The Dawn of

European Health

"Even Within the Limits, the Possibilities are Limitless"

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Executive Summary of "The Dawn of European Health"

The health policy arena is in flux across Europe. In most member states, health is at the very top of the political agenda because the national health systems are not living up to the citizen's expectations. Traditionally, health has been a subject whose policy-making was restricted to national governments and whose business was shaped by national markets. But recently the European institutions have started to play a stronger role in health policies, particularly in the area of public health.

This raises the question how this emerging role of Europe is perceived by the relevant public policy bodies, by the non governmental organizations (NGO's) and by representatives of industry and professionals groups (grouped as *stakeholders*; all those who have an interest or involvement in the issue of people's health)? How do the stakeholders who are assembled in Brussels, intend to translate this emergence into strategies and priorities for their own respective organizations?

One of the stakeholders is the European Heart Network (EHN), who is actively involved in contributing to the debate. In order for the EHN to get an overview of the views and opinions of the various stakeholders, a stakeholder analysis was commissioned to the Strategy Academy. This analysis, based on desk research and a survey conducted among 17 key decision makers in Brussels, aims to provide the EHN with input for their own strategy making process.

The fundamental issue at stake in this debate is: What value can the European institutions add, (and where), towards solving the problems and challenges of the national health systems? More to the point, what value can Europe generate for the European citizen's health?

On account of some of the interviewed stakeholders, there are powerful reasons to expect only little added value from the European level, and that accordingly health would remain primarily a national issue: that the financing of health care is tightly bound into the national solidarity systems; that health sensitivities are strongly connected to national cultures; that health products are almost always consumed locally; and that health business is a state-dominated, or at least heavily state-influenced industry.

According to other stakeholders, there are equally powerful reasons to believe, that there may in fact be considerable benefits to a European involvement, and that therefore a lot more European activity in the area of health can be expected. The key reasoning for that is that the subject of health cannot be isolated from the rest of society and the economy; that the EU markets grow closer together; that EU citizens use their rights of mobility to work and live ever more extensively across European borders; and that if the European Union develops into some kind of a matured and established supranation state, the subject of health may invariably be more Europeanized as well.

One of the key findings of this research is thus, that there is still a very broad diversity of view on the best division of competences between the EU and the member states. Amidst that debate, many stakeholders appeared to be still shuffling the evidence to identify whether the emerging role of Europe is an opportunity or a concern to accommodate their interests, and how this emergence will impact their strategic future. Some, however, have made up their mind, and one of those is EU Commissioner David Byrne. He is one of the driving forces behind putting health into the centre of European policy making, summarizing his logic in a straightforward formula:

> "Let us together form a coalition for a Europe of Health. Because the Health of Europe depends on it."[1]

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[1] David Byrne, at the European Health Forum on September 26th 2002

Currently, the momentum of initiative appears to be with the EU Commission, and this report outlines the first and unmistakable signs of such a "Europe of Health" emerging. Yet, these are still early stages – and therefore the title of this report: "The Dawn of European Health". The reader may judge from the evidence reported, whether this is the lengthy dawn of a short and cold winter day, or whether it is the rapidly rising dawn of a bright and shiny summer morning.

The research uncovered some clues, how this "dawning" can be expected to occur, and how opportunities may arise from that. The broad range of views on the value which Europe can bring for the health of its citizens is demonstrated in four key issues, outlined below. These ranges could be organized into a "minimalist" view on one side of the spectrum, and an "entrepreneurial" view on the other side. The minimalist view endorses strategies which respect the least necessary requirements for defining a health action strategy in Europe. These necessities are deeply entrenched developments in Europe and the member states, with a high degree of inevitability to them. Any strategy for action in health, whether more member state-oriented or more European-oriented, will need to incorporate these minimal necessities.

The entrepreneurial view on the other side of the spectrum, sees larger opportunities for a strengthened European involvement. This maximalist view points to significant political, social and economic opportunities for a 'Europe of Health' and welcomes the emerging role of Europe as a key driver for innovation and fulfillment of the promise to 'build' and 'connect' Europe for all its citizens.

The respective 4 key issues that emerged from the discussions with stakeholders in Brussels are:

1. On whose agenda is Health?

At a minimum, the research and interviews with all stakeholders encountered no doubts about Europe playing some role in the area of health. That suggests that it is already clear that at the very least health will be both on the national member states agendas, as well as on the European agenda. The spectrum on seeing additional value opportunities reaches all the way to the other extreme, where Europe's contribution is seen to be so significant, that the national agendas of health should succumb more or less entirely to the European rhythm.

2. What should be the target of the agenda, Public Health, Health Care, or both?

All viewpoints agree that the European health agenda is strongest in the public health arena as a starting point for its health policy making, not least because that is where the strongest legal mandate exists today. But many see also significant value opportunities to build a strong European presence in the health care sector, especially since increasingly the boundaries between public health and health care are likely to blur. In the future more and more of the health opportunities may need the professional attention of both areas, since regulatory interventions in people's lifestyles may be increasing, with the intention of making the European citizen more responsible for his or her own health situation.

3. What are the instruments for implementing the agenda?

How can the policy making bodies in Brussels be most effective in implementing the agenda for Health? All viewpoints can agree that at least for now, Europe will be most effective in using its powers of coordination, or the employment of so-called soft laws, since these are pragmatic instruments and can flexibly adapt to local realities. However, here too the spectrum reaches as far as to say, that the most valuable opportunities could be gained through making full use of European binding hard law, since ultimately this is the most reliable way to assure access to best practice for all European citizens.

4. How can the agenda be supported or influenced ?

Finally there is widespread agreement that in the European scene, especially in Brussels, the professional and technocratic working atmosphere dictates that one must need to know

the facts and be fully aware of the winding routes of the decision making process. Yet, while this is efficient for its own purposes, Europe also longs for "connection" to its citizens. Substantial opportunities are seen for advocacy groups, who can serve the key strategic need of the European institutions to connect and who can therefore be expected to experience a significant rise of their powers of influence.

Overall, it can thus be said, that there is a minimalist consensus available on basic European necessities, but that the spectrum of opportunites in the future beyond those basic necessities spans very wide. Since the future of European health is apparently not yet charted, any organisation looking into its own future, will need to determine where its sees its own best opportunities in that spectrum, and then proceed accordingly.

Chapter 1:

Introduction to Health in Europe and Its Players:

Stakeholder Analysis and Research Presentation

This chapter introduces the structure of the research, the basic legal framework for health in Europe, and the stakeholders at large. Of those stakeholders, EHN chose 17 interview partners for the research, who can be categorized as follows:

1. European policy makers (DG Sanco, EU Parliament)
2. Health Attachés of Permanent Representations of Estonia, Germany, Netherlands, Poland and Sweden
3. Industry representatives (Food& Drinks, Pharma, Retail and Health Insurance)
4. Civil society representatives (EHN, EPHA, BEUC)
5. Professionals associations (UEMS, CPME, ESC)

Structure of the Research and its Presentation

The subject of health is a relative newcomer to the European Union. Policymakers, companies and consumers are still in the process of determining what the responsibilities and priorities should be, which the EU Institutions will assume for the health of the EU citizens. Since the agenda for the next decade is currently being decided for those responsibilities and priorities, it is now the right time to inspect closer what is at stake for this agenda. In this way, the report aims in the first place to facilitate the EHN in exploring the agenda in relation to its own organizational purpose. Further on, it may also stimulate policy-makers, advocacy groups and business executives alike to explore the rich arena of choices, opportunities and partners available to them during and after the "dawning of European health".

This objective of the report is to be reached by deliberating an overview to the question "What is the value that Europe can add to the health of the European citizen?" The research was trying to answer this question by asking it to 17 decision makers (see detailed list in the Appendix) in Brussels, and by studying key publications by various stakeholders. However, it should be pointed out, that by doing so, the authors do not take a stance themselves on that question.

The report is structured into two parts. In the first part, the authors have edited a "story" from what they heard and read in the course of the research. The report presents more than just raw data, it instead produces the result of a first round of digestion, or a first round of sense-making. To prove authenticity, the story-line is illustrated extensively with quotes taken from the research. All quotes are double checked with the interview partners, but of course sole responsibility for the story line lies with the authors.

To the individual insider in Brussels, that first round of digestion may have cut away some worthwhile nuances. However, in the course of the interviews it was discovered that only a very small number of the stakeholders really felt they had a total picture of what was at stake, let alone the much larger majority of Brussels' outsiders. The authors have therefore written

this report in the service of both types of readers, insiders and outsiders, to whom access to the total picture will be more important than the nuances.

The story is broken apart into the four key issues:
- Key issue #1: On whose agenda is health?
  The European Institutions and the Individual Member States
- Key issue #2: What is the target of the agenda?
  The Arena of Public Health and Arena of Health Care
- Key issue #3: What are the instruments for implementing the agenda?
  The Power of Legislation and the Power of Coordination
- Key issue #4: How can the health agenda be supported?
  Mastering Expertise and Mastering Networks

The second part, consisting of chapters 6 and 7, adds a further round of digestion to the first part. In the second part the reader is introduced to the overall European background against which the health debate is unfolding, and it spells out more clearly the strategic opportunities for organizations, which seem to emerge from the research. Well versed insiders to the European process may skip chapter 6, as it does not introduce new facts.

Also, the second part has a glossary, which is very recommended to the Brussels outsider. Throughout the report, the term "Europe" needed to be mentioned in a number of declinations. The word "Europe" has geographical, cultural and political dimensions. Since in common day usage, definitions seem to abound at will, a glossary of how the terms are used in this report is necessary.

The Current Legal Status of Health in the EU

What is the value of a Europe, and what on that bases should be the goals of the European Union is precisely at the heart of the current debates on the Constitution for Europe. The draft of the first 16 articles circulated in early 2003, spells out these goals in Article 3. Article 3 (1) emphasizes peace of the European peoples, which was the starting momentum for the modern Europe to begin with. Article 3 (2) spells out various aspects of material wealth creation, taking into account such issues as environmental protection, gender equality, social welfare, generational solidarity, etc, it even includes an endorsement of space exploration – but it does not even touch with a hint on anything related to health. Article 3 (3) makes statements about various freedoms and (4) explains Europe's contribution and relationship to the rest of the world.

The mentioning of health is notable only for its absence. One could argue, that love or faith (religious or other) are also not mentioned, even though they will feature high on anybody's personal priorities. But love and faith are in most European nations not considered to be a matter for the State either – health on the other hand, is in most cases a very fundamental State deliverable. Furthermore, the current Treaty of the EC (which is a central part of the EU, for the precise relationship see the glossary) has

> "the raising of quality of life"

as a task for the EC in Article 2, and

> "the contribution to the attainment of a high level of health protection"

as one of the activities of the EC in Article 3, and devotes the entire Article 152 to Public Health, stating in 152 (1)

> "a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities."

Whether these legal foundations are a strong enough basis for European health, is already a point of contention among Brussels-based stakeholders, with the full spectrum of "fully satisfactory" to "vastly insufficient" being represented. At any rate, for the time being this is

the legal basis that is available, and which the stakeholders for the moment need to base their actions on.

The Key Decision-makers and Stakeholders in European health

At the center of the policy making, all stakeholders point out, are the three triangle European institutions, the Council, the Commission and the Parliament. An organisation wanting to have an impact on policy, will therefore have to aim its message at all three of these institutions in the appropriate form and timing.

The Parliament draws its legitimacy from being directly or indirectly elected by the European citizens. Since laws (in the First Pillar of the EU) have to be co-decided by the Parliament, it has considerable influence on the outcome of the legislative process.

The Council draws its legitimacy from being the representatives of the national governments in the European project, who are respectively elected by the European citizens. The Council is the other co-decision partner and thereby directly influences the outcome of the legislative process.

The Commission is not elected, but draws its legitimacy from the Treaties establishing its powers, which were agreed by the member states to be in their interest to achieve the "ever-closer union of European nations". The Commission has the right to initiate and terminate the legislative process, but does not vote itself. The Commission influences the legislative process through its agenda-setting powers, its extensive documentation and policy drafting, and power-brokering in the EU Institutions.

These three core institutions are assisted in their policy creation by numerous official bodies, which will not be described in detail here. However, another important part of the policy making scene are the associations, representations and organizations who want to influence the policy making process for any number of reasons. Their impact on the policy making is no where contested. Broadly they can be categorized into public organisations, industry associations, or non-governmental organisations. Usually, European level organisations are umbrella representations for national member state organisations. They come in all different sizes and appearances, and no direct correlation between size and impact was found in the research.

In 2001 the EU Health Forum (EHF) was inaugurated to bring together many of the organisations concerned with health issues into a structured consultation process. Although most interviewees concerned indicated the relevance of this initiative, no specifics were received on the impact or achievements so far. There are between 40 and 60 invited members in the core Health Policy Forum of the EHF. The following three charts describe the breadth of activities of these organisations, and show the positioning of those organisations who have been interviewed for this report.

Positioning charts:

Chart 1:	Advocacy on behalf of	vs	advocacy target
Chart 2:	Advocacy on behalf of	vs	degree of specialization
Chart 3:	# of google search hits	vs	degree of specialization

Chapter 2:

On Whose Agenda is Health?

The EU Institutions and the Individual Member States

This chapter outlines both the challenge and the opportunity of creating value in the subject of health for the European project in general, and the EU in particular. In this chapter there is not yet a difference made between public health and health care. The reason for this is influenced by the fact that the interviewed stakeholders typically refer to 'health' indiscriminately, until specifically asked for the distinction between the two. But current legal basis aside, the challenges and opportunities for the EU institutions in the field of health apply, if different in degree and nuance, to public health as much as to health care.

The challenge of health for the EU

From the findings of the research one gets the sense, that of all the policy making areas that the European Union has targeted for its agenda, health may very well be the most challenging one. Challenging in the sense of identifying and fulfilling an arena of responsibility, where the European project can better contribute to the improvement of the health of the EU-citizen, than separated actions by member states can.

> "We are a long way away from having a unified single market in Europe in those areas where it matters"[2]

The interviewees arguments can be grouped into 6 key reasons for why health is such a particular challenge for the EU.

1. Health is a core political achievement by the member states:

The list starts with the fact, that having made possible almost universally a healthy life for their citizens regardless of personal income and wealth, is one of the core achievements of most European modern developed countries, also in the accession countries. Member state institutions and governments are therefore reluctant to let go of a subject that they have been comparatively successful in dealing with, and for which they are highly accountable to their electorate.

> "For the forseeable future, a single EU health system would not be regarded as a beneficial alternative to the varying national systems. Many member states are justifiedly sensitive about the - after all - high quality of their national solutions. They want to further develop these solutions - whereever reasonable in European cooperation - and to reach the necessary compatibility between member states systems, but all this while maintaining national responsibility."[3]

> "We have a fairly good own public health program, for some elements we bilaterally work together with another country, eg. with Denmark on a program at schools. We see little advantages coming from European cooperation or legislation. On the contrary, we see Europe fail in its objectives to cooperate. We paid for instance for two years a contribution to a drugs prevention program that has not delivered any results."[4]

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[2] Alan Howard, ESC, European Society for Cardiology

[3] Health Attaché at a Permanent Representation

[4] Health Attaché at a Permanent Representation

2. Health is interwoven with culture and therefore organised very differently from nation to nation:

Health is a deeply "cultural" issue, in the sense that health issues are intensely interwoven with political processes, traditions and moral values of the various European societies. What is considered to be a health issue, what the sharing of responsibilities for health between individuals and the state are, how a high level of health can be achieved and most other questions in this area, are usually deliberated primarily on political grounds – and therefore respond strongly to the widely differing cultural and political traditions in European societies. Accordingly there is a very large diversity of organisation in how to achieve health throughout Europe – and by extension fewer obvious chances for harmonization.

> "We consider health (care delivery) to be part of the national responsibility, because it is intertwined with taxation and solidarity issues that are being dealth with differently from country to country."[6]

3. Health is a local product:

Much of the prevention work in the field of public health, even if its conceptual framework has been conceived on a higher level, is realized on a local level, eg. in schools or working places. The same is true for health care. When people get sick, they usually want to visit a doctor around the corner, or visit a hospital nearby. They want to be treated by people who speak their language, who respect local customs and in the case of stationary care want it possible for families and friends to visit them.

> "We are not going to see large scale cross border patient flows, which would make national planning impossible. The demands by the ECJ on cross border care concern only a small minority, and are currently being adressed by the national health ministers. It should be possible to effectively answer these demands between the member states without destabilising the national health systems." [6]

4. Embedded interests in national health structures:

At the same time, the industry engaged in "producing" health, is in every member state a very large and important industrial sector and has had to adjust its own business dynamics to the many local flavors and nuances of the member states. That has typically produced highly vested economic interests; or equally significant, the firm conviction by millions of highly educated professionals in the medical and welfare sectors, that their way of doing things is next to the best way possible already.

> "The pharmaceutical industry continues to amaze me. One would think they have an interest in a unified European market, but I wonder sometimes if they actually prefer the present situation."[7]

5. The importance of health to the everyday life:

Health is not the first politically highly sensitive topic for the EU, the trend towards a common judicial and security policy for instance strikes even deeper into the political core of the member states. But the creation of a joint military force to be at the disposal of the EU if NATO does not fit the bill, is far away from the everyday experience of the EU citizen. Health

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[5] Jim Murray, BEUC, European's Consumer Organisation

[6] Health Attaché at a Permanent Representation

[7] Lisette Tiddens-Engwirda, CPME, the Standing Committee of European Doctors

on the other hand, is on most people's mind, almost every day (save for the few who enjoy pristine and perfect health). It is therefore very difficult to legislate or coordinate measures that the common EU citizen would neither care nor know much about – if his or her health is affected, he or she is concerned.

6. The political weakness of the EU:

The difficulty for the EU with regards to the latter aspect, is the weakness of its political mandate (discussed in more depth in chapter 6). EU citizens will entrust their mandate to the political body that they know best and value highest – which may not be the EU Institutions. It was cited in the interviews frequently, that the European citizens would generally be sceptical about the EU Institutions, and that the European Union is seen to be remote from the interest of the citizens. There is a widespread believe among interviewees that it may be considered unlikely that, if asked, the EU citizens would want a strong, or even unified EU health policy with real decision making power vested in the hands of EU institutions.

> "The national politicians are not always fair about the EU. In national politics they claim the good outcomes for themselves and blame the bad on Europe. At the moment we lack European visionaries who remind the citizens of the impressive political and social achievements that Europe has brought for them"[8]

The whole challenge of health (public health and health care) for the EU is captured by this statement:

> "In my personal view, member states are not yet ready or willing to be dealing with the health care systems on the EU level. It may need quite some years for them to get there, if ever."[9]

The necessities and opportunities for a Europe of Health

While respecting the reasons of the above list, some interviewees presented also powerful arguments for why now is the appropriate time for the European project to take health full blown on its agenda. The European health agenda was triggered by the need for European public health responses in food chain issues (BSE, etc.) bioterrorism threats, and international treaties (WHO, WTO). In the meanwhile, however, much stronger underlying forces are surfacing as well beyond those initial triggers. These forces, which are creating their own necessities and opportunities for a Europe of Health can be divided into three categories: political, economic and institutional. Each of the three categories will be considered now in turns.

> "All the major instruments for enacting European health policy seem to be in place" [10]

Political reasons for a Europe of Health

One lesson from the perceived weakness of the political mandate for the European State is its lack of relevance to the EU citizen. As long as the EU is seen primarily as squabbling over the details of the shape of bananas, the retail structures of automotive spare parts, or the allowable amounts of vitamins in nutritional supplements, it may deservedly be perceived as yet another burocracy too much in the business of nittygriddying everyday life.

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[8] Dominique Taeymans, CIAA, Confederation of the food and drink industries of the EU

[9] Health Attaché at a Permanent Representation

[10] Ria Oomen-Ruijten, Member of European Parliament

The European project is seen to need a big idea, according to the 'entrepreneurial' interview partners, a totem pole of identification where people know why they want to support this institution with their mandate.

> *"People need to be proud of Europe – that is how it all starts!"[11]*

1. Health as a "big idea".

The line of thinking of the advocates of this idea is as follows: The original starting point of the European project was to once and for ever bring an end for the divisions of the continent to be the reason for war and violence, which have characterized its history since the end of the Roman empire. This political foundation is still mentioned at the very beginning of the current Treaty. Its first two sentences state:

> *"Resolved to mark a new stage in the process of European integration undertaken with the establishment of the European Communities, recalling the historic importance of the ending of the division of the European continent and the need to create firm bases for the construction of the future Europe,…."*

It is a measure of how successful the European project has been in achieving this aim, that it might have lost power as a source of pride for the European citizens. Two thirds of Europeans know World War II and its immediate difficult economic aftermath only from tales and books and even the lifting of the iron curtain is already half a generation ago. The difficulties in the Balkans may have served as a reminder of what happens if disagreements among people and governments are resolved with the force of the gun, but it has not necessarily increased the support that Europeans give to the EU. If the achievement of peace on its own merits is not enough to further support the integration of Europe, then it needs to find a new target, a new "big idea".

> *"It would be a dream to gain access for all to the best health services available. But I cannot imagine such a paradise"[12]*

If this disillusionment could be turned around, then health could serve as such a "big idea", is being argued. Despite its cultural overtunes, to achieve and maintain good and and even better health can safely be assumed to be a universal target among the European people. It is also, together with peace, personal freedom and high levels of material wealth, likely to be one of the highest priorities for a European citizen to ask from their state. Therefore, if the EU wants to be a State for Europeans, health could or even should be an important and central item on the agenda of the EU agenda, as the advocates of this view point out.

> *"Why should health not be one of the goals for the European Union? It is after all one of the most important issues for the people! But is the European citizen really ready for it? "[13]*

2. Health in the Convention and Treaty debates:

Despite the mentionings of health in the Treaty texts, the interview partners varied widely in their opinion on the strength of them as a basis for action in the European context. A few public health laws have been created on the basis of 152, but for instance the arguably strongest health measure so far adopted, the package of policies on tobacco, rests on the legal basis of the internal markets. Therefore, existence of the health statements in the current Treaty should not be overestimated.

> *"So far in Europe, health products are typically dealt with on the basis of internal market instruments, i.e. regulations and directives"[14]*

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[11] Lisette Tiddens-Engwirda, CPME, the Standing Committee of European Doctors

[12] Health Attaché at a Permanent Representation

[13] Health Attaché at a Permanent Representation

All the more, to no small extent, the question of whether the mentioning of health will be included in Article 3 of the Constitution as a goal of the European State is a litmus test of whether Europe is really ready and willing to act the role of an being an appreciated state for its citizens.

3. Exploiting the gap left by member states:

The political opportunity arises not only from the question of what will be the essence, the big idea to spark pride and confidence, in the European project. It also arises from a gap that the national member states are beginning to leave open. Many of the interviewees report that where the member states have traditionally delivered a high level of health to their citizens, they have in the recent decade or so let their attention slip. In most member states, inadequate provision of health services, limited attention to public health and health education campaigns and fragile finances have swept the issue of health to the top of the domestic reform agenda. So, some interviewees suggest, this may create an opening for an eager builder in the European project to seize the chance to drive reform from Brussels instead of from the national capitals.

> *"We dearly need a unified European system of health delivery, and we are putting all our efforts behind it. Unfortunately, I am also convinced that this will take longer than I will be able to experience it"* [15]

Earlier research has indicated that it is one of the most proven tricks of how the European project has in the past created space of policy action for itself. At the risk of a bit of overgeneralization, it is for instance how the common currency Euro was made possible. Too many national governments saw themselves incapable of getting profligate state spending and ambivalent monetary policy under control. By surrendering the necessary reforms to a technocratically governed European EMU, politicians found a way to shift the responsibility for austerity packages and new government accountability systems on the need to be a "good European", instead of having to take the electoral blame on themselves. Another example of this mechanism is when national governments in the late 80's/early 90's could not get their state-oriented, hidebound and monopolistic telecommunication companies moving, the competition authorities of the European Commission did that dirty work for them. And only when the same treatment was pressured on the energy sector, the national governments finally agreed to come up with a European solution on their own, instead of having the competition burocrates do it for them again.[16]

To end the political aspect with a quote from David Byrne, as the "Health Commissioner" who describes health as the 'big idea' as follows:

> *"Health is a preoccupation of Europeans. We need to get it right on health, if we are to get it right on a new Europe that means something to our citizens. … Connection means citizens believing that this Europe, is their Europe. That it exists to serve their needs, to protect their interests, to promote their values. That far from being a threat to their cherished traditions, systems and values – in fact Europe empowers them to greater choice. That in short, Europe is good for their health. Indeed, citizens are telling us that the European Union should not only be preoccupied with better markets, predictable rules, stable international relations, sustainable jobs and public finances. They are telling us **that there can be no Europe, without a Europe of Health**."*[17]

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[14] Alan Howard, ESC, European Society for Cardiology

[15] Lisette Tiddens-Engwirda, CPME, the Standing Committee of European Doctors

[16] "Policy Learning in Embedded Negotiations: Explaining EU Electricity Liberalization", by Rainer Eising, Massachusetts Institute of Technology, 2002, p. 104

[17] David Byrne, at the European Health Forum on September 26th 2002

Economic Reasons for a Europe of Health

Health is not just a political and cultural good, it is also a very large industry. Therefore any regulation and law on the health sector has an immediate impact on the growth performance of an economy. That is also true for the European economy.

1. Health as a high tech industry:

Both the EU commissioner's office as well as, of course, the industry representatives point out that the West European economy is made up of highly advanced developed industries, straddling the global frontlines of science and sophistication. The Central European economies aspire to catch up soon. If the European standard of living should stay at the top of the world, it will have to continue to invest and grow in products and services which are sophisticated and high tech. The various businesses in health are at the very top of the technology pyramid. Pharmaceuticals, biotechnology, high precision instruments, but also a highly specialized and trained workforce of professional doctors, nurses, welfare workers and educators are an important driver of sustainable economic growth for the European economy. If Europe can promote the high-tech and high-serve elements of the health industry, it will provide a significant contribution to the economy.

> *"Health is an economic good"[18]*

2. Efficiencies due to a pan-European health system:

More over, the same interviewees argue, there are also additional efficiencies in running a pan-European health system. Innovative products and effective practices and campaigns do not need to be invented several times over. Once discovered and approved in one part of Europe, they can rapidly spread across the continent. Highly specialized expertises and interventions can be made available for patients and risk groups in entire Europe, or in fact be exported to customers from the entire world. A related effect to this is that the large diversity across Europe in climate, food, traditions and sciences, can be successfully leveraged to improve health maintenance and health care delivery.

> *"We just do not have enough knowledge of best practices around Europe"[19]*

> *"We believe European practice of medicine would benefit substantially, if we could achieve a unified system of medical education certification"[20]*

3. Good Health as a necessity for doing business at all:

In a strongly interconnected world, health issues spread rapidly around the globe, interrupting business and commerce. The "SARS" crisis has crippled Far East Asian business in spring of 2003, necessitating a global public health coordinated response.

> *"Never in the history of Lufthansa has the downturn of business been as severe as in the first quarter of 2003. Load factors to the Far East are down to 25% due to SARS."[21]*

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[18] Dr. John Bell, cabinet of David Byrne, DG Sanco of European Commission

[19] Health Attaché at a Permanent Representation

[20] Dr. Bernard Maillet, UEMS, the European Union of Medical Specialists

[21] Press Announcement of Lufthansa on April 10th 2003

4. Europe as a breaker of national market inefficiencies:

Still advocated by the same interviewees, but with less agreement, it is argued that the national health systems are typically riddled with large market inefficiencies, resulting from state interference and deliberate disabling of market mechanisms. For understandable reasons. If the European influence on health can help to break up the national structures and unlock these market inefficiencies, then this would in itself already be a big boost to the competitiveness of the European economy. For this to work, the EU is playing its typical role of advancing liberal market economic policies, where more emphasis is placed on the empowered customer who chooses, rather than the protected customer who is provided with.

> "*The target is Health for Wealth. Health is a driver of wealth. Investment in health is a pre-condition to social and economic progress. We would like to see the European patients empowered with information, to enable them to assume more personal responsibility for their health condition, to make them proactive clients to the world of medicine, not a subject to it.*"[22]

5. Comparative advantage of free trade:

Then there is the old and well proven free trade argument. If Europe creates a large internal market for freely tradeable health goods and services, then the magic of comparative advantage between regional economies leads to everybody being better off than before.

> "*Economic growth requires new products, new products require innovation, innovation requires large and accessible markets*" [23]

6. Health as an investment:

Finally, where all interviewees reunite in their beliefs, there is also a very significant macroeconomic opportunity, if health related finances are not viewed as consumption, but as investment in human capital. Improved health increases not only the life expectancy of the people, but also the time that they are in good health to work into older age. This is critical, because the fact of rapidly aging populations within the next 20 years will make it mandatory to extend the retirement age, otherwise there will not be enough supply of labor for the economic strength required to maintain high living standards.

> "*Health and Wealth – the economic and social dimensions of health*"[24]

Institutional reasons for a Europe of Health

Health is not an isolated industry. It is integrated into society on all levels – and by that mere token, if broad sectors of European society have been harmonized and integrated already in the EU, this will exert pressure on the issue of health to do likewise. Apart from the general background noise of "ever-closer union", there are a number of very concrete European processes in place which exert considerable pressure for harmonization in the area of health.

1. The agriculture and food chain:

Food is obviously an important determinant of people's health, both in terms of food safety as well as its nutritional impact. Agricultural production is heavily regulated by European rules and laws, and inner-community trade in agricultural products is vibrant. In the past few years,

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[22] Dr. John Bell, cabinet of David Byrne, DG Sanco of European Commission

[23] Dominique Taeymans, CIAA, Confederation of the food and drink industries of the EU

[24] Title of the 2003 European Health Forum in Gastein

the BSE crisis, the Mouth and Food Disease and the Dioxin problems have shown that it has become almost impossible in the food chain to rely only on national regulatory regimes. Therefore a new European agency came into being, the European Food Safety Authority, accompanied by a framework for EU food law. All this has significant impact on public health regimes in the member states, and ultimately on the entire health sector. How this will unfold, is still unclear. Beyond the obvious concrete measures like food labeling and a regulatory framework for food safety issues, interviewees differ widely on the question how far the impact will go.

2. Free movement of people:

People travel extensively across Europe, increasingly take up multiple residences and there is an increasing amount of crossborder employment, not only within the EU, but also migrants from outside Europe seeking jobs. These migratory movements and travels can be accompanied by the import of (exotic) diseases or 'unhealthy' lifestyles and customs that can cause a threat to public health. With the free movement of people within the EU, managing the containment and eradication of diseases has now become a European concern, according to the interviewees.

Then there is the issue of the health care systems which are typically tied to national financing, reimbursement and medical treatment structures. It becomes an administrative hassle for instance to take the health care coverage across the border. The interviewees all refer to the recent ECJ rulings on these matters, which had quite an impact on their modus operandi. While this is increasingly being addressed with various measures and bilateral contracts between member states, it remains a de facto hurdle to the free movement of people within Europe. As part of its "Skills and Mobility Plan", the European Council has therefore asked the European Commission in March 2002 to table a proposal for introduction of a European health insurance card. The Commission proposes in February 2003 the introduction of the "European Health Card" from June 1st 2004, where all the relevant data are stored and which would replace all administrative paperwork currently in place, so that citizens can take their health care arrangements more easily across the border. This measure is also praised for its symbolic value:

> "After the Euro, the European health card is another piece of Europe in your pocket"[25]

> "We expect patient mobility to be a key driver for raising the political profile of health policy in Europe.[26]

3. The Euro as a common currency:

Some interview partners indicated, supported by earlier research, that the introduction of the EMU (European Monetary Union) can also have an impact on the national health systems and policies. It is stipulated that a currency can only be as effective, as its credibility by the issuing institution. In legal theory, holders of Euros carry only the credit risk of member states, in acknowledged reality, the de facto backer of the Euro is the European Union. If one or several of the member states would return to levels of fiscal debt high enough to incur inflation, then the currency would be put at risk. Therefore fiscal guidelines were adopted to be adhered to, if a member state uses the Euro. However, the fiscal risks are minor compared to the unfunded social liabilities that most member states are facing in 15 to 20 years. The spiralling costs of medical care for an aging population are part of these unfunded social liabilities. Due to the currency link, the provision and promotion of health in the

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[25] Anna Diamontopoulou, EU Commissioner for Employment and Social Affairs in a EU press release on February 21st 2003

[26] Tamsin Rose, EPHA, European Public Health Alliance

member states does become a matter of concern for the European Union, when the systems are so financially inadequate as to endanger the monetary system.

> *"One of the reasons for increased awareness for health on a European level are the problems related to the steep increase of health care expenditures and the financial sustainability of the national health systems"* [27]

4. *The Lisbon Process*:

In particular among the interviewed Health Attachés there was the mentioning of 2 other processes, which they regarded to be influential in shaping a European health agenda. They were the Lisbon Process and the Malaga Process.

In March 2000 the Lisbon European Council set out a 10-year strategy to make the EU the world's most dynamic and competitive economy. This has come to be called "The Lisbon strategy for economic, social and environmental renewal". From this target, the so-called Lisbon process has started, where every spring summit of the European Council is used to examine the progress on the Lisbon Strategy and to take stock of the economic, social and environmental situation. Each year this progress is measured in a number of reports comparing the measures taken by the member states to fulfil this target. This Lisbon process has become a powerful European institution in its own right, since no member state could doubt the benefit of achieving the ultimate goal of the process. In the Gothenburg summit of June 2001 a subject was included into the Lisbon process on what is needed to meet the challenges of an aging society, especially on the challenge of providing health and long term care for the elderly. In the Barcelona summit of March 2002, the council endorsed as a basis for a co-operative exchange in the field of health care three broad headings: a) access for all, b) a high level of quality of care, c)the financial sustainability of systems.

Thus, as it is stated, even though health care is officially barely on the agenda of Europe, and is currently not a goal of the European Union according to the draft of the Convention, health enters through the backdoor with the Lisbon Process.

5. *The Malaga Process*:

During the Spanish EU presidency 2002, an informal meeting of the Ministers of Health was assembled in Malaga, and then continued on an expert level in Menorca, in order to be actively shaping the European developments also in the health care sector. In Malaga, the Ministers of Health agreed that

> *"Doing nothing is not a viable option. Health care policy should be directed by politicians, and it does not seem that allowing the Courts to draw up health care policy is the proper thing to do for the health of patients in Europe."* [28]

Clearly the before mentioned pressures of Europeanization have started to make an impression on the health ministers, so they are now working to regain the initiative. The Malaga meeting has identified four issues of peculiar merit, or as said in the press release:

> *"the Ministers have found that there is added value in considering certain health issues from a perspective that goes beyond national borders",* [29]

with them being: a) highly specialized reference centers; b) sharing spare capacity with patients on waiting lists from other countries; c) facilitating care in the neighboring country to those living near the border; d) providing care for persons who set up residence for long periods of time in another country. Thus, a start has been made by the member states to

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[27] Willy Palm, AIM, Association de la Mutualité

[28] Summary of the Meeting of Ministers of Health on February 8th, 2002

[29] Summary of the Meeting of Ministers of Health on February 8th, 2002

coordinate their health policy. The start has resulted in a so-called "high level interest reflection group" which is on consultation tour in early 2003 to gather ideas.

> *"The national health ministers understand the need for creating compatibility between the national systems of health care delivery and have agreed to working on that issue also on a European level, while keeping it in national responsibility."* [30]

6. The 6-year Public Health Action Programme:

Many interview pinned high hopes on the upcoming Public Health Action Program. In spring of 2003 a €312 milion research program will start. This program funds research of non-profit organisations across Europe to identify and promote effective ways to address public health issues in Europe. Commissioner David Byrne comments on the program:

> *"What we are aiming for, is to build a formidable EU public health policy for the future … the program gives us a solid foundation for EU health measures to be carried out over the next six years … moving away from the fragmented, disease-oriented approach of the past".* [31]

Clearly, this program is intended to build the case for an active health policy in Europe. The first wave of research in the program is concentrated on

> *"putting together a comprehensive health information system that will provide policy makers, health professionals and the general public with the key health data and information that they need."* [32]

One member of the approval board of the program expressed:

> *"It is hoped, that from this program the key lever will emerge, with which the EU institutions can make their strong policy impact felt for the benefit of the EU citizen."* [33]

7. The European Court of Justice:

As was referred to earlier by almost all the interviewees, the European Court of Justice contributes its own institutional dynamics into the European process. They regard the role of the ECJ in the matter of health to be weighing the varying strengths of different European legal principles against each other when deciding its cases. In 1998 it cleared some priorities in its landmark Kohl and Decker rulings, which it then subsequently confirmed in a string of further cases. In these rulings the ECJ essentially established the precedence of the European legal right of free movement of people, goods and services over national considerations of health provision organisation. At national level, this results in legislatures having to make their health care system and access to health care "eurocompatible". Furthermore, the social protection system may not be, either directly or indirectly, discriminatory with regards to foreign providers (unless there is legitimate justification as interpreted by the Court). [34]

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[30] Health Attaché at a Permanent Representation

[31] Consumer Voice, Newsletter of DG Sanco, January 2003, page 2

[32] Consumer Voice, Newsletter of DG Sanco, April 2002, page 3

[33] Lisette Tiddens-Engwirda, CPME, the Standing Committee of European Doctors

[34] „Time for Restructuring Social Security", summary by Francis Kessler on the MISSOC correspondents in January 2002, pp 7/8 (MISSOC is a EU Commission service to exchange information about social security between member states)

Summaric observation

In total, it is widely agreed that there have been numerous ways in which the EU Institutions have put the subject of health on their agenda, mainly by making it part of institutional processes which then forced actions for coordination and even harmonisation. But there is still plenty of room for argument on the issue how much further these institutional processes should go. There is ample reasons to believe either side: either that health does not, will not and should not belong into the realm of the European Union, with possibly the exception of the current extent of public health affairs such as food safety issues and disease management. This is the minimalist point of view. The primary reason for that being that health would be such a deeply cultural and political value anchored in the member states, that it would be stretching the already weak political mandate of the EU in this field just too far.

Against that, some tasks in health policies have established themselves firmly on the European agenda. And according to the entrepreneurial point of view, there are amply strong political, economic and institutional reasons for the EU Institutions to become even a lot more influential in health policy beyond those basic necessities. The key notion behind this stance is to use the power of EU Institutions as a source of social and economic renewal and reinvigoration, as a forum for cracking outdated structures and delivering the EU citizen to a freer and wealthier condition.

As the following two charts show, the range of perspectives among the interviewed stakeholders vary substantially on this question, where they would like to place their strategic emphasis:

Chart 4: Stance on public health Europe

Chart 5: Stance on health care Europe

Whether an organisation chooses more a national or more a European-oriented strategy for its own future, it will need to answer to the primary necessities posed by both the national and the European levels. Beyond those basics, the European level offers further opportunities for additional value added, which are summarized in the following chart: (the national level may offer additional opportunities as well, but that was not in the scope of this research)

Chart 6: Matrix

Chapter 3:

What is the Target of the Health Agenda –

Public Health and Health Care

In the previous chapters, the term health was used generically. However, health is typically divided in two parts, public health and health care, with two separate professional communities serving them. As far as the EU is concerned, that distinction is particularly important, because there exists a legal framework for the first, whereas only a limited one for the second. At the same time, it appears this distinction is more valid when looking into the rear view mirror, than when steering forward. When interview partners outlined particular measures, the impact or organisation of these actions appeared increasingly difficult to be confined to one area only. That gives rise to the notion, that there is a significant overlap between health care and public health emerging.

> *"Whether it is public health and health care is less relevant to us, because from a policy making perspective the distinction between the two is blurring"* [35]

Along with the blurring of the lines between public health and health care, it also appears to become increasingly difficult to categorize the term prevention. The research encountered an assortment of different definitions for prevention, for instance primary vs secondary prevention, state-driven vs individual-driven prevention, education-oriented vs regulation-oriented prevention. The dilemma of definition becomes clear when the example of obesity is considered, which almost every interview partner expected to be an agenda item for the next coming years. Is obesity already a disease itself that requires medical treatment, or is the reduction of obesity a prevention measure against other diseases? If the latter, is the reduction of obesity a state responsibility or a matter of individual choice? Can obesity be regulated or at best be discouraged? And which of these actions deserve to be named prevention, medical treatment or just plain common sense? The research could not provide a conclusive answer, except that as the boundaries on the concrete issue seem to blur.

Aspects of public health

During the interviews, it was established that the stakeholders use many different definitions of what exactly entails public health and health care. However, the differences appeared to be nuances or pragmatic references, influenced by professional predispositions. In general, the following definitions and links to other issues, such as food, were taken down:

Public health measures broadly fall into two set of instruments: programs of education and promotion, or actions of regulation and restriction. Both sets are aimed at either the prevention of diseases or the general promotion of health. These can be particular illnesses, such as salmonella infections, or general health concerns, for instance work place safety.

The toolbox of public health is thus very broad. Food safety is a key instrument to protect the population from the ill effects of poisened foods. Food safety regulation is concerned with the production, processing, storage, transportation and retailing of foods. Throughout this food chain assessments must be made on what are safe levels of ingredients, and safe processes of handling, so that consumers will not suffer from adverse effects of eating the food.

Food contributes also in another way to public health. Apart from being a potential source of poisening, it has the much more obvious and omnipresent role of supplying nutrition to the

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[35] Ria Oomen-Ruijten, Member of European Parliament

people – the nutrition that the body needs to maintain and heal itself far before a medical treatment may become necessary.

> *"Without food there is no health"* [36]

Another instrument of public health that was mentioned is disease management. Traditionally disease management used to be a matter of vaccination programs. Today, more emphasis lies in broad scale screening programs or instituting treatment regimes for instance for diabetes.

The third major area of public health are attempts to influence people's tastes and preferences towards healthier lifestyles. Through education, information, taxes and fines, people should be encouraged and/or punished towards being healthy. Taxes for instance are levied on alcohol and tobacco, fines and criminal procedures are imposed on the consumption of illegal drugs, education programs on proper nutrition are aimed at school children, information campaigns on safe sex are aimed at adolescents, and so on.

Interviewees were less outspoken on the issue of prevention of the so-called civilization diseases, ie lifestyle induced illness rather than infectionary illnesses. Here only the professional community dealing with public health referred to the inclusion of this element in the definition. In that it emerged that prevention has always been a good idea, but for a state it was a difficult lever to pull, as it was largely up to the individual to be careful about his or her life. Furthermore, hard evidence on the economic success of this type of prevention appears to be slim.

> *"We are strongly in favor of preventative and life-enhancing strategies, but it has not been well proven so far that prevention can save future health care costs"* [37]

However, some interviewees, in particular DG Sanco, points out that technology may be changing that rather soon. Genetic screening for instance can pinpoint high risk groups for various ailments, such as cardiovascular diseases, and enable various public or individual prevention programs geared towards those high risk groups. Of course, as some stakeholder pointed out, even when the technology is available, Europe will take a very long time to debate the ethics of its application.

> *"DNA-screening could lead to an entirely different health system. For example, it may give an assessment about the person's required prevention and treatment attention. That could some day lead to individualized care"* [38]

Chart 7: on Survey results of NP and MEP prioritisations of health policy objectives

Aspects of health care

Again in general terms, the following definitions and links to related issues, such as differences in national budget allocations, were taken down:

The other part of health is the health care sector – the part that is more immediately associated with the subject of health – the care&cure people as they are also called in the jargon. To the health care sector belongs the entire system of doctors, hospitals, pharmaceuticals and medical devices. Although presented here as one system of professions and services, within the system the actors seem to turn inwards. This is also reflected in how they operate in Brussels, according to the interviewees. A more united

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[36] Dominique Taeymans, CIAA, Confederation of the food and drink industries of the EU

[37] Jim Murray, BEUC, European's Consumer Organisation

[38] Dr. John Bell, cabinet of David Byrne, DG Sanco of European Commission

stance or integral view on certain issues would certainly be welcomed, was voiced by other NGO representatives and EU policy makers. The medical goods and services are financed by the health insurance industry, and are supported by a number of specialized service businesses, like hospital management, laboratory networks and so on. All told, throughout the EU 15, the health industry has about € 820 billion of sales.

The overall health budget is under tremendous pressure to increase faster than GDP, which is due to three reasons:

1. aging demographics
2. technology advances, which are outpacing overall economic growth
3. growing demands by consumers on the health system

In total this means, that if the status quo health provision systems in the member states are maintained, the health budget would grow substantially faster than the general welfare. This is split among the countries in the following:

Chart 7: on distribution of health budget.

Research indicates that the composition of this health budget by disease groups can vary substantially from one country to the next. For instance, the budget for cardiovascular diseases ranges from 12% in France to 21% in Ireland of the total health budget.

Chart 8: CVD in relation to health budgets

The overlap between public health and health care

It is precisely at this point where the two sides of health seem to meet. The cheapest form of treating a disease is to prevent it from breaking out or even occuring in the first place. During the interviews, an example of the prevention of CVD was introduced. As this example indicated, all interviewees agreed that there is obviously still enormous scope throughout Europe to prevent diseases from breaking out or occuring. However, to do this effectively, it was said, it is necessary for health care and public health professionals to increasingly cooperate and coordinate their work.

Chart 9: Overlap between public health and health care

Asked for the reasons why this was not happening yet enough, the interviews revealed that the "care&cure" profession on the health care side faces a double dilemma with prevention. First, their professional training and more importantly the workflow of the organisations that they work in, make it difficult for doctors to spot the need for prevention in a patient. Typically the medics are only made aware of the disease, once it has broken out. They are neither well trained for, nor is it usually financed, to be looking for a disease before it has broken out (with some broad scale cancer detection programs being the exception).

> *"We are getting active on the prevention side, particularly some secondary prevention programs. But this is only one of many of our activities."[39]*

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[39] Lisette Tiddens-Engwirda, CPME, the Standing Committee of European Doctors

Second, the care&cure professions suffer from a systematic financial conflict of interest. The faster they cure their patients, and the more the diseases do not break out to begin with, the less business the doctors, hospitals and pharmaceutical companies have. The medical profession deals with this conflict of interest remarkably well, but it would be naïve to believe, that it does not influence therapy and treatment decisions. Everybody inside the health industry knows of plenty of incidences, where the need to create business or fill capacity has led to prolongation of hospital stays, the provision of unnecessary treatments and worse.

On the other side, the professionals in the public health arena, typically do not have the infrastructure, or the depth of training required to conduct medically-oriented prevention programs on a large scale. In many cases, they require the health system infrastructure of the doctors to deliver their program.

> *"Prevention and health education has traditionally developed seperately from the health system, whereas it should go hand in hand with Care&Cure"*[40]

Both health care professionals and public health program management depend on each other in order to deliver modern prevention programs on a significant scale. That is also why it is problematic, if the EU only has a mandate for public health, but none for health care. It means that the EU is hampered in fulfilling an important part of its task.

> *"The fundamental problem is that health care and social protection lack a sufficient legal basis at EU level. Therefore, we support the idea of a horizontal clause defining the common fundamental principles in order to counter-balance the application of European internal market rules in this field"*[41]

Prevention Necessities and Opportunities for the European Institutions in the Overlap Between Public Health and Health Care

The public health mandate for the EU really rose only after the BSE crisis, which required an European coordination to stop the epidemic from spreading, while minimizing the disruption to agriculture. Apparently it was felt that the established agricultural processes were by themselves not equipped well enough to deal with the resulting health concerns in the food chain.

Other pressures developed as well. Both the World Health Organisation and the World Trade Organisation asked for a more profiled stance of the EU on public health issues in their own rounds of negotiations. Then came the rulings of the European Court of Justice on patient mobility. With the 9/11 attacks the issue emerged of how to deal with poison attacks on the population, which was deemed to be a suitable task for the European level.

> *"Before BSE, WHO and WTO, public health was viewed by some as a cinderalla subject. Now from BSE, through Tobacco Control to Bioterrorism, public health is at the centre of the policy agenda"*[42]

The issue of health in broader terms emerged for the EU only recently from these relatively humble beginnings, according to the interviewees. But when EU Commissioner David Byrne speaks of his vision of a "Europe of Health", they agree that there seems to be more ambition to enlarge that mandate to encompass the whole area of health. Effective and large scale prevention of disease coordinated through the European level could become a value driver in achieving such a Europe of Health. The question then, which was put up several times after interviewees admitted to this reasoning remains, how could such prevention be achieved?

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[40] Willy Palm, AIM, Association de la Mutualité

[41] Willy Palm, AIM, Association de la Mutualité

[42] Dr. John Bell, cabinet of David Byrne, DG Sanco of European Commission

Supported by the interviews and subsequent further research, there seem to be fundamentally two philosophies on how to achieve prevention in Brussels. One is to take the "protective" route, and one is to take the "empowering" route. The protective route is an approach, where through the criminalisation, banning, regulated access or official discouragement, the use of products or certain lifestyles is inhibited, such that the consumer is protected from their ill effects. This philosophy is in particular adhered to by the public health/NGO community. No other interviewed stakeholder groups seemed to explicitly subscribe to this view.

The empowering route is to make the consumer as stringently aware of the consequences of his life choices as possible, and thereby achieve, that as an enlightened and empowered individual he or she will remain from harmful actions and pursue health enhancing lifestyles. Here DG Sanco and the industry associations were apparent subscribers.

As a strong example of the first philosophy that emerged from the inteviews, a protective action in public health would be for the EU to trigger a process throughout Europe to condemn the consumption of sugar (or similarly, the wrong kind of fats). It is after all proven that excessive sugar consumption has all sorts of harmful effects on the people: diabetes, obesity, CVD's and so on. Also children might be less hypernervous, if they reduced their sugar intake, possibly even gain better concentration in school, have less dental problems and so on, and adults could be alleviated of their secret chocolate addictions. An economic modelling of this measure would almost certainly prove that the reduction of sugar consumption has very little economic downside and no adverse effect on the value of nutrition, but that people would live many additional years of healthy lives with all the associated benefits that this has (vastly reduced health care costs, longer working years, higher quality of life, and so on.) In other words, it would be a clear case for public health action!

The example was taken further. The condemnation of sugar could start with educational measures throughout the population. It could continue with restrictions on advertising for sugary products, especially when aimed at children, it could introduce tough labelling requirements with warning labels, it could even introduce a sugar tax so that the recalcritant consumer pays up for the external cost to society that his unhealthy lifestyle is creating. People who agree in writing to refrain from sugar consumption could get cheaper health care coverage to provide also a positive motivation, and so on.

> "Why do we buy a food item in a shop? Often not because it tastes good, but because advertising has linked this product in our minds to a core human emotion" [43]

The similarities of this fictional example to the Europe wide condemnation of tobacco are not coincidental, as parallel to the research for this report the WHO convention on tobacco control was taking place in Geneva. Interview partners openly mused on whether these successes could now be built on in other public health areas as well, for instance food. Even The Economist suggested a promising strategy for legally strangulating the food industry in its year end issue 2002.[44]

Granted that sugar consumption does not cause harm to passive by-standers as does tobacco smoke, or in fact as do the side-effects of alcoholism on families, but all three examples still share the same problematic "anti-liberalness". Even if the case of sugar condemnation (as in the case of tobacco), would generate substantial benefits to the EU citizen, it is unlikely, as interviewees readily pointed out, that it would really endear the EU to the European citizen. That is, because such a measure infringes on the personal freedoms of the people to freely choose the way they want to conduct their lives.

It is a very difficult line to draw, interviewees claim, where the European level might protect the citizen from his own weak judgement and therefore ban products (illegal drugs) make

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[43] Tamsin Rose, EPHA, European Public Health Alliance

[44] The Economist: Fast Food in the Dock; Fat Lawsuits, 21st December 2002

access to them difficult (pharmacies), tax its ingredients (alcohols), or highly discourage consumption (tobacco). In all cases, personal freedoms are infringed, but public benefits greatly enhanced.

> *"Tobacco was a comparatively easy situation, as tobacco is obviously bad for health. There are no positive aspects to Tobacco at all, not even anymore the argument of providing income in poor developing countries. Tackling the food industry on issues of fat and sugar will be a much harder target; we have to eat to live and because consumption of unhealthy foods does not harm other people directly"* [45]

One other argument that was voiced by the public health professionals as well as the Health Attachés, is that the difficulty with the traditional public health approaches is, that their benefits are typically diffuse and noticeable only through the absence of harm, which means they are usually not noticed at all or only in the long term. The associated costs of the program, however, are specific and typically need to be born by the general tax paying public in the short term. The same is true, where citizens are specifically forced to change their lifestyles due to a public health measure, while the associated benefits accrue to them may be decades ahead. That is a difficult proposition for a state action to be appreciated by the population even in the best of cases, whereas the EU may only enjoy a weak political mandate to begin with.

> *"The promotion of individual prevention measures would be very useful, but for Europe it is hard to do, because citizens have very little or no feeling for Europe,when it comes to health issues, that is even a difficult task for national governments"* [46]

The example of sugar or fat condemnation may sound like an extreme one, but the underlying dynamics are the same. The more active and protective traditional public health policy becomes, the more intrusive it gets into the freedoms of personal and business conduct. That applies to food labeling requirements as much as to the introduction of widespread genetic screening.

Summaric Observation

For the EU the proposal of protective-oriented public health measures are a double edged sword. On the one hand it can produce tangible economic and quality of life benefits for its citizens, on the other hand, those same citizens are unlikely to be grateful for it, more likely they will even be hostile to the loss of liberties.

Interviewees therefore believe, that it is likelier that the EU citizens would be more unequivocally appreciative of EU policies if they were seen to reduce waiting lists for treatments, reduce costs of pharmaceuticals, secure high levels of care for the elderly, and so on. But these are exactly the areas where the EU does not have a mandate for action, (at least not on health grounds) and where it would also be hard pressed to find good solutions, since local and national considerations are so intermingled with these issues.

> *"We will not develop a competence to recommend and manage waiting list policies. That is a too operational issue, that should be dealth with at a national level. We do not want to replace existing health systems in member states, but to ensure that the European level facilitates through flanking policies. We can best identify what is missing, tap into the expertise around Europe and share it among members."* [47]

> *"We want to keep health care mainly on the national level"* [48]

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[45] Tamsin Rose, EPHA European Public Health Alliance

[46] Health Attaché at a Permanent Representation

[47] Dr. John Bell, cabinet of David Byrne, DG Sanco of European Commission

[48] Health Attaché at a Permanent Representation

The trick is therefore to achieve with public health action programs, health care related effects for the citizens. In that a trend can be observed towards "empowering public health" and away from "protective public health".

> "We cannot have a risk free society"[49]

Member states seem to be generally on the same track. Research has indicated that for most of the member states, the traditional promise of protecting the citizens from all evil, and in return covering all expenses related to health provision, has become an unfinanceable proposition. Modern health programs are targeted towards strengthening individual responsibility, instead of burdening solidarity.

> "I think there must be some hard mechanisms in the systems to control costs through personal responsibilities. Otherwise the aging demographics will make the costs of health provision just too expensive."[50]

The large majority of industry has also indicated to prefer to have "informed consumer" based market mechanism for providing health goods and services (except where they have vested interests in protected niches), which makes the "pro- protective" faction an increasingly lonely camp. It could very well be, that the latest big victory on combating GMO (genetically modified organisms) foods, has become a similar phyrric victory to the public health NGO's as the Brent Spa turned out to be a post-factum disaster for Greenpeace: the battle was won, but the credibility was spent.

> "To my knowledge, nobody has died from eating a GMO. But here in Europe we have been suffering from what might be called GMO psychosis. With GMO's we have a very clear example of something that poses little if any risk, but which has proven to be unacceptable. There has been a massive communications failure – mainly on the part of the industry I have to say."[51]

Since the GMO protests in Europe in 1998/99, planted hectares of transgenic crops have risen by 50%, and an end to biotechnology driven agriculture is still not in sight. [52]

The breadth of perspectives among the interviewees was even wider on this strategic question, whether to place more emphasis on public health and health care, which is not in the least caused by the fact, that the borderlines between the both fields are increasingly difficult to define, as was explained earlier:

Chart 10: Stance of interviewees

As the borderlines between public health and health care are blurring, it should be considered for one's own strategy, which are the least necessities that Europe will need to serve, and where Europe's special opportunities for additional value creation are:

Chart 11: Matrix

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[49] David Byrne, on his website under key quotes and key messages to EU citizens

[50] Health Attaché at a Permanent Representation

[51] David Byrne, on his website under key quotes and key messages to EU citizens

[52] The Economist, March 29th 2003, Survey of biotechnology, page 12

Chapter 4:

Instruments for Implementing the Health Agenda –

The Power of Coordination and the Power of Legislation

Traditionally, states have two sources of power: the power of legislation to enact laws through parliament, and the power of administration to put the law's intentions into practice. As the European project progresses, it increasingly transpires that a third state instrument is being invented, the power of coordination. It has become a standard instrument for virtually all EU policy areas to set up so-called "Processes". Even though these Processes carry no legally binding force, they have become powerful instruments for achieving something in the European Union. This chapter will examine the power of coordination vs the power of legislation with regards to the subject of health.

Processes: Necessities and Opportunities in the Power of Coordination

Most interviewees refer to the European processes as a somewhat ominous procedure. They essentially consist of four elements: a) a pre-planned meeting cycle (typically annual or biannual); b) a protocol of interaction; c) a roster of allowed participants; d) a subject area to talk about.

For instance the before mentioned "Lisbon Process", felt by many as probably the highest level Process around, meets once a year. The participants are the heads of the member states and their entourage during the spring Council meeting. They are interacting with each other on the basis of benchmarking and measurement reports which the Commission is preparing in the meanwhile. The subject is to identify actions for the EU, and to compare progress on the national level, that will turn Europe into the world's most advanced and competitive economy by the year 2010.

> *"I favor an approach for voluntary participation in benchmarking processes. They are an excellent inspiration for policy making at home"* [53]

> *"Health monitoring is an example for what we believe should be dealt with on a European level by cooperating and building best practices."* [54]

The whole purpose of the Process is, as an adept stated, to exchange information, to learn from each other, and to coordinate actions. While this may not sound like much, it is infact a very sophisticated structured approach to hammer out policy. It replaces the infamous smoke filled backroom with a transparent, professional and official forum for agreeing and achieving.

> *"When in a benchmarking report France emerged occupying the first rank, the other countries became quite curious. Coordination could be a natural process for governments to learn from each other and grow together."* [55]

It was widely agreed that the non-binding character of the Processes does not mean that they are not under pressure to achieve tangible results for reforming and advancing the European project. Processes are pressured for results from, mainly, four directions:

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[53] Health Attaché at a Permanent Representation

[54] Jim Murray, BEUC, European's Consumer Organisation

[55] Health Attaché at a Permanent Representation

- From other Processes (with and without representatives from the NGO community, professional associations and industry participating)

- From the more traditional legislative side

- From the European Court of Justice

- From executive powers vested in European supervisory authorities, (the most powerful ones being the European Central Bank and the DG Comp, the competition authority)

A previous chapter mentioned the "Malaga Process". There the national Health Ministers agreed to meet informally to begin considering joint policies. How carefully conducted this action is, can be gleaned from the concluding paragraph of the summary of their meeting:

> " *If it is deemed advisable, the results of the Menorca meeting will be referred to the Council Health Group in order that they may be referred to the COREPER and, from there, to the Health Council where the possible approval of a formal conclusion can be considered".[56]*

Infact, so far this Process is not even recognized officially as the "Malaga Process", but some Processes never earn this official title. Once a Process is established it usually has its own website and remains very transparent to anybody who is interested.

Apparently the Malaga Process is getting started, because otherwise the European Court of Justice will shape health policy instead, as the Health Ministers are recognizing and openly complaining about. But not only the ECJ is a concern, the Lisbon Process has for example gotten an action under way to create the European Health Insurance Card on the basis of the free mobility principle, and DG Enterprise is getting highly restive on copyright issues for European pharmaceuticals, because it wants to promote opportunities for small and medium sized European companies. The legislative process is producing EU wide food laws with health implications and an European Food Safety Authority is encroaching on health as well. Then there are numerous other minor Processes such as the "Cardiff Process", which deals with economic reforms for a free internal market for financial products and capital. Cardiff is already dealing with funded retirement schemes, but of course health insurances are also a financial product. The Luxembourg Process is dealing with unemployment schemes and so on. If the Health Ministers would not take the initiative to draft a European system of health, then the rest of Europe will do it for them. However, as was in particular voiced by the interviewed NGO community, this does not make their work easy either:

> *"The impact of lobbying of the various actors is very different according to the means at their disposal. For example, the pharmaceutical industry lobby takes a strong position especially at DG Enterprise, but also at the European Parliament. Civil society generally finds better understanding with DG Social Affairs and DG Sanco. There is ambiguity about the domain of which DG a topic belongs to – and everybody tries to get it on the agenda of the DG where they have the strongest ties with."[57]*

Background research on similar developments in other sectors indicates that in this way, a Europe of Health is becoming a seemingly unstoppable self-fulfilling prophecy, if in eratic fashion. The mere fact of talking with each other produces on occasion amazingly fast results. For instance as late as 1993, discussions in the EU to create a liberalized, internal market for energy were opposed by almost every member state as well as the largest part of the European utility industry. The national energy systems were deemed to be too much tied in to local systems of government, and the role of the state in each nation too different as to find a useful common approach. Furthermore, every member state had its own ideas of how to deal with network monopolies, and felt responsible for fulfilling political obligations of

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[56] Summary of the Meeting of Ministers of Health on February 8th, 2002

[57] Willy Palm, AIM, Association de la Mutualité

universal access to energy and the like.[58] Yet, only three years later in 1996 a European law came into being, that created in effect a European largely liberalized internal market for energy. In 2002 a follow-up law was issued, even with the unthinkable title only a few years ago "Completing the Internal Energy Market ", a law that was supposed to close various gaps in the first round of decisions.

The relative success of creating a unified system of European energy markets, though still far from perfect, was largely attributed to the fact of talking and learning from each other in the course of the legislative process at the Council of Energy Ministers and the Commission. In order to continue that beneficial effect of exchanging knowledge between member states governments, regulators, companies and consumer groups, the "Process of Florence" was started for the electricity industry, whereby delegations descend on Florence twice a year to thrash out the agenda for European electricity. The same is happening in the "Process of Madrid" for the gas industry. The example of the energy industry also shows, that even once an internal market is created, the role of the government, national or European, is far from finished with its task to provide guidance and supervision to the industry.[59]

> *"It would be nice to emulate the pace of Europeanization in the energy industry, unfortunately the health markets are so much more difficult."[60]*

Officials and industry executives from the energy industry would probably beg to differ with that statement. At any rate, there are also equivalents of such Processes in the health sector, according to the interviewees. They refer to the "EU Health Forum" (the discussion group of health lobbyists which is sponsored by the EU Commission), and the "European Health Forum Gastein" (EHFG) (which is the annual event by policy makers, industry and NGO's to determine the future of health in Europe. The EHFG was co-founded and is heavily supported by the EU Commission).

> *"Not everyone is invited to the EU Health Forum, but everybody wants to be there. That seems to be a signal that it is an important group"[61]*

Laws: Necessities and Opportunities in the Power of Legislation

As the example of the energy markets shows, ultimately even "Processes" result in various European laws. As powerful as the Processes of coordination are, they are in the end non-binding and unenforceable. When asked about this limitation, most interviewees would agree that also within the EU, a law provides a more reliable and a better secured platform of action. However, this was only from an academic point of view. As the chart on this clearly indicates, in reality many of the interviewees advocate a more pragmatic approach. Not however the DG Sanco:

> *"It is surely time to entrench firmly the health of our citizens into the new Treaty. So that we can continue to build the Europe of Health that our citizens demand, and that our citizens deserve."[62]*

To explain their preference, interviewees point out at the disadvantages of the EU legislative process. It is, that it is surely the most complicated legislation process in the world. This is supported by observations that each year, about 200 laws and several thousand executive

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[58] "Policy Learning in Embedded Negotiations: Explaining EU Electricity Liberalization", by Rainer Eising, Massachusetts Institute of Technology, 2002, p. 93

[59] "An Industry in Search of its Future", research study on the challenges for the European energy industry, by Strategy Academy, available on website of Strategy Academy.

[60] Lisette Tiddens-Engwirda, CPME, the Standing Committee of European Doctors

[61] Lisette Tiddens-Engwirda, CPME, the Standing Committee of European Doctors

[62] David Byrne, at the European Policy Centre on October 29th 2002

acts are in fact being adopted through the EU Institutions.[63] There are a number of different voting systems in place, whose applicability depends on the subject and the chosen legal instrument. A broad portfolio of legal instruments are available, for instance (in somewhat descending order of force): "Treaties", "Regulations", "Directives", "Guidelines", "Mutual Recognitions", "Conventions", "Decisions", "Agreements","Compromises", "Benchmarkings", "Self-regulation", etc. For so-called "hard" legal instruments, i.e. enforceable by the Courts, the three most important voting systems are the qualified majority vote in the Council (QMV), the unanimous vote in the Council and the Co-decision procedure with EU Parliament.

> *"It is very difficult to get hard laws enacted, so therefore soft laws are expedient. They are de facto the only instrument available in the short term"* [64]

For health related measures (especially public health), normally the procedure applies where both the Parliament and the Council have to approve of it. If one of the two do not approve of it, a Conciliation procedure starts, where the two, with assistance of the Commission, try to narrow their differences. In other instances, a European law will be decided by the Council alone.

Some Council decisions require the QMV, others require the unanimous vote. The counting of QMV, and how it influences the decision making process in the Council, is a science in itself, according to a veteran adept. Very simplified, it is tried as much as possible to decide unanimously, since it is considered a precious good to have everybody "on board", and not to railroad over some disagreeing member states. On the other hand, disagreeing member states are disciplined by the fact, that if they are too obstinate, then they may be trounced by qualified majority and lose influence on the outcome.

Voting in the Parliament is barely more straightforward than in the Council. By necessity, Parliament is a mosaic of national interests and political factions. Where the majority will be on any particular decision is difficult to fathom in advance, unless a lot of lobbying and fact-finding is being done prior to the voting date. In the view of some of the interviewed officials, NGO's and special interest groups, do not appreciate the required effort for the legislative process.

As said, in order to become law, a measure has to pass both of these complex institutions. Some interviewees describe it as fascinating that law-making happens at all, and that is in no small degree due to the general willingness of all parties concerned to place good solutions above burocratic bickering.

> *"For the actions in health care, there is not such a clearly defined legal basis in the Treaty as with Article 152 for public health. Therefore health care related conclusions are usually introduced with a wording, making clear that the Ministers are explicitly speaking in their national responsibility, not just as parts of the European institution fo the Council."* [65]

Summaric observation

By and large, the legal basis for a Europe of Health is weak, and at the point of writing this report, the health agenda seems to be fighting rather a rearguard battle for the next Treaty to even maintain the small basis it has, than a forward thrust to enlarge it. This is exemplified by the current controversy on whether health should remain in Article 12 of the Constitutional draft text, stipulating the "shared competences", and already its absence in Article 3 of the goals of the European State. A shared competence is "worth" less than an exclusive

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[63] "Governing Europe" by the Clingendael Institute, The Hague November 2002

[64] Alan Howard, ESC, European Society of Cardiology

[65] Health Attaché at a Permanent Representation

competence of the EU, because in it policy making must be divided (shared) between the EU and the member states. Without even this "shared competence", however, the EU would have no higher legal mandate for its health policies at all.

> "We need to have a better legal framework in place, so that on a number of important issues we can speak with one European voice"[66]

At the same time, the executive powers of the EU Commission and the Processes of Coordination for the health agenda are just picking up steam. For instance, the European Health Forum Gastein as well as the EU Health Forum are getting into full swing, the 6-year Public Health Action Programme has just been kicked off in March 2003, the European Food Safety Authority is being established, and already Commissioner Byrne is putting forward proposals for a European Centre for Disease Prevention & Control, and furthermore he is promising for later in 2003 a new "Communication on the EU's role in health policy". Byrne is confident that:

> "Together with the Public Health Programme, these initiatives will put health firmly at the centre of EU policy making".[67]

Advocacy groups active in the health arena clearly voiced that a lot is at stake, whether David Byrne can succeed in his mission and in his vision of a Europe of Health. They are called upon to direct their own messages and efforts to the right targets.

The European Convention has 102 members. Only two are from the EU Commission, 16 are from the EU Parliament, 28 are representatives of member state and candidate governments and 56 are representatives from member state and candidate parliaments. This composition shows clearly, that advocating at this body is more fruitful if conducted through a coordinated project of influencing the national representatives, rather than through Brussels.

The same is true for Council Working Parties, which acts on instruction and in interaction with the ministries in the national capitals. Advocacy at the Council for either more or less health competence in the EU, will have to address member states governments also directly.

> "Good lobbying must happen at home as well"[68]

If the target of the advocacy is not the upcoming Treaty or the Constitution, but more specific health measures winding their way through the legislative process, than the right body to address one's concerns to seems to be the European Parliament, as was indicated earlier. Parliament has the possibility to co-decide on public health measures and is therefore a powerful partner in the legislative process.

> "For NGO's, as far as Brussels is concerned, the Parliament and the Commission could be regarded the preferred place to go and advocate. The Council side requires national lobbying even more than addressing the Permanent Representations, which act on instructions. But of course, one of our tasks is to transmit to the national capital arguments and developments which we learn aboutin Brussels." [69]

The authors observe, that the original intention of the institutional triangle was, that the EU Commission would have the exclusive right of initiating legislative texts. If that was so, advocating at the Commission for legislative drafts would make sense. In practical reality, the Commission has seen this power been diluted substantially. By its own counting, the Commission today will start only 10% of all legislative proposals on its own initiative.[70] In health, its powers are particularly curtailed due to the weak legal basis and a sceptical Health

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[66] Dr. John Bell, cabinet of David Byrne, DG Sanco of European Commission

[67] David Byrne in a press release on March 18th 2003 on the launch of the PHAP

[68] Dominique Taeymans, CIAA, Confederation of the food and drink industries of the EU

[69] Health Attaché at a Permanent Representation

[70] European Commission: Better Law Making 2001, COM 2001, 728 final, Brussels 7. Dec. 2001

Council. The Commission therefore seems to have taken the route to throw its efforts behind Processes of coordination and institutions building, and thereby create "facts on the ground", with a deep legal basis or not. For advocacy groups that probably means, if they want to participate in the Commission's game, than they need to become part of the Processes.

As is the case in the previous chapters, the full range of perspectives on preferences for instruments is represented here. Again, when formulating the strategy the basic necessities of the European level, due to the inevitable character of certain issues, must be respected, and the opportunities be evaluated for one's own purposes:

Chart 12: on stances of interviewees public health

Chart 13. health care

Chart 14: Matrix

Chapter 5:

How to implement the Health Agenda –

Mastering Expertise and Mastering Networks

Much of the previous chapters have illustrated, that creating policy in general, but creating European policies with added value and innovative ideas even more than usual, involves a lot of talking and meeting with each other. Paradoxically, it seems that since everybody is so very busy in talking with everybody else, it is in fact difficult to get access to talk, in particular with the key decision makers. This is even more the case for 'newcomers' to the Brussels forum of policy making. In order to be heard amidst all that talking, one must contribute something special. Broadly speaking, the research suggests that this something special can either be valuable facts and expertises, or it can be the representation of a significant large stakeholder network.

Neccessities and Opportunities in Mastering Expertise

By and large, the EU Institutions are described by most of the interviewees as a fact-driven, professionally-conducted forum of policy making. It is generally felt that if an organisation has valuable facts to contribute, it will be given a fair chance to make its point.

> *"Our approach has been mainly to produce studies and assemble facts to substantiate our views. On that basis, we are invited to participate in several important reflection groups"* [71]

Commanding the facts, and knowing one's way around appears to be a basic ingredient to be taken serious.

> *"'Facts and figures' are important tools in the negotiations and crucial if you want to persuade other parties. NGO's which impress me are well aware of the EU-decision making process and institutional matters."* [72]

But, as everyone is aware, creating facts is expensive. It involves research, making sense of the findings, presenting and distributing the results in a fashion that the intended audience is enticed to read it and can understand it, and so on. Good ideas are available a dozen a penny, well founded facts are hard work to produce.

> *"We are continuously working on building and updating our expertise. On food for example we have 20 experts within our member organizations that are full-time dedicated to this"* [73]

But they would be appreciated. For instance, several interviewee partners had a hightened interest in the following:

> *"I would like to have an economic model that shows how health functions as an investment, and not purely as consumption. Then the cost argument could be contextualized, and we could begin talking about productivity and wealth creation instead. That could serve to strengthen the public debate."* [74]

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[71] Willy Palm, AIM, Association de la Mutualité

[72] Health Attaché at a Permanent Representation

[73] Jim Murray, BEUC, European's Consumer Organisation

[74] Dr. John Bell, cabinet of David Byrne, DG Sanco of European Commission

Some interviewees, who represent a large constituency with many different interests, stated that there is another risk with being a facts-supplier. If the debate moves on to a different subject, to where one happens not to have spend the past three years of research, then one has nothing to contribute anymore. Developing a highly pinpointed expertise carries the risk of being off-target or out of fashion for a while. But what to do in the meanwhile?

Necessities and Opportunities in Mastering Networks

From all interviews concerned, and supported by further research, one gets the clear signal that the EU Institutions appear to be desperate about connecting to their citizens. Any organisation, that can credibly speak for a significant group of stakeholders and communicate back to them, will be included in the policy creation process.

> *"We are invited to participate in many places, because we represent 1,6 million doctors around Europe. We tell our discussion partners, that by the time that we have reached a position on something, we have already gone through Europe once. Meaning, we have already created a position, which all the national member organisations can agree on. That is what makes us strong."[75]*

And although this is not always possible because of limited internal mandates, several interviewees regret the lack of pooling momentum for what should be a common goal for all. One interviewee exasperates:

> *"Why don't we have a Greenpeace for public health? Public health used to be the origin of all these movements, where the environmental movements started, the social reform movements came from. But public health itself has lost its history, figureheads and power."[76]*

Another interviewee sheds some light on this as he adds his own observation:

> *"Interested parties all want the same goal, which is a successful Europe. They may not always agree on how to get there. But why can we not focus on where we have common purposes and common paths?"[77]*

Working together and pooling resources will also help to attract and use financial resources:

> *"The key word is 'European value added', when applying for EU research funds and programs. Organisations, which are networked across Europe, have a particular opportunity to illustrate how in the course of their project, European value can be created (eg. by mutual learning, synergy effects in the development and implementation, etc.) "[78]*

Observers from the NGO community also note, that there is a still small but growing awareness among their thought leaders that working together with even the industry might yield better results for both[79]. Whether the industry is part of the problem or is part of the solution, they have a competitive advantage when it comes to knowledge, means and access to key decision makers. Given the complex nature of many challenges to modern society, of which Public Health is definitely one, it is naïve to think that governments and NGO's can tackle those without the help of the profit sector. Moreover, increasingly the NGO's have also

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[75] Lisette Tiddens-Engwirda, CPME, the Standing Committee of European Doctors

[76] Tamsin Rose, EPHA European Public Health Alliance

[77] Dominique Taeymans, CIAA, Confederation of the food and drink industries of the EU

[78] Health Attaché at a Permanent Representation

[79] Jean-Francois Rischard in *High Noon – Twenty Global Problems, Twenty Years to Solve Them,* 2002

something to offer to the profit sector (expertise, access to stakeholders), so a more balanced relationship could emerge.

Of course, the disadvantage in being a network manager is, that for all the momentum that it might create, one has less chances to retain a specific message. One's own specific ambition is easily drowned by the wave of power created in the network, as is summarized by the following remarks:

> *"There are 10.000 to 15.000 industry representatives in Brussels and we are the only consumer platform. We place a high value on interaction with industry representatives, but there are so many of them that it is impossible to respond to all the requests for dialogue"* [80]

> *"It is a bit difficult to prioritize actions. In my structure I have more than 80 member organizations advocating policy ranging from the need of installing better mirror systems on trucks, so that fewer children on bycicles get killed, to promoting sustainable agriculture."* [81]

Finally, as any organization, one needs to know where to focus one's energy in order to be effective:

> *"We need to focus our efforts. Public Health, for instance, is not one of our main topics."* [82]

Summaric observation:

Brussels works with scientists from universities all around Europe to assemble and sort the massive amounts of facts it needs to feed the information requests of all its Processes, Benchmarkings, Working Groups and the like. Furthermore, EU-Brussels is a government of highly-trained and well-versed technocrats, who typically constitute a preselected elite from their national home bases. Underfunded as many advocacy groups typically are, it is a tall order for them to build a reputation by regularly contributing striking fact-based insights or innovative solutions, that all these scientists and technocrats have not considered already as well or do not have access to from a neutral source.

> *"The European Commission and the national governments are the key forces in determining the outcome of the political debate. Our role is to voice concerns from our members working in the field"* [83]

The strategic opportunity for advocacy groups seems to be rather on the other end, to be a communication channel to and from the EU citizen, to be a manager of networks. Every interviewee has confirmed the perceived "remoteness" of the EU by the citizens. If there is one pervasive theme running through documents of any EU institution that one looks at, then it is the concern about how to "connect" with the EU citizens. By answering this desperate call for help, is where advocacy can build its own home base for the next number of years.

> *"Gradually the ESC would want to become a point of reference to the European citizens and medical practitioners on heart health related measures"* [84]

The impression one gets from the interviews is, that in general the advocacy groups are not yet making much of that strategic opportunity. Instead, there seems to be a lot of energy spent on internal coordination inside the groups, and friction within the advocacy community.

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[80] Jim Murray, BEUC, European's Consumer Organisation

[81] Tamsin Rose, EPHA, European Public Health Alliance

[82] Dr. Bernard Maillet, UEMS, European Union of Medical Specialists

[83] Willy Palm, AIM, Association de la Mutualité

[84] Alan Howard, ESC, European Society of Cardiology

The first energy sink, is probably a reflection of European reality. The same complexity resulting at the EU Institutions from accommodating the overwhelming rich diversity of the European societies, seems to afflict the advocacy groups as well. It also appears, that just like the EU Institutions, the more structured an advocacy group goes about channeling that diversity into organised forums of interaction (Processes), the more functional and effective the organisation becomes as a result.

> *"We would like to stimulate a lot more structured networking among all stakeholders"[85]*

The second energy sink, the friction within the advocacy community is more puzzling. The community appears to divide itself up into many camps. For instance the "in for the money people" vs the "for the good of the people people". Or the "cure and care people" vs the "prevent and stay healthy people". Or of course "the anti big bad tobacco people" vs "on the tobacco payroll people", the "don't care GMOers" vs the "anti GMOers" and several more. Not only is there only little cooperation across these divides, there also seems to be high amounts of suspicion and even disdain across them. As was stated earlier, it appears that this conduct of the European advocacy community represents a missed opportunity both for its own effectiveness of working in Brussels, but also for relating the European project to the European people.

One general judgement of an EU official working in Brussels since three years should given reason to think:

> *"We do not like working with NGO's, because their voices are generally very weak, and they are more interested in accusing than having a dialogue. There are a few exceptions, for instance the NGO for disabled people".[86]*

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[85] Dr. John Bell, cabinet of David Byrne, DG Sanco of European Commission

[86] Health Attaché at a Permanent Representation

Part II

Chapter 6:

The Wider Context for a Europe of Health –

Is a European statehood being created?

It was expressed frequently in the interviews, and is referred to as much in the report, that European citizens feel too "unconnected", "detached", or "sceptical" towards the EU and its institutions. The "too", of course is a value judgement, and begs the question of "too" in respect to "what" ?

The European health debate is unfolding while Europe as a whole is being shaped. It is therefore useful to illuminate this wider context as well, which is constituting a noisy background to the European health developments. For those however, who find themselves being part of the Brussels forum of policy making on a day to day basis, this chapter may be a familiar read and can therefore be skipped.

The development of the European project

Since the middle 80's, European nations have been undertaking fundamental and rapid institutional changes in their governance structure on a large scale. Starting with 1986, Europe has produced four major intergovernmental Treaties (Single European Act, Maastricht, Amsterdam and Nice) and numerous minor Treaties, each completing another step towards an unprecedented and unknown form of supranational statehood, whose final shape only few dare to foresee.

The year 2004 will be a climactic landmark year for the European project on that path, and it is the year 2003 which is the busy ramp up to that. The EU has offered 10 new countries to become a member, who, barring any surprises will join in 2004. Also in 2004, the EU is embarking on yet another round of intergovernmental negotiation which will yield yet another Treaty. In 2004 the European project has to determine whether it is ready for a Constitution for Europe, and if so, what it will be. The timetable for attempting the creation of a Constitution was decided in December 2001 by the member states, because "the Union stands at a crossroads, a defining moment in its existence."[87]

May be the most important event in 2004: the European Parliament elections in June. These elections could well turn out to be a de facto European referendum on the European project. They are the first election after the introduction of the Euro, after the enlargement of the EU from 15 to 25 member states, and after the Nice Treaty, which has tried (and in the eyes of many, failed) to simplify the governance structures of the EU.

Thus, the year 2004 has the potential to enter the history books as either the rise, the "1776", of a European statehood, or the opposite, of its continued limbo or even demise.

There are no clearly delineated battle lines of opposing camps towards how the European project should develop further. But two of the most notorious, and so far unsquareable views on that development, can be called the *federalist* and the *intergovernmentalist* views. The federalists believe, that ultimately the EU will acquire its own statehood identity, with due respect for the subsidiarity principle vis a vis the national governments being bound into an integrated, federal structure. The intergovernmentalists instead see the EU only as a deepening alliance between nationally elected governments of sovereign states.

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[87] The Economist, 28th February 2002

The trend in the past, especially in the recent past, seems at first sight to have gone the federalist way. With each round of Treaty negotiations, the European institutions have been acquiring new and deeper functions and powers more typically associated with sovereign nation states, such as:

- a common currency and an independent central bank
- free internal movement of goods and people
- an elected, representative parliament with real legislative powers
- a central ministerial burocracy with supervisory powers and enforcement capabilities (the European Commission DG's and assorted executive institutions/agencies)
- a functioning policy-creating government (European Council/Commission College)
- a permanent seat of government (in the Eastern Center of Brussels)
- a significant budget with reliable revenue sources
- a military presence (just set up)
- a high court system with the power to override national courts
- a police for criminal investigation (Europol)
- a network of ambassadors (though called differently) throughout the world
- the removal of internal border controls
- the harmonisation of infrastructure networks
- a flag
- an anthem (based on Beethovens 9th symphony and in use since 1986)
- a Europe day (May 9th, the day in 1950 when Robert Schuman proposed the creation of an organised Europe, known as the Schuman declaration)
- a citizenship (in addition, not instead of the national citizenships)
- and possibly soon even a constitution

For intergovernmentalists, this list is nonetheless not a reason to despair. In the end, a state also needs citizens, and so far only a minority of people in Europe seems to believe or wishes it to be seen, that the EU has become for all practical purposes a state by itself. For instance, if only the fewest people know of the European anthem, than that may be due to the reason, that at the typical occasions where anthems can be heard, such as at international sport and music events, the EU is not on the start as a state. May 9th is also not exactly known for extensive celebrations across Europe. Only 31% of all EU citizens know that they are EU citizens and are aware of what that means. 32% have never even heard of EU citizenship.[88]

More formally speaking, intergovernmentalists would point out, that so far it has not been clarified under international law what the legal identity of the EU would become, or whether it can have one at all. Can the EU be a signatory to international treaties?

Another key ingredient to statehood would be the ability to tax its citizens. That has been proposed already a number of times, but so far it has been firmly rejected, and therefore the EU budget is financed exclusively from member state government budgets. If "money" is "power", then the EU is certainly in the hands of the paying governments, and not a state by itself.

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[88] Flash Eurobarometer 133, on European citizenship in October 2002

It might also be the case, that both the federalists and the intergovernmentalists are right as well as wrong in equal measure. Quite possibly, the European project is inventing a new form intergovernmental statehood as it goes along. Just as the United States of America was a new form of federal statehood for its day, and as the republican European nationstates of the 19th century were an innovative replacement for the feudal bonds of monarchy, Europe may currently be inventing a new and so far unprecedented form of statehood.

What is in it for the European citizen?

As long as the statehood character of the EU in European civilian society is not clarified, its legislative and regulatory actions are continuously threatened by a lack of a strong mandate from a committed citizen base. But regardless of whether the federalists, the intergovernmentalists or a combination of both, will carry the day, the question remains, why the European citizen is seen to be "too" unconnected to the EU.

Among scholars, there are a few main hypotheses for why Europeans are sceptical or even unappreciative about the EU institutions. Some commentators believe this to be part of a wider trend, according to which a better off and better educated European population is generally sceptical of distant elite's ability or legitimacy to govern their polity, be they political, economic or burocratic elites.[89] If that is true, then EU Institutions have a difficult stance vis a vis their national counterparts in the member states by no fault on their own, just as national institutions have increasing difficulties governing vis a vis their regional counterparts. Plausible as that may sound, in fact the EU Institutions enjoy in general a higher level of trust from the EU citizens than the national governments do. 53% of EU citizens trust in the UN, 46% trust in the European Union, and 39% give their trust to national governments.[90]

A different source of scepticism might be due to the fact that the European project is still under construction. There is a simple practical side effect to the fact that the European politicians are more or less in a permanent state of Treaty negotiation. Mainly, this imparts the impression to the common European citizen of a permanent condition of politician's squabble. A more detailed look at the trust levels in EU institutions seems to bear this out. European Parliament leads with 54% of the citizens tending to trust it, followed by 49% for the ECJ, 47% for the European Commission, 47% for the European Central Bank and then finally the Council of Ministers, where differences of opinions are most visible to the public, with only 41%.[91]

With hindsight, the time scales involved in the historical statehood building exercises such as the creation of the United States of America in the late 18th century or the momentuous debates in Europe in the middle of the 19th century get compressed to a few pages in a history book, with many of the failed experimental strands of thinking and discussion not being illustrated anymore.

If such events are unfolding in real time, as they currently do in Europe, they appear inefficient, glacial and even irrelevant to the onlooking public – yet they are not, because the principles and laws that are being hammered out in the process, are likely to last for many centuries, and shape the way people think and live for dozens of generations to come. Europeans are generally prepared for that. 63% approve of the principle of a European Constitution.[92]

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[89] Michael Newman, "Democracy and Accountability in the EU", in Jeremy Richardson (ed.), European Union: Power and Policy-making, London: Routledge, 2001.

[90] Eurobarometer 57, asking 16.000 citizens in April 2002, p.5

[91] Eurobarometer 57, asking 16.000 citizens in April 2002, p.8

[92] Eurobarometer 57, asking 16.000 citizens in April 2002, p.9

Still, unless one takes particular pride or academic interest in being a contemporarian of such a process, it should be acknowledged that there is nothing really spectacular for the common European citizen about this! So why should he or she get excited about it – or even suffer the consequences of failed experiments and second tries as the governing elites are trying out how it could work? Unless, EU citizens are in a situation, where they knowingly rely on the EU to provide an efficient service for them, "the resilience of existing systems of governance at the domestic level is too strong to permit a sense of belonging to Europe".[93]

Furthermore, a historical peculiarity of the creation of the European statehood is that it appears to be driven entirely by pro-creative voluntary forces. The USA arose from the power struggle against its colonial ruler in England, the structurally still feudalized states of Europe in the 19th century needed to come to terms with the radical transformation of the economic fabric of society brought about by the industrial revolution. None of these reasons apply to the definition of the European statehood. The creation of Europe is not a defensive act, it is neither externally nor internally under a political, military or economic threat (anymore). It is already the most potent economic power in the world (an honor it swaps with the USA depending on which statistics one wishes to believe in), and there is a lengthening queue of nations who want to join and effectively surrender their sovereign powers to become part of this venture in whatever form. This very lack of that threat, makes the steady advancement of the European project an even more tenuous affair, as the narrow base of support for it could falter at any moment, once people might call for explicitly, that "enough is enough".

As an observing scholar interested in history and political processes, it is easy to be either fascinated or horrified with a European statehood emerging. But concerning the general public, the academic school of "public choice" or "economethics" may provide a useful clue, as it takes a more pragmatic view of these developments.[94] According to this school, the modern industrialized economies have produced a departure from preindustrial moral and value systems to which the people are subject to. Instead today, morals and values are subjected to the people. Something is "good" , if it helps the individual to achieve the maximization of his financial and emotional welfare, and "bad", if it does not. Therefore, federalist, intergovernmentalist or any other "–ist" or not, very pragmatically, if the EU can prove to deliver an increase of economic and emotional welfare, then it is good, and if not, then it is not good.

It is exactly that "daily life impact" for the European citizen, that is somewhat elusive. One of the most ambitious, and also least contentious programs of the EU, the creation of a single internal market, has in its decade old existence yielded only 1,4% of additional GDP for the average EU citizen.[95] Granted that it is a positive number – but a 1,4% increase per decade (!), is unlikely to impress the EU citizen.

Other major initiatives of the European project are not unquestioned and resounding successes either. To have a common currency is certainly convenient, but unfortunately its introduction coincided with one of the worst economic downturns of postwar history – and rightly or wrongly the EU citizen may associate the one with the other.

It is also convenient to have open borders when travelling around, but the openness goes both ways. Significant portions of the national electorates are concerned about the crime and cultural stress arising from immigrant populations and therefore feel uneasy about the open borders – even if the factual connection between the Schengen Agreements and immigrant problems is highly doubtful.

Then there is the regulatory debacle of the enormously expensive common agricultural policy, one of the earliest and most change-resistant common policy areas of the EU, for

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[93] Laura Cram: "Governance 'to Go': Domestic Actors, Institutions and the Boundaries of the Possible", Journal of Common Market Studies, vol. 39, no.4, pp. 595-618, quote from p. 613

[94] For instance Prof. Karl Homann at Ludwig Maximilian University in Munich, Germany

[95] The Economist, March 13th 2003, "Still sclerotic after all these years"

whose progression nobody seems to find an appropriate path, even if regulators, farmers and consumers alike are in large agreement for the need of radical change of the system.

Most recently the unsightly divisions of EU member states over Iraq foreign policy has not only blown to pieces the Second Pillar of the EU, the common foreign and security policy – more importantly, it repeated the reckoning to the European citizens that their governance structure, national or otherwise, is not strong enough to prevent the USA from taking actions that the majority of Europeans strongly object to.

In other words, if the EU delivers the goods, then it will not have to worry about its legitimacy. To quote EU Commissioner David Byrne for the final time in this report:

> *"Perhaps all this would be clearer to our citizens – if we were obsessed a little less about Europe, and a little more about Europeans."*[96]

What does all that mean for Brussels-based organisations?

The EU Institutions of the emerging European statehood are an amazingly complex system of governance, which is often frustrating to non-insiders. Even a simple glossary of "what is what" as in the glossary of this report, is already confusing. The European project, however, is not complex by its own choosing – the complexity arises from the dual fact of creating a new and unprecedented form of governance and statehood, and doing so for a continent full of highly sophisticated peoples, who treasure their freedom and their diversity.

In the estimation of the authors of this report, and in fact most others who deal with the EU on a regular basis, the EU Institutions are not, however, byzantine. The EU Institutions are trying their utmost to be transparent, to conduct their affairs in a professional manner and to base their proceedings on solid facts and broad consultation. Working with and for the European project is therefore neither fruitless nor unappreciated – it is just simply very hard work!

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[96] David Byrne, at the European Health Forum on September 26th 2002

Chapter 7:

Successful Strategies for the Dawn of European Health

This chapter brings together the various strands of analyses presented throughout the report and ventures proposals for successful strategies for the EHN and its member organisations across Europe. The analyses so far have represented the evidence as they were found, while leaving the final conclusions from them still open to the reader. This chapter will now stake positions. When deciding on a strategy, one needs to close down options, and decide in favour of a particular course of action. In other words, it requires casting a judgement on the four key strategic questions on what their ultimate import is. The following represents how the authors of this report would judge the evidence. This aims to constitute a basis for discussion on the strategic choices that the EHN has to make regarding their own mission objectives and organization positioning vis-à-vis the other stakeholders in the Brussels forum of policy making.

Key Suggestion I :

Develop a European agenda for a European approach.

Main logic:

The center of gravity for action on health policies across Europe has been shifting to the European level. Until only a few years ago, even public health played only a minor role on the European level. Now, public health policy has moved to the center of policy making in Europe, and health care policy is following rapidly in its footsteps. Since that is a relatively new development, national stakeholders may not yet see this development and may therefore be reluctant to submit themselves to a European approach. However, the sooner the organisation adjusts to this new reality, the better its strategy will be suited to the policy and business demands of the future health market. Those, who do not adjust to this new reality will in the medium term become sidelined.

Core arguments:

- Since almost every other national area of policy making is being dealt with on a European level, this institutional pull invariably draws health policy into that same stream of creating compatibility, coordination, harmonisation, or even integration.

- As the national health systems are increasingly failing politically to deliver affordable quality in health provision, the European level institutions are eager to score on that subject in the hearts and minds of the EU citizens, and thereby prepare the grounds for a "big idea" to support Europe.

- Common aging demographics, common financial sclerosis and the common currency provide a strong European economic framework to force health policy to live up to the unmet economic needs and expectations of the EU citizen in that sector.

- Contrary to common perceptions, the average European citizen in fact trust their European "government" more than their national governments. There should not be a per se reason, that Europeans reject health policies to be dealth with on the European level, as long as the results of these health policies yield better and cheaper health results for them as what they have now.

High level developments to watch out for:

- Outcomes of the European Convention on drafting the Constitution, concerning the mentioning of health

- The upcoming "Communication" by EU Commissioner David Byrne

- The evolvement of the legal base in health for EU Institutions, especially also upcoming rulings of the ECJ

- Conduct and results of the European Parliament elections in June 2004

Case example: Economic modelling of CVD's

Whether one prefers the national or the European route for health policies, at stake is the fact, that quality of life still varies widely across Europe, and that human capital is a precious social and economic good to lose to preventable diseases. One way or the other, it will be necessary for the "Health of Europe", to narrow the differences and yield the benefits, of for instance the following examples:[97]

- The mortality from Coronary Heart Diseases is more than twice as high in North European countries than in South European countries

- If the incidence of CVD's was as low throughout Europe as in France, then a total of 23 billion Euros could be saved throughout the EU 15 per year, close to 3% of the total health budget, and about 20% of the total CVD budget

- If the incidence of CVD's could be halfed from that imaginary French level, that would save a further 55 billion Euros per year in the health system, close to 7% of the total budget.

- The economic opportunity cost of CVD's striking in working age across Europe, caused by the inability to work, amounts to 40,5 billion Euros, which comes on top of the approximately 120 billion, which the treatment of CVD's costs.

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[97] Economic modelling by Deutschland Denken! eV. based on WHO data, especially DALY's

Key Suggestion II:

Exploit the emerging overlap between public health and health care.

Main logic: Technology and increased sophistication of management practice enable prevention programs which until recently have not been possible or worthwhile, but will now become useful. They cannot be instituted however, while the traditional chasm of non-communication between public health and health care persists. Both sides will have to adjust to working together, to make large scale disease prevention, for instance in CVD's, a success. A facilitator for bridging this chasm can build a considerable franchise and raison d'etre.

Core arguments:

- Traditional public health programs are protective and inhibitive by nature and therefore an unattractive sell to the EU citizen. That is not an effective way to gain friends and win a sustainable franchise with the public

- There is only a weak basis for health care programs on the European level, and at any rate, the delivery of health products and services will be dealt with best on the local national level

- In the emerging overlap between public health and health care, the public health mandate of the European level can be leveraged to achieve tangible, measurable and appreciated health care benefits to actual citizens, primarily in the field of proven prevention of concrete diseases.

High level developments to look out for:

- Developments in technology, particularly genetic sciences, non-invasive screening technologies and database-driven disease management programs

- Results of the Gastein forum in October 2003 with the subject "Health and Wealth"

- Research findings in the course of the €312 public health action program

- Impact of choice-oriented, self-responsible empowerment policies in the field of health throughout the member states

Commenting the Alternatives:

Advocacy groups active in Brussels share the same dilemma that the EU has. If they advocate for public health measures, they risk alienating the citizen base – if they advocate for health care measures, they find that the EU has little mandate, few convincing means of action and at any rate will face strong opposition from the member states.

In the overlapping area of public health and health care, the EU can claim a mandate for action, while at the same time delivering tangible and appreciated value to the EU citizens. Furthermore, since the overlap is only just emerging with new technologies and systems, actions in this field have not yet been extensively occupied by national structures in member states.

That is not to say, that the EU should not fulfil its public health tasks in the more traditional fields. It is also not to say that advocacy groups like the EHN should not target high aims for the health of the European citizens. But it is to suggest, that whatever action is being undertaken or advocated for, it will be easier and speedier to turn into reality, if a broad and

explicit support by the EU citizens can be assumed. The emerging overlap between public health and health care is likely to be a fruitful hunting ground for identifying such measures.

Case example: Early, pre-harm stage detection of Cardio Vascular Diseases

CVD's are illnesses associated with the heart and the blood vessels. They are the leading cause of death for people in the industrialized nations. But that is not their only significance. They are also the leading cause of disability among the working-aged groups, and even where not always lethal, their occurrence often leads to other follow-on diseases, which are either then lethal or drastically limiting quality of life (partial paralysis for instance).

The causes for CVD are quite well known. The by far largest cause is premature aging due to specific risk factors. The heart and the blood vessels age with time, wear out, lose functionality and eventually break down. Virus or bacterial infections play only a minor role, or none at all, and genetic disposition is a factor, but only in the background, and it is not influencable anyway. It is also known what causes the cardiovascular system to age faster or slower. Certain diets, nicotin, a lack of exercise, overweight and the frequent release of stress hormones causes the CV system to age prematurely; certain other diets, regular exercise, standard weight and a balanced life style, will lead to maintaining significant strength of it into old age.

In other words, the question of how fast or slow the CV system will age, and by extension, how early in life CVD's can be expected, is for the largest part a matter of personal lifestyle. Furthermore, CVD's are typically not noticeable until a major breakdown of the system occurs, which is usually a stroke or an acute coronary symdrom. A pre-stroke diagnosis of acute CVD can only be determined, if the system is significantly impacted already, so that it shows up in chemical compositions of the blood, in certain rhythms of the heart and the like – and even then, they will only be discovered accidentally since patients are mostly not suffering from "warning symptoms".

For both of these reasons, the cause and the pattern of occurrence, prevention programs against CVD's are focussed on motivating or discouraging certain lifestyles. The difficulty here is, in how to convince a 35-year old to change his lifestyle now, as not to experience a CVD problem in 20 years. In fact even 55-year olds might be hard to reach with this message.

New technology can begin to change that picture. They will soon allow to have a look into the arteries and the heart, long before an irreparable damage of the system has occurred, and can evaluate for the customer, how "young" or "old" their cardiovascular system is. If an unhealthy lifestyle can be shown to have caused significant deterioration of the health of the system, this may prompt the person to really change that lifestyle. Or the condition may already have reached a stadium, where it is advisable to begin secondary prevention with medication or even rehabilitative surgery. In this way, with such early detection technology, the severe outcomes of CVD associated with strokes can long before occurrence already be predicted and thus prevented.

Until today, to have a look into the arteries or the heart, is only possible by invasive procedures using catheders and radiological markers. Unless there is a concrete reason to do so, this procedure would not be done "just for checking". Non-invasive and non-intrusive imaging technology with magnetic resonance was so far not helpful, because the heart and the coronary arteries are "moving" parts. In the time it takes an MR scan to produce an image of this part, it keeps on pulsating and changing its shape, thus blurring the picture.

That is besides the fact that MR scans used to be too expensive "just for checking". Three years ago, an MR scan of a single organ would cost up to € 2.000. Today, it is already possible to do a complete body scan for as little as € 1.500 in 20 minutes. In another three years it will be possible to do a body scan in 5 minutes for below € 500 and further improvements are expected.

That means very soon through a combination of increased speed of the MR and improved computer processing of the data streams, ever more useful pictures of the inside of the heart and blood vessels will become available at much reduced cost. Trained experts will be able to assess from these pictures the general health condition of the CV system as well as early warning signals for likely problems to occur in the future. Such MR scans could be deliberately offered for CV scans, or they might be a by-product of a scan for a different disease (bone fractures, cancer, etc.), in which case the CVD scan is almost for free.

This case exemplifies how public health concerns and health care would overlap, and in fact would only jointly become very successful. One aspect to this case is that it will require highly trained experts to diagnose something useful from the MR generated pictures. Another aspect is, that the pictures are in fact a computerized data stream. Therefore the data from an MR scan can be transmitted to a far away center of excellence, where all the experts are congregated. They create a diagnosis and send their results back to the local doctor with accompanying documentation. This center of excellence could be located in a university thousands of kilometers away from the MR scan taken in a regional city, somewhere in Europe.

One of the key factors of success to the best possible diagnosis is to accumulate large databases of comparison case histories. The more cases are in the database, the better are the diagnosis results – in other words it would be good to have a European case database for this new technology, instead of setting it up in 25 different countries seperately (it would also be significantly cheaper overall).

One of the European public health concerns in this case would be, to determine a regulation of what the compatibility standards have to be, so that a European-wide database system can be constructed for this, be it private companies or not, who will offer that service. Another public health concern in a European wide system would be to analyse the database for disease patterns, the evaluation of usefulness of treatment regimes and determination of lifestyle choices across regions and countries. This input can be used for better public health program design. A third aspect would be to enable reasonably uniform access for European citizens to this new technology, regardless of residence. A fourth aspect would be to uniformly quality-control the outcome of these diagnoses, so that its recommendations are for instance free of financial conflict of interest in therapy intensification (which is another reason to conduct the diagnosis remotely by disinterested parties).

Finally, a European regulatory public health regime of such a system may also issue recommendations for how this service could be financed. Naturally, citizens could always feel free to pay for it themselves, but that would only constitute a minority. There will be an economic breakeven point between the cost associated with screening as many people as possible, vs. the costs saved later due to the successful prevention of serious CVD outbreaks. This breakeven point would determine which age and risk groups should be invited to participate in the scans and who should pay how much for it. This breakeven point will become a permanently moving target, as on the one hand the costs of the scan would diminish further over time, while on the other hand the prediction accuracy of the forecasting system for high risk target groups gets finetuned.

It is plainly obvious, that it requires the health care medical technology and professionals to institute such a system. But the medics will not be able to reap the systemic effects, (and by that token may not be able to develop the service at all) unless public health know how and resources are also involved and are guiding the system. And both will likely remain undercritical, if they do not coordinate their activities on a European level.

In this sense, this is a case example of how European as well as national, public health as well as health care, regimes can work in hand in hand to build a "Europe of Health" with tangible benefits for the European citizen, without even an increase in the overall health budget – on the contrary, it would probably lead to a reduction of health expenses overall, and certainly an increase of quality of life, if CVD's can be prevented on a large scale from it.

Key Suggestion III:

Become a pro-active architect of an institutional process or at least be involved in the decisive processes already there

Main logic:

Institutionalized processes of the kind which the EU has developed over the past few years, are an efficient, and possibly the only viable, way to manage the inherent complexity when dealing with policy on the European level. It is a successful model worth emulating and exploiting for one's own ambitions.

Core arguments:

- Structured processes are an excellent forum for mutual learning and exchange of know how. In this way the rich diversity of Europe can be used for optimal benefit

- The protocols of behaviour for the processes enforce a negotiation logic which has proven to efficiently overcome vested interests with step-by-step solutions

- Participation in processes allows repeated, consistent and accountable contributions to policy making. Campaigns, position papers and debriefs are instead one-offs with diffuse if any impact on policy.

High level developments to look out for:

- Opportunities arising from the Lisbon Process

- Proceedings in the EU Health Forum

- Outcomes of the "Malaga Process" of the national health ministers

- Keeping tabs on assorted processes within the EU related to social policy, for instance through MISSOC

Commenting the Alternatives:

Leveraging the institutional approach: The EU Institutions are at their best, when they establish or augment institutional (or technocratic) arrangements for agreeing on or coordinating common measures of policy among the member states. A sinister view of that method is to use the analogy of a busy (EU) spider, that keeps on spinning strings until the target of its desires begins to eventually entangle itself in this web, and with every wriggle will be drawn deeper and deeper into it. A positive view of this institutional process is to see it as organizing a structured forum where a group of principally willing but still sceptical members can bounce off each other long enough to get to know each other, trust each other and find scope of agreement on joint action. Sinister or positive, an advocacy group wanting to influence the EU health agenda, can probably be most effective if it manages to become part of these institutional processes as much as possible, or even start a process itself.

Leveraging the economic approach: A less successful angle for the European institutions has been to justify its actions on grounds of increased economic benefit for the European citizens. This angle is less successful, because so far the economic benefits are either not significant or too diffuse to measure. On the other hand, the EU has acquired a reasonably strong mandate for proven wealth creating policies, so it has room for action on these

grounds. To be able to demonstrate economic benefits through measures that a group wants to advocate for, is therefore a double boost to its influence: first, the EU appreciates in principle any help it can get to make its economic mandate work better for the EU citizens, second, such proposals are comparatively easier to operationalize into concrete policy actions.

Leveraging the political approach: The most difficult route is to advocate on behalf of political targets. There are clearly opportunities for that as part of the European project, but they are scarcer, and much harder to turn into policy, for all the reasons that were mentioned before. The building of the European statehood identity has seldom been a headline grabbing affair of ideological debates on political aims. One official of the Commission once commented:

> *"You do get people with funny ideas arriving in Brussels sometimes, but they usually become house-trained pretty quickly."*[98]

An American academic familiar with the sharply ideology driven think tank scene in Washington DC, finds Brussels to be "almost soviet". Which is not to say that Europe does not move at all, or ignores controversy. Instead the European project moves a lot more like a technocracy: listening to political targets politely, but finding proven economic mechanics or even institutional processes much more comfortable to work with.

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[98] The Economist, 5th December 2002, "The Brussels Consensus"

Key Suggestion IV:

Create a bond or a connection between the EU citizen and the European level organization, delivering to him or her, tangible and valuable results.

Main logic:

The building of Europe will in the future be less driven by higher ideals, but by tangible results for the EU citizen. Networks who can credibly speak with the explicit mandate of a large franchise of affected EU citizens, will enjoy considerable power in influencing policy in a Europe that is currently concerned about wanting to "connect", as well as the other way around. Such a mandate is easier to achieve, if a "good" can be sold in return for membership, than having to rely on ideals-based donations.

Core arguments:

- Fact-based advocacy is appreciated in Europe, but it requires very deep pockets to distinguish oneself repeatedly with new facts and insights in a Brussels environment already drowning in facts, papers, reports and researches

- Ideals-based advocacy is rather not appreciated in Europe, since there exist so many different ideals in the rich diversity of Europe, that common ground based on ideologies is very difficult to identify. In general, Brussels is effective because of its technocratic manner

- Franchise-based advocacy would be highly appreciated, but is little supplied. The European institutions feel the urgent need to be in touch and to be seen to be in touch with the EU citizen. However, due to institutional and geograhic distance, this is difficult to accomplish. Therefore advocacy groups which have a proven and committed franchise of members they can speak for, will be very welcome partners in the policy creation process.

High level developments to look out for:

- Impact of the "2003 European Year of the Disabled"

- Opinion polls and benchmarkings on the needs and preference of EU citizens, especially in the accession countries

- Unserved information and service needs citizen stakeholder groups

Case example: Obesity

Excess weight and obesity are rising throughout Europe. Excess weight gain now affects significantly more than 50% of the adult population in Europe and obesity affects between 10-20%, in some countries up to 30% of all adults. According to a parliamentary report, already 20% of the British population is severely overweight, a level that has tripled over the past 20 years. At least 135 million EU citizens are affected, another 70 million in the countries soon joining the European Union. The speed with which obesity is spreading over Europe reminds some people of an epidemic. The rates have doubled in only a few years in some countries and could well double again in the next two decades. [99]

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[99] Obesity: The Case for Action, EASO, September 2002

Among children the prevalence of obesity is rising significantly ranging from around 13% in Slovakia, Finland and the Netherlands up to 35% of the children in Malta and Italy. Children are becoming increasingly inactive and eating energy dense diets rich in fats and sugar. The Eurodiet report 2000 states that if children are already overweight at the age of 6-10 there is a high probability they will stay overweight their whole life and this would have particularly deleterious effects.[100]

Already now the direct costs acording to collated data from the IOTF (2002) are around 1 bio € in France, 800 mio € in the UK and 10,6 bio € in Germany. In relation to the percentage of health expenditure obesity accounts for 7% in the USA (70 bio US$), 4% in the Netherlands (454 mio €) and 3,5% in Portugal (230 mio €).

Obesity thus constitutes a major problem for European health, as it is a major factor for diseases such as diabetes mellitus, several types of cancer, gallbladder disease, high blood pressure, blood lipid disorders, obstructive sleep apnoea, osteoarthritis, psychosocial problems and cardiovascular disease[101] among others. An increasing proportion of obese people in Europe will lead to increasing costs and a substantial loss of quality of life in the coming decades. The risk of diabetes is increased up to 100-fold in obese children that continue to gain weight. The Eurodiet report also states that at least 80% of the increasing number of diabetics can be contributed to excess weight gain.

To find the causes of obesity one has to look at people's environment. The European Association for the study of Obesity (EASO) states that only 1% of all cases has genetic deficiencies as main cause for obesity. All the other cases can be traced back to an increasing abundance of energy dense foods and drinks rich in sugar and fat and an environment that restricts physical activity, for example through television, cars, and limited space for doing sports or letting children play. The EASO has identified four environmental factor-groups which can enhance obesity and thus need to be addressed: Sports and Leisure, promotion of high energy foods and drinks, family environment and education and information. The stakeholders in these areas state that fighting obesity is a major goal to them for the future.

European health politicians, national health politicians, public health professionals, medical professionals, the food industry, the pharmaceutical industry, health insurers, patient groups – every stakeholder group has a concern in how to tackle the rising health threat of obesity.

Will the chance be taken up by all these different stakeholders to understand their respective complimentary contribution to this problem and thereby contribute to solving it together? Will in particular the advocacy groups be able to provide a connection between the policy making process and the affected citizens? And if not, what are the alternative outcomes?

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[100] Eurodiet: European Diet and Public Health, The Continuing Challenge, Working Party 1, Final Report June 2000

[101] Clinical Management of Overweight and Obese patients, Royal College of Physicians of London in: Milan Declaration of The European Association for the Study of Obesity, 1999. (www.iotf.org/media/ecorelease991.htm)

Glossary

"Europe" refers in this report to all those nations on the geographic European continent, who strive towards some form of common unity. In the judgement of the authors, this excludes for the time being the nations of Russia, Belorussia, Ukraine and the Caucasion nations, but it should include Turkey, the Balkans and the "EU-associated" countries such as Switzerland, Norway, Iceland and the various tiny states. This is not an official definition, but a customary one.

"European citizen or European markets" are citizens or markets of the nation states of the above countries

"European project or level" is a definition used in this report to describe the encompassing effort of all the above nations to achieve European commonality and to achieve a better future for the European citizen (the 'grand philosophical idea'), of which the European Union is the major one, but not the only one.

"European statehood" is a definition used in this report to describe a semiconstructed statehood identity for the European project, of which the EU is a central part.

"European Communities" Over the course of its history since 1949, the European project created numerous treaties. Three of these treaties constitute the so-called "European Communities", which are the European Economic Community (EEC of 1957), the European Steel and Coal Community (ECSC of 1951) and Euratom (also 1957). The two most noticeable additional treaties to these are the Economic Monetary Union (EMU of 1992, which emerged from the EMS of 1979) and the Schengen Acquis (in force since 1995). However, membership of the latter two needed not be identical with that of the three Communities and are still not today. When the Maastricht Treaty established the European Union in 1992, the European Three Pillars were introduced, which together make up the European Union. The First Pillar consists of the established three Communities enlarged by additional responsibilities (noticeably health for instance), the Second Pillar is a "Common Foreign and Security Policy" (which subsumes the European Political Cooperation EPC of 1970, the Single European Act SEA of 1986 and the Western European Union WEU of 1948) and the Third Pillar is "Cooperation in Justice and Home Affairs". In practice the European Union uses most of the established institutions and legal frameworks of the EEC, which is why most of them were renamed in 1993 to their current names. Because the EEC institutions proved to be so critical for the functioning of the political intentions of the EU, the name of the EEC was also changed into "The European Community" or EC (dropping the reference to "economic"). To make the confusion complete, EMU continues to function de facto outside of the Three Pillars, even though the European System of Central Banks (ESCB) is installed in Article 8 as part of the EC. Therefore, today there exists the "European Community" as being one of the three "European Communities" which in turn is one of "Three Pillars" of the "European Union", of whom most member states use the common currency EURO in the EMU supervised by the ECB, but where yet a different member group are signatories to the Schengen Acquis (which has been incorporated into the EC nonetheless), and where even yet another group of members are part of the defense-oriented WEU, and so on. This melange has led to the term "Europa á la carte", whereby member and even non-member states de facto choose from a menu of European offerings that suit their needs best.

"European Union" (for definition see above). In this report the EU refers to all existing 15 members as of the printing date plus the 10 new members who have been offered to accede in 2004. Where the report refers only to the current 15 members, it will say EU 15.

"EU citizen or EU markets" refers to all citizens or markets of the above 25 member/accession states.

"Council of the European Union" (Council in short) is one of the three "triangle" institutions of the European Union, the other two being the European Parliament and the European Commission. Through the Council, the member states are represented in the legislative process of the EU.

"PERM. REP'S" is the "Committee of Permanent Representatives of the Member States", who are the Brussels-based officials preparing the decisions of the Council.

"DG" are the "Directorates General" of the European Commission, of which there are 23. The nearest equivalent to them would be to consider the DG's as the ministries of a European government. Two key differences are however, that the Commission has the exclusive right to initiate policy, and that the Commission is neither elected nor a government. Likewise the EU Commissioner in charge of a DG, is not exactly a minister, but also has some chancelry powers invested in this post. Head of a DG is not the Commissioner but a Director General. DG's used to be called by Roman numbers, but have recently acquired informal short names. The DG in charge of health is the DG Sanco, ie DG for Health and Consumer Protection. Director General of Sanco is R.J. Coleman, and the EU Commissioner for Sanco is David Byrne.

"European Council" is the regular meeting of all the Heads of State or governments of the member states of the European Union

"Health Council" is an official meeting of all health ministers of the member states (and respectively with other names for other subject-oriented minister level Council meetings)

"EU Institutions" are in a narrow definition the three triangle institutions plus seven other institutions such as the European Central Bank (ECB) plus fifteen other executive agencies such as the new European Food Safety Authority (EFSA). In the broad definition used in this report, EU Institutions refers to the countlessly numerous official and semi-official governance systems of the EU. The official term for this broader definition is the "European Architecture".

"European Convention" is a process under way since 2002 charged to draft a "Treaty Establishing a Constitution for Europe". It is noticeable, that this effort is targeting all of Europe, and not only the current EU arrangements. (The European Convention is not to be confused with conventions, which are legally binding arrangements in the Third EU Pillar)

"EU Treaty" in this report refers to the most recent valid Treaty underpinning the entire European Union. At the moment that is the Treaty of Nice in force since February 1st 2003.

"Council of Europe" (COE) is not a term used in this report, but is important to be distinguished from the European Council. It refers to a political institution that was started in 1949 and today has 44 members (every European nation except Belorussia, Serbia and Montenegro, and the Holy See). Any European state can become a member of the COE, if it accepts the principles of the rule of law and guarantees human rights and fundamental freedoms. The COE is a a completely separate organisation from the EU.

"European Economic Area" (EEA) refers to an agreement of the EU with Norway, Iceland and Liechtenstein, so that they can fully participate in the economic Single Market of the EU, while not assuming the full responsibilities of membership in the EU. The EEA was supposed to emerge in 1994 from the "European Free Trade Association" EFTA, but the fourth EFTA member Switzerland decided by referendum not to participate in the EEA. Therefore now, both organisations exist and are typically referred to as EEA/EFTA.

And finally:

"European Health" is referred to in this report as all issues related to health for EU and EEA citizens, be they provided by EU/EEA institutions, by EU/EEA memberstate institutions or by private market economies. The EEA is included in this definition, because as far as the health issues in question are of economic nature, they must be implemented in the EEA countries as well. Health here is supposed to encompass public health affairs as much as health care concerns.

"Europe of Health" is a term coined by the EU Commissioner David Byrne of DG Sanco, the "Health Commissioner" so to say. He calls it to be his vision, and quotes this term frequently.

"Health Care" in this report is defined as the medical treatment of an identified disease, typically through a doctor, through medication, or in a hospital.

"Public Health" in this report is defined as the prevention of a disease from occuring, by minimizing point of contact of people with poisons, viral or bacterial infections. The minimization is achieved through influencing lifestyles and personal behaviour, through regulations on cleanliness and hazards, or through the definition of regional treatment regimes.

The overlap between public health and health care emerges from the fact, that provocatively speaking, life is a disease in itself. If in the course of doctor led wide spreed diabetes screening, high risk patients are advised to change their diets, is that still a public health prevention, or already a medical treatment of a disease? Does it become a medical intervention once a doctor gets involved, or once he starts using medication? Instead of trying to define borders between the two, it seems more fruitful to define this as an overlap, where both professional skill sets are required for success.

Authors of "The Dawn of European Health"

"Dawn for European Health" is a research study undertaken by the Rotterdam-based think tank *Strategy Academy. Strategy Academy* is specialized on combining academic rigor and pragmatic relevance in the field of strategy to yield meaningful conclusions for its clients. Employing the power of strategic thinking and based on empirical analysis, *Strategy Academy* helps those who must decide Europe's priorities in companies and in government. For this Strategy *Academy* regularly conducts research projects and provides insights for key decision makers. One of *Strategy Academy's* publication products is the book *Strategy Synthesis*, Europe's leading textbook at universities and academies for instructing the subject of strategy.

The lead researchers for this study were Peer Ederer and Leonard Zijlstra. Important aspects to the research were contributed by Marc Padberg, Volker Weidinger and Stephan Willms. The research study utilized an economic modelling tool developed by the German-based think tank Deutschland Denken! which is specialized on financially quantifying public policy choices.

Peer Ederer holds academic degrees from Sophia University in Tokyo and the Harvard Business School. He has worked for Deutsche Bank and McKinsey&Co, and started a business in the sector of health care before joining the *Strategy Academy*. He has also authored two best-selling books on German public policy.

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