

Working Group XI

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Working Group XI “Social Europe”

Subject: Social Europe and Health

Members of Working Group XI on “Social Europe” will find hereafter a paper from Mr. David O’Sullivan, alternate member of the Convention.



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Contribution to the Working Group XI of the European Convention

Social Europe

Contribution from David O’Sullivan on Social Europe and Health

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Social Europe and Health

Many members of the Working Group have identified the link between modernising Social Europe and the need to mainstream health and public health issues in this process.

Health services are one of the pillars of European social protection systems (alongside employment, pensions and social inclusion).

In my contribution of 9 January 2003, I provided information to the Group on the impact of recent Court of Justice cases in relation to healthcare. This contribution addresses other issues relating to health that have arisen at EU level.

Objectives

Providing healthcare that is of high quality, accessible to all and financially sustainable are governing principles of European social protection. Maintaining these principles is one of the most important political requirements for citizens and one of the greatest economic challenges for governments in Europe today.

A high level of public health should be one of the basic objectives of the Union.

Meeting this objective will largely be the responsibility of Member States. There are, however, a number of important developments where Member States acting alone cannot adequately meet the challenge and where action at EU level is limited.

On **Communicable Diseases** the threats to public health in an enlarged Europe are growing. Greater free movement in an enlarged Europe brings greater need to respond to the consequent health risks. Fewer barriers to European or global interaction also means fewer barriers to disease. Just as we need the means to expand free movement, so we need the ability to handle its downside. The European Council has asked to prepare adequate European capacity to deal with communicable diseases. But under

Article 152 of the EC Treaty, whilst the Union can take some steps to improve surveillance and monitoring, this provision does not provide the power to co-ordinate responses. In a multi-state emergency, the Union would not be empowered to co-ordinate the investigation of outbreaks. And in anticipation of a grave cross-border threat, even if the Member States so wished, the Union could neither co-ordinate agreed vaccination strategies, nor stockpile essential medicines. Nor can a European Centre for Disease Control be established on the basis of Article 152.

The same arguments apply to the issue of **bioterrorism** as to traditional communicable diseases.

In the event of such a major threat to health occurring in the Union, it would be difficult to explain to the public why no safeguard measures were put in place. At a time when both Europe and the cross-border threats we face are changing, the Union would not be in a position to respond.

Another area of classic public health intervention where the Union's ability to act is severely circumscribed is **tobacco control**. No binding measures can be taken on the basis of article 152 to limit consumption – for example to control advertising, availability (age limits), or contents (tar levels). As to Article 95 of the EC Treaty which allows approximation of national legislations, whilst it is not forbidden that such measures have an impact on the protection of human health, they can only be adopted insofar they have genuinely as their object the improvement of the conditions for the establishment and functioning of the internal market.

To date the Treaty provides only for the limited obligation to ensure a high quality and safety for **blood, tissues and organs**. It remains to be seen whether science (biotechnology) will offer new challenges for which there are currently no health provisions available.

As regards the international implications, the **International Health Regulations (IHR)** now need to be revised in the light of rapidly increasing travel and trade and changing disease patterns. Many more diseases will be identified as major threats that require co-ordinated responses in order to protect public health. The rules will require for example not only effective surveillance and reporting systems to be in place, but also the establishment of quarantine arrangements for people and goods. Ways will have to be found to reconcile these rules with the freedoms of the single market (free

movement of persons and goods). Without prejudice to the existing Union competences under the common commercial policy, the arrangements for applying the new IHR in practice will therefore have to be agreed for the Union as a whole, and will require the sharing of competence between Member States in the overall common interest. The proposed Centre for Disease Control may well be the most suitable mechanism to co-ordinate the implementation of the Regulation for the Union.

Conclusions

A high level of public health should be one of the objectives in Article 3 of the Constitution for Europe.

In addition, we need to assess what may be necessary in the text of the Constitution to achieve this objective, and in particular how far Article 152 should be adapted accordingly.
