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Is health in the European Convention?

An historic moment was reached on 18 July when the President of the European Convention, former French President M. Giscard d'Estaing, officially handed over the draft EU Constitution to Sr. Berlusconi, the current chair of the European Council. This event marked a significant point along an often-tortuous road to developing a new Constitution for the European Union.

Background

The Convention on the Future of Europe was set up following the 2001 December summit of European leaders. Its original mandate was to hold discussions on how the various Treaties on which the EU is based could be consolidated into a single text. The key players in the Convention debate are as follows.

15 representatives of the Heads of State or Government of the Member States (one from each Member State),

13 representatives of the Heads of State or Government of the new Member States set to join the EU in 2004 (1 per State), in addition to representatives from the other three accession candidate countries, Bulgaria, Romania and Turkey.

30 representatives of the national parliaments of the Member States (two from each Member State),

26 representatives of the national parliaments of the candidate States (two from each candidate State),

16 members of the European Parliament,

2 representatives of the European Commission.

As well as consolidating existing Treaties, the draft Constitution makes explicit the

values and goals that guide the European Union, defines citizens' rights and duties, and clarifies the powers of the Member States and the EU and the relationships between them. The weighty text covers all aspects of European Union activities and the following observations tease out those parts of the text that are of particular relevance to health. The full text is available at the Convention website.¹

Health as an 'objective' of the EU

Against the background of an international debate characterised by calls to shift measurement of the progress of nations beyond the conventional measures of wealth to include health, as well as evidence of the fundamental linkage between the two, illustrated by the recent Commission on Macroeconomics and Health, there were numerous calls from health NGOs and professional associations (notably coordinated by the European Public Health Alliance) for health to figure prominently in the Constitution. However the draft text fails to mention health explicitly in Article 3, which lists the objectives of the European Union, instead concentrating on issues such as the creation of the EU Single Market, sustainable development, and environmental protection.

Calls for health to be mentioned explicitly were motivated by concerns that the existing commitment to build a social Europe should be made more concrete, with health as a social objective being equivalent and not subordinate to the economic goals of European integration. However, while health is not included in Article 3, other wider EU objectives are stated which could be interpreted as having health implications. These include promoting well-being, social justice and protection, the eradication of poverty and protection of human rights and, as in the past, offer scope for creative interpretation by those seeking to ensure that progress in social and economic policies go hand in hand.

Two types of EU health powers

The draft Constitution divides EU health powers into 'common safety concerns in public health matters' and 'protection and improvement of human health'.

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The first area is defined as a ‘shared competence’ between the EU and Member States (Article 13) and provides the possibility of enacting binding EU legislation. It is seen as a response to increasing health threats from communicable diseases and bio-terrorism.

The second part is considered an area of ‘supporting competence’ (Article 16) which rules out any European legislation that could harmonise national laws and regulations.

Describing this split to the European Parliament on May 6, the European Commissioner for Justice and Home Affairs, Antonio Vitorino, said that actions supporting Member States’ health services would fall under this weaker ‘supporting competence’.

Many health observers have reservations about splitting EU health policy into these two different areas of shared and supportive competencies. There is some confusion as to how “common safety concerns in public health matters” and “protection and improvement of human health” can actually be differentiated in practice. There is a danger that, as with the European Union’s earlier efforts to legislate in the area of public health, these words will give rise to an industry of commentators seeking to interpret what the legislators actually meant, rather like those visiting the oracle at Delphi, when it is not at all clear that the legislators have any idea what they mean.

Rights to healthcare

For the first time in a European Treaty, ‘healthcare’ is explicitly mentioned. The Charter of Fundamental Rights, adopted in December 2000, has been fully incorporated in Part II of the Treaty. Article II-35 states that:

“Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.”

The right to healthcare has been carefully worded to ensure that Member States, not the European Union, determine how their citizens access healthcare within their own territories. Yet, once again, this leaves many issues unresolved, in particular those facing patients and health professionals who cross borders and who experience

quite different “national laws and practices” that in effect block the ability to move freely. It is difficult to avoid the conclusion that the drafters of this article have been unaware of the unfolding events in the European Court of Justice in recent years.

In addition, the Charter includes other rights that have health implications. These include the ‘right to life’ (Article II-1) and the ‘Right to the integrity of the person’ (Article II-3) which impacts on medical research:

Right to the integrity of the person

Everyone has the right to respect for his or her physical and mental integrity.

In the fields of medicine and biology, the following must be respected in particular:

the free and informed consent of the person concerned, according to the procedures laid down by law,

the prohibition of eugenic practices, in particular those aiming at the selection of persons,

the prohibition on making the human body and its parts as such a source of financial gain,

the prohibition of the reproductive cloning of human beings.

While these provisions may, superficially, seem sensible and in accordance with accepted practice, once again there is a risk that careless drafting may create future problems. For example, at present, in several Member States, there are real concerns about the way in which restrictive requirements on informed consent may block necessary research using health data (for example, in cancer registries) or stored samples (such as blood taken for routine testing) where it is necessary to investigate a hypothesis that was not anticipated when the data or samples were collected, and so the individual was unable to give precise consent for the particular analysis involved. There are many examples of major advances that would have been impossible if such restrictions had existed in the past. Furthermore, the ability to opt out renders cancer registries, a key tool in monitoring progress in public health, unrepresentative and so almost useless. Consequently, there is a strong argument that this Article should contain some attempt to balance the right to consent with the benefit that society as a whole will gain from the ability to undertake population-based monitoring and research where they cause no harm to the participating individual.

“There are plenty of reasons for the IGC to revise this Article”

Rewording of Article 152

Until now, explicit mention of health in the EU Treaties has centred on Article 152, which outlines EU powers in “Public Health”. There is no specific Article on “healthcare” as national powers in this area are guarded jealously by the Member States.

The draft Constitution includes an amended version of Article 152, which is now renumbered Article 179. At first sight it appears little different from the previous text, with its many limitations and uncertainties, but several observations can be made.

First, some observers note that the scope for EU action could yet be widened depending on the final definition of “common safety concerns” in paragraph 4. A previous version of the draft, which remained intact until an 11th hour amendment, did not limit action merely to blood, organs, and veterinary and phytosanitary measures. Other than simply reproducing what was in Article 152, the arguments for adopting these criteria are far from clear and certainly do not take into account to the growing literature on, for example, international cooperation in the production

of global public goods for health. The rather tortuous language, with its inclusions and exclusions, contrasts with the much simpler, and arguably more effective, wording of Articles on issues such as the environment.

Second, in response to requests made by many members of the Convention, the so-called ‘open method of coordination’ has been acknowledged, in all but name, for use in a number of areas including health and social policy. This method of working seeks to encourage Member States to coordinate their actions voluntarily, without using EU legislation, such as Directives and Regulations. In the field of health, Article 179 applies this to ‘initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation’.

Finally, the revised text maintains the accepted principle that “European Union action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care.”

ARTICLE 179 (EX ARTICLE 152) PUBLIC HEALTH

A high level of human health protection shall be ensured in the definition and implementation of all the Union’s policies and activities.

Action by the Union, which shall complement national policies, shall be directed towards improving public health, preventing human illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education. The Union shall complement the Member States’ action in reducing drugs-related health damage, including information and prevention.

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

Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any use-

ful initiative to promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation. The European Parliament shall be kept fully informed.

The Union and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.

4. A European law or framework law shall contribute to the achievement of the objectives referred to in this Article by establishing the following measures in order to meet common safety concerns:

(a) measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures;

(b) measures in the veterinary and phytosanitary fields which have as their

direct objective the protection of public health;

European laws or framework laws shall be adopted after consultation of the Committee of the Regions and the Economic and Social Committee.

5. European laws or framework laws may also establish incentive measures designed to protect and improve human health and to combat the major cross-border health scourges, excluding any harmonisation of the laws and regulations of the Member States. It shall be adopted after consultation of the Committee of the Regions and the Economic and Social Committee.

6. For the purposes set out in this Article, the Council of Ministers, on a proposal from the Commission, may also adopt recommendations.

7. Union action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care. In particular, measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

“The Treaty text was drafted without sufficient consultation or involvement of relevant actors”

Did the Convention deliver on public health?

Promisingly, all the signs were present for a new political approach to health at EU level. Many health commentators had been calling for a reform of the EU competence in health for years. This revision of the Treaty, the last foreseen for some time, was an excellent opportunity to get the text right. Despite the careful drafting of Article 152 in Amsterdam to ring-fence national healthcare systems from EU interference, the recent cascade of case judgements from the European Court of Justice had made it abundantly clear to all concerned, both in the Commission and Member States, that EU policy in areas such as the internal market has an impact on healthcare. A committed Commissioner campaigned on the slogan that he had more powers to protect animal welfare than to protect human health.

For many in the health community the goal is the integration of ‘a high level of human health’ in Article I-3, (EU Objectives) in combination with a robust public health Article that is inclusive and not simply an exclusive list of potential EU legislation. This combination would enable the Union, through unanimous decisions of Member States, to take actions – including legislation – in order to fulfil these overall objectives.

The end result is mixed. The Open Method of Coordination forges a new role for the Union in terms of developing indicators and exchanging best practice. But EU legislation is excluded except for existing issues such as blood and human tissues. In this context EU Member States may unilaterally go further than the EU standard. The Article confers the EU only with the job of supporting Member States, and not even coordination of national policies, a role reserved for governments alone in ‘liaison’ with the Commission.

The Convention debate threw into stark relief the absence of consensus across Europe about what constitutes ‘public health’, with interventions ranging from the dangers of biological and chemical contaminants and communicable diseases to dire warnings about ‘creeping competence’ over hospitals by a power-mad Brussels bureaucracy. Advocacy by health organisations about the major health threats in Europe (cardiovascular disease, obesity, cancer and mental health problems) all of which are non-communicable, largely preventable and require a concerted international approach were overshadowed and

ignored. The Health Ministries, whose participation in the High-Level Reflection Process on Patient Mobility and Healthcare has underlined the added value of European collaboration, were absent from the Convention process, which was largely undertaken by Foreign Ministries. Once again the Treaty text on health was drafted without sufficient consultation or involvement of relevant actors.

Next steps

With the Convention’s task complete, work on the draft Constitution now shifts to Member State representatives within the ‘Intergovernmental Conference’ (IGC) which may be concluded before the end of the Italian EU Presidency on 31 December 2003. Further changes to the draft text are inevitable, particularly on Article 179. In the final moments of the Convention, the UK government reserved the right to revisit Article 179, the Dutch called for the inclusion of nutrition and food safety into the Article, France requested a specific reference to an EU role in facilitating cross-border patient mobility and Germany raised the need for a rapid response to health threats. Scandinavian concerns were also tabled about the importance of regulating the sale and marketing of tobacco and alcohol. So there are plenty of reasons for the IGC to revise this Article in spite of the warning from Convention President Giscard d’Estaing against reopening negotiations, saying that it was “a finished product”.

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Royal College of Physicians, London
[www.rcplondon.ac.uk/college/
international/index.htm](http://www.rcplondon.ac.uk/college/international/index.htm)**

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**European Public Health Alliance
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**European Observatory on Health Care
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www.observatory.dk**

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REFERENCE

1. Draft text of the Convention can be accessed at the Convention website:
[http://european-convention.eu.int/
bienvenue.asp?lang=EN&Content=](http://european-convention.eu.int/bienvenue.asp?lang=EN&Content=)