The Europeanization of Health Policy

STEFFEN Monika
CNRS Senior Research Fellow
PACTE/Science-Po, Grenoble University (France)

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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

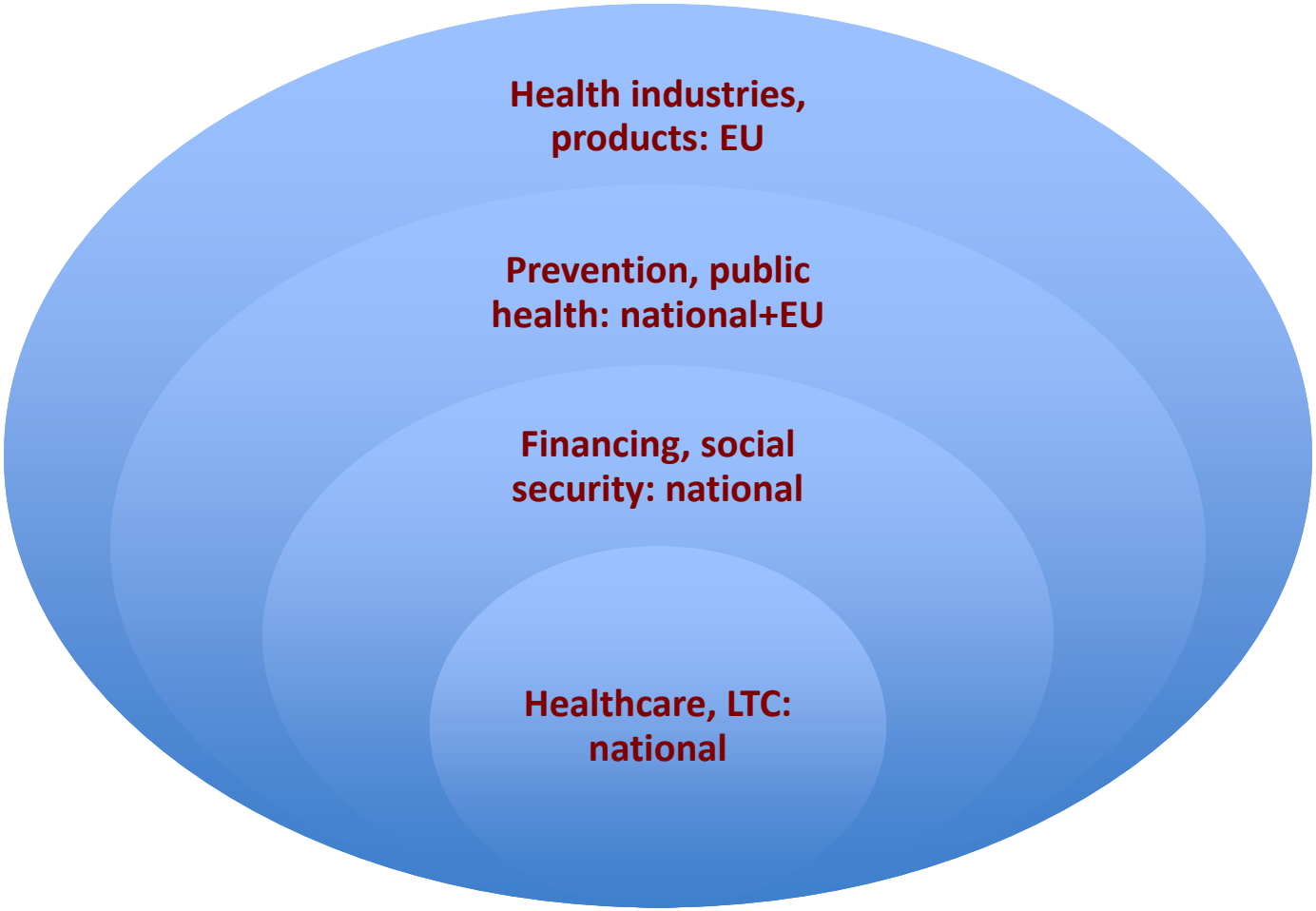
Health and social security are the exclusive **competency of Member State**

- 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 debtis (10 % of GDP)

The Health Policy Field



The EU has a direct impact on approximately <25 %

Distribution of national health expenditure (% of total)	France, Germany	Japan
Medical care and auxiliary	58 %	65 %
Pharmaceuticals and goods in outpatient care	**20 %**	22 %
Long term care (LTC)	10 to 12 %	9.2 %
Administration	5 to 7 %	1.7 %
Prevention	**2 to 4 %**	2.5 %

Social + Health in the Treaties

1. 1957 Rome: transportability of social security benefits. Reinforced 1971-72
2. 1975: “White Europe”, mutual recognition diplomas. Renewed in 2005
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
- lnterconnectability 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 bench marking (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
  - Health (2004)

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”)

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.
- New EU agencies : Medicines 1993, Drugs and Addicts 1993, Foodstuff 2003, Transmittable Disease 2005
- 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

The difficult part: Health Care

- "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

The new Cross-border healthcare Directive (2011)

- 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 imbursement. 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 health**care:** Open Coordination, growing "spill-over effects" (soon EU budget review?)
- Not a coherent policy, but multiple dynamics with cumulative effects
- Contrains 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

Authors

- Political science, EU Health policy:
  - Scott GREER
  - Wolfram LAMPING
  - Monika STEFFEN
- Legal aspects on EH health policy:
  - Tamara HERVEY
  - Elias MOSSIALOS
- Retirement, social assistance, unemployment:
  - Maurizio FERRERA

Thank you for your attention

Enjoy a view of the French Alps and Grenoble