European health policy: where now?

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The rejection of the proposed European constitution by voters in two of the original six member states, France and The Netherlands, has brought to the surface a wide range of concerns about the future direction of Europe. These include, among many others, Europe’s ability to speak with one voice in a world increasingly dominated by the United States; the scope of any future enlargement of the European Union, in particular the possible accession of Turkey; how best to enhance Europe’s global competitiveness while not undermining its social protection systems; and how to spend the European Union’s budget, which continues to be dominated by agricultural subsidies. Faced with all of these profound political questions, some might excuse the governments of member states if they allowed health policy to slip down the political agenda. Yet this would be unfortunate as there are many pressing issues that need to be addressed.

Many aspects of contemporary European health policy flow from the Lisbon Agenda, agreed by member states in March 2000, which seeks to make the European Union ‘the most competitive and dynamic knowledge-driven economy by 2010’ (http://europa.eu.int/growthandjobs/index_en.htm). Underpinning this agenda is a growing recognition of the synergistic relationship between health and wealth. While it has long been recognized that wealth is a major determinant of population health, the work of the Commission on Macroeconomics and Health showed, at least for poorer countries, that good health was an important driver of economic growth.1 A European Commission report has now assembled the evidence for rich countries.2 Among its key findings are that a country’s current economic status is to a considerable extent a reflection of the health gains it has achieved in the past and that individuals in good health are more likely to participate in the labour force, to invest in their own education, to earn more, and to delay retirement. The overall conclusion is that countries do not face a choice between investment in health and investment in the economy but rather the question of how they can do both in a way that creates a mutually reinforcing upward spiral. The public health article in the Treaty of Maastricht made provision for the European Commission to assess the health impact of its policies. So far the Commission’s capacity to undertake meaningful health impact assessment has been extremely limited.3 In the light of this new evidence linking health and the economy, the development of this capacity within Directorate General Sanco has become a high priority, even more so because of the pressing need to develop policies that close the health gap between the old and new member states.

Appropriate investment must, of course, be based on evidence, and there is increasing recognition that the evidence base for action on health in Europe is often very weak, and that what exists can be difficult to access. The ease with which data can be obtained from Eurostat. However, the main problem is the widespread absence of even basic data on many topics. Thus, researchers and policy-makers have nothing providing European coverage that is comparable to what is available in the United States, such as the National Health Interview Survey (http://www.cdc.gov/nchs/nhis.htm), the National Health and Nutrition Examination Survey (http://www.cdc.gov/nchs/nhanes.htm), or the Behavioral Risk Factor Surveillance System (http://www.cdc.gov/bfrs/). The maintenance of such data collection systems, based on standardized methods, should be seen as an essential component of the European infrastructure, integral to the work of Eurostat.

One way in which the European Union can increase its competitiveness is by the creation of a more flexible economy in which skilled workers can move to areas where their skills are in short supply. Uncertainty about the ability to access effective health care is an obstacle to mobility. Although the right to obtain health care when abroad has been established for several decades, in practice there are still many problems.4 These have become more important as increasing numbers of people move between member states, with particular challenges facing those who, with the help of low-cost airlines, are dividing their time between two or more countries. At the same time, enhanced mobility of those providing health care offers scope for tackling skills shortages in some countries. While it is generally accepted that harmonization of health systems is neither desirable nor feasible, there are many areas where improved coordination at a European level is needed. An example is the new European Health Insurance Card, which is being rolled out progressively throughout the European Union, although there will be much to do to achieve the potential benefits. So far, many elements of the law on patient mobility have emerged in a policy vacuum, with the European Court of Justice resolving ambiguities that the Council of Ministers and European Parliament have failed to tackle.5

As this brief and inevitably highly selective overview shows, there is an extensive European health policy agenda. This raises the question of whether it can be delivered. Contrary to what is often said by some politicians and journalists, the European Commission works with extremely limited resources. Can Europe’s politicians give the institutions of the European Union the resources they need? The European Centre for Disease Control, recently opened in Stockholm, provides a test case. It has the potential to make a real difference, tackling longstanding weaknesses in communicable disease surveillance and control,6 but only if there is investment in both high-calibre staff at the centre and in effective systems within member states on which it can draw.

The uncertainty at the heart of Europe creates many difficulties. However, it also offers opportunities for Europe’s public health community to make its voice heard.

References


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