Journal of Health Systems and Policies, Vol.1, No:3, 2019
Submission Date: November 19, 2019 *Acceptance Date: November 30, 2019*

European Union Health Policy: A Short Overview

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ABSTRACT

Since its foundation the European Union has increased, after a long initial period of mainly economic integration and to differing extents, its effect on many social policy areas including health issues. The main objective of this study is to provide an overview of EU health policy within a conceptual framework. EU health policy has mainly evolved via two contradictory strands: one is the public health strand and the other one is the internal market strand. The EU has struggled to have a more direct role in health care in recent years in order to overcome challenges that have emerged from internal market dynamics, such as cross-border care issues. At this point, a strategic approach should be able to effectively manage this process in favor of citizens' health through strategic planning and approaches guided by scientific information and collaboration.

Keywords: European Union, Health Policy, Public Health, Internal Market, Health Services

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Submission Date: November 19, 2019 *Acceptance Date: November 30, 2019*

INTRODUCTION

The European Union (EU), which has 60 years of history and is continuing its enlargement and deepening processes mainly on the axis of economic integration, has extended its competencies in social areas such as health and health services in recent years. Health and health care services have been excluded from the general competencies of the EU on the basis of the subsidiarity principle, whereby they are accepted as the responsibility of Member States. The Lisbon Treaty (Article 168) strongly reasserts the principle of subsidiarity in public health**:** "The Union shall fully respect Member States responsibilities for the definition of health policies and organizing, delivering health services and medical care, and management of health services and medical care and the allocation of the resources assigned to them" (Official Journal of the European Union, 2007a). However, in recent years, this situation has changed dramatically and health and related issues have increasingly been placed on the EU agenda. This is mainly due to other EU policies, such as the internal market and rulings of the European Court of Justice (ECJ). It is impossible for member and candidate states to exempt their health and health care systems from the dynamics of the EU. Consequently, it can be said that the health care sector is one of the main fields directly and indirectly affected by the context of the EU and, as such, it requires a certain level of conformity and approximation.

The main objective of this study is to provide an overview of EU health policy. To this end, this study is organized into five main sections including the introduction. The second section defines EU health policy, explores the objectives of EU health policy and discusses the guiding principles of EU health policy. The third section provides an overview of the evolution of EU health policy competencies. The fourth section looks into the future. Finally, the paper concludes with some recommendations.

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EU Health Policy: Definition, Objectives and Guiding Principles

What is EU Health Policy?

It is sometimes said that 'the EU does not have a health policy,' yet such judgments do not reflect reality. Of course, the EU does not currently have a 'common health policy' regarding organization, finance, and supply of health services applicable to all member countries; however, the EU has an official health policy that is emerging gradually and incrementally. This process, especially over the last 10-15 years, has reached a certain density.

The official health policies of the EU, as in other areas, are policies that have been shaped and executed predominantly in the context of legislation. Consequently, when we speak of EU health policies, all provisions in the EU legislation regarding health should be borne in mind. On the other hand, within the coverage of other EU policies, especially the internal market strand, a definite EU health policy is emerging. In this regard, what does it mean to speak of EU health policy? Answering this question is not an easy task since there are no clear-cut boundaries for the issue and it has a dynamic and cross-cutting nature. Nevertheless, for the sake of conceptualization, we will suggest a more general definition.

For the purpose of this paper, the broader definition, including both the public health strand and the internal market strand, is taken as the basis of discussion. Within this context, the EU health policy can most generally be defined as follows the sum of values, principles, and rules that have been taking shape at the EU level since the 1950s, which consists of (1) action programs and policy strategies that relate to health and health care that are directed within the scope of institutional structures and the acquis (at the primary, secondary and the ECJ's case laws levels), especially Article 129 of the Maastricht Treaty and Article 152 of the Amsterdam Treaty, and Article 168 of the Treaty of Lisbon, which amended Article 152; and

(2) internal market dynamics regarding the health sphere, especially the four freedoms of movement.

The Objectives of EU Health Policy

The primary objective of the European perspective in terms of development, formulation, and implementation of health policy is to improve the health status of EU citizens based on the legal groundwork of the Treaties (European Commission; 1999) such as the Lisbon Treaty (Official Journal of the European Union, 2007a). When we look at the health policy objectives in the context of the general objectives of the Community, it can be stated that certain issues, such as improving public health, preventing illness and disease, and countering conditions that are dangerous to human health, are at the front line. The European Commission in its 'Communication on the Health Strategy of the European Community', COM (2000) 285 final, by referring to Articles in the Amsterdam Treaty which relate to health, stated the key objectives in relation to public health: contributing to the attainment of a high level of health protection; improving public health; preventing human illness and disease; and obviating sources of danger to human health (Commission of the European Communities, 2000). It is possible to put the main objectives of the EU health policies into place, as described below:

1. To Improve the Health Status of EU Citizens;
2. To Play A Role That Is Complementary to Member States' Health Policies;
3. To Constitute Accessible, Sustainable and High Quality Health Systems In The Context Of The EU In General, And In The Member Countries In Particular;
4. To Create 'European Value Added';
5. To Realize 'Economies of Scale';
6. To Contribute to The Final Objective of the EU- Political Union.

The three far-reaching objectives of the EU in health care and long-term care have been stated as 'accessibility', 'sustainability' and 'quality' in the Communication (Commission of the European Communities 2001). In other words, the health care systems and long-term care systems of the EU have to ensure and materialize sustainability, quality and accessibility for all synchronously, without regard to income or wealth (Commission of the European Communities, 2001; 2003). Furthermore, European common values and principles were adopted in the conclusions of the Council of the European Union of June 2006 as universality, access to good quality care, equity, and solidarity (Official Journal of the European Union, 2006). These values are guiding the shape and practice of the EU health care systems.

Guiding Principles of EU Health Policy

When health and health care services are considered at the EU level, and when the EU's roles in health have been determined and its health policy has taken shape, the main guiding principles can be stated as subsidiarity, universality, access to good quality care, equity and solidarity, an open method of coordination (OMC), and 'European value added'. Among these principles, subsidiarity and OMC come to the forefront.

The EU's role and responsibilities in the health field are shaped primarily by the subsidiarity principle, which means that Union competence is limited to areas where national governments cannot meet policy objectives through their own actions (Aust et al. 2002), and predominantly concentrate on the prevention of illness and health protection. According to Cucic (2000), the subsidiarity principle means that everything that is or can be properly regulated at the national level should not be subjected to European regulation. However, it should be noted that the EU, which has left the responsibility for financing and delivering health services to the Member States, has recently started to undertake more responsibility in the health arena, especially in the free movement of health professionals and patients within the context of internal market dynamics.

The OMC is a process that was agreed to by EU Member States that aims to intensify the exchange of knowledge and information, with pressure to achieve common targets set in each field. The OMC typically follows four stages. Firstly, broad common objectives are agreed to at the EU level. Member States then draw up national policy strategies to achieve the agreed upon objectives. Thirdly, the strategies are analyzed and their progress is monitored using agreed upon indicators if possible, leading to a joint Report signed by the Commission and the Member States (through the Council). Finally, this report can lead to modifications of the objectives or particular emphasis on certain objectives in future national strategies (AGE, 2005). The OMC is based upon mutual learning and the identification and transfer of best practices rather than a top-down regulatory approach (Arrowsmith et al., 2004). The areas of application selected for the OMC were, in the first instance, employment, followed by pensions and social exclusion. With its communication "[t]he future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability" of 5 December 2001, the European Commission submitted a report that represented a first step towards the application of the OMC to the health care system (German Federal Associations of Health Insurance Funds, 2002).

Furthermore, as mentioned above, the European common values are also among the guiding principles. In this sense, solidarity, in European practice, means cross-subsidization from healthy to sick, from men to women, from young to old, from rich to poor and from individuals to families. Universal coverage means that the entire population is covered in terms of health services, which finance access to and the utilization of health services without regard to an individual's ability to pay. Equity means that an individual should be able to access and utilize health services according to their needs, irrespective of their ability to pay. Access to good quality health care, a main purpose of European healthcare services, can be defined as providing and maintaining the sustainability of healthcare services at a level that

meets the expectations of consumers within the existing technological facilities of a healthcare system (Council of the European Union, 2006).

Furthermore, White Paper (Commission of the European Communities, 2007a) describes the basic principles for EU action in the health field as: (1) a bundle of more comprehensive common health values which includes, alongside European Common Values (ECVs), citizen's empowerment, reduction of inequities in health care, and scientific evidence; (2) health as the greatest wealth; (3) health in all policies; and (4) strengthening the EU's voice in global health. The recently published White Paper on the future of Europe - reflections and scenarios for the EU27 by 2025 (European Commission, 2017) indicates that EU's scientific community is aimed to tackle health challenges such as for the treatment of Alzheimer's disease and to support the vanguard of global research.

Evolution of The EU Health Policy Competencies

The EU, which continues to extend and deepen step-by-step, has arisen as an entity with its own policy, politics and polity that impinge on almost all areas of daily life in Europe (McKee and Nolte, 2004), including health and health policies. The EU now wields authority in many areas, including social, political, and economic and health policy. Nevertheless, it is certainly the case that EU competencies in health policy are significantly less developed than those in other areas (Mossialos and Permanand 2000). Generally speaking, however, since its outset, the Community has had an interest in health, and many Community policies have had important influence on the health status and health systems of the Community (Byrne, 2001). Randall (2000) has noted that 'accident and tragedy, together with serendipity and understandable opportunism, have played a major element in the development of the EU's growing role in health and health-related policy-making.' For example, Europe Against Cancer, which was the first public health program of the EU, was suggested by President Mitterrand who himself was a victim of cancer.

Lamping and Steffen (2005) note that there are three distinct sources of change and pressure for Europeanization in the health policy field: '1) public health crises, 2) market integration and compliance, and 3) policy diffusion and discourse'. These main factors, which are responsible for the Europeanization of health policy, i.e., the evolution of EU health policy competencies, can be detailed as below:

1. EU Legislation (Agreements and Directives, Etc.)
2. Internal Market Dynamics, ECJ's Case Laws, and Spill-Over Effects from Other Policies
3. Extraordinary Situations, Scandals and Crises (For Example Crises Caused By BSE, SARS And, More Recently, Avian Influenza)
4. Member Countries (Especially Presidencies, Ministries of Health Of Member Countries, The Malaga Process, Etc.)
5. Reforms at The EU Level, Such as Romano Prodi's Reforms
6. The Point-Of-View of Politicians and Eurocrats (For Example, Mitterrand And David Byrne's Successful Programs)
7. Roles of Non-Governmental Organizations (Ngos)
8. Roles of Various Bodies Established at the EU Level (Such as the EU Health Forum, the High Level Group on Health Services and Medical Care, and so Forth)
9. The Role of Scientists.

When the historical background of the EU competencies in health is explored, it can be easily seen that the evolution of EU health policy has taken place in two main contradictory strands: one is the public health strand and the other one is the internal market strand. As Mossialos and McKee (2002) have discussed, the Treaties state explicitly that health care is

the responsibility of Member States. On the other hand, several health and health care-related areas within the mandate of the EU can be explained by 'spillover effect'. It would appear that these single market aspects of health policy have developed because of Community activities in the broader field of social regulation.

The Public Health Strand

As is well known, the legal constructions that constitute the backbone of the EU have had a considerable and fundamental role in shaping EU health policies, especially in recent years. For that reason, when the evolution of EU health policies is considered, it is useful to depart from an analysis based on EU legislation and related developments, especially the Treaties (i.e., narrow definition of EU health policy).

In 1952, an ambitious project entitled 'European Community of Health Care' had failed. The project, which was proposed by Paul Ribeyre, the French Public Health and Population Minister, was aimed at creating a 'supra-national high authority' in order to pool and manage all health care resources available in the participating countries (Rossert & Goate, 1994). Following the failure of this project, health policy did not secure a strong place in the Community agenda until the early 1990s.

The earlier treaties (Paris and Rome Treaties) contained a few provisions of direct relevance to health, mainly regarding health and safety at work. However, other policies including agriculture, freedom of movement, research programs, internal market provisions for medical products, mutual recognition of medical qualifications, free movement of services, and environmental and transport measures have had a considerable impact on the health of the public (Chambers, 1999/ 2000).

Social concerns, especially health-related issues, were not an integral part of the Paris Treaty's provisions. However, Article 55 included allowances for research and co-operation

between Member States with respect to the health and safety of workers in the coal and steel industries (Mossialos and Permanand 2000; Mossialos et al. 2002). Euratom includes a chapter on health and safety at work, and led to the early establishment of standards and safety levels for protection against ionizing radiation, not only for workers, but also for the general population (Mossialos and Permanand 2000; Mossialos et al. 2002; Cucic, 2000).

Between the 1960s and early 1980s, several Scientific Communities were established (some of which were health-related). It was not until 1986, with the Single European Act (SEA), however, that the integration process was substantially reinvigorated (Mossialos and Permanand 2000; Mossialos et al., 2002). The SEA of 1986 established an extension of Community actions in relation to health, although health policy was not treated as a separate policy sphere. This act enlarged the scope of occupational health and safety as well as environmental and consumer protection (Cucic, 2000; Lethbridge, 2002). This has resulted in a number of directives on product safety, occupational safety and health (Cucic, 2000).

One of the milestones in the evolution of EU health policy competencies was a resolution of the Council and the Ministers for Health made during a meeting within the Council on 11 November 1991 concerning fundamental health policy choices. The Council "emphasized that it is a matter for the Member States to determine the organization and funding of their health care systems and to make fundamental health policy choices" (Official Journal, 1991).

When we come to the early 1990s, it can be seen that health policy has found a firm place on the EU agenda, basically on the grounds of Treaties. The Maastricht Treaty (Treaty of European Union) of 1993, which amended the Treaty of Rome for the first time, formalized the powers relating to health (Lethbridge, 2002). The EU Treaty provides a specific definition of the Union's powers related to public health in Articles 3 and 129 (Cucic, 2000). Article 129 of the 1993 Treaty of the European Union provided a legal base for health policy across the

entire European Community. Article 129 confirmed the Community's role in tackling narcotic drugs, AIDS, and cancer, although these programs had been ongoing since the 1980s under the Treaty of Rome. Various Communications from the Commission have since been formalized into public health competencies for the EU (Mossialos and Permanand, 2000). Article 129 gave the Community legal competencies 'to contribute to the attainment of a high level of health protection' for its citizens, and thus made it possible for the Commission to plan and develop a consistent approach to public health by means of various actions. It also creates an obligation for the EU to ensure that 'health protection requirement formed a constituent part of all the community's other policies' and to 'encourage cooperation between the Member States and, if necessary, lend support for their action' (Randall, 2001; Mossialos et al., 2002; Hamalainen et al., 2004).

The Maastricht Treaty also introduced the principle of subsidiarity which is intended to ensure that decisions are made as closely as possible to the citizen and that there are constant checks to determine whether action at the Community level is justified in light of the possibilities available at the national, regional or local level (Hamalainen et al., 2004). With regard to health systems, this means that (as quoted below) the organization and delivery of health services and medical care are the responsibility of the Member States themselves.

Another Treaty in which health has been arranged is the Amsterdam Treaty. In Article 152 of the Amsterdam Treaty it is stated that, 'A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities.' Furthermore, it is stated in Article 152 that 'Community action in the field of public health shall fully respect the responsibilities of the Member States for the organization and delivery of health services and medical care' (Official Journal of the European Communities, 2002).

The Treaty Establishing a Constitution for Europe (TECE) (Official Journal of the European Communities 2004), which remains unimplemented due to its rejection in referenda

by French and Dutch voters, also included Community health powers (public health article, III-278). The Charter of Fundamental Rights, which was incorporated in the Constitution but now, stands alone, further states that 'everyone has the right of access to preventive health care and the right to benefit from medical treatment. A high level of human protection shall be ensured in the definition and implementation of all Union policies and activities' (Official Journal of the European Communities, 2000).

Furthermore, following the failed ratification of the proposed Constitution, the Treaty of Lisbon (Treaty of the Functioning of the European Union-TFEU) was signed by European Leaders on 13 December 2007 in order to fill the gap. This treaty was designed to "provide the EU with modern institutions and optimized working methods to tackle both efficiently and effectively today's challenges in today's world" and succeeded the 'unborn Constitution'. It includes a public health article (article number 168) amending Article 152 of the Amsterdam Treaty. The Treaty of Lisbon entered into force on 1 December 2009 after all 27 Member States ratifying it. Therefore, currently, at the EU level, arrangements governing health in terms of Treaty provisions are obligations included in Article 168 of the Lisbon Treaty (Official Journal of the European Union, 2007a). The general idea of EU action in the field of health remains the same. Article 168 states that "Community action shall be directed towards improving public health, preventing, human illness and diseases, and obviating sources of danger to human health by encouraging cooperation between the Member States and lending support to their action.". A key area of potential impact on health policy is the inclusion of the EU Charter of Fundamental Rights (EUCFR) into binding law for most Member States. This will have an impact on EU health law as the EUCFR contains a number of rights that may have an impact health care decision-making and to other matters of law, including clinical research and public health (Hervey and McHale, 2005).

The current Union's health activities and programs are conducted on the basis of Article 168 of the Lisbon Treaty. As is well known, implementation of EU health policies is carried out through 'health strategy' and 'programs' at the meso and operation levels. Based on the Maastricht Treaty, the Community Health Strategy of 1993 (Commission of the European Communities, 1993) was prepared by the Commission. In this policy document, the Commission declared that it was not only maintaining and developing its activities but was also identifying a range of other public health programs and activities.

In 1993, the European Commission developed a framework for action in public health, a strategy to implement the provisions of the Treaty of the EU. Eight action programs have been developed: AIDS and other communicable diseases, drug dependence, cancer, health promotion and health monitoring (Cucic, 2000).

In addition to Article 168 of the Lisbon Treaty, current EU health policy is also based on the Commission Communication, a European Health Strategy, and the New Public Health Program, which ran from 2003 to 2008. The Program has three main objectives: improving health information and knowledge, rapidly responding to health threats, and addressing health determinants (Commission of the European Communities, 2000). In addition, on 23 October 2007, the European Commission adopted a new Health Strategy titled 'Together for Health: A Strategic Approach for the EU 2008-2013.' "This Strategy, concentrating on four principles and three strategic bases for improving health in the EU, proposes to provide an overarching strategic framework covering core issues in health as well as in all policies and global health issues.

The principles consist of taking a value-driven approach, recognizing the links between health and economic prosperity, integrating health in all policies, and making strong the EU's voice in global health" (EUROPA, 2007a).

The Second Program of Community Action in the Field of Health 2008-2013 came into force on 1 January 2008 and succeeded the first Program of Community Action in the Field of Public Health (2003-2008). The objectives are threefold: 1) improve citizens' health security; 2) promote health, including a reduction of health inequalities; and, 3) generate and disseminate health information and knowledge (EUROPA, 2007b).

As the third health programme of The European Commission which was titled "Health for Growth" for 2014-2020, was published on 9 November 2011. The main focus of this proposal is to promote Member States for internalizing constructive solutions in health and prevention that will make contribution to the sustainability of health systems, and in implementing EU health legislations. Regulation (EU) 282/2014 is the legal basis for the current Health Programme. This programme has a budget of €449.4 million and 23 priority areas. The objectives of the Europe 2020 strategy are related with health objectives in this programme and they are 1) contributing to innovative and sustainable health systems, 2) increasing access to better and safer healthcare for citizens, 3) promoting good health and preventing diseases, 4) protecting citizens from cross border health threats (EUROPA, 2013).

Several aspects of European health policy integration are indirect consequences of other Community provisions and policies rather than results of a genuine health policy initiative (Lamping and Steffen, 2005).

The Internal Market Strand

In parallel with the direct involvement of the EU in public health policies through its legal power (public health strand), other EU activities may impact health-related issues, in particular the organization of EU Member States' health care systems (the internal market strand). As Hervey and McHale (2004) point out, the internal market strand is the more vitally important of these systems. Permanand and Mossialos (2005) have argued that, despite the Member States' persistence that healthcare should remain a national competence, many of the

apparently economic and single market initiatives that have been implemented impact healthcare policy and financing at the national level. For example, internal market and ECJ rules influence health care provision and financing. Moreover, the ECJ is seen as a 'wild card' in the process of health policy-making in the EU, and this kind of policy making is called 'unintentional health policy making' (Duncan, 2002). As mentioned previously, the second strand in the evolution of EU health policy is mainly taking place within the context of internal market dynamics.

Mossialos et al. (2002), and Mossialos and Palm (2003) pointed out that the 1957 Treaty of Rome provided the basis for a common market, with its requirements fleshed out by the 1992 Maastricht Treaty. This market is characterized by four fundamental freedoms of movement: people (patients and health professionals), goods (pharmaceuticals and medical equipment), services (health services and health care insurers), and capital (hospital investment). These four freedoms have continued to lie at the heart of the European idea and have important implications for the development of health policy in Europe.

The creation of a single market has had a dual role in the development of an EU health policy framework. On the one hand, as it enables the Community to regulate only in some areas, it has not had a fundamental impact on national health policy regimes. On the other hand, the SEM has served as an important magnet that secures intergovernmental agreement on the economic aspects associated with health policy in Europe (Mossialos et al., 2002).

The free movement of patients across borders within the EU has taken place according to a framework of arrangements, especially those related to the provisions afforded by the Rome Treaty. The Community mechanism for the co-ordination of social security systems, based on EEC Regulations 1408/71 and 574/74, has guaranteed access to health care to migrant workers and their dependent family members moving to or residing in another EU

Member State. These Regulations were subsequently extended to almost the entire EU population (Mossialos et al., 2002).

However, as Mossialos and McKee (2002) discussed, the regulatory framework for access to health care abroad has traditionally been based on the principle of free movement of people within the EU, but the ECJ was required to assess these rules in 1998 in light of the free movement of goods and services. The delivery of health services and medical care to patients was previously thought to be unaffected by European integration politics (Lamping and Steffen, 2005).

Nevertheless, European health policy has been rising rapidly up the political agenda following several rulings by the ECJ with respect to individuals seeking care in various member countries (Iain, 2004). The ECJ has been systematically creating something akin to a single market for health services through decisions that allow patients and professionals to travel to the system that will treat them most quickly (Greer, 2004).

The ECJ has clarified, through rulings such as the Kohll and Decker ruling, the Smits-Peerbooms ruling, the Vanbraekel ruling, and recently the Watts case, that Treaty provisions on free movement apply to health services, regardless of how they are organized or financed at the national level (Commission of the European Communities, 2006). Thus, national health policies have been moved to the heart of the EU policy-making process. As can be seen, the ECJ has played a major part in raising health policy issues. This stems from its role in 'constitutionalizing' the process (Mossialos et al., 2002).

In recent years, however, the Commission has made attempts to create more initiatives in order to minimize the 'wild card' role of the ECJ. In order to respond to issues raised by ECJ case laws, and thus to take initiative for health policy making at the EU level, European health ministers came together in February 2002 in Malaga to take part in a high-level process of reflection on patient mobility and health care developments at a European level. This

process can be regarded as a turning point in dealing with health services at the EU level. As a reflection of this process, EU Member States have made it clear that they want the European Commission to propose ways to increase legal certainty; even a problematic framework is better than piecemeal judicial health policy making (Greer, 2006). The Commission launched a consultation process regarding Community action on health services (Commission of the European Communities, 2006). As a result of this process, the Commission has recently adopted a new Health Strategy (White Paper, Together for Health: A Strategic Approach for the EU 2008-2013) (Commission of the European Communities, 2007a) and the Council approved the EU Health Program for 2008-2013 (Official Journal of the European Union, 2007b). The Strategic Plan 2016-2020 (European Commission, 2016) was introduced by the Directorate-General for Health and Consumers, or DG SANCO and it was based on four points. They are improving and protecting human health, and supporting the modernization of Europe's health systems; ensuring safety and quality of food and medicinal products; protecting animal health and welfare and plant health; contributing to a well-functioning and fair internal market in food, feed, agricultural and medical products. The third Health Programme for the 2014-2020 period prepares in order to support policy coordination in health. It aims "to complement, support and add value to the policies of Member States, in terms of improving the health of EU citizens and reducing health inequalities"(EUROPE, 2013). The European Union's (EU) 2011 Directive on cross-border patient mobility determines an EU citizen's rights to healthcare in the European Economic Area (EEA). According to this directive, every EU citizen has the right to travel abroad for treatment, and the rule of reimbursement is the same as it is in their own states. The mobility of patients is an attractive policy; but, its implementation paves the way for financial difficulties for patients due to a lack of coordination among providers, insurers and governments within EU (Official Journal of the European Union, 2011; Greer, 2013).

The Future

As has been discussed throughout this paper, an EU health policy arena has been evolving, especially since the early 1990s. Health policy in the European Union affects both health and health systems. Over the last two decades, there has been a significant increase in the influence of the EU on the health field. Health policy topics are occupying the European political agenda at an exponentially increasing rate. With this agenda, the EU plays an increasingly significant role (concerning health issues) in cooperating, promoting and coordinating with and between the Member States (EUROPA, 2007a; Skar, 2007) by concentrating on disease prevention, overall preparedness, rapid response to potential dangers (Skar, 2007) and cross-border issues, such as patient mobility, pharmaceuticals and medical devices (pharmacovigilance, falsified medicines, clinical trials) (EUROPA, 2007a; 2013). 'Work on health at the Community level adds value to Member States' actions, particularly in the area of prevention of illness, including work on food safety and nutrition, the safety of medical products, tackling smoking, legislation on blood, tissues and cells, and organs, water and air quality, and the launch of a number of health-related agencies. However, there are several growing challenges to the health of the population, which require a new strategic approach' (Commission of the European Communities, 2007a).

When the information concerning the EU health policy is considered, and the policy documents that will shape the future of EU health policy are analyzed namely the Lisbon Treaty (Official Journal of the European Union 2007a), the Communication from the Commission on Consultation Regarding Community Action on Health Services (Commission of the European Communities 2006), the Health Strategy White Paper (Commission of the European Communities 2007a), the Health Strategy Staff Working Document (Commission of the European Communities 2007b), the Health Strategy Impact Assessment (Commission of the European Communities 2007c), the Program for Community Action in the Field of

Health 2008-2013 (Official Journal of the European Union 2007c), A Discussion Document (European Commission. 2007), Proposal for a Directive of the European Parliament and of the Council on the Application of Patients' Rights in Cross-Border Healthcare (Commission of the European Communities 2008), the European Union's 2011 Directive on Cross-Border Patient Mobility (Official Journal of the European Union, 2011), the Strategic Plan 2016-2020 (European Commission, 2016), the European Commission Proposal of Health for Growth for 2014-2020 (EUROPE, 2013) and The White Paper on the Future of Europe: reflections and scenarios for the EU27 by 2025 (European Commission 2017) they present five points related to the future direction of EU health policy.

First, it can be noted that a new phase has begun in which the legal bases with regard to EU health policy have been strengthened. The first concrete indication of this is the Lisbon Treaty, which was agreed to by EU Heads of State and the Government in Lisbon on 19 October 2007, entered into effect on 1 December 2009, and has superseded the 'unborn' Constitution. The Lisbon Treaty, which includes a public health clause (Article 168), has reaffirmed the EU's essential role in health policy. The Treaty proposes/envisages to strengthen the political importance of health (Official Journal of the European Union, 2007c). A new overall aim that supports citizens' well-being and encourages cooperation amongst Member States on health and health services is expected (EUROPA, 2007a; Commission of the European Communities, 2007a).

On the other hand, the Commission's proposal for a Directive on Cross-Border Healthcare (Commission of the European Communities, 2008), as a product of the movement that began with the Malaga Process (which required that the EU political authorities take direct roles in the health field that the ECJ tried to shape via case laws, especially in the context of the free movement of patients in 2002) brought to the agenda, for the first time, the determination of a common policy for health services at the EU level. The 27 Member States

and the EU Institutions have contended with challenges as they arise, the priorities in health are regularly followed, and new legislation is thawed out in this direction. As a result, they follow a joint agenda for action (European Commission, 2017).

These types of legal developments have justified the long-running disclosures that the EU was required to take on more roles and responsibilities based on legal grounding in the health services policy area (McKee and Mossialos, 2006).

Second, together with strengthening the legal basis, the EU's competencies concerning health policy will gradually increase and will eventually coalesce into a true picture. Likewise, it can be noted that, by determining policy norms and standards, an EU common health policy in health services centred on the free movement of patients and the movement and regulation of the healthcare workforce and the movement of third country nationals (non-EU citizens) will evolve and the 27 Member States will progress together as a Union (European Commission 2017; Greer et al., 2019).

Third, the subsidiarity principle, which is a main principle of the EU's competencies related to health, will continue to be a principle on which the EU's health authority is based. Accordingly, the main responsibility concerning health policy and health services will be in the hands of Member states, as was the case before. In this regard, the EU role' is not to duplicate the activities of Member states, but to perform duties that are not effectively managed by Member States on their own or to participate in situations where collaboration at the Community level is required. These situations include major health threats and issues with cross-border or international impact, such as pandemics and bioterrorism, as well as those relating to the free movement of goods, services and people (EUROPA, 2007a; Commission of the European Communities, 2007a). As a matter of fact, in Article 168 of the Lisbon Treaty relating to public health (19), it is stated that 'Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organization and

delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them.'

Fourth, it is expected that the EU will function on the basis of more comprehensive principles that will be determined for the health field. These principles will include '(a) shared common values (aforementioned EU common values, strengthening of citizens, decreasing of equities in health , and acting based on scientific evidence); (b) health is the biggest wealth; (c) health in all policies; and (d) a strengthening of the EU's voice in global health' (EUROPA, 2007a; Commission of the European Communities, 2007a). A set of core values and principles stated in the 2006 Council Conclusions on Common values and principles in European Union Health Systems. While the "overarching values'' are: "universality, access to good quality care, equity, and solidarity"; the "operating principles" are that health systems should emphasize "quality, safety, care that is based on evidence and ethics, patient involvement, redress, privacy and confidentiality" (Greer et al. 2019). It will be desirable for the individual member countries to consider these principles.

Fifth**,** even though the health systems of Member States present differences due to political, economic, cultural, and historical reasons, the problems confronting the health systems of EU are generally similar with regard to demographical changes including aging populations experiencing changes in disease patterns and challenges to the sustainability of health systems; pandemics; important physical and biological accidents and bio terrorism which potentially affect public health; technological progress altering the organizational manner and behaviors in the health system; increasing expectations of citizens; migration; and the free movement of health professionals and patients (EUROPA, 2007a; Commission of the European Communities, 2007a). To be able to respond to these challenges at the EU level

requires developing common policies and strategies together. Put another way, to solve the health problems collectively necessitates adopting a common health policy at the EU level.

To confront these major challenges to health in the EU, the health strategy in 2007 determined three objectives as key domains of action for the coming years: '1) Fostering good health in an ageing Europe, 2) protecting citizens from health threats, and 3) supporting dynamic health systems and new Technologies'(EUROPA, 2007a; Commission of the European Communities, 2007a).

However, the consequences of the economic crisis in 2008, the migration and refugee crisis have caused to emerge warning signals for solidarity among Member States and the importance of the European project has been put into question. In this context, the Commission will focus its efforts on these points; achieving greater cost-effectiveness; safety versus competitiveness; tackling emerging global threats; evidence-based policy making; and addressing sector interests in the Strategic Plan 2016-2020 (European Commission, 2016). This strategic plan which was prepared by the Directorate-General for Health and Consumers, or DG SANCO has three priorities; 1) a new boost for jobs, growth and investment in the EU; 2) a deeper and fairer internal market with a strengthened industrial base; 3) a balanced and progressive trade policy to harness globalization (European Commission, 2016).

CONCLUDING REMARKS

This paper has provided a brief overview of policy developments in a field where the EU has not yet officially embarked on a "common policy", namely the health policy. Despite the original restrictions on EU health policies, the EU is gaining increasing power and influence in many health policy areas, especially since the 1990s. We stress that EU health policy has mainly evolved via two contradictory strands that are nevertheless interconnected: the public health strand and the internal market strand. The EU has struggled to have a more direct role in health care in recent years in order to overcome challenges that have emerged

from internal market dynamics, such as cross-border care issues. At this point, a strategic approach should be able to effectively manage this process in favor of citizens' health through strategic planning and approaches guided by scientific information and collaboration.

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