What Is EU Public Health and Why? Explaining the Scope and Organization of Public Health in the European Union

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Abstract Public health is notoriously difficult to define, and that is the case for public health in the European Union as much as other political systems. In this article, the authors try to identify the actual scope and meaning of public health as it is institutionalized in the EU political system. Using a mixture of historical policy and legal analysis, the authors show how the evolution of the institutional space called public health in the EU has been shaped by the EU's distinctive constitutional nature, its focus on regulation, and the legacy of its focus on market making as well as the preferences of its political leaders. The European Union does have an increasingly large space named "public health," in which health ministers, the health directorate-general, and invocation of its public health treaty article 168 can be found, as well as a much broader and older area of activities justified by the need to manage adverse health consequences of market-making policies in other areas such as labor standards and agriculture. The COVID-19 crisis of 2020 not only led to a strengthening of EU public health but also showed that the EU is one of the many political systems in which the legal and bureaucratic domain of public health is far smaller than the actual issues affecting the public's health.

Keywords European Union, public health, politics, communicable disease control

It is a staple of reflective writing on public health to note that it is a hard field to define, and one preoccupied with self-definition. And with reason: different images of public health have significant consequences (Solomon, Murard, and Zylberman 2008). If public health is policy to prevent avoidable morbidity and mortality, then its scope is immense, from nuclear war to early-years education to income inequality to desertification to office

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ergonomics (Beaglehole and Bonita 2004; *Lancet* 1997). This view dates back to at least Rudolf Virchow, who famously wrote a report on a typhus outbreak that attributed the outbreak to the lack of "education, together with its daughters, freedom, and welfare," and focused on broader social and political reforms (Taylor and Rieger 1985: 551). Others point out that public health knowledge of a topic adds little that an informed citizen would not know. In nuclear disarmament as well as many other issues it is clear that while the public health stakes might be great, public health practitioners are not making key decisions, and public health expertise is not sought by the actual decision makers (Fox 2003; Rothman, Adami, and Ttichopoulos 1998). The grey areas are, of course, not so much nuclear war as issues such as global heating or crime, in which there is indeed public health expertise but also other kinds of knowledge, framing, bureaucracy, and power at work.

The empirically identifiable bureaucratic manifestations of public health tend to be more sharply limited. If we look at what tends to be called public health (including hygiene, social medicine, and such alternative names and enterprises), we find much less. In most countries, "public health" tends to mean some combination of sanitarian work (food and water quality inspection), epidemic intelligence and response (surveillance, contact tracing, microbiology, etc.), vaccines, health education, and outreach in areas such as mental health, homelessness, sexual health, and prenatal care. In other words, the observable bureaucratic scope of public health tends to be a 19th-century foundation focused on communicable diseases. To this have been added a number of functions, as social movements and the welfare state expanded the range of issues states address. A field with many practitioners who agree with Virchow on the underlying causes of disease nonetheless has bureaucratic incentives and political demands to focus narrowly on topics such as typhus and its ilk rather than on education, freedom, and welfare.

The political space called public health differs yet again. It is a common move in politics to identify a problem as a public health one, whether it is guns in the United States (Cagle and Martinez 2004), knife crime in Britain (Bowcott and Elgott 2019), or pornography in Arizona (Polletta 2019), to take three fairly recent salient examples. Reframing an established topic, such as guns, crime, pornography, or inequality, as public health is a political action (Lynch 2020), as is calling for "health in all policies" as a way to collaborate with other sectors that have public health priorities. In many cases, successfully labeling an issue as public health could have serious consequences, because it could warrant changes that undermine powerful

interests. Turning drug use, prostitution, or homelessness into public health issues, for example, involves changing the role and the work of police and social workers. The result is that the political sphere of problems being called public health does not always map onto the actual policies to reduce morbidity and mortality, or the widely acknowledged professional expertise of public health bureaucracies and researchers, or the established legal and bureaucratic organizations identified as working on public health.

Public health in the European Union (EU) creates a particularly sharp and confusing version of this overlapping set of fields (Greer 2012; Greer and Kurzer 2013; Hervey, Young, and Bishop 2017). The European Union is sometimes quite comparable to a conventional federation or a member state, but looking at it through the lens of comparative federalism tends to reveal just how different it is from existing federations or member states (Greer 2019; Greer 2020). Compared to member states, what is striking is how little it does directly. If the key sources of power for a government are money, resources such as staff and equipment, and law, the EU stands out for the weakness of its financial resources,[1] the near absence of resources such as staff, the total absence of coercive authority, and the impressive power of its legal system (Page 2001). It is hard to compare the EU to its member states because it simply does not do most of what they do. Even the budget, which attracts so much attention and bulks so large relative to the small economies of countries such as Hungary, has been capped around 1% of the EU gross domestic product (GDP), a fraction of the percentage any member state spends on any major policy area.

Furthermore, the EU still operates, however loosely, on the basis of enumerated powers from quasi-constitutional treaties (called "treaty bases"). Outside times when the European Council of heads of government reveals its power, typically by legislating under what is now article 352, EU action requires authorization from some article of its founding treaties. The political contests surrounding EU action are often about just what the treaties authorize (Page 2012). These designated treaty bases, as interpreted by EU law, also led to somewhat hazy distinctions between public health as a population-focused public law issue and health care as a private law issue that conflict with most other definitions of health or public health policy (de Ruijter 2019; Vos 1999). Finally, the member states that refine EU law and implement it are not just tools of the EU. Most EU implementing legislation is developed by committees composed of member state representatives

1. The European Central Bank has tremendous financial resources, far beyond the more accountable and better-known EU institutions answerable to the European Council. But that is a different article.

who can ensure that it does not diverge from their preferences (Kleine 2013), and the member state courts that drive so much European integration also seek to shape EU law (Pavone and Kelemen 2019).

This article asks: what is the scope of EU public health action as an identifiable bureaucratic and political domain, what policy instruments lie within, and why? In other words, of the three frames, it looks at the institutional and legal rather than political or mission-focused definitions. This is because it is the least debated and most empirically researchable definition of public health, and one that at least identifies the areas of ambiguity and contestation between public health and other fields. The approach is historical, focused on the treaty bases and organization of European Union public health and policy to understand the scope and organization of public health in the EU.

European Union Public Health Policy in History

The European Union began as a set of trading arrangements, with a concept of public health that came from trade law.[2] Public health was an exception to free trade arrangements: member states would be able to legally restrict trade on grounds of public health protection. One of the foundational decisions of what is now European Union law, *Cassis de Dijon* (Case 120/78), was about exactly the scope of the public health exception. Germany argued that it could ban the French drink on public health grounds because of likely public misunderstanding of its alcohol content, leading to drunkenness. The court disagreed, seeing protectionism in the German law. Through the 1990s, looking up "public health" in an EU law textbook would produce nothing but the small and shrinking public health exception to internal market law (e.g., Weatherill and Beaumont 1999). This narrow discussion of public health, or health in general, was a clear political choice. A French health minister proposed a much more ambitious European public health agenda in 1953 and was roundly rebuffed—though many of the items in the agenda are actually now EU law (Davesne and Guigner 2013; Parsons 2003: 32, 86–88).

Over time a broader consolidation of EU health policy interactions took place (de Ruijter 2019), but before 1992 it was hard to see any coherent

2. The EU only took on its current name, and its relatively unified organizational form, from the 1992 Maastricht Treaty onward. To avoid anachronism, we here refer to the various communities' work as "European." This and the following sections rely heavily on de Ruijter 2019; Greer and Kurzer 2013; Hervey and McHale 2015; Hervey, Young, and Bishop 2017; and Greer et al 2019. Any errors are very much ours.

public health domain in name or form. There was some explicit European action on health issues, notably the Europe Against Cancer initiative of the 1980s, but there was no real treaty base for health and no apparent eagerness to establish one. In member states, the appearance of HIV/AIDS started to push public health bureaucracies, expertise, and concepts back on to the political agenda. If public health is at core the areas of personal health in which the health care system cannot address the problem alone, then HIV/AIDS was a classic public health issue. Member states responded by breathing life back into their public health bureaucracies and codes (Baldwin 2005). The EU slowly started to take action on HIV/AIDS at their behest through exchanges of data and practice and some research support (Steffen 1992, 2012).

Much of the work that produces public health in the EU came through other treaty bases, then as now. The logic of these actions was built into the "Europe 1992" single-market agenda, in which member states moved much internal market law (not social security law) to qualified majority voting in order to pursue an aggressive agenda of market construction. Market construction meant the removal of trade barriers through mutual recognition of different member states' standards and the elimination of discriminatory ones (e.g., ones that required member state citizenship, education, etc.). To avoid a race to the bottom, EU law was to produce not just regulatory floors but shared and shareable regulatory approaches to different issues. Member states were free to regulate in nondiscriminatory fashion above the shared floors in EU law, but they were not free to lower their standards below the EU minimum. This logic did not always work well, since the deregulatory process was mostly legal and driven by courts and litigants, while the EU-level reregulatory process typically required legislation and therefore was harder to achieve (Scharpf 1996). In other words, the public health effects of the 1992 agenda already passed through one filter: they could plausibly be part of the European-level reregulation of areas being deregulated at the member state level by EU law (or one of the few EU budget areas, in particular, research and regional aid).

The second filter was the politics of the day, part of which can be read off organizational charts such as council formations, European Commission directorates-general (DGs), and ministerial portfolios in the member states. The 1980s saw a strong environmental movement in Europe, which, aided by the undeniable externalities of environmental policies (e.g., British acid rain killing Northern European forests), exploited internal market treaty bases to develop a powerful body of EU law on topics ranging from the

protection of birds to water quality. The 1980s likewise were a time of relatively strong, if declining, labor movements and viable neocorporatism. Protection of collective bargaining and workers' rights became a priority for those concerned with avoiding a race to the bottom. This did not always mean support for EU law. Some of the most encompassing and wage-compressing industrial relations systems produced the most resistance to EU labor law, which unions expected would reduce their flexibility and power. But it did mean legislation on the basic protections that the EU would afford workers, including workplace health and safety law. Legally, promoting health in this political environment often meant incorporating health, consumer, and labor protections into sectoral directives. Thus regulation of the use of lead is unquestionably good for public health but is found in environmental protection and labor law areas of EU activity, for the simple reason that there was no public health treaty base for them and no public health DG to promote or oversee them when they were passed.

As a result, the EU before 1992 was heavily engaged in action promoting public health in the areas of environmental policy and labor or workplace policy, often with some institutional engagement (e.g., a Health Council formation) (de Ruijter 2019). Much as in the member states, issues such as workplace safety and clean air were acknowledged to have health effects, but that did not lead to agreement that a professional, legal, or organizational field of public health was best suited to protect against those ill effects.

The Institutionalization of EU Public Health Policy

This section traces the legal development of EU public health, namely, the treaty article authorizing public health action, from its inception in 1992, and the organizational development of public health, namely, its manifestation in the commission, council, and agencies. It is divided by the three treaties in which the public health article was elaborated and the politics and organizational change that occurred between each treaty.

Maastricht, 1992

The Maastricht Treaty, signed in 1992, had a particular symbolic weight: it was to refashion the EU for a post–Cold War Europe and provide a new agenda as the 1992 single market project was triumphantly completed. In content, it was to create the European monetary union, and it would

develop a social agenda that could counterbalance the market-making focus of the Single Europe Act and the monetary integration project.

Article 129 on public health was an inventory of words used in EU law to avoid creating firm mandates for EU action:

1. The Community shall contribute towards ensuring a high level of human health protection by encouraging cooperation between the Member States and, if necessary, lending support to their action. Community action shall be directed towards the prevention of diseases, in particular the major health scourges, including drug dependence, by promoting research into their causes and their transmission, as well as health information and education. Health protection requirements shall form a constituent part of the Community's other policies.
2. Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination.
3. The Community and the Member States shall foster cooperation with third countries and the competent international organizations in the sphere of public health.

The restrictive language can be read two ways. One is that member states wanted more EU public health action but were alert to the risk that the public health article would turn into a warrant for greater EU action than they intended and took care to circumscribe it. Another is to look at health actions before the treaty and infer that the article was actually written to contain existing momentum toward more EU health activity. (If this is the case, it might also explain the appearance of environmental law and consumer protection in the same treaty, after dramatic legislative action in those areas.)

The effect was to authorize EU actions in, and more importantly, called, "public health" if they had political support, while grounding the explicit goal of health in very weak treaty language. From that point on, the questions would be: What would the EU political process fill in under the treaty base of public health? What would adding a public health justification do to policies made in other fields? Unanswerable is the question of what the continued evolution of health policy, or environmental or consumer protection policy, would have been had these areas continued to be grounded only in the internal market or the broad powers of then-article 235 establishing the European Economic Community.

Note also that illegal drugs are specifically identified as an EU area of interest and a public health concern. The border between drugs as a criminal activity and drugs as a public health activity is complex, fraught, and political (Kurzer 2001). In part the logic of the treaties dictated this placement. EU actions at the time required instruments such as agencies and significant budgets to be in the first "pillar" of the treaties. Since there could be no criminal justice or similar components of the first pillar treaties, drugs became a public health concern for the EU. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA, in Lisbon) was almost immediately set up, with a regulation passed in 1993 and the organization beginning operations in 1995. The EU role in illegal drugs and addiction has remained soft in legal form but has contributed, as the EU does in so many other ways, to shared framing, expertise, and a network. It is done on a public health treaty base, rather than crime or home affairs. (The location of EMCDDA's headquarters in the capital of a country widely known for successful "public health" approaches to addiction after serious problems in the 1980s might influence it as well.)

Meanwhile, an EU effort to restrict tobacco advertising on internal market grounds was struck down by the European Court of Justice after Germany filed suit, arguing that its restrictions went beyond what the promotion of the internal market required (Kurzer and Duina 2010). This made clear the limits of pursuing public health on market regulation treaty bases.

Amsterdam, 1997

The infectious disease that next put communicable diseases on the EU agenda was actually a zoonosis: bovine spongiform encephalopathy (BSE), nicknamed "mad cow" disease by the media, which could if ingested by humans give them the alarming and fatal neurodegenerative variant Creutzfeldt-Jakob disease (vCJD). Apart from the shocking images of dying cows and the terrifying implications for human victims, BSE had such impact because it revealed ways in which an established area of EU internal market activity, agriculture, was failing to regulate a rapidly changing food system. A relative of the sheep disease scrapie, BSE was spread by agricultural techniques that converted rendered remains of dead animals into animal feed, thereby turning herbivorous food animals into not just carnivores but cannibals. Tracing infection proved extremely difficult, owing to limited and antiquated procedures for tracking animals or products. Member state relations deteriorated, with France putting an

embargo on British meat in March 1996, other countries restricting blood donations by people who had eaten meat in the United Kingdom, and the UK press and government responding robustly to the insults being aimed at the national icon of British beef (Ansell and Vogel 2006; Rogers 2004). It seemed like a textbook example of an area in which European integration had outpaced the capacity, or political willingness, of the member states to undertake coordinating activities at an intergovernmental level—and in which a crisis revealed the gap and created the impetus for new European regulation.

In part, the EU already had the treaty base, since shifting to an EU-level agricultural markets regime had included creating treaty bases for regulating that market. The disease led member states to use existing EU treaty bases to regulate the agricultural and food system more tightly, an agenda that coincided with the various pressures to change the focus of the Common Agricultural Policy from the maximization of food production to more environmentally sustainable and market-responsive production. The result, set out in the General Food Law Regulation of 2002 (178/2002) was an agency, the European Food Safety Authority, and a far tighter set of mandates to do with every aspect of the food chain and its surveillance (Grant 2012). Notably, the General Food Law Regulation, while its management would be placed in the health DG, states clearly that its treaty bases are in internal market and agricultural law, with only one narrow reference to the public health treaty article.

Variant Creutzfeldt-Jakob disease did not just lead to tighter zoonotic and food safety law, however. The debacle happened during the preparations and negotiation of what became known as the Amsterdam Treaty of 1997, which went into effect in 1999. In that treaty the EU acquired new powers in public health:

1. A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities.

   Community action, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to human health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education.

   The Community shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.

2. The Community shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action.

   Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination.
3. The Community and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.
4. The Council, acting in accordance with the procedure referred to in Article 251 and after consulting the Economic and Social Committee and the Committee of the Regions, shall contribute to the achievement of the objectives referred to in this Article through adopting:
   (a) measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures;
   (b) by way of derogation from Article 37, measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health;
   (c) incentive measures designed to protect and improve human health, excluding any harmonisation of the laws and regulations of the Member States.

   The Council, acting by a qualified majority on a proposal from the Commission, may also adopt recommendations for the purposes set out in this Article.
5. Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care. In particular, measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

Two things have happened here. One is that the article has become longer and wordier. Article 129 allowed actions with no force; article 152 added some actual EU powers, along with a broader set of mandates, and therefore came with restrictions. Second, the specific powers it added were about blood (Faber 2004; Farrell 2005) and dimensions of animal and plant (phytosanitary) policy with an impact on public health. Nonetheless, almost

every key word remained noncoercive in EU law, from verbs such as *complement*, *encourage*, and *coordinate* to the modifying clauses clarifying that member states' decisions to coordinate are crucial, and EU institutions may support them. Finally, the last sentences make it clear that the public health article "shall fully respect" member states' "organisation and delivery of health services and medical care."

If the new treaty base authorized public health activity, there was still no agent in Brussels to promote public health. The council formation responsible for health remained primarily focused on social and labor policy. (It is known as EPSCO from the French for Employment and Social Policy; its full name is Employment, Social Policy, Health, and Consumer Affairs.) The Prodi Commission, however, created a directorate-general for public health and consumers, uniting public health, food safety, and consumer protection and known awkwardly as SANCO under the Irish commissioner David Byrne (1999–2004). There were three basic reasons. The first is that the Prodi Commission took office in the wake of the resignation of the Santer Commission due to a corruption scandal, and the new College of Commissioners had an interest in showing a valuable face of the EU. The second is that the number of DGs was derived primarily from the number of commissioners, which was derived from the number of member states, and so EU expansion meant expanding the number of commissioners and therefore DGs. The third, and most important, is that the BSE episode had not reinforced confidence in the old model of uniting regulatory and promotional functions in one organization, in this case, the DG for agriculture. Moving public health regulation away from its previous home in industry-promoting DGs such as agriculture was a way to strengthen public health and reduce bureaucratic and political incentives to downplay public health issues.

While the impetus to create SANCO was based on food safety issues, organizationally it was also split off from the old DG V, responsible for social policy (now EMPL—Employment, Social Affairs, and Inclusion). Both the location of existing offices and the political priority for Luxembourg of keeping commission jobs in Luxembourg meant that it was to be primarily based there. Commissioner Byrne, however, demanded a Brussels presence and located policy and strategy units there in the full awareness that Luxembourg is a physically and politically marginal office location from which to influence EU politics.

Consumer protection, despite being part of SANCO for five years, continued much on its separate and legislatively inactive agenda. The undeniably important area of medicinal and medical device regulation did

likewise. There, an extensive process of European integration and institutionalization was well underway, to the point that there is no real autonomous sphere of member state medicines regulation today (Hauray 2006, 2013). On paper, health, medicines, and consumer protection added up to a substantial DG, but they had different legal bases, politics, and policy regimes and remained quite separate from the health portfolio, as shown in part by the ease with which Jean-Claude Juncker was able to split off consumer protection and nearly was able to split off medicines before a political backlash. In this, the DG was not unlike member state health ministries, which, if they do not control health care delivery, inevitably seem to be marginal regardless of how interesting and consequential their other activities may be (Greer 2010).

The problem for those who sought a European Union public health agenda was simple enough: article 152 worked as drafted, preventing legislation that did not have very substantial political support, and there were not many areas of public health that had such support. It was a thin basis for important law, so the patient mobility legislation that was a key achievement of DG SANCO at the time had to be drafted on the internal market treaty bases that the court had been reading in its decisions on the topic and which authorized EU legislation—though with regard to the aims listed in article 152.

What was built on article 168 and the public health power is the European Center for Disease Prevention and Control (ECDC) (Deruelle 2016; Greer 2012; Greer and Löblovà 2017). The ECDC is a small agency in Stockholm that the EU quickly legislated to create in 2004, when SARS had raised the prominence of communicable disease threats, and made operational in 2005. It was created as a European agency, and its role is to be a network center, standardizing and Europeanizing data and procedures; a resource center, building capacity and sharing expertise; and a data hub. This model, typical of EU agencies, gave it a role in practical Europeanization, especially for smaller member states with less capacity of their own, without threatening member states' autonomy or empowering the commission.

Lisbon, 2007

The Lisbon Treaty changed much in the EU, including once again the relevant treaty article, which now became article 168, but the treaty definition of the scope of public health changed little; the main difference was more text specifying the predominance of the member states in policies

related to the organization and finance of health care. The entry into force of the Lisbon Treaty in 2008 eased ordinary legislation (and made the trilogue crucial, which in principle eases passage by keeping nonconsensual items off the agenda) and thereby might have contributed to the passage of legislation on tobacco products and food labels in 2011.

The Lisbon Treaty's entry into force coincided with a global financial crisis, which European elites turned into a public-sector debt crisis, and which by 2012 had launched the EU into a new era of integration dominated by creditors' priorities and otherwise focused on promoting economic growth through a policy mix we might broadly call neoliberal. It was not a nurturant environment for a recently created area of EU policy whose broad goals are often harmful to the interests of key European industries such as alcohol, tobacco, food, medical technologies, and the manufacture of diesel-powered vehicles (to name a few).

European Union Public Health from Lisbon to January 2020

The immense structuring power of EU treaty bases on EU politics means that it is relatively easy to identify the formal place of EU public health policy. Directly atop article 168 we have almost nothing: the regulatory regime for blood and blood products, and the ECDC's founding regulation and activities. A number of clearly health-related internal market laws make some reference to article 168, notably the directive on patient mobility, the General Food Law Regulation, the medicines regulation structure, health professional mobility law, some tobacco regulation, and a proposed regulation on health technology assessment. But article 168 on its own authorizes, and structures, little.

Within the health realm, as of late 2019, the core of explicitly named health policy was DG SANTE, a small DG with many of its staff still in Luxembourg that the Juncker Commission clearly did not want to support or empower. In a way that is typical of both the EU and much international public health thinking, it operates through four executive agencies: ECDC, Consumers, Health, Agriculture, and Food Executive Agency (CHAFEA), European Food Safety Authority (EFSA), and European Medicines Agency (EMA). An administrative body without an independent legal base, CHAFEA services multiple DGs, including the far larger DG for agriculture in areas such as grant management. The others have their own legal bases and authority. The EFSA legally and practically is more connected to food and agriculture than to health, and the EMA operates in its own, highly

institutionalized world of drug regulation. The ECDC is thus the most important agency connected to SANTE. In areas such as blood, the commission interacts directly with the member state competent authorities, which are mostly executive agencies; in areas such as health emergencies, it interacts with member states and the ECDC; in areas such as routine public health surveillance (e.g., case definitions), the agencies are largely left supervised by their boards.

The ECDC has not had an entirely happy life. One of us argued years ago that its success, given its small size (280 full-time employees in 2019) and limited resources, would be dependent on establishing network centrality such that it could become known and valued by many different players as a unique source of expertise and response (Greer 2012). Vis-à-vis its most immediate competitor, the World Health Organization's Regional Office for Europe (Guigner 2006), it has been predictably successful in the EU arena, but it has had trouble with staffing, and its culture is not necessarily a good fit with an agency whose success depends on successful networking and scientific credibility. If cognitive Europeanization, that is, the creation of a focus on Europe and on European practices within public health fields, is an indicator of success, then it is really not clear that the ECDC has done much better than the smaller and more scattershot Health Programme funding for the broader edifice of "European" public health, meaning organizations such as ASPHER (Association of Schools of Public Health of the European Region) or EUPHA (European Union Public Health Association).

In terms of its key mission, competent epidemic intelligence and response, the ECDC has seen some success in developing surveillance across Europe, training and improving technical quality of epidemiology, diffusing information about disease outbreaks and overall disease profiles, and helping coordinate responses. In this area it has been hobbled by dependence on member states for surveillance and data (Greer 2017), though its work made clear from the start just how much variation existed (Elliott, Jones, and Greer 2012; Reintjes 2012) and directly and indirectly contributed to some improvement. It has not been the powerful public health entrepreneur that some of its advocates appear to have imagined, but it is not reasonable to ask of any public health agency that it singlehandedly redefine the public health politics within which it exists, and the ECDC has helped to shape agendas in key public health areas such as anti-microbial resistance (Deruelle 2020).

At the start of 2020, the EU's role in broader health emergencies was limited. It was not just a place in which the EU was competing with member

states and other international organizations, but also an arena in which health actors are often competing with security agencies, including militaries (e.g., NATO). There was no EU health emergencies budget line. The ECDC's expertise and ability to coordinate expertise competes with member states' own ability to tap their own expertise, which in turn means that the biggest member states, with the most faith in their own capabilities, are less reliably "European." Technical skills and resources can, if well presented, create a default configurational effect,[3] but the ECDC by no means monopolizes them, the commission has almost none, and in a crisis, including COVID-19, the EU is not obviously the most important player unless heads of government have decided to collaborate through it.

The EU's role in overall disaster response, including pandemics, is organized through its civil protection mechanism, which is mostly focused on coordinating member state assets and actions, above all looking for win-win solutions (e.g., facilitating the loan of spare firefighting equipment from one member state to another). A new civil protection facility, RescEU, created the capacity to develop its own stockpiles as of 2019. The EU contribution to issues such as pandemic response developed most strikingly in less visible areas, for example, joint procurement and facilitating rapid vaccine testing and approval (de Ruijter 2019; Purnhagen et al. 2020).

The Juncker Commission downgraded the EU's health agenda. Originally, the Barroso Commission passed the 2008–13 Health Strategy, "Together for Health," which united existing programs and ambitions but sought to give them coherence and some additional mobilizing and authorizing potential (European Commission 2007). The strategy, notably, was to inform the Health Programme, which directed funding to core strategic areas and whose evaluation was scathing (ECA 2009). The Health Strategy was not renewed, under the pretext that the basic EU commitments remained the same and the renewed Health Programme contained the relevant strategic goals. Commission statements under José Manuel Barroso said that the Europe 2020 strategy incorporated health, which obviated the need for a specific health strategy. As is well rehearsed, Europe 2020 was in large part designed to deflect policy from areas such as health toward competitiveness as defined by business advocates, so this claim amounts to the claim that health should be less important in the EU.

The erosion of the Health Programme was particularly important, because much of the impact of EU action on the scope and organization of public health is through its ability to empower networks of like-minded

3. We owe this phrasing to José Maria Repullo Labrador.

advocates—whether they are in nongovernmental organizations or in government—around priorities, framings, and portable concepts of best practice (Greer 2011, 2012). Thus it is possible to see the Court of Auditors' sole evaluation of the Health Programme as showing successes for the Europeanization of public health, even if the program was disappointing as a set of public health measures (ECA 2009). Losing the Health Strategy as a mandate to promote public health, and the Health Programme as a way to sustain an EU-centric public health world, undermined the ability of EU public heath actors such as DG SANTE, or activists hoping for an EU public health policy, to work effectively. It belies the notion that EU institutions always promote integration; the Juncker Commission clearly preferred, for ideological reasons, to slow or reverse European public health integration.

At the start of 2020, the key legislative victories for advocates of public health were in the area of causes of noncommunicable diseases and were mostly dated to the Barroso Commission. In tobacco control, the 2014 Tobacco Products Directive (TPD, 2014/40/EU) tightened regulations on the marketing and sale of tobacco in the EU, including providing legal cover for novel restrictions on marketing such as tobacco plain packaging and extending regulation to more esoteric forms of tobacco consumption that were novel (e.g., vaping) or had been local peculiarities (e.g., snus). Notably, the TPD relied solidly on article 114, the broad market-making and market-regulating authority, rather than the public health article 168. The directive, which is probably the most consequential EU public health policy of the decade (given tobacco's health consequences), was essentially a public health law on internal market grounds. It could not have mattered as much otherwise.

To a lesser extent, food policy was also reshaped to bring more attention to public health consequences of the food system as well as production, farmers' income, and the environment. The Regulation (1169/2011) on food labeling, for example, specified in detail what information should be on all food sold in the EU. In both cases, they are achievements compared to earlier policies, though they disappointed many activists and public health observers (Passarani 2019). In both cases, they received no real impetus from EU member states after around 2010. Most EU food policy under Juncker seemed to be focused on the entrenched legal priority of food safety (with the petition procedure used, in the case of a call for a glyphosate ban, to force revisions to the General Food Law Regulation) (Bazzan and Migliorati 2020).

In 2019 the shrinking health agenda had reached a logical endpoint with a substantial debate about whether there would be a health DG and commissioner at all in the new commission. The "five futures" paper put out by the commission in the aftermath of the Brexit vote had suggested that health was a topic the EU could vacate entirely (European Commission 2017). This would not have meant ceasing to influence health, which would be impossible; it would have meant making policies that influence health without reference to or explicit thought about health.

As it happened, Commission President Ursula von der Leyen, faced with a more fragmented European Parliament, retained SANTE and issued a mandate letter to her choice of commissioner with a larger and more ambitious set of goals than the very narrow ones Juncker issued to Commissioner Andriukaitis in 2014. The new commissioner, Stella Kyriakides, was asked to promote action on medicine affordability, stronger regulation of medical devices, e-health, vaccination, antimicrobial resistance, and cancer as well as a separate and fairly extensive set of issues in food safety, including sustainability, traceability, and control of pesticide use. Medical devices, a neglected relative of medicines (Altenstetter and Permanand 2007), had moved up the agenda as a result of scandals involving poorly regulated devices in Europe (Jarman, Rozenblum, and Huang 2020). These might be characterized as consumer protection or industrial policy and food safety issues, but assigning them to the health commissioner is a statement that health, rather than market promotion or similar objectives, should be a dominant goal. The EU public health policy space had survived the Juncker Commission largely intact, even if it had been hemmed in and its key actors weakened.

COVID-19 and the Expansion of European Union Public Health

The COVID-19 pandemic had dramatic effects on EU member states, and then the EU. The scale of the pandemic, and the reactions to it, was unprecedented to the lives of Europeans. Initially, all of the dramatic responses were made by the member states; the EU barely registered in March and April 2020, reduced primarily to defending the free movement of goods and people in the face of member states' border closures and the export bans on medical equipment. The logic of integration nonetheless brought it back onto the scene with some force. By the end of summer, RescEU was stockpiling medical supplies, the RescEU budget had been massively expanded, the ECDC's budget was increased, and the Health Programme

had been reborn as EU4Health with a far larger budget and a remit that included strengthening surveillance and health systems in the member states. The slow and awkward joint procurement system was supplemented by a Vaccines Strategy, the goal of which was to secure a useful vaccine in large quantities at a good price, and a late-2020 Pharmaceuticals Strategy that would address broader issues of access to therapeutics and research for COVID-19 and other future public health emergencies (Brooks, de Ruijter, and Greer, forthcoming a; Brooks, de Ruijter, and Greer, forthcoming b; Greer, de Ruijter, and Brooks, forthcoming).

Compared to the budget, stature, and political importance of EU public health policy in February 2020, it was a different world. What is noticeable for the purposes of this article, though, is that the additional expenditure was a massive reinforcement of existing EU public health structures and institutions. The scope of EU public health changed little, save for the tentative moves of EU4Health into health systems for strengthening and better surveillance. Instead, the EU attacked the issues of communicable disease control, civil protection, and RescEU as well as the medicines and vaccines market with an unprecedented amount of money and seriousness. With the COVID-19 pandemic, the EU's member states opted to strengthen the existing model of EU public health.

Conclusion: Understanding the Evolution of "Public Health" as a European Union Policy Area

Three key factors have shaped the scope and organization of public health activity in the EU to date. The first is the shape of the EU itself. It has a strong legal system with a direct effect that is enforced and shaped by member state courts, such that R. Daniel Kelemen (2019: 251) has called it a "law-state." Its legal system and legislation go far beyond federations such as the United States, Australia, or Canada in promoting cross-border trade and removing discriminatory practices based on territory (Matthijs, Parsons, and Toenshoff 2019). But unlike other federations, it has a very limited budget that is not easily directed to health care, since it is dedicated mostly to agriculture and regional aid (EU4Health and the expanded RescEU budget are very large by the historical standards of those sectors, but they are small compared to the rest of the EU budget or member states' budgets). The EU has still fewer staff and physical resources. Finally, the EU has essentially no coercive powers. Its contribution to public health, like its contribution to most areas of European life, is likely to remain legal and intellectual, with mechanisms such as guidelines and soft law doing much of the cognitive Europeanization of public health.

The second characteristic that explains the shape of EU public health policy is the historic dominance of regulatory and, in particular, market-making powers within the EU's constitutional law. The basic constitutional asymmetry of the EU has been that it is easier for courts to deregulate under EU law than it has been for politicians to reregulate via EU legislation (Scharpf 2010). Despite this asymmetry, the EU has regulated in important ways that affect health. It is almost certain that the other EU treaty bases that mention health as a policy objective (in consumer protection, labor law, and environment) have done more to promote and protect health than article 168, and many actions taken only under single-market or other rules have contributed to health. Insofar as public health means regulation, the EU, as a regulatory state, has powerful policy tools that can be used for public health. The most effective EU public health actions take place in contested policy domains, where arguments and advocates invoking public health do not enjoy any kind of definitional or scientific monopoly.

The third has been the slow extension of EU public health over time, with public health law and organizations appearing in more of those contested areas, and, with communicable disease control and civil protection, increasing coherence and strength. It is here that living politics, as against institutional logics, intervene.

Public health in the EU means two things: a warrant for taking health into account, which is a response by the left and health advocates (including many ministers) to their legal exclusion from decisions; and a specific set of activities in preventative health areas such as joint procurement of vaccines, epidemic intelligence and response, and blood supply safety. The former use public health to try and tilt the scales in long-standing policy debates about issues such as chemical regulation, food safety, or health technology assessment and regulation. Article 168 helps justify the list of areas such as medical device regulation, pertaining primarily to health care where DG SANTE leads. Entrusting a policy area to SANTE and invoking article 168 make a statement about priorities and stack the odds in favor of public health, as against other goals such as industrial policy.

The list of areas where we saw the extension of public health (including article 168 treaty bases) before 2020 is essentially what is useful at the collective level for solving problems that health care systems cannot solve. The COVID-19 response greatly strengthened the EU's role in some of those same areas, where neither health care systems nor member states could solve the problem: (1) public health measures for managing a pandemic in the absence of a vaccine and medicinal measures for ensuring the effective introduction of a safe and effective vaccine in what will be a very contentious market, and (2) the use of RescEU for stockpiling medical goods.

If it is indeed the case that European public health is called upon to solve human health problems that member states and health care cannot, then European public health mirrors its evolution in member states. Public health is what is useful at the collective level for solving the problems state-level public health cannot solve.

Public health in the EU is comparable to public health in many member states in its domain, but its priorities and preoccupations differ because the EU is a regulatory law-state. It is one with deliberately weak health policy powers and no direct coercive resources, and the EU has grown through regulations built mostly on internal market law. Article 168 limits EU action, except when member states very much want it—when they needed another European "rescue" from the COVID-19 crisis, they found they were too small and too integrated to manage individually. The EU's public health policy goes beyond article 168's limited powers, but much of what the EU, like any government, does for health is outside the public health field entirely. Public health in the EU has grown within the limits of the EU's enumerated powers and history for addressing problems health ministers cannot manage domestically with health care systems. Public health and the EU, it seems, both survive because policymakers address the problems that member state health care systems cannot solve.

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