

## **Forging a European Health Union: between subsidiarity and sovereignty?**

By: Elizabeth Kuiper and Mary Guy

**Elizabeth Kuiper** is Associate Director and Head of the Social Europe and Well-being programme at the European Policy Centre, Brussels, Belgium; **Mary Guy** is Lecturer in Law at Lancaster University, UK, co-coordinator of the [EU Health Governance](#) research network, and founder of the virtual discussion forum [Health in Europe](#). Email: [m.guy2@lancaster.ac.uk](mailto:m.guy2@lancaster.ac.uk)

**Summary:** Developing a European Health Union necessarily involves re-examining European Union (EU) and national level interaction. While this is currently framed around limited legal competence, its political identity is notable: the EU's role is restricted because health is a Member State competence. Although this has not precluded more subtle EU-level involvement via, for example, internal market rules and fiscal policies such as the European Semester, the explicit development of a European Health Union is more contentious and political by nature. We consider here how the principle of subsidiarity and concerns about national sovereignty may help – or hinder – the shaping of a true European Health Union.

**Keywords:** European Health Union, Subsidiarity, Sovereignty, Solidarity, COVID-19

### **Introduction**

The development of a “European Health Union” was announced by Commission President von der Leyen in September 2020 as a response to the COVID-19 pandemic. Although the leadership of the Commission was welcomed initially in the context of the global pandemic, it inevitably invites longer-term questions of how the EU and national levels will interact within this Union, and how the relationship between Commission and Member States constrains or facilitates its development. Thus far, there has been limited explicit EU-level competence: health is seen fundamentally as a national competence, circumscribed by the principle of subsidiarity. However, the effect of EU-level involvement has evolved over time and (public) health goes far beyond the treaty competence (Article 168 Treaty on the Functioning of the European Union (TFEU)) to include the effects of internal market rules and fiscal policy.<sup>(1)</sup> The reluctance of Member States to give more power to the EU level over health can be linked to various concerns, which are often political in nature. However, linkages between perceptions of the EU and the sovereignty of national governments (and by implication health care systems) can be at once misleading yet extraordinarily politically salient. This has been evidenced by the kneejerk reaction of national governments to close their borders at the start of the COVID-19 pandemic, as well as the Vote Leave campaign's bus promising more money for the National Health Service in the 2016 United Kingdom referendum on EU membership. While this latter may suggest an extreme example, it nevertheless highlights how concerns about national sovereignty in health care can be fragmented within the perma-crisis and could easily hold back, if not derail, the development of a true European Health Union.

### **Subsidiarity and sovereignty in health around COVID-19**

Insofar as initial EU-level responses to the COVID-19 pandemic were found wanting, this was attributed to the clear demarcation of health as a national competence – this outcome emerged because “Member States wanted it so”.<sup>(2)</sup> If the Maastricht Treaty is notable in part for introducing the first public health competence, then other notable aspects can be seen in the identifying of “incentive measures” to underscore EU-level competence to coordinate and support national measures, and in the linking of the principle of subsidiarity with health care. The initial formulation of the public health competence provided at least two key responses: to those who recognise that (at least some) health policy issues and certainly health crises warrant action beyond the national level; and to those concerned about “competence creep” by the EU institutions regarding health. These tensions – which reflect the importance attached to sovereignty regarding health care – remain constant and find reflection in responses to the construction of a European Health Union.

EU-level activity in health is largely confined to incentive measures (Article 168(5) TFEU) – whether forming the legal basis for successive health programmes, or being referenced in connection with the Joint Procurement Agreement, developed in the context of the H1N1 pandemic, but also a key aspect of the COVID-19 response.<sup>(3)</sup>

The benefits to incentive measures are clear – they allow scope for a greater EU role while still respecting national sovereignty of health care.

The demarcation of Member State competence regarding health care system organisation provided by the “subsidiarity clause” for health care (Article 168(7) TFEU) appears to encompass a curious mix of political and legal force: on the one hand, it might be considered to “shut down” discussion of varying degrees of EU-level activity in health; but on the other hand, it clearly fails to prevent perceptions of EU-level “incursion” into national health care associated with fiscal policy. This, for example, is the case for the Country-Specific Recommendations issued by the Commission in the context of the European Semester economic assessment cycle. Another illustration of EU health legislation that goes beyond pure public health concerns is the Health Technology Regulation (HTA), which explicitly sets out that “HTA can (...) assist Member States in creating and maintaining sustainable health care systems and stimulate innovation that delivers better outcomes for patients.”

However, perhaps the most notable “threat” to national sovereignty regarding health care systems has been with the steps taken to facilitate access to cross-border health care – with the legal basis for this coming from internal market rules, like the above mentioned HTA Regulation that has its legal basis both in Articles 114 and 168 TFEU.

### **Two visions of a European Health Union – crisis response, and beyond...?**

Calls for a European Health Union can be traced back to around May 2020, at EU level by the Socialists and Democrats as well as in France following calls by French President Macron to construct “une Europe de la santé”. (4) These calls gained significant momentum with reiteration by Commission President von der Leyen in her inaugural State of the Union address in September 2020. At that stage, questions of the Member States’ role within the Union, and the expansion of EU-level competence, appeared open to negotiation – with suggestions that Treaty change was both feasible (by Commission Vice-President Schinas)(5) and necessary (by former German Chancellor Angela Merkel)(6).

The initial elaboration of how a European Health Union should be constructed was published by the Commission in November 2020, and clarified the legal basis as Article 168(5) TFEU, concluding with the pithy remark: “The European Health Union will be as strong as its Member States’ commitment to it(7)”.

Developments of a European Health Union saw this take on two conceptualisations: one as fundamentally a crisis response, and the second relating to wider concerns about continuity and resilience of health care systems. Over time, it has become clear that the Commission’s position lies somewhere between the two, albeit with an arguable emphasis on the former. This can be seen by the focus in von der Leyen’s 2021 State of the Union address shifting to HERA, with less mention of the European Health Union.

The distinction between the two visions of a European Health Union is helpful for indicating where questions of subsidiarity and sovereignty may prove contentious: with calls for “more Union” being clearer in the direct response to the pandemic. The question is whether the momentum and political will remain to construct a true European Health Union, now that the worst of the pandemic seems behind us, and the agenda of the Heads of States has been taken over by other priorities.

### **Forging a true European Health Union: solidarity, not just subsidiarity and sovereignty?**

As outlined elsewhere in this Special Issue, a true European Health Union will strengthen our health systems beyond crisis preparedness and response. This is needed to face not just COVID-19 as a single event, but the perma-crisis including economic, climate and refugee crises. For this, health systems will be needed to be strengthened with a view to prioritising Universal Health Coverage and improving health system performance, and (investment in) health needs to be seen as a prerequisite for a well-functioning society.

Tackling the potential barriers posed by subsidiarity and sovereignty in this endeavour will be a challenge. But the nature of this challenge needs further elaboration – is it legal, or political? Or both?

The possibility for revisiting the Treaties to build a European Health Union had been reserved to consideration by the Conference on the Future of Europe (CoFoE). Those dubious about what this event could achieve regarding changing EU-level competence in health may have found their scepticism justified by Health Commissioner Kyriakides' clarification in September 2021 that "[a] strong European Health Union is not about redrawing the competences of Member States".(8)

Nevertheless, at the time of writing in June 2022, the CoFoE proposals have been published, indicating a strong willingness to change the interaction between the EU and national levels to a "shared competence". This would require amendment of Art. 4 TFEU – something which has already been picked up by the European Parliament. It might be anticipated that aspects of Article 168 may also benefit from amendment – although Article 168(7) TFEU can be seen to offer a range of flexibility which is often overlooked.(9) Nevertheless, a conscious effort should be made in parallel to reflect on the discussions and suggestions of the CoFoE regarding the potential need for an expanded EU role in health policy.(10)

In view of the fact that any legislative change will require significant and sustained political will of EU Member States, it remains the case that policy framings may help the development of a true European Health Union. By shifting the focus of sovereignty to the EU level – arguably by referencing the value of solidarity – it may become possible to leverage a sense of "European sovereignty" in tackling the perma-crisis, an identity which distinguishes less between EU and national levels, and more between Europe and other global actors.

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