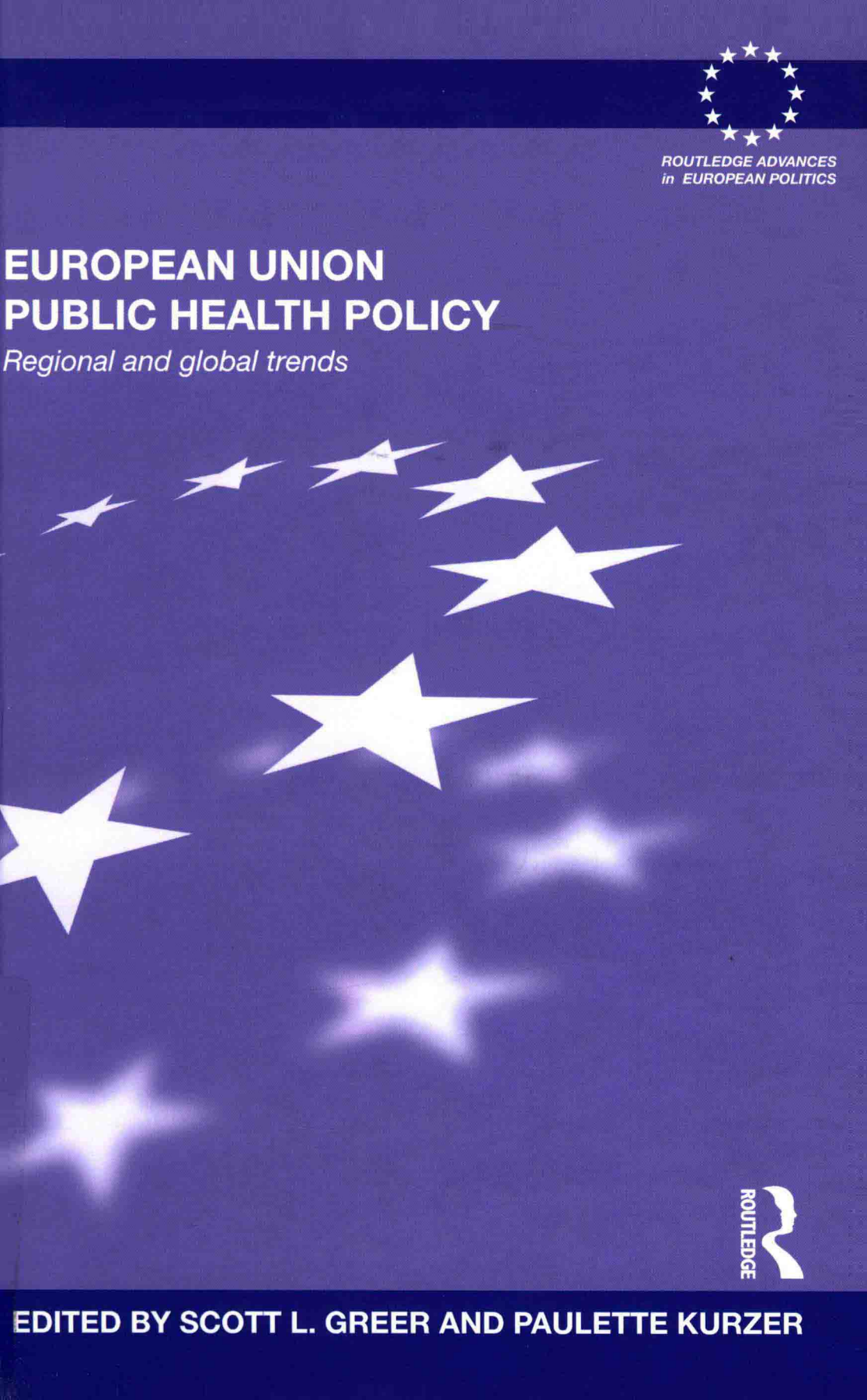
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European Union Public Health Policy

Regional and global trends

Edited by Scott L. Greer and Paulette Kurzer

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European Union Public Health Policy

Ranging from influence over world trade laws affecting health to population health issues such as obesity to the use of comparative data to affect policy, the EU's public health policies are increasingly important, visible, expensive and effective. They also provide an invaluable case study for those who want to understand the growth and impact of the EU as well as how states can affect their populations' lives and health.

European Union Public Health Policy capitalizes on extensive new research, providing an introduction to the topic and indicating new intellectual directions surrounding the topic. An introductory section and extended conclusion explore the meaning of public health, the relationship of EU public health policy to health care policy, and the place of public health in the study of European integration and Europeanization. Focusing on health system transformation, global health governance and population health, the chapters address:

- relevant policy issues and EU policies;
- effects of the EU policies on practice or outcomes;
- an explanation of the policy trajectory;
- current issues and likely future directions or conflicts.

Drawing together an international and multidisciplinary selection of experts, this volume is an important contribution for all those interested in public health policy, EU health policy and EU governance.

Scott L. Greer is Associate Professor of Health Management and Policy at the University of Michigan's School of Public Health, USA, and Honorary Senior Research Fellow at LSE Health, London School of Economics and Political Science, UK.

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1 Introduction

What is European Union public health policy?

Scott L. Greer

Defining European Union public health policy is hard: because the place of public health in the EU is new and still under debate; and because the borders and meaning of public health are less agreed than its scholars and practitioners might think. This introductory chapter first addresses the problem of defining public health. The second section addresses the issue of public health policy in the European Union, identifying it and separating it from the very substantial economic policies associated with the EU that also have economic effects. It argues that the public health policies of the EU are concentrated in three areas: the EU as a global actor (with repercussions inward on the EU itself); the EU as a supporter of health systems; and the EU as a public health regulator in its own right. The third section presents the chapters in the book.

What is public health policy? A plea for empirical definitions

At its most abstract, public health is the health of the population: their freedom from disease, incapacity, and avoidable death. Public health policy is that range of policies that contribute to such an end—from injury prevention to anti-smoking campaigns, to health systems strengthening, to microbiological research. Public health stands in relation to society like the doctor in relation to the patient: charged with diagnosing, prescribing, and treating its ills. In other words, public health is affected by almost every policy in government, and almost every policy in government could potentially be seen as more or less successful public health policy. And just like medical diagnoses, prescription, and influence over patients are highly imperfect, the influence of public health diagnoses, advice, and influence over states and peoples are highly imperfect.

We see the confusion in the endless definitional conversations that afflict public health. They are sparked by practical organizational requirements (such as degree accreditation or reorganization of a ministry), by professional self-definition (such as the border wars between medicine, nursing, and public health), by disagreement about whether a public health policymaker should be attending a given government meeting, or by simple disagreement about what topics are fit for public health scholars. The particularly neuralgic definitional divide is between public health and medicine; stances range from outright opposition (the argument

that prevention and public health, rather than clinical medicine, save lives) to a variety of tangled syntheses that mirror the tangled relationships between public health and medically trained people in governments, practice, and scholarships.

The first problem for scholarship in particular is conceptual overreach. It arises when the impact of every policy on public health becomes a warrant for public health advocates to intervene in any and all areas of public health. On one hand, the odds are good that their expertise is either irrelevant (as with many discussions of social and health care services policy within public health) or very partial (epidemiology can say something about almost any topic in society, but not necessarily something other scholars and policymakers will find useful or want to hear). On the other hand, basic politics suggests that the expertise, connections, and coalitions of public health policymakers, like any other policymakers, have limits. The problem of integrating public health into the thinking of other policymakers, aka "Health in all policies," has scarcely been solved (Ståhl *et al.* 2006; Geyer and Lightfoot 2010; Greer 2012b).

The second problem arises when the difficulty of discussing public health's nature and borders leads to unreflective definitions that mix the quintessence of public health with the organization and preoccupations of any one country. It is a basic methodological mistake to confuse the field of action (public health) with the people acting on the field (whatever corps of people have "public health" in their job description) (Bourdieu 2012, p. 334). Public health's definitional debates are particularly prone to go wrong when participants cross borders; every one of the small number of studies comparing public health in Europe reveals major differences in the form and content of public health organization and activity (Mereckiene *et al.* 2010; MacLehose *et al.* 2001; Reintjes *et al.* 2007; Reintjes 2012; Elliott *et al.* 2012; Mounier-Jack and Coker 2006; Coker and McKee 2008; Brand 2012).

It stands to reason that the starting point of a conversation in the UK, where public health is dominated by highly trained medical specialists, will take a different course from conversations in the United States, where the two-year Masters of Public Health is the dominant degree, or from the numerous countries of continental Europe where there is no particularly prestigious degree or profession associated with the field. Furthermore, the big differences between polities matter and might not be easy to explain. Historical research, by far the dominant kind of scholarly research into public health politics and organization, has so far found path-dependent and otherwise patternless variation, a challenge to social scientists of all kinds (Baldwin 2005a,b). It has also made it clear just how different "public health" looks from different standpoints (Solomon *et al.* 2008)—and how often a writer's assumptions about "how it is done" turn out to actually mean "how it is done in my country."

The way out of these two problems—overreach and parochialism—is to abandon such "legislative" definitions, in which the academic observer determines the nature and scope of the topic. Instead, we should examine the scope of the policies—and the definitional debates—in different jurisdictions. Searching for the true nature of public health, or public health policy, is an activity best

left to philosophers and advocates. Those from the social sciences who wish to understand the dynamics of public health policymaking would probably be better off starting with the policies, and understandings, of the participants in the system they are studying. In the case of the European Union, this means understanding two separable issues: the effects of the EU on public health, which are mostly from its role as an economic actor, and the set of policies that, as a practical question of EU politics, *do* involve the justifications and people associated with public health. The former might constitute a challenge to public health systems and advocates, and something they can use their participation in government to attack; the latter is what they are accustomed to doing.

What is the European Union? A public health policy approach

The European Union is a distinctive organization in world politics. Its institutions and politics are like those of many other polities, but as a whole it resembles little else. It began as a club of six countries that agreed to pool sovereignty over coal and steel, and later share atomic energy—and, fatefully, then, to form a common market with supranational institutions. Over decades it grew in both territorial expanse and the power of its law and institutions. Sometimes extension was due to great interstate bargains such as the ones that relaunched the internal market for 1992, admitted the post communist states of central Europe, or founded the currency union. Often, though, the deepening of integration was the work of the institutions: the entrepreneurial executive Commission and the European Court of Justice, which between them created many a *fait accompli* of integration that states found they could only accept. Later, the European Parliament would start to become a credible voice, heard in many of this book's chapters.

The EU might have distinctively powerful and entrepreneurial institutions, but its powers are theoretically enumerated in treaties, the most recent of which is the Lisbon Treaty. Like the constitutions of most federations, the treaties enumerate the powers of the EU. Where there is no "treaty base," there is no basis for EU action. But like the constitutions of many federations, this restriction has proven more able to channel than to prevent the expansion of EU power. The mechanism is simple: the EU might not have treaty bases authorizing significant action in the area of health care, for example, but it is firmly within its rights (as defined and expanded over the years by the Court of Justice) when it regulates the internal market that includes the patients, doctors, providers, devices, and money of a health system.

The activity of these institutions then drives further European integration in a process known as spillover, in which integration essentially begets integration. Sometimes integration creates a demand for integration—if European integration allows farmers to buy and sell cattle across borders, it creates demands, come a crisis, for somebody to certify the quality of meat. Such spillover creates pressure for integration in the form of a nexus for cross-border coordination, and in the geopolitical and institutional environment of Europe it works (Knab 2011). Sometimes integration operates in a largely political sense: once the Court has

created a right to health care across borders, everybody with an interest in health care has a reason to flock to Brussels and populate a new and once-unthinkable European Union health policy community (Greer 2006b). Both kinds of integration process are at work in this book.

The logic of integration instills its own biases, however. The powerful treaty bases have actually given rise to the "constitutional principles" of the European Union, known as the "four freedoms" in an appropriation of a phrase first coined for more inspiring ends by Franklin Delano Roosevelt. The four freedoms are the freedom of movement of goods, services, capital and people within the EU. A policy that interferes with such freedoms needs a powerful justification in theory, and a strong coalition in politics, to survive.

A European Union with a derisory budget, powerful legal system, and "constitutional" commitment to freedom of goods, services, capital and people is a perfect example of a regulatory state. Its principal policy tool is regulatory: setting the conditions under which others, including states, may make their decisions and ensuring that they do not interfere with the four freedoms in the internal market. Regulatory states can be infuriating because they make others pay for their policy goals; the Court can enunciate a right to health care, but member states must pay for it. Policy advocates in the EU often spend much of their time developing forums, programs, and initiatives that will help them counteract the information deficits, democratic deficits, and distrust such an organization creates among those it regulates.

Once European integration has taken place in a policy area—once the EU has an acknowledged role—the problem becomes one of action and impact. After integration comes EU policymaking and Europeanization. Those topics involve asking what combination of lobbying, institutions, entrepreneurship and luck explains EU agendas and policy decisions, and then, what impact it has and why.

What this all means is that the EU has two kinds of impact on public health. One comes through its role as an economic actor. The other is through policy justified by and intended to improve Europeans' health. The latter is the focus of this book, but the former is the crucial context.

The EU: Economic actor

The EU is first and foremost an economic actor; it is no accident that it was called an "Economic Community" until 1992. The economic influence of the EU on public health comes through two routes. One is the regulatory agenda of the internal market. This is the core business of the main EU institutions: Court, Commission, Council and Parliament. They are engaged in developing law and policy that broadens and deepens economic integration. Policy in this area suffers from the "constitutional asymmetry" that Fritz Scharpf identified (Scharpf 2002). The Treaties enable more liberalization ("negative integration," the removal of barriers to trade within Europe) than promoting new EU-wide standards and proposals ("positive integration," the creation of programs that raise standards,

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