Conflict of interest statements: The authors organized the conference European Public Health 20 Years of the Maastricht Treaty, which this comment refers to.

References


Glass half empty: the Eurozone and internal market overshadow the health effects of Maastricht

In the past 20 years, the European Union (EU) has become part of health policymaking to an extent that few commentators would have predicted. But the EU’s positive contributions as an advocate for public health have been overshadowed by the effects of its internal market regulation and centralized fiscal governance on the health of Europeans.

Three things happened in Maastricht 20 years ago. European heads of state met to celebrate the completion of the internal market as prefigured in the Single Europe Act, agreed to create a common currency and added the first clear and positive words about health to the Treaties. This first mention of health was the harbinger of more effective promotion of health issues within EU policymaking. In time, however, the internal market and the single currency have had the biggest health consequences of the three.

Public health policies

Putting aside some specific areas of EU competency created under the public health power, such as blood safety, the public health language in the treaties as they stand authorizes EU action, obliges the EU to take health into account and clarifies that it does not have a role in the organization and finance of health care services.

Within this framework, most of EU public health policy is expenditure. This means it is limited. EU expenditures as a percentage of gross domestic product (GDP) are nowhere near as much as a member state health system spends, and health is a tiny share of EU expenditures (the EU member states’ average expenditure on health in 2012 was 9% of GDP, according to the Organisation for Economic Co-operation and Development; the whole budget of the EU, including agriculture and regional aid, is capped at around 1% of GDP).

What does EU public health expenditure do, then? It pays for research and networks that can steer agendas, identify promising areas for EU activity and encourage countries to build capacity in a given area. It is easy to devalue the endless drip of EU projects, grants, guidelines and memoranda, but over time, they can shape agendas. The achievements of the EU in promoting cancer research and its development of communicable disease policies and public health resources in the European Centre for Disease Prevention and Control are probably its most notable successes. These are areas where comparatively cheap EU policies have an important impact on agendas and policies across Europe.

Internal market

The EU has at its core one main tool, which is regulation, and one main objective, which is the integration of the single market. There are powerful treaty bases for the removal of member state policies that interfere with the freedom of movement of goods, services, capital and people. It is comparatively easy to find treaty authority for legislation promoting the internal market, and EU law and courts are sceptical of public health or other rationales for legislation impeding the market’s development. Areas of EU law that have affected health in this way notably include the patient mobility decisions of the European Court of Justice (ECJ), which culminated in the Directive on Patients’ Rights in Cross-Border Mobility, the application of competition and state aid law to health care providers and the integration of pharmaceuticals regulation around the European Medicines Agency.

It is much harder for the EU to do things that are not regulatory in form or market-making in purpose. The tilt towards markets and regulation creates a systematic ‘constitutional asymmetry’ in EU policy. That constitutional asymmetry does not work to the benefit of population health or health systems. Countervailing regulations promoting social objectives face three obstacles that judicial and legislative deregulation do not. First, social or health policy requires legislation that passes through the slow and veto-ridden EU legislative process (observe the time it took to formulate and pass a patient mobility directive). It does not enjoy the additional route of cases under EU internal market law. Second, the treaty bases for health or other social policy provide less authority for positive EU action. Third, serious social or health policies require money that the EU simply does not have available in its ordinary budget. As a result, legislation that re-regulates to put a floor under standards in a new EU market is often liberalizing (for good or ill) relative to what many member states had, and any compensation for losers is
implemented via more regulation such as the Working Time Directive rather than through redistributive policies (such as taxes, disability payments or pensions in the member states).

**Monetary union, fiscal governance and health**

Until 2010, the direction of EU public policy could be seen as positive, with achievements from the European Centre for Disease Prevention and Control to cancer care to the exclusion of health from the Services (‘Bolkestein’) Directive to patient mobility law that was less liberalizing than expected.

Since 2010, the situation has changed radically. The EU has become a major part of health policymaking—not because of changes in the Treaty clauses about health, but because of the extension of EU fiscal powers into health. Just as many health care services policymakers were blindsided by the Court’s application of internal market law to patient mobility, they are being blindsided anew by the new EU powers to examine budgets and priorities, including health budgets and priorities, in depth.

On one hand, this means the Economic Adjustment Programmes (EAPs) for the four particularly unfortunate countries whose balance of payments crises forced them to turn to the ‘Troika’ of the Commission, European Central Bank and International Monetary Fund for assistance. The EAPs are long and detailed documents with a great deal of specific health policy content (e.g. recommending e-prescribing for Greece, or changes to the health financing scheme in Cyprus).

On the other hand, the temporary EAPs come along with the construction of a permanent framework for member state finances built into the Treaty on Stability, Coordination and Governance. This entrenches the Growth and Stability Pact, in EU and member state law, permitting the Commission and ECJ to enforce it. EU institutions can now scrutinize most member states’ budgets before their own parliaments can, in an ongoing process called the European Semester. Violations of the Stability and Growth Pact are cause for judicial challenge and fines from the ECJ (the UK and Czech Republic did not sign this treaty). There is not much evidence that EAPs or fiscal governance take public health as a policy objective.

The EU has become a health policymaker because health is expensive and the EU is now the guardian of fiscal rules for most member states. Fiscal rigor, not health, is the justification and mission of a vast new apparatus of EU oversight.

**Three legacies of Maastricht**

The achievement of the Maastricht treaty’s public health article and subsequent action has been overshadowed on its anniversary by the fallout from the better known events of those years: the single market and the creation of the Euro.

How should public health advocates respond? As ever in European integration, the answer to potentially bad EU policy is to engage in the process of making better EU policies. The specific proposals for health system reform in the EAPs or European Semester are frequently formulated in the many European advisory gatherings or committees that formulate lists of desirable policies. They are therefore the best opportunity to bring public health expertise and values into the detailed mechanisms of fiscal governance and policy—especially by making a serious evidence-based case for investment in health.

The Maastricht Treaty clause on health began to give public health advocates a foothold in EU debates. That was only the start of a long struggle to incorporate health as an objective of an organization long known as the ‘Common Market’. Lately, that struggle has not been going well for public health, but that need not remain the case.

**Acknowledgements**

I would like to thank Holly Jarman for her comments.

**Conflicts of interest:** None declared.

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doi:10.1093/eurpub/ckt163

Advance Access published on 31 October 2013