare States
EU is “Constitutional Asymmetry”

1. Between the strong economic mandate and weak social and health competency.
2. For Scharp (2002), European integration is asymmetric in general, because:
   – Weak “positive” integration (by legal obligation)
   – Strong “negative” integration (by Euro-compatibility)
3. Member States (MS) can do what they like, as long as it is compatible with EU demands
Health and social security are the exclusive competency of Member State

• Therefore:
  – Soft law
  – Negative integration
  – Low politics

• What can the EU do to gain power over the MS’s national health policy? Take side ways!
UE interest in the health sector

• Cross border issues
• Multiple connections to EU main stream policies:
  – The free market
  – Fundamental rights for the Individual
• Similar life (and market) conditions throughout the EU
• Public finance: Health source of public debt (10% of GDP)
The Health Policy Field

Health industries, products: EU

Prevention, public health: national+EU

Financing, social security: national

Healthcare, LTC: national
The EU has a direct impact on approximately <25 %

<table>
<thead>
<tr>
<th>Distribution of national health expenditure (% of total)</th>
<th>France, Germany</th>
<th>Japan</th>
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<tbody>
<tr>
<td>Medical care and auxiliary</td>
<td>58 %</td>
<td>65 %</td>
</tr>
<tr>
<td>Pharmaceuticals and goods in outpatient care</td>
<td>20 %</td>
<td>22 %</td>
</tr>
<tr>
<td>Long term care (LTC)</td>
<td>10 to 12 %</td>
<td>9.2 %</td>
</tr>
<tr>
<td>Administration</td>
<td>5 to 7 %</td>
<td>1.7 %</td>
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<tr>
<td>Prevention</td>
<td>2 to 4 %</td>
<td>2.5 %</td>
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Social + Health in the Treaties

3. 1980s: Trans-border public health crises (Aids, tainted plasma, “mad cows”, Chernobyl)
4. 1990s-2000: Bad public health situation in the East, transmittable diseases, drop in life-expectancy
   – 1993 Maastricht: EU mandate for public health
   – EU norms for quality and safety (pharmaceutics, food..)
   – New EU agencies
5. Lisbon 2009: recognizes the “Method of Open Coordination”
The EU is engaged in:

- Research, big programs (bio-med, social sc)
- Priority programs: Cancer, Aids, Alzheimer
- Rare pathologies: Network of Reference Centers
- Organ donation and attribution systems
- Health inequalities
- Healthier work conditions
- Information technology, e-medecine, e-health
- Interconnectability of systems
The EU is an Economic Union

• Unified market, concurrence, free movement
• Four fundamental “freedoms”:
  – persons
  – goods
  – capital
  – Services
• How articulate the economic and the social policies?
EU tool for social and health policy: Open Method of coordination (OMC)

• Intergovernmental process, legally not binding, no sanction, but potentially important
• Based on mutual learning, critical discussion, and benchmarking (naming and shaming)
• Created with the European Employment Strategy, treaty based (Amsterdam Treaty 1997)
• Baptized and generalized at Lisbon Summit, 2000
• Followed OMCs on:
  – Social Inclusion – Poverty
  – Education – Professional training
  – Immigration – Integration
The Health OMC

• The Parliament proposed to the Commission “Health and Long Term Care”
• Commission reframed: relate to the EES, modernize organization and financing
• Participation: employers’ unions, trade unions, health professionals, health insurance specialists
• Main task: agreed indicators for comparable data
• Works with 2-years “country reports”, and “National Action Plans” to improve situation
• At present: OMC reformed, unclear picture.
• Since financial crisis: EU imposes budget savings, impact on health policy
The European Center of Disease Control (2005)

- From AIDS to the ECDC
- How did an unexpected epidemic lead to a new sustainable UE policy?
- How was this achieved despite national competency?
- How did the new policy extend to the enlarged EU (and beyond)?
Why and How?

• AIDS: an “ill-structured” problem
• Health ministers need exchange on “bad” topics (addicts, sexual behavior)
• The PH problem of Eastern Enlargement
• AIDS provided the practical model, the treaties the legitimacy, and the EU the money
  ▪ for a policy that goes beyond PH: participation, Human Rights, liberal morals
  ▪ and beyond the EU (“Neighborhood policy”)

24 Jan 2015 / M. Steffen
Institutionalizing “EU Public Health”

- Maastricht Treaty 1993, Art 129 “high level of health”
- Amsterdam Treaty 2000, modified Art 152: “public health dimension in all EU policies”, the UE “completes” the national policies.
- Lisbon Treaty 2009: reinforces the trend, insists on coordination EU-MS, and between MS
How was it done?
Policy style, instruments, diffusion

• “Cognitive Europeanization”, but how does it become real policy?
• Cross-border Networking
• Data harmonization: collection systems, methods of collection, statistical categories
• Peer-coached cross-border policy-making: innovation, local implementation
Data Harmonization
Benchmarking

• Only professional expert can do it
• They act in « bad » policy environments
• Fostering collaboration from administrations
• Based on grass-level local « experiments »
• It builds up Europe from « beneath »
• With blaming from « above »

EU role: providing finance and legitimacy
• “Spill-over” from Market to Healthcare
• Impact of EU mainstream policies on national healthcare systems:
  – Mobility of patients, health professionals and workers
  – Euro-wide concurrence: prohibition of public monopolies, and of subsidies
  – Working Time directive, Service directive, Cross-Border Patient’s directive...

THREE problems to solve
Problem I – Mobility of Patients

- National authorities opposed
- European Court of Justice delivered:
  - Country of origin MUST reimburse
  - Free choice for ambulatory care
  - Hospitalization only with prior authorization
- Little real impact (few patients travel, lack of information, unequal conditions)
- Commission promotes mobility as « choice, quality, right and protection for patients » (individual client)
- EU favors regional “trans-border projects” in capacity planning

- Transposed into national law 25 Oct 2013, for “more general application”
- No “new” provisions
- Confirms and generalizes ECJ case-by-case decisions
- Same conditions imposed to all MS (who is “patient”, affiliation state pays,
  but respect of the national competency (reimbursement tariffs, care basket, quality standards)
- MS have to organize the information for patients
- MS have to create a “national contact point”
- MS have to aim at “interconnectability” of IT systems
Problem II – Social Health Insurances

• EU principal: “all insurances are subject to the to concurrence”, including health
• Strong opposition from ALL member states
• ECJ defined exclusion from concurrence: “if the goal is clearly social”:
  – compulsory membership
  – no link between risk and premium
  – no link between contribution and benefits
• For private non-for-profit complementary HI: “if limitation of risk screaming”
Problem III – “Services”

- EU principal: “Health services are services, and as such under the competition and market law”
- Conflict: Service Directive legalized “regulation of the country of origin” (Bolkenstein crisis)
- France mobilized MS for “Services of general interest” (public services)
- Compromise: each MS can give in his « list of exceptions » (nearly none did)

2008 “Health” withdrawn from the Directive
The final answers, by the ECJ

- Not organizations, but precise « activities », even parts of activity are or not under market rules
  - Avoid cream-skipping to reinforce the economy of public services
- “Decentralized” application of EU-law
  - Back to the traditional principal of subsidiarity, to avoid opposition from MS
- Confirm the country-of-origin tariffs for reimbursement. Confirm the prior authorization for non-urgent hospital care
  - Protect national planning capacity
Explaining the puzzle

• EU health competency is **treaty-based only for public health**

• In healthcare: Open Coordination, growing “spill-over effects” (soon EU budget review?)

• Not a coherent policy, but multiple dynamics with cumulative effects

• Constrains for the laggars
Three sources of Europeanization of health policy

1. Trans-border public health (crises create policies)
2. European integration (spill-over from Market policy)
3. Networking of professionals (statistics, best practice)

An incremental process:
- often accidental
- problem specific
- negotiated
Concepts describing the Europeanization of health

1. *Uninvited* Europeanization (Greer): spill overs

2. *Health Policy institutional Compound* (Lamping, Steffen): shared competency needs negotiation and mutual agreement

3. *Chaordic* (Steffen & Lamping): a crises driven dynamic process, part of European integration.

*It will grow*
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Thank you for your attention

Enjoy a view of the French Alps and Grenoble