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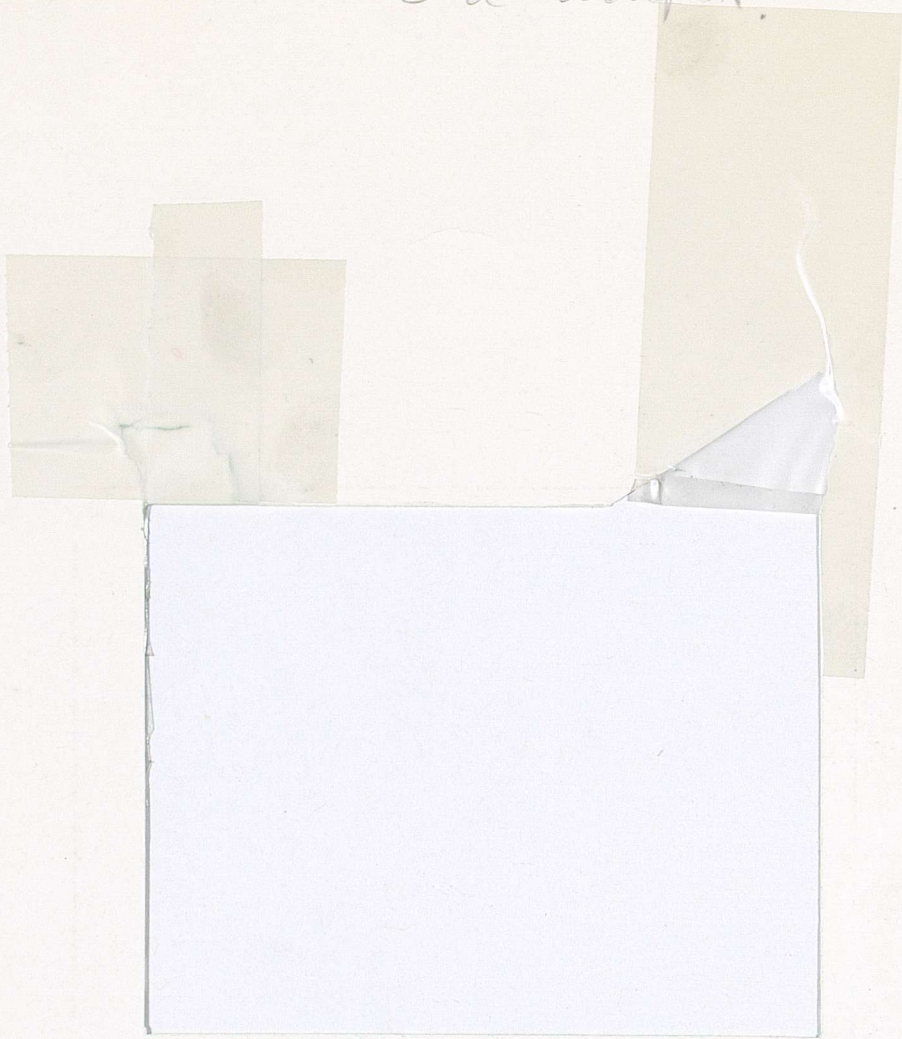
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**INSTITUTE FOR HEALTH POLICY STUDIES
UNIVERSITY OF SOUTHAMPTON**

**THE IMPACT OF EUROPEAN INTEGRATION
ON THE NATIONAL HEALTH SERVICE
AND ON HEALTH POLICY**

by

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INTRODUCTION AND SUMMARY

This Occasional Paper¹ explores the impact of European integration on the National Health Service (NHS) and on health policy. It focuses on two major phases of European Community (EC) development (1973 to 1992 and the period since 1992, the year the Treaty on European Union (Maastricht Treaty) was signed.

The Paper argues that no coherent Community health policy can be identified for the period 1973 to 1992. Instead, the NHS and health policy were most affected by regulations and initiatives emanating from other policy sectors; in particular the Single European Market, the social dimension, research and information technology. The impact of initiatives from these other sectors seems to have intensified since 1992.

The new Article on public health in the Maastricht Treaty could be seen as marking the launch proper of a coherent Community health policy. What is argued here, however, is that Article 129 represents a high degree of continuity with, rather than a radical departure from, past EC initiatives and actions by EC institutions. Overall what this illustrates is a "ratchet-like" and logical development of Community policy.

The players who exerted most influence in getting Article 129 included in the Maastricht Treaty are identified as the member state governments, the European Parliament and the Commission. With the exception of the European Citizen Action Service, non-governmental organisations and professional interest groups seem to have had little influence.

Finally, an in depth examination of Article 129 highlights that certain aspects of the policy process are as much in evidence at the Eurotransnational level as they are at the national level. Some differences between the two levels can, however, be detected. It is suggested that these are to do with degree and complexity. There seems to be greater openness and accessibility to outside interests, and potentially greater

¹ This paper is a rewrite for a wider audience of a dissertation which was submitted in July 1994 for the award of MSc in Policy Studies (School for Advanced Urban Studies, University of Bristol).

opportunities for the formation of policy networks, at Eurotransnational than at national level. Furthermore, the policy process at European level comes across as being even more complex than that operating at national level.

PART ONE: AIMS, SCOPE OF THE RESEARCH AND METHODOLOGY

1.1 The three research questions

This Occasional Paper aims to address three questions. These are :

1. What impact did European integration have on the NHS and on health policy during the period 1973 (the year of Britain's accession to the Community) to 1992, when the Maastricht Treaty was signed?
2. What impact is European integration likely to have on the NHS and on health policy in the period following the Maastricht Treaty?
3. How did Article 129 on public health, a new competence for the EU, come to be included in the Maastricht Treaty?

1.2 Clarification of terms and topic boundaries of the research

Two issues - the definition of social policy at the European level and the wide range of EU policies which impact on health - underline the need to clarify terms and the topic boundaries of research examining the impact of European integration on the NHS and on health policy. Each of these issues is explored below.

EU social policy

The "problem" here is to do with the definition of social policy at the European level, when compared with the definition commonly used in a British context. At EU level, social policy, as set out in Articles 117-22 of the Treaty of Rome, has a restrictive meaning and is mainly concerned with the labour market and employment conditions (Lodge, 1989; Liebfried and Pierson, 1992; Brewster and Teague, 1989, Nicholl and Salmon, 1990; Tsoukalis, 1991 and Pinder, 1991). Although the Maastricht Treaty and the White Paper on European Social Policy (Commission of the European Communities, 1994) arguably signal a widening of the scope of EU interest in social

policy, labour market concerns continue to predominate. EU social policy is definitely not, as Lodge puts it, "a generalised scheme for providing social welfare", the meaning commonly attributed to social policy in the British context (Lodge, 1989 and see also Tsoukalis, 1991, Kleinman and Piachaud, 1993 and Hill and Bramley, 1986). This important difference in definition highlights that it is necessary to look well beyond the literature on EU social policy to identify the impact of the EU on the NHS and health policy.

The wide range of EU policies which impact on health

In recent years there has been increasing acknowledgement that there are social, psychological, emotional and physical components to health (McKeown, 1980; Hart, 1985; Whitehead, 1988; Blaxter, 1990 and Eurolink Age, 1993). It therefore follows that a wide range of policies impact - albeit often indirectly - on the health status of individuals and populations. At EU level, these include the Single European Market and its regulation, socio-economic policy concerning the poorer sections of the Community's population and policies on the environment, agriculture, food, consumer protection and transport (O'Connor, 1992; Richards, 1991; Whitehead and Dahlgren, 1991; Joffe, 1993 and Commission of the European Communities, 1993). Also relevant is taxation policy; for example the harmonization of taxes will change consumption patterns of tobacco and alcohol.

In a Paper of this length it would be difficult to examine this wide range of policies in detail. In addition, the precise impact on health of a number of the policies listed is a highly contested area; for example the debate about the possible link between socio-economic policy and health has aroused - in Britain at least - much controversy. For these reasons it was decided that the research should focus on those policies having a **direct** impact on health policy - including preventive health, health education and health promotion - and on the NHS, both in its capacity as a provider of health services and, for example, as an employer and a procurer of goods and services.

1.3 Methodology

Three main methods for addressing the research questions set out in Section 1.1 were used. These were a literature search and field work involving a visit to Brussels and a small number of interviews, one of which was conducted in Brussels and the remaining five in Britain.

Two data bases - BIDS EMBASE and MEDLINE - were used in the literature search. The field work in Brussels took place during a study tour on "European Health Management" organised by the Health Services Management Centre, University of Birmingham (see Appendix B for the programme and details of the main speakers addressing the group). The names and job titles of the people interviewed are given in Appendix C.

The surnames of the speakers who addressed the Brussels study tour group and of the six interviewees provide the basis for the scheme used in Part Two (Findings) of this Paper for referring to data obtained during the field work. Data from one of the interviews is identified by the surname of the interviewee, followed by two abbreviations: "BRU" or "UK" (to denote whether the interview took place in Brussels or the UK) and "INT" for "interview". Similarly, data drawn from informal discussions with speakers who presented to the Brussels course is referred to by the speaker's name, followed by the abbreviations "BRU" and "DISS".

PART TWO: FINDINGS

2.1 The impact of European integration on the NHS and on health policy during the period 1973 to 1992

This section begins by summarising the legal basis for EU action on health and welfare. It then focuses on the initiatives and policies directly affecting the NHS and health policy during the period 1973 to 1992, using a framework of analysis developed by Ham (in Harrison (1992)). Finally a number of themes emerging from the analysis and which are to be found at the heart of European integration are highlighted.

2.1.1 The legal basis for EU action on health and welfare

A cursory examination of the legal basis for EU action on health and welfare before the 1992 Maastricht Treaty immediately highlights a paradox. Although the Treaties do contain provisions of direct relevance to the protection of health and welfare, health services are not generally covered. The emphasis overall seems to be on supporting positive or preventive health - for example through health protection measures - rather than on addressing ill health, for example through policy directly affecting health services. Instead, as Svensson and Stephenson point out, it is the regulations made for other sectors which tend to have repercussions for health services (Svensson and Stephenson, 1992).

For example, health and safety at work was given from the outset a prominent place in the EEC Treaty (Articles 117 and 118 of the 1957 Treaty of Rome, which were given additional impetus by Article 118A of the Single European Act (SEA)). Other provisions in the Treaty which also directly or indirectly affect health are detailed in the table in Appendix D. Broadly these concern the Community's duty to raise the standard of living (Article 2), health protection (Articles 36, 100A, 130r and 130s, and 155) and freedom of movement of persons and services (Articles 48, 51, 52-58, 59, 85-88). In addition, there are Articles on agriculture (43) and research, including health research (130f - q). Finally, Article 235 allows - in certain circumstances - for

the Council to take decisions after merely consulting the Parliament. This so-called "mixed competence" Article has provided the basis for decisions and regulations on various health-related issues such as information to the general public and training of the health professions.

A number of publications contain an overview of the wide range of Community policies and instruments giving effect to the Treaty Articles of relevance to health and welfare (see for example Health Committee of the House of Commons, 1992; Normand and Vaughan, 1993 and Commission of the European Communities, 1993). Despite the significance of these policies and instruments for, say, health protection and the general health status of the Community's population, the intention of this research is to focus, as highlighted in Part One (p.3) on initiatives directly affecting the NHS and health policy, including preventive health, health education and health promotion. In order to do this a framework of analysis developed by Ham will be used (in Harrison, 1992 and Ham and Tremblay, 1993). Ham's framework is valuable in that it helps us to make some sense of what, on the surface, seems a "rag bag" of initiatives which, rather than adding up to a coherent Community health policy, strike us more as by products of policies in other areas. This initial judgement is borne out by Ham's framework which identifies three main categories of EU initiatives affecting the NHS and health policy. These are:

- 1) initiatives taken as a consequence of the move towards the Single Market;
- 2) initiatives resulting from the growing importance of the social dimension (in EU terms, this is defined principally in terms of the position and rights of workers although, as we shall see, the EU has taken a number of public health initiatives);
- 3) initiatives which have arisen as by products in related policy areas such as research and information technology.

These three categories are examined in more detail below.

2.1.2 The impact of the Single Market

The key aim of the original Treaty of Rome - freedom of movement of persons, goods and services - has been considerably strengthened by the 1986 SEA. Overall

the Act has greatly stimulated progress towards the creation of a Single European Market. Each of these three freedoms will now be examined in more detail in relation to the NHS.

Free movement of persons

As has been highlighted above and in Appendix D, Articles 48, 51, 52-58 and 85-88 of the EC Treaty provide the basis for directives concerning freedom of movement of persons. In a health service context, these directives affect both workers and patients.

There are various types of directives facilitating free movement of workers. For example, Sectoral (or Vertical) directives are about the mutual recognition of professional qualifications. They entail some standardisation of educational curricula and achievement (Health Committee of the House of Commons, 1992 and Svensson and Stephenson, 1992). The Community has been actively developing Sectoral directives since the mid 1970s. In the health sector directives are in place for doctors (from 1975 onwards : see Allman, 1993); general practitioners (1986); nurses (from 1977 : see Trevelyan, 1990); dentists (1978); pharmacists (1985) and midwives (1980).

General (or Horizontal) directives are, by contrast, much broader than Sectoral directives and cover those professions regulated by statute or common law, such as chiropractors, or by a Professional Association, for example psychologists (Health Committee of the House of Commons, 1992).

In addition to Sectoral and General directives, a system for mutual recognition of Higher Education diplomas awarded on completion of professional education and training of at least 3 years' duration was agreed in January 1989. This general directive (89/48) affects a number of the health professions, for example physiotherapy. It had to be implemented in national law by the member states by January 1991 (Featherstone, 1990; Institute of Health Services Management, 1992; Schutte, 1990 and Haase, 1992).

A second key group affected by measures in support of the Single Market objective of ensuring freedom of movement of persons are patients. The coordination of the social security systems of the member states means that under the E111 procedure, for example, emergency treatment is available to tourists (Richards, 1991). Under this procedure member states reimburse each other for emergency care provided to their citizens in other parts of the Community.

A less well-known procedure, the E112 procedure, is concerned with non-emergency treatment and requires prior approval to be sought from the Department of Health. About 400 UK residents per year are affected. The number using the procedure in other member states is generally higher. Again, member states reimburse each other for the cost of this treatment (Institute of Health Services Management, 1992). Finally the E106 procedure recognises people as both workers and patients by setting out special arrangements for frontier workers who live in one state and work in another. These arrangements enable workers and their families to use health services in both states.

The overall impact of the coordination of social security systems can be seen in changing cross border flows in health care (Institute of Health Services Management, 1992 and Allman, 1993). For example, there is the flow of tourists and retirees which tends to be along a north-south axis (Altenstetter, 1992, and Allman, 1993). In addition, there is the group of people - so called medical tourists - who may migrate for the purposes of health care - whether on a temporary or permanent basis - to centres of excellence. As such centres tend to be located predominantly in the northern member states migration is thus on a south-north axis (Allman, 1993). This type of flow looks set to intensify as a result of the liberalization of the private insurance market in July 1990 (Schutte, 1990). Finally, there are signs of increasing demand for medical procedures available in some member states but not in others, for example organ transplants and termination of pregnancy (the latter was highlighted by the case of the fifteen year old girl who had to leave Ireland to obtain a termination) (Richards, 1991).

Free movement of goods

The second freedom established by the Treaty of Rome and given new impetus by the 1986 SEA is that of freedom of movement of goods. Differences between national standards were identified as the major barrier to free circulation of goods and hence to trade. It is therefore not surprising that the establishment of common technical standards across the EC is one of the most fundamental components of the internal market programme. Since the internal market White Paper, however, the Community's original policy of seeking to achieve - through regulation - total harmonisation of technical and other standards - is increasingly giving way to an approach which stresses the importance of mutual recognition between Community member states for technical testing and certification procedures. Responsibility is vested in the European Standards Organisations (CEN and CENELUC), and not the Commission, for drawing up the technical specifications setting out essential requirements (Palmer, 1989 and Feathersone, 1990). This overall change of approach, coupled with the introduction of qualified majority voting in the Council of Ministers for decisions relating to the removal of technical barriers, is expected to speed up the process of agreement on standards.

In the health sector "goods" such as pharmaceuticals, medical devices, aids and appliances and medical equipment, for example dental material, hearing aids, X ray equipment and respiratory support equipment, are covered by Community legislation on common technical standards. Measures affecting pharmaceuticals and medical devices are discussed in more detail below.

Pharmaceuticals

A number of commentators have provided a comprehensive overview of major EC initiatives from 1965 onwards to create a single market for pharmaceutical medicines (Health Select Committee of the House of Commons, 1992; Orzack, Kaitin and Lasagna, 1992 and Taylor in Normand and Vaughan, 1993). These commentators have echoed the view strongly expressed by Cecchini, the architect of the Single Market programme, that integration is unusually difficult to realise in the pharmaceutical sector. Amongst the reasons for this are that societies are most

reluctant to tolerate "a liberalisation of controls for medicine that might threaten personal and social well-being" or "undermine national regulatory hegemony" (Orzack, Kaitin and Lasagna, 1992).

Notwithstanding these difficulties, the EC has pressed ahead with a range of measures. A significant number of these have been concerned with the safety and efficacy of drugs². Other measures have dealt with transparency in pricing (Schutte, 1990) and rules on the length of patents for new drugs. Steps have also been taken to encourage member states to participate in the mutual recognition of the licensing of drugs (see Section 2.2).

Medical devices

Similar themes have shaped EC directives on medical devices such as pace makers, a type of medical technological implant. The emphasis of Directives 90/385/EEC and 93/42/EEC is on safety requirements, incident reporting and recall and quality assurance in the medical device industry (de Bijl, 1993; Ludgate and Camm, 1993 and Department of Health, 1991). However it should be noted that Community legislation on medical devices, as well as that affecting pharmaceuticals, is not concerned only with free movement. Another important theme is consumer protection - the notion that the population needs protection from products and also from the potentially harmful effects of some services.

Free movement of services

The third type of freedom at the heart of the Single Market programme is the free movement of services. Here the discussion will focus on EC public procurement rules affecting services, although it should be noted that goods/supplies and construction/works contracts in the public domain are also subject to the rules. The overall objective is to remove all barriers to EC wide public tendering by opening up

² Measures concerned with safety and efficacy encompass good manufacturing practice, the conduct of inspectors of manufacturers of medicinal products, the training of inspectors, the conduct of tests and trials, conditions for both approval and suspension of licences and withdrawal of medicines : see Muhlen, 1993; Blasius, 1993; Leidl, 1991; Richards, 1991; de Bijl, 1993 and Orzack, Kaitin and Lasagna, 1992.



the award of public contracts, thus applying principles of non-discrimination and free competition. In the health sector the subjects of tenders of public contracts are very diverse, ranging from cleaning, laundry, maintenance, management consultancy, Department of Health research contracts and architecture to pharmaceuticals, hospital equipment and capital development (Featherstone, 1990 and Health Committee of the House of Commons, 1992). All invitations to tender for public contracts with a value above a certain threshold have to be published in the Official Journal of the European Communities and also in its on line version, known as Tenders Electronic Daily (TED). The threshold applying from July 1st 1993 for service contracts is 200 000 ECUs or £141, 431 (Directive reference 92/50/EEC). Other provisions cover procedures to be followed for applications and selection and what happens in the event of failure to comply with the EC public procurement regime (European Information Service Issue 126, Jan.1992; Issue 131, July 1992; Issue 136, Jan.1993; Issue 141, July 1993; Issue 142, Aug.1993; Health Committee of the House of Commons, 1992 and Chartered Institute of Public Finance and Accountancy, 1995).

Despite the fact that public procurement accounts for about 15% of the Community's GDP, the evidence available suggests that the economic impact to date of EC public procurement rules - for example savings achieved as a result of EC-wide competition - has been limited. The main reason for this is that there is in practice little cross border tendering (Emerson, 1988 and European Information Service Issue 142, Aug. 1993). Moreover it should be noted that the future regime for public procurement in the health sector is unpredictable. Two issues illustrate why this is so. First there is the difficulty of predicting the potential impact of the Private Finance Initiative (first launched in 1992 and extended in early 1995 : see Section 2.2.1 below). A second, and similarly complex, issue is raised by the interpretation of the EC's 1977 Acquired Rights Directive. This appears to guarantee pay and conditions for staff transferred from one employer to another through competitive tendering. If this interpretation of the directive is correct (it is still being contested), it could lead to contracting out in the NHS grinding to a halt and to workers who have lost or who lose their jobs as a result of competitive tendering receiving compensation (Sheldon, 1993 and Ham and Tremblay, 1993).

The liability of suppliers and goods and services for negligence

Despite the range of strenuous measures - for example the EC's public procurement directives discussed above - aimed at removing barriers to the free movement of services, a number of difficulties remain. One such difficulty is the wide variation in the substantive law of the member states about where the burden of proof for allegations of negligence rests (Hughes, 1992). With the aim of reducing the variation, the Commission has now issued a draft directive on the Liability of Suppliers and Services. This could eventually apply to areas of practice within the health and personal social services. The directive - framed in the context of consumer protection policy - shifts the onus of responsibility for disproving malpractice from the client to the supplier or practitioner who would have to demonstrate that his / her actions were not negligent.

In a health context, emergency services are excluded from the scope of the proposed directive, although it is not yet clear whether this includes ambulance services. Nor is it yet clear whether the directive will apply to medical services. Not surprisingly, perhaps, a great deal of concern has been expressed by doctors in this country about the prospect of EC law overriding UK law on medical negligence in which the onus is on the patient to prove malpractice (Leidl, 1991, Allman, 1993 and Health Committee of the House of Commons, 1992).

2.1.3 The social dimension

Ham's second category for making sense of EC action on health groups together initiatives resulting from the growing importance of the social dimension, including the interest shown in health and safety at work and public health (see Appendix D). It is to this second category that we now turn.

Health and Safety at work

It is Article 118A, added to the Treaty of Rome in 1986, which has set EC member states on course to harmonise conditions in the working environment and to establish a common cause in "achieving a better level of protection of workers' safety and health" (quoted in Vellenoweth, 1992). In June 1989 the EC published a framework

directive (89/391/EEC) under which a number of more specific health and safety directives have been issued. These contain minimum health and safety requirements for workplaces. However what is stressed is that application of the directives must not lead to a lowering of existing standards. In addition all the directives underline the need for adequate information, consultation and training for workers (Collins, 1992a).

The directives adopted by the Council of Ministers for implementation by 31st December 1992 all have implications for the NHS. They concern the use of personal protective equipment, work equipment and display screen (VDU) equipment, the manual handling of loads and facilities in the workplace, for example sanitary facilities, clothing storage, meals facilities and rest rooms (Southampton University Hospitals Trust, 1992; Vellenoweth, 1992; Richards, 1991 and Hughes, 1992). The directives relating to the manual handling of loads and the use of VDUs are perhaps of particular significance to the NHS and have already led to changes in working practices. In addition the NHS has had to respond to the requirement that "particularly sensitive groups must be protected against dangers which specifically affect them" (Directive 90/679, which had to be implemented by 26th November 1993) (Hughes, 1992). In effect the offer of hepatitis B virus inoculation to many "front line" health staff has become mandatory. There could also be implications for the availability of prophylactic ziduvodine after needlestick injury (European Information Service, Issue 138, March 1993).

Other health and safety initiatives emanating from the EC and having a particular impact on the NHS - particularly on Radiology Departments - have been implemented through EC Euratom directives. For example the 84/466/Euratom directive has compelled member states to "establish fundamental measures for the protection of persons exposed to radiation for diagnostic or therapeutic reasons" (Schutte, 1990; see also de Bijl for examples of the measures). In addition, member states are bound by the EC Euratom directive based on the 1990 recommendations of the International Commission on Radiological Protection (ICRP). This directive sets dose limits for both workers and members of the public (Clarke and Stather, 1993 and European Information Service, Issue 143, September 1991).

Another significant change introduced by the 1986 Treaty amendment of Article 118A concerns voting rules in the Council of Ministers. Health and safety directives, in common with measures to implement the Single European Market, can now be imposed on member states through majority voting. In other words, unanimous agreement is no longer necessary (Vellenoweth, 1992). This is resulting in a range of directives being brought forward on a health and safety legal base - several of them provisions which originally appeared in the Social Charter (the Social Protocol of the Maastricht Treaty). So the irony here is that Britain's much vaunted and bitterly fought for "opt out" from the Social Protocol is looking increasingly meaningless. As a report in The Times recently put it, "EC social legislation already has a great impact on British employment law and practice and its effect looks certain to continue" (Times, 18th March 1994). The NHS, as a major employer, is certainly feeling the impact of a range of directives affecting employment, whether or not these have been brought forward on a health and safety legal base. For example, as has already been identified, the EC's Acquired Rights Directive is threatening to bring contracting out in the NHS to a halt. A number of the new and amended rights introduced by the 1993 Trade Union Reform and Employment Rights Act stem directly from EC directives which Britain was compelled to legislate on at national level (the 1991 directive on proof of employment relationship and the 1992 pregnant workers' directive) (Collins, 1993b, European Industrial Relations Review, 1993, European Healthcare Management Association, 1994 and Bevan, 1995). Even more recently, Britain has had to raise the level of maternity payments (by £65 million), solely as a result of an EC directive (Times, 18th March 1994). Following the ruling by the House of Lords in March 1994 there is also the prospect of employers having to extend the employment rights enjoyed by full-time workers to part-time workers also (Times, March 11th 1994). Finally, another major item in the EC pipeline which will have a far reaching impact on the NHS, as a major employer of shift and on call workers, is the EC's working time directive (due to be implemented by 23rd November 1996). (For details of the directive, see Addison and Siebert, 1993; National Health Service Training Directorate, 1993; Health Committee of the House of Commons, 1992 and Department of Health, 1994). This directive is being brought forward on a health and safety legal base, which Britain is to challenge in the

European Court of Justice (Department of Health, 1994). As a result, however, of negotiations led by the Department of Employment on behalf of the Department of Health, the directive includes an exclusion from its scope for doctors in training. Notwithstanding the exclusion of doctors, the directive will have significant implications for the NHS which has a wide range of other staff working long shift patterns and on call rotas (Royal College of Nursing, 1994).

Public health

It has already been highlighted that the social dimension of the Community's work has been defined as mainly to do with the position and rights of workers. This provides the rationale for including the above discussion of EC health and safety and employment initiatives affecting the NHS under Ham's "social dimension" heading. However the next area of EC action to be examined - that of public health - is one which, in a British context, we feel much more comfortable about describing as part of the EC's social dimension. As Section 1.2 highlights, this is because of the broader connotation the term "social policy" has in Britain, when compared with the EU's definition.

Since the mid 1980s, the EC's public health activities have gone beyond the control of and protection from environmental and workplace health hazards to "the encouragement and coordination of measures to combat major diseases and positively to promote health" (Commission of the European Communities, 1993). The activities have been based on so-called mixed competence, which involves drawing on general powers within Article 235 of the Treaty of Rome. In addition, some of the actions which have been taken or proposed have been initiated under Article 100A (Appendix D) which provides for the free exchange of goods. It is on this basis that proposals have been formulated on health warnings on tobacco products and tobacco advertising (proposals relating to the latter continue to be strongly resisted by Britain).

Prior to the Maastricht Treaty, the Community's public health programme focused on three main areas : cancer, AIDS and drug abuse (Richards, 1991; Trevelyan, 1990; Commission of the European Communities, 1993 and 1994). These areas will now be examined in turn.

Cancer

The Community's 1987-1989 programme to combat cancer was its first major disease prevention programme. Known as "Europe Against Cancer", the programme focused on actions in areas ranging from tobacco and alcohol consumption, dietary habits, exposure to carcinogens and to the sun. Appropriate screening programmes and information on early detection were encouraged. In addition, a ten-point European Code Against Cancer for the general public was promoted (European Information Service, Issue 124, November 1991). Finally, as has already been highlighted, using Article 100A (ie internal market provisions), legislative measures on tobacco - to improve and control the labelling of tobacco products and the tar content of cigarettes - have been adopted (Joffe, 1993). The draft directive to ban tobacco advertising is still under consideration (Commission of the European Communities, 1993 and Department of Health, 1995a).

A second programme to combat cancer (1990-1994), entailing expenditure of some 50 million ECUs has now been completed. The aim of this programme was to continue working towards the target of reducing deaths from cancer among the Community's population by 15% by the year 2000. This second programme comprised forty actions largely based on those in the original programme and which concerned four areas : prevention, health information and education, training for health workers and research (Collins, 1992b and Commission of the European Communities, 1993a and 1993b).

Europe Against AIDS

The action programme Europe Against AIDS was launched to run from 1991-1993 following a Council decision adopted in 1991. The programme, run by the Commission in collaboration with international organisations such as the World Health Organisation, comprised ten main action areas. These were broadly concerned with the raising of public awareness, information and health education in the prevention of HIV infection, treatment, social care and counselling, epidemiological assessment and manpower training and development (European Information Service, Issue 121, July 1991 and Collins, 1992c). The Community's contribution for the

Europe Against AIDS programme in 1992 was 2.5 million ECUs, and in 1993 8.3 million ECUs. The programme was in fact extended to the end of 1994 and received an additional budget allocation of 9 million ECUs (European Information Service, Issue 144, October 1993).

European Plan to Combat Drugs

This Plan encompasses a wide range of measures, some concerned with reducing the demand for drugs - for example by tackling trafficking and the drugs economy - and others focusing on information exchanges, education, assistance for pilot projects on prevention and rehabilitation and research and coordination (Commission of the European Communities, 1993; European Information Service Issues 121, July 1991; 125, December 1991; 130, July 1992 and 138, March 1993 and Department of Health, 1994c). An annual European Drug Prevention week is seen as "an important means of fostering cooperation and raising awareness" (Commission of the European Communities, 1993). In addition, 1994 saw the setting up, in Lisbon, of a European Monitoring Centre for Drugs and Drug Addiction (Department of Health, 1994c).

Although the focus of the Community's public health programme before the Maastricht Treaty has been on cancer, AIDS and drug abuse, there are a number of other activities which warrant a mention. These include, for example, actions to promote the attainment of safety and self-sufficiency in human blood plasma derived from voluntary non-remunerated donations (see Buechner, 1992 and Department of Health, 1995b), to improve the prevention and treatment of acute human poisoning and to develop the European Emergency Health Card (Commission of the European Communities, 1993b).

2.1.4 Research and information technology

Ham's third and final category for making sense of EC action on health groups together initiatives which have arisen as by products in related policy areas, for example research and information technology.

For a number of years the Community has been funding research on biomedicine and health. These activities should be seen in the context of the Community's overall programme of research and technological development based on Treaty Articles 130f to 130q (see Appendix D). The legal basis of the research budget is to improve the competitiveness of European industry. This applies to medical research, even though it is perhaps more difficult to see medical research in this context. "EC Research and Development Framework Programme" is the term used to denote the overall research programme covering all the different science subjects. Biomedical and health research (BIOMED) is thus part of a Framework Programme (Dickens, 1993).

The Medical and Health Research Programme (MHR4), part of the Second Framework Programme which ran between 1987 and 1991, had as its key target areas cancer, AIDS, age-related health problems, environment and life-style related health problems, medical technologies and health services research (Department of Health, 1991). The 1990 - 1994 BIOMED programme in the Third Framework Programme had a budget of over 130 million ECUs and covered four main areas. These were the coordination of research on prevention, care and health systems, major health problems and diseases with an important socio-economic impact, human genome analysis and medical ethics (Dickens, 1993; Commission of the European Communities, 1993 and Richards, 1991). Many projects within the programme crossed the Community's borders, that is to say involved extensive cross national research networks.

Another major area of EC research in the health sphere is the Telematics Programme for Health Care (formerly the Advanced Informatics in Medicine (AIM) programme). The activities in the programme, which formed part of the Third Framework Programme and had a budget of nearly 110 million ECUs for the period 1991-1994, were "intended to improve the quality and cost-effectiveness of health services by the use of 'telematics', ie the combination of informatics and telecommunications" (Commission of the European Communities, 1993). Various projects carried out under the Health Telematics programme have led to standardisation of different kinds; for example, as Svensson and Stephenson highlight, there is now a standard

nomenclature for and method of measuring and reporting laboratory results. The advantage of this is that test answers can now be exchanged across borders with minimal risk of errors of interpretation (Svensson and Stephenson, 1993). In addition the Multimed project was designed to "undertake research on multimedia communication technologies for health care professionals, encompassing such areas as access to medical records and organ bank data" (Ham, in Harrison, 1992). Multimed came, and continues to come, under the aegis of Directorate General XI11 whose remit covers telecommunications.

A brief discussion of two more areas of EC action affecting research will round off this examination of the implications of European integration for the NHS and for health policy. The first of these areas is the draft legislation on data protection, and the second the EC's guidelines on conducting clinical trials. These are now considered in turn.

Draft legislation on data protection

The Commission's original draft directive on confidentiality of personal data caused considerable alarm in medical research circles. Translated into the health care sphere, the directive implied a requirement to obtain the written consent of a patient before written or electronically held data on that person could be processed (Hughes, 1992 and Health Committee of the House of Commons, 1992). Had this draft directive become law, it would have had a considerable - and many argue an adverse - impact on epidemiological research (Allman, 1993 and Stiller, 1993). For example, cancer registries would have had a duty to obtain permission from patients before registering them : a duty which would "be always impracticable and sometimes impossible" - if the patient has died - to discharge (Stiller, 1993). This would have been ironic given the Community's policy of funding research on the major health scourges, for example under BIOMED and as part of the "Europe Against Cancer" programme. Much of this research depends on the use of records which the directive would have rendered illegal.

Negotiations on the draft directive have, however, resulted in valuable modifications

to the original text which prevent it from having "an undesirable impact on medical and health research" (Department of Health, 1995a). Notwithstanding these modifications, the British Government continues to be concerned about the cost and administrative burden that the implementation of the Directive may place on the public and private sectors, including health bodies (Department of Health, 1995a and 1995b).

Guidelines on conducting clinical trials

Given the increasing emphasis on cross national research it is perhaps not surprising that the EC should have taken a number of initiatives, although none of them with legal status, to encourage good practice in the conduct of clinical trials. In addition to the guidelines 65/65/EEC and 75/318/EEC, the EC has published a document "Good clinical practice for trials on medicinal products in the European Community" (111/3976/88 -EN). The purpose of the EC's recommendations is "to ensure that the rights and integrity of trial subjects are thoroughly protected and to improve the ethical, scientific and technical quality of trials" (Royer, 1992).

2.1.5 Concluding remarks

This section has examined in detail the impact of European integration on the NHS and on health policy in Britain focusing mainly on the period 1973 to 1992. The analysis overall has highlighted a number of important policy themes which underpin the process of European integration. For example, it is apparent that the majority of the EC's initiatives affecting the NHS and health policy have been taken as a consequence of the move towards the Single Market, strengthening the freedoms of movement of persons, goods and services. Patients tend to be defined principally as consumers who need to be protected from, for example, dangerous pharmaceutical products and medical devices, while health related research and development is ultimately driven by the imperative of improving Europe's competitiveness. Thus the overriding concern is with economic issues. Similarly aspects of the EC's social dimension affecting the NHS are mainly to do with the rights and position of workers and working conditions. Although the EC has taken some initiatives in the sphere of public health, these do not amount to a coherent health policy. So we should not be

surprised that the EU has not sought directly to influence the level and method of health service funding in the member states, or the way in which health services are organised and delivered. It is interesting to speculate, however, about the prospects for the phase of EC development triggered by the signing of the Maastricht Treaty in 1992. Will the majority of the EU's health related initiatives continue to arise as by products of other policy areas, or will the EU take steps to develop a concerted health policy? These questions are considered in detail in Section 2.2.

2.2 The impact of European integration on the NHS and on health policy following the 1992 Maastricht Treaty

This section examines what impact European integration is likely to have on the NHS and on health policy during the period of EC development triggered by the signing in 1992 of the Maastricht Treaty, which includes an important new Article on public health (Article 129). Ham's framework of analysis is again used to analyse the extent to which the post 1992 developments and trends highlighted represent continuity or change in the future impact of European integration on the NHS and health policy. Throughout the section examines the convergence / divergence debate in relation to health services and health policy in Europe. What are the pressures for closer convergence of, for example, the funding and organisation of member states' health services? Conversely, what factors suggest that a high degree of heterogeneity or divergence will persist into the future?

2.2.1 The impact of the Single Market

The majority of EU initiatives affecting the NHS and health policy - according to Ham's framework examined in detail in Section 2.1 - are those taken as a consequence of the move towards the Single Market. The view generally held by commentators is that mobility of persons, goods and services in the health context will increase as the Single Market becomes ever more established. Specific recent developments have implications for future freedom of movement in each of these spheres.

Free movement of persons

The creation of the European Economic Area (EEA) on January 1st 1994 brought together the then five European Free Trade Association (EFTA) countries (Austria, Finland, Iceland, Norway and Sweden) with the then twelve EU member states. A year later, on January 1st 1995, three of the EFTA countries (Austria, Finland and Sweden) acceded to full EU membership. On May 1st 1995 Liechtenstein formally joined the EEA following the positive outcome of its national referendum. These developments mean that citizens of the EFTA countries (currently Iceland, Norway

and Liechtenstein) enjoy the same four freedoms of movement - of persons, goods, services and capital of the Treaty of Rome - and are bound by the same rules such as those on competition and state aids as citizens of the "fully fledged" member states. As far as free movement of persons is concerned, the adoption and operation by the EFTA countries of the EC Social Security Regulations 1408/71 and 574/72 - which coordinate social security and health care schemes across Europe - means that EFTA country citizens now have the right to use the E111, E112, E106 and E121 procedures. Greater mobility of both workers and patients is very likely to result (Department of Health, 1994a and 1994b).

A couple of other developments also look set to increase the mobility of health workers. In 1992 the European Commission expressed concern that the system in place in Britain for the mutual recognition of specialist medical qualifications between the UK and its European partners might not fully comply with the 1975 EC directives on medical training. The nub of the problem is that the relevant bodies in Britain require a specialist to possess a certificate of accreditation awarded by the medical royal colleges. In effect, "this makes it difficult for specialists outside the UK to obtain an appointment even if they hold an EC certificate on the completion of specialist training" (Ham and Tremblay, 1993). The problem was examined in more detail by a Government-appointed Working Group on Specialist Medical Training chaired by the Chief Medical Officer, Sir Kenneth Calman. The Group, which reported in April 1993, recommended the introduction of improved training programmes by 1995 and of a new Certificate of Completion of Specialist Training. In addition, it called for the establishment of a single training grade by mid-1995 to replace the career registrar and senior registrar grades (Department of Health, 1993). In effect this will reduce the length of specialist training in the UK to 7 years, which will bring it into line with other EC member states. Clearly these recommendations - which look set to be implemented in full - will have a major impact not only on the free movement of doctors but also on hospital staffing arrangements. More specifically there are implications for the consultant appointment system, the numbers of consultants employed, medical career structure, manpower planning and overall service provision and skill mix (Department of Health, 1993).

The second development which could impact on - and perhaps increase - the free movement of health workers is the new trade in services agreement reached at the GATT negotiations. These were concluded on 15th December 1993 and involved the then twelve EU member states negotiating as one party or block. The agreement allows, among other things, for greater recognition of professional qualifications from one country to another and sets out rules for this. However, according to the terms of the agreement, each country may keep its own regulations which means that they will not be obliged to recognise qualifications gained in other countries (Department of Health, 1994b).

Free movement of goods

A number of other agreements reached at the GATT round will impact on the health sector. For example, as a result of the tariff reduction agreement on pharmaceuticals, the four main negotiating parties are committed to working towards the elimination of all tariffs on pharmaceuticals over a period of five years. The increased freedom of movement of pharmaceutical goods will give greater opportunities to EU pharmaceutical exporters, who already make an important contribution to the EU's trade balance with the rest of the world. A similar tariff reduction agreement was reached for medical equipment (Department of Health, 1994b).

Another important development affecting the pharmaceutical sector - this one emanating from the EU itself - was the decision to create a new drug agency, the European Agency for the Evaluation of Medicinal Products. This is located in London, employs about 150 people and started operating in January 1995 (Department of Health, 1995a). The Agency's main jobs are to coordinate new drugs registration and to monitor product marketing. Underpinning its work is the overall aim of creating a single market for pharmaceuticals by taking forward the harmonisation of the licensing of medical products for human and veterinary use in the EU (Department of Health, 1994a). There are now two routes for drug registration in Europe. The first - applying to all new biotech products - entails the new Agency handling a centralised review, resulting in one decision for all member states. For nonbiotech products, "the sponsoring company can take this route or can opt to have

one member state do the evaluation, and then the other EC states will be asked to recognise that decision" (Vanchieri, 1993). If disagreement occurs, the Agency will act as arbitrator. The decision made at arbitration will be binding on all member states.

Supporters of the Agency claim that these new arrangements will speed up registration and save money. However, the Agency also has its detractors who argue that the proposals "are inspired more by the EC's free market philosophy than by a regard for public health. Proposals would lead to a lowering of standards and an undermining of consumer protection" (Editorial, Lancet, 1991). Overall there seems to be considerable resistance to anything which threatens a nation's regulatory hegemony (Orzack, Kaitin and Lasagna, 1992). This links to wider, and indeed familiar, arguments about the impact of increased European integration on national sovereignty. These will be returned to later in this section.

A final example of a development affecting the free movement of goods in the health sector is the European Commission's 1995 Proposal for a Directive to regulate the safety and marketing of in vitro diagnostic devices (IVDs) (Department of Health, 1995e). The Directive is the third in a series (see p.11) and will come into force on 1st July 1998, although its application will not become mandatory until four years after its adoption.

Free movement of services

The third type of freedom of movement which can be expected to increase in future is that of services. This trend is underlined by the fact that EFTA countries are now subject to EC public procurement rules (see p.23 above). Ham and Tremblay argue that purchasers and providers of health care will seek to operate increasingly across national frontiers. They highlight the fact that in the UK, some hospitals are exploring opportunities to attract patients from other parts of the EC. Indeed, this kind of cross border trade is likely to be boosted by the introduction of market-style reforms in a number of the member states (Ham, Robinson and Benzeval, 1990 and Tremblay, 1993). In addition, "private insurers are offering their subscribers the option of treatment in hospitals overseas" (Ham and Tremblay, 1993).

Another development which looks set to increase the freedom of movement of services is the Private Finance Initiative (PFI). Originally launched by the Chancellor of the Exchequer in 1992, the Initiative requires Trusts to demonstrate that they have actively sought private finance before they can seek funding from government sources. What this means in practice is that NHS Trusts have to advertise in the official journal of the European Union at the stage when finance is wanted.

Additional PFI guidelines introduced by the Treasury in 1995 (in EL (95) 29) place the emphasis on using private finance "not only for the cost of new building but also for the provision of associated services" (Ham, 1995). As Ham goes on to point out, these services could, over time, come to include clinical services - a highly significant new departure for the development of the purchaser provider split in health care. In effect what is implied here is that clinical services could also become subject to market testing and to the EU public procurement regime (Berman, 1995).

Before moving on to consider the future impact of EU initiatives in the social dimension - Ham's second category - on the NHS and health policy, the following section seeks to explore the implications of increased freedom of movement of persons, goods and services in the context of the convergence debate.

2.2.2 Implications of increased freedom of movement : pressures for greater convergence

A number of commentators have argued that the greater movement of people - both health workers and patients - accompanying the completion of the Single Market will make more transparent the differences between member states' health care services, for example in access or entitlement to and availability of services, standards of care, outcomes and levels of funding³ (Ham and Berman, 1992; Ham and Tremblay, 1993

³ Two examples illustrate the variations in availability and standard of treatment between the member states. The first is the widely reported case of the 59 year old British woman who, having been refused fertility treatment in Britain, gave birth to twins after being impregnated with eggs donated by a younger woman in Rome. This case underlines the variation in regulations on, and hence availability of, fertility treatment to older women (Times, 28th December 1993 and The European, 7th-13th January 1994, Society section). Although the European Commission has so far seemed reluctant to be drawn into the debate about controversial fertility treatment, it would have to become involved if anyone decided to test in the European Court of Justice the principle of freedom to provide services as enshrined in the Treaty of Rome.

The second example is provided by findings from the 1994 "Eurocare" survey of cancer registries in eleven European countries. This highlights Britain's very poor record on breast cancer in terms of survival rates and treatment. The survey attributes observed differences in breast cancer survival between populations to differences in access to health systems and in cancer care (Times, 22nd March 1994).

and Altenstetter, 1992). This increased transparency is likely to increase the pressure to reduce the differences through action at EU level. We are reminded here of the trend in industrial relations for the domestic bargaining agenda to take on board more and more of the practices in other member states (Doogan, 1992). In a health context, differences could be reduced either by ensuring that "European citizens have access to broadly similar standards of health care, whatever the chosen method of funding or delivery" (Ham, 1991) or by adopting a single EC-wide approach to the financing and delivery of health services. De Bijl and Svensson and Stephenson are among those who call for a common approach to quality control and standards in health services, while Palmer talks of growing pressure for the closer alignment of different systems (de Bijl, 1993; Svensson and Stephenson, 1992 and Palmer, 1989). Heginbotham, writing in Room (1991a) reports on the way in which a move to harmonize mental health legislation in Europe is gathering pace. He also underlines that "there may be a need to deal with European-wide concerns on euthanasia; in-vitro fertilisation and embryology is not a concern only for the UK but Europe as a whole". In this way Heginbotham lends his support to calls from other commentators who have identified the need to respond to a range of challenging ethical issues at EU level and increasingly to converge towards unity in the field of medical ethics (Royer, 1992; Riis, 1993 and Collins, 1993c). Heginbotham also highlights medical negligence as an area which is receiving increasing attention, with widening interest being shown in other systems such as that of 'no fault' liability. In addition, it is important to recognise the way in which the legal underpinning of informed consent and attitudes towards invasive procedures differs from country to country (Room, 1991a).

Overall the argument that has been explored here is that greater freedom of movement - in particular of health workers and patients - is increasing the pressure for convergence. Two types of convergence can be envisaged; the first of funding and organisation or delivery of health care systems while the second is about comparability of entitlements and standards between different member states. Counter arguments to this view that some convergence is both necessary and inevitable are discussed in more detail below after a consideration of the future impact of EU

initiatives in the social sphere - Ham's second category - on the NHS and health policy. The discussion which follows should be seen in the context provided by the 1994 EU White Paper on Social Policy (Commission of the European Communities, 1994).

2.2.3 The social dimension

The Maastricht Treaty signed in February 1992 represents a watershed for the EU's future role in a number of areas (see Section 2.3). Most notably, in the context of our present discussion, Article 129 - reproduced as Appendix A - accords the EU a new competence in the field of public health. The genesis and implications of this new competence are explored in detail in Sections 2.4, 2.5 and 2.6. For the moment, however, it should be noted that the Article means that the EU is to contribute towards the promotion of health by encouraging cooperation between member states and by lending support to such action. The Article refers to EU activities being directed towards prevention of diseases, and in particular of the "major health scourges". It makes special reference to a role for health education and education at EU level, and also states that "health protection requirements shall form a constituent part of other policies". Significantly the Treaty Article specifies that decisions will be taken by qualified majority voting. This means that individual member states will no longer be able to exercise a veto and the Council will be able to act more decisively than in the past (Commission of the European Communities, 1993).

The specific programmes to be developed over the next three years - for example the Europe Against Cancer Third Action Plan for 1995-1999 with a budget of 64 million ECUs - both build on, and go well beyond, the EU's existing public health activities. Priority areas for future Community action identified by the Commission include health promotion, the development of health information systems, cancer, drugs, AIDS and other communicable diseases, accidents and injuries, pollution-related disease, rare diseases and "other health threats (if circumstances require)" (Commission of the European Communities, 1993).

Opinion varies considerably as to what this extension of Community competence will mean in practice. Article 129 seems to restrict EU activities in the field of public health to primary and secondary prevention, with health care itself remaining a matter for national governments ("harmonization of the laws and regulations of the Member States" is specifically precluded). So what Article 129 may lead to is the convergence of goals and effects, but not of systems to achieve these goals (the second but not the first type of convergence described above) (Altenstetter, 1992; Ham and Tremblay, 1993 and Crawford, 1991).

Other areas of possible future EU action in the social dimension which could have implications for the NHS and health policy are on the European Charter of Patients Rights (stemming from the European Parliament's resolution of 19th January 1984) and on health emergency cards (the European Parliament's resolution of 16th November 1984) (Collins, 1993a). In addition, the European Parliament has invited the Commission to put forward a proposal on action to be taken to develop a European Public Services Charter. Best seen against the backdrop of the Single Market, the Charter, which has resonances with the Citizen's Charter "movement" in the UK, would guarantee Europe's citizens fair access to, and minimum standards of, goods and services in the public domain (European Information Service, Issue 138, March 1993).

Also in the pipeline are new health and safety measures relating to pregnant workers (Bevan, 1995) and various draft directives - for example on parental leave, part time and temporary work and the posting of workers - which also have implications for employers (Department of Health 1995a and c). These measures and draft directives should be seen in the context of the rolling social action programme adopted by the Commission on 12th April 1995. The programme can be seen as the culmination of consultation and debate on the Green and White Papers on the future of European Social Policy (Department of Health, 1995d). However, given Britain's opt out from the Social Protocol, the potential impact of social policy measures in the pipeline on British employers, including the NHS, is difficult to assess. One development, though, which does have definite implications for Family Health Service Authorities

(FHSAs) and GPs is the GP Vocational Training directive which came into force on 1st January 1995 (Department of Health 1995a). This directive means that all doctors providing general medical services will have to be vocationally trained or, where they are not so trained, will have to benefit from an acquired right to practice. Guidance on the operation of the arrangements for acquired rights has now been issued to FHSAs and GPs.

Economic and monetary union

Before moving on to consider the implications for the NHS and health policy of future EU initiatives in the spheres of research and information technology, mention should be made of the potential impact on the NHS of the EU's policy of economic and monetary union. Even though Britain is not (yet?) committed to the final move to a single currency, it is important to recognise that the fiscal changes necessary to bring about monetary union - lower budget deficits, public borrowing and inflation - would have considerable implications for the NHS. Economic and monetary union perhaps provides one of the most powerful illustrations yet of how a policy made for another sector could have far reaching implications for health services (Buchan, 1993 and Doogan, 1993).

2.2.4 Future EU initiatives in the spheres of research and information technology

Ham's third and final category for examining EU initiatives on health matters concerns those that have arisen as by products in related policy areas such as research and information technology. The EC's Fourth Framework Programme for Research and Technological Development started on 1st January 1994 and will run until 1998. The total budget available over the next four years could reach almost four billion ECUs (with a possible 700 million ECU "top up" to be considered in 1996). As with previous Framework Programmes, the main emphasis is on improving the competitiveness of European industry. However the biomedical and health research theme has been retained. BIOMED 2, as this theme is being called, could claim about 3% of the expenditure of the Programme or potentially up to £300 million, or 336 million ECUs over four years (Department of Health, 1994a). Research topics featuring in the Fourth Programme indicate a high degree of continuity with previous

Framework Programmes. Topics include major health problems in Europe such as cancer, AIDS, cardiovascular disease, mental illness and problems associated with ageing and telematics in health care. The type of research being conducted under the latter programme ranges from the keeping of medical records, to resource management in health care, to highly sophisticated medical imaging (Collins, 1993a). The first call for proposals under BIOMED 2 was issued in December 1994 with a budget of 140 million ECUs. The second and last call will be on 15th March 1996 (Department of Health 1995a).

2.2.5 The convergence / divergence debate in relation to health services and health policy in Europe

Overall the above discussion of how the EU can be expected to impact on the NHS and on health policy following the 1992 Maastricht Treaty suggests that continuity - a development of existing themes and initiatives - is more likely to characterise future action than radical change (Altenstetter, 1992). Arguably this can even be said of initiatives based on Article 129. The forces holding back the development of a European-wide health policy regime in the near future would appear considerable. Some of these are now explored in more detail below.

The increasing mobility of health workers and patients is a central plank of the argument that pressures will intensify for greater convergence of health systems in the member states. While mobility does certainly look set to increase⁴, it must be recognised that free movement of persons in the health sector has, overall, been relatively limited⁵ (Schutte, 1990; Leidl, 1991; Berman, 1992 and Hughes, 1992).

⁴ Recent reports have revealed that a growing shortage of British trained doctors is forcing hospitals to recruit from overseas (Times, 3rd June 1995 and Berman, 1995).

⁵ While data on mobility tends, on the whole, to be scant and dated (Gray and Phillips, in Normand and Vaughan, 1993), figures presented by Anke Oosterman Meulenbeld reveal that in 1988, 2035 health professionals (doctors, nurses, dentists, pharmacists and midwives) from other member states came to practise in the UK, whereas only 180 British health professionals went to work in other EC countries (Institute of Health Services Management, 1992). Slightly more up-to-date are Gray and Phillips' own data on nurse migration. These indicate that the UK is presently a net importer of nurses from the EC, but an exporter of nurses generally. For example, in 1989/90, the UK was a net importer from the EC of 591 nurses, a very small number when compared to the total nursing workforce in the UK. As far as patients are concerned, only about 400 UK residents per year are affected by the reciprocal

Thus pressures for greater convergence arising from increasing mobility of persons are arguably weaker than some have perhaps suggested.

Furthermore it is worth reiterating that Article 129 of the Maastricht Treaty confirms that "European health policy" is mainly concerned with disease prevention and health promotion. It specifically excludes harmonization of medical care itself. In other words there is to be no attempt to act upon issues to do with the financing and delivery of health services (Harrison, 1992 and Ashton, 1992). This stance accords completely with familiar arguments in the convergence / divergence debate relating to the heterogeneity of policy regimes in EC member states, to national sovereignty and to the basis set out for EC action. These arguments are now briefly summarised.

On heterogeneity, Altenstetter reminds us of the entrenched nature of national health policy regimes which have been shaped by different political and cultural forces. Similarly, McPherson points out that "European traditions, beliefs and practices of health, health provision and health behaviour have evolved in an extraordinarily independent manner" (McPherson in Normand and Vaughan, 1993). The unique interplay of these various forces in individual countries has resulted in wide variations in the way health care is provided and financed, and in the legal basis underpinning it⁶ (Room, 1991a).

Given the differences between member states' welfare regimes, it is not surprising that there should be such strong resistance to a "Europeanisation" of health policy regimes and health care delivery systems. Health care is still seen overwhelmingly as an area of national competence, the exclusive preserve of domestic ministries. Political resistance to further undermining of national sovereignty can be expected to

arrangements for non-emergency treatment requiring prior approval from the Department of Health (the E112 procedure) (Ham in Harrison, 1992).

⁶ Notwithstanding the variations, attempts have been made to find overall themes and patterns which link together the health policy regimes of different countries. These have contributed to the development of welfare regime types, which draw together "clusters" of individual welfare states (Esping-Andersen, 1990; Bulmer, George and Scott, 1992; Titmuss, 1958; Room, 1991a and 1991b and Altenstetter, 1992).

persist into the future.

As has already been highlighted, Article 129 sets out the basis for future Community action in the field of health policy. The Community is charged with the responsibility of acting "with due regard to the principles established by the European Council in Edinburgh (subsidiarity, openness, transparency and proportionality), and vested with powers to discharge this responsibility in a manner that ensures respect for Member States' policies and activities, prevents unwarranted intrusion and interference, and leaves room for adjustment and choice of the means for their implementation" (Commission of the European Communities, 1993). This clear statement should serve to allay fears in member states that their national competence in a key area of social policy could be undermined. Increasing Europeanisation of health policy regimes and delivery systems seems to have been explicitly ruled out.

The EU's clear stance here is arguably not only a philosophical one but a practical one also. A brief examination of the EC's institutional and financial capacity to lead and provide incentives for the increasing convergence of member states' health care systems reveals that it is inadequate for the enormous task that "Europeanisation" would entail. A number of commentators have highlighted, for example, the fragmentation of political institutions and EU decision-making structures when it comes to health (Richards, 1991 and Harrison, 1992). There is no European Commissioner with specific responsibility for health and health services. Instead, health matters are "carved up" between various Directorates General (DGs) of the European Commission. DGV, for example, is concerned with employment, industrial relations and social affairs (including public health, an area in which only a small number of Commission officials are working : see Footnote 13, Section 2.5). DGIII deals with Single Market matters, DGXII with research, DGVI with food policy, DGIX with environment, DGXIII with information systems and DGI with external relations. Given the current fragmentation and the recent extension of Community competence into the field of public health, it is not surprising that there have been increasing calls for the current health competences of the various Directorates General to be reviewed and for "one of its members to be specifically responsible for the

coordination of all aspects of public health policy, including research" (Collins, 1993a).

The second point about the EC's capacity for overseeing the closer convergence of member states' health systems relates to the resources at its disposal. Contrary to popular belief, the EC's resources are in fact relatively limited. The EC budget amounts to less than 1.3% of the total GDP of the member states. This is obviously woefully insufficient to support an EC-wide health policy, for example one that involves transfers of resources from the richer to the poorer member states to bring the level of funding for health care in the latter closer to the level enjoyed in the former. Similarly the emergence of an EC-wide social policy - even on a modest scale - is difficult to imagine (Majone, 1993).

This final part of Section 2.2 considers a range of other factors - some going well beyond policy and action at EC level - which further illuminate the convergence / divergence debate in relation to health services. First some lessons from comparative analysis are highlighted to illustrate the likelihood of continuing divergence of health care systems in the EC member states. Second, the trend towards convergence of policy options in the member states is discussed. Finally reference is made to the wider issue of what sort of Europe is likely to emerge in the future.

One clear lesson which emerges from comparative analysis - comparing and learning from other countries' health systems - is that developing an optimal structure for a health care system is an elusive task for a number of reasons (Hsiao, 1992). First, health systems are a means to an end : they seek overall to achieve three important goals (universal and equal access, cost control and effective use of resources). The point here is that because most individual countries have not reached a consensus on the relative importance of these goals, nor indeed on the role the market or the state should play in funding and delivering health care, it would seem unrealistic to expect consensus on these issues to be reached at EU level. Thus there seems very little likelihood of an acceptable blueprint for a European-wide health care system ever emerging.

Second, comparative analysis highlights how little is known "about the performance of various types of health systems and the key dynamic forces which shape outcomes" (Hsiao, 1992). The paucity of information and inadequacy of understanding about performance and also about links between cause and effect in health care (Culyer and Meads, 1992) also underlines how difficult it would be for the EC to formulate and also to defend a blueprint for a European-wide health care system.

Finally, comparative analysis also makes abundantly clear that the problems faced by health care delivery systems in countries in the industrialised world are now familiar and strikingly similar. These problems - discussed in more detail in Section 2.4 - have led to the emergence of new health scourges and combine to put enormous pressure on resources (Commission of the European Communities, 1993; Abel-Smith, 1993 and Ham, Robinson and Benzeval, 1991).

Faced with strikingly familiar problems, Tremblay argues that governments around the world are considering similar solutions (Tremblay, 1993). This adds another interesting dimension to the convergence debate in the context of European integration. For even if the EU does not, in the future, as seems likely, adopt policies to encourage increasing convergence of member states' health care systems, Tremblay's analysis suggests that more similarities between health care systems in Europe will emerge as member states adopt policy instruments drawn from the same relatively narrow range. These include, for example, the increased use of internal or managed markets, technology assessment and accreditation (Tremblay, 1993 and Hurst and Pouiller, 1993). Europe should increasingly be seen as a laboratory offering considerable scope for countries to learn from the policies adopted in other countries' health care systems to tackle problems which are no respecters of national boundaries (Ham, 1992). A recent development which will support this type of cross-national policy learning is the establishment, in April 1994, of a European clearing house on health service reforms. The project, funded for three years by the EU's BIOMED PHARE programme, is being coordinated by the Nuffield Institute for Health at Leeds University (Royal College of Nursing, 1994, British Medical Association, 1994 and Department of Health, 1995b). Also based at the Nuffield

Institute for Health is a separate project called the European Clearing House on Health Outcomes (ECHHO) funded under the same programme (Department of Health, 1995d).

Ultimately it is difficult to separate the debate about the possible Europeanisation of health services and policy and social policy from the wider issue of the type of Europe that is being envisaged (Palmer, 1989). Here there are a number of competing visions. Kleinman and Piachaud, for example, identify three possible types of Europe : customs union, economic integration (the 1992 model) and economic and political union. This third model represents the most fundamental change and implies that "citizenship of the welfare state will ultimately be replaced by citizenship of Europe. With a super state all social policies would be the responsibility of a centralised European Government" (although a super state could choose to devolve powers to nation states) (Kleinman and Piachaud, 1993). The closer to the super state model, the greater the intervention that can be expected and justified at the European level to provide comparable social services across member states.

Recent developments in the Community suggest that the superstate model entailing vigorous social policy intervention is unlikely to be the type of Europe that will emerge in the future. Instead the prevailing trend seems to be the "renationalisation of the Community" or the emergence of a Europe of the nations as the most likely model for the future. In this model, member states' essential hegemony or sovereignty when it comes to health services and health policy will remain largely intact.

2.3 The Maastricht Treaty

This section sets the scene for the detailed examination in Sections 2.4, 2.5 and 2.6 of Article 129 of the Maastricht Treaty. Following a summary of the main provisions of the Treaty, there is a brief discussion of the main pressures which led to the revision of the Treaty and of the process - the parallel intergovernmental conferences for the Treaty revisions.

The Maastricht Treaty emerged from two intergovernmental conferences (IGCs) - one on economic and monetary union and one on political union - which were both launched in Rome in December 1990. It was a year later during the meeting of the European Council in Maastricht on 9-10 December 1991 that the member states finally reached agreement on all the outstanding points in these IGCs. However the Maastricht Treaty was not signed by the Foreign and Finance Ministers until early the following year - on 7th February 1992 - at a ceremony, again in Maastricht. Also in attendance were Members of the European Parliament (notably the President Klepsch and a senior vice president David Martin) and the then President of the European Commission, Jacques Delors (Corbett, 1993).

2.3.1 Main provisions of the Treaty

The Maastricht Treaty formally declares that the Community is to be more than just a commercial enterprise. As Buchan puts it, "the word economic was deleted from its name; and the 'European Union' now has additional dimensions" (Buchan, 1993). What has been added is considerable. For example, as well as containing a commitment to achieve monetary union by 1999 - binding on all member states except Britain which has been allowed not to commit itself to the final move to a single currency - the Treaty includes provisions for common foreign and defence policy, cooperation on police, judicial and immigration affairs and common "citizenship", giving the EC citizen the right to vote in each other's local and European elections and, when in third countries, to seek diplomatic or consular protection from another EC embassy if his / her country is not represented there. Not all of these issues, however, are to be dealt with in the Treaty of Rome framework involving proposals

from the Commission, amendments from the European Parliament and possible adjudication by the European Court of Justice (Buchan, 1993). While issues relating to monetary union will come under the Treaty of Rome, new foreign, security, immigration and judicial policies will be agreed and carried out on an intergovernmental basis with the rotating Presidency of the Council of Ministers in charge. This is the "three pillar structure" of the Maastricht Treaty (Buchan, 1993).

The various new competences for the Community created by the Treaty also come under the Treaty of Rome. The key watchword here, however, is subsidiarity, a principle which is specifically written into the Treaty (Article 3b). This principle entails the formulation and implementation of policies at the lowest appropriate level and only doing at European level what can best be done at that level (Buchan, 1993).

So with subsidiarity as an important guiding principle, the Community's competence is extended not only into the field of public health but also into education, consumer protection and industrial, infrastructure and cultural policy. Furthermore the Treaty reforms various Community decision making processes and institutions. For example, qualified majority voting is extended to a number of areas - environment policy (except fiscal, land-use, water and energy aspects), some aspects of social policy under the social protocol applicable to all member states except Britain, and to various of the new policy areas added to the EC Treaty. These include incentive measures in the fields of public health, education and vocational training, consumer protection and development policy (Corbett, 1993). Linked to this, the Treaty strengthens the role of the European Parliament by introducing a new co-decision procedure. This gives the Parliament the right to negotiate amendments directly with the Council and to veto laws on consumer protection, public health, education, trans-European networks, culture, environment strategy, research and the single market (Swann, 1992). Finally, the Treaty establishes a new Community institution, the Committee of the Regions, to increase regional representation.

2.3.2 Main pressures which led to the revision of the Treaty

A number of commentators discuss the main pressures which led to the revision of the Treaty. Synthesising the work of Corbett and Buchan, these can be summarised as the general dynamic of unification, the implications of the Single Market, the changing international context, the perspective of enlargement and pressure from the European Parliament. Each of these factors is examined briefly below. In Sections 2.4 and 2.5, a number of these issues are examined in relation to Article 129 on public health.

The general dynamic of unification

The first pressure - the general dynamic of unification - highlights the important idea that the Community is never at a standstill. Throughout its history, the whole process of integration has been characterised by successive - albeit sometimes tentative and halting - steps forward "on the basis of compromises negotiated by the member states" (Corbett, 1993). The Maastricht Treaty represents an important "staging post", and not an end point, in this process. Indeed, the Treaty contains provision for an automatic constitutional revision in 1996. As Buchan argues, this reflects the wish of some national governments to move more boldly towards the goal of a federal Europe in 1996 (Buchan, 1993).

The Single Market

A similar dynamic - that of moving inexorably forward - can arguably be observed also in relation to the Single Market. As the Single Market has taken shape, its implications have become increasingly apparent. Certain member states have led the way in arguing that separate regulation of matters such as consumer protection, emission standards and other environmental norms, and many social standards is increasingly impossible. This type of argument is largely based on the perceived need to create and maintain a "level playing field" if the Single Market is to operate fairly and efficiently. In addition, "cooperation in matters of police and customs becomes imperative" (Corbett, 1993). Most importantly perhaps, the issue of monetary integration arises. It was this issue that was to lead the way to the IGC on economic and monetary union, while the other issues arising from the Single Market highlighted

above arguably sowed some of the seeds for the IGC on political union.

The changing international context

Of even greater significance, however, in understanding what gave rise to the IGC on political union is the rapidly changing international context of the late 1980s and early 1990s. The revolutions across Eastern Europe in 1989 led to a growing view that the Community should become a stronger actor on the international stage. In addition the reunification of Germany provided an important imperative for seeking to anchor the new Germany firmly in a strengthened Community (Corbett, 1993). Linked to this, the development of a less German-dominated, more equal currency system than the European Monetary System (EMS) was felt to be essential (Buchan, 1993). Finally the Yugoslav crisis and Iraq's invasion of Kuwait in 1991 highlighted the need to strengthen the Community's foreign policy cooperation.

Another aspect of the changing international context is the prospect of a greatly enlarged Community. This also acted as an important spur to the Treaty revision process; for example the need to reform Community decision making processes and institutions has been recognised for some time. In the medium to long term, the "1989 revolutions" could lead to a large number of central and eastern European countries applying for EC membership. These will join the queue already formed by countries such as Turkey, Malta and Cyprus (Corbett, 1993).

The European Parliament

The final source of pressure leading to the revision of the Treaty to be examined is that emanating from an EC institution, the European Parliament. Corbett traces how, in the period 1987-1989, the Parliament produced a series of reports; for example on the costs of "non Europe" (Catherwood Report, 17th July 1988; written in response to the Commission's famous Cecchini Report) and on the democratic deficit (Toussaint Report, also dated 17th July 1988). These, and other Reports, served to highlight the shortcomings of the Single European Act and gave rise to a number of important Parliamentary Resolutions. Throughout 1989 and 1990 the Parliament pressed for IGCs on both economic and monetary union and on political union. It was

also very proactive in shaping the agenda for each Conference, publishing its own detailed proposals, for example on 14th March 1990 (Martin I Report), 16th May 1990 (Herman Report on economic and monetary union) and on 11th July (Martin II Report) (Corbett, 1993). Overall the key changes sought by the Parliament can be grouped under three headings : enlargement of the Community's competences, improving the efficiency of Community decision making, and making the Community more democratic.

The European Commission

According to Corbett, then, the picture which emerges here is of the European Parliament at the forefront of agenda-setting for the IGCs, and in particular for the IGC on political union. This is not to say, however, that the Parliament made all of the running. The then President of the European Commission, Jacques Delors, for example, called on several occasions for IGCs to be established. The Commission went on to produce its "Opinion", required under the Treaties in order to convene the IGC on political union, on 21st October 1990 (Swann, 1992, Buchan, 1993 and Corbett, 1993). The latter shows that, broadly speaking, the Commission's substantial agenda for reform matched that put forward by the Parliament; for example the Commission supported the extension of Community competence to largely the same fields proposed by the Parliament. However there were some differences, such as the Commission's - perhaps unsurprising - reluctance to support reforms which would strengthen the Parliament's powers. It was opposed, for example, to the introduction of co-decision.

Member state governments

This flurry of activity on the part of the Parliament and the Commission in the run up to the IGCs should not divert attention from the discussions which were also taking place between and within member states. Faced with the "flood of proposals and ideas coming from all directions" (Corbett, 1993), the member governments started to put together their own memoranda and position papers. These contained early signals about how they would approach the IGCs, and what key changes to the Treaty they would like to see emerging.

2.3.3 The process for the revision of the Treaty

The above account of the period leading up to the IGCs highlights a number of key players - Community institutions and member state governments - involved in setting the agenda for the negotiations. It is important also to appreciate the range of influences shaping the negotiations proper. However a number of obstacles stand in the way of developing such an appreciation, not least the fact that IGCs are shrouded in secrecy in much the same way as discussions and votes at the Council of Ministers (Mazey and Richardson, 1993 and Mills, 1993). It is therefore difficult to establish exactly what went on. However, because the IGC is a meeting of sovereign states, it could be assumed that the member state governments meet in a vacuum, "untainted" by other inputs. Of course the member governments' influence should not be underestimated : the intergovernmental context means that member states take the final decisions about how the Treaty should be revised. What should also be noted is that countries holding the Presidency during IGC negotiations would seem to wield particular influence. The IGCs on economic and political union in fact took place under three presidencies (Italy, Luxembourg and the Netherlands). Both Luxembourg and the Netherlands produced draft treaties which had a central role in the negotiation process (Corbett, 1993).

While the key role of the member state governments is fully acknowledged, it is also important to recognise, as has already been highlighted, the possible influence of other players on the whole process. Corbett, for example, points out that the Commission is present at IGCs, and then goes on to give a fascinating account of how the Parliament pressed to be allowed to participate in the IGCs on economic and political union. The Parliament based its case on Article 236 of the Treaty of Rome, arguing that although this Article did not envisage that the Parliament should participate at IGCs, "neither did it envisage participation by the Commission which, however, was present". The argument continued that there was therefore no formal reason why another European institution, namely the Parliament, could not be present as well. (Corbett, 1993).

In the event the Parliament's argument was not fully accepted by the member governments although in true European fashion a compromise eventually emerged. It was agreed that the President of the Parliament would be invited to address IGC Ministerial-level meetings at their openings and that the inter-institutional pre-conference meetings - which had brought together MEPs and the Finance and Foreign Ministers of the member states - would be transformed into an "inter-institutional parallel conference" meeting during the same period as the IGCs⁷ Overall it meant that the Parliament had a permanent and formal channel of communication to the IGCs (Corbett, 1993).

Such a permanent and formal channel was not opened up to other players. Corbett identifies a range of external influences - including non-governmental organisations, third country governments, national parties and political factions thereof - which did not have their own formal channel but which nevertheless sought to influence the IGC process, for example by means of statements and actions. The interaction of these external influences with the key players already identified complete the sort of picture painted by Hogwood and Gunn of the policy process involving the "interplay of many actors and organisations and the working out of complex relationships between them" (Hogwood and Gunn, 1984). Section 2.5 explores the interplay of actors and organisations in relation to Article 129 of the Maastricht Treaty, while Section 2.4 highlights the other sources of pressure - described broadly as environmental - for an extension of Community competence into the field of public health.

⁷ The inter-institutional parallel conference meetings followed the general pattern throughout the IGCs which was for monthly ministerial meetings during 1991, except for the August break. Thus the parallel conference met virtually monthly, alternating between political union and monetary union.

2.4 The environmental system in relation to Article 129

Sections 2.4, 2.5 and 2.6 explore a number of policy process issues at European level by focusing on Article 129 in the Maastricht Treaty (the Article is reproduced in Appendix A). The key question which these sections set out to answer is how this Article, representing a new competence for the EU, came to be included in the Treaty. The main areas of the analysis - which draws on data from interviews and discussions during the Brussels study tour as well as on the literature - are the environmental and political systems, including the key players, which shaped Article 129.

The reader should note that the data from the Brussels study tour and the interviews are referenced according to the scheme described in Part One, Section 1.3.

This section starts by describing the two models which provide the framework for examining Article 129. Drawing on these models, the section then goes on to discuss key features of the environmental system in relation to Article 129.

2.4.1 Models used in the examination of Article 129

Sections 2.4, 2.5 and 2.6 draw on two models or typologies to classify and then explore the pressures leading to the extension of Community competence into the sphere of public health. The first model is Easton's analysis of political activity in terms of systems theory (Easton's model is reproduced in Appendix E). (Easton, 1965 and discussed in Ham, 1992b). This theory is predicated on the assumption that political activity can be analysed in terms of a system containing a number of processes which must remain in balance if the activity is to survive. Feeding in to the "black box" of the political system are a range of inputs (demands and supports). The output of the system is usually a series of decisions and actions. The system overall is in constant interaction with the environment which contains a number of variables, for example socio-economic, physical and political. Similar ideas feature in Barrett and Fudge's description of elements of the policy process in terms of environmental, political and organisational systems (Barrett and Fudge, 1981). The environmental

system is where demands and needs originate, and upon which policy seeks to have an effect, the political system is the one in which policy decisions are made, while the organisational system is the one through which "policy is mediated and executed". This section will focus on the environmental system in relation to Article 129.

The key features of this system to be explored are pre Maastricht EC public health initiatives, the wider context of EC preventive and social policy and the main health related problems and challenges facing the member states.

2.4.2 Key features of the environmental system

Pre Maastricht public health initiatives

Section 2.1 has already examined the various EC public health initiatives which predate the Maastricht Treaty. These were attributed to the growing importance of the social dimension. Arguably of particular significance since 1989 has been the stricter regulation of tobacco product advertising and labelling initiated under Article 100A of the Single European Act (an Article about the Single European Market and therefore "governed by" QMV rules). According to Bomberg and Peterson, the tobacco directives "point to a new activism on behalf of both the Commission and the EC Health Council in developing EC policies which are genuinely preventive" (in Mills, 1993). Indeed, an examination of health initiatives taken in the past by Community institutions reveals a longstanding interest in and commitment to developing Community health policy (Collins, 1993a and Commission of the European Communities, 1993). In particular - and this underlines the "new activism" - the Community's public health activities have extended beyond "control and protection from environmental and workplace health hazards to the encouragement and coordination of measures to combat major disease and positively to promote health" (Commission of the European Communities, 1993). A number of my sources (Harlow, BRU DISS; Spence, UK DISS⁸ ; see also Birt, 1993) argued that that even

⁸ David Spence, Principal Administrator, DGX, European Commission, highlighted in a conversation with my supervisor, Randall Smith, that the 1986 Single European Act was an important new departure for public health, mainly because it led to the debate about tobacco advertising. The Commission found itself in the public health arena using either Article 235 or 100A in relation to the internal market discourse.

though the tobacco directives are bound up with the Single Market discourse, they nonetheless played a significant part in preparing the ground for Article 129.

So the picture here is of Article 129 representing a high degree of continuity with past Community policies and actions taken by Community institutions. As Buchan argues, the new Community competences in the Maastricht Treaty "are hardly new activities for the EC. So it was more a case of making new bottles into which to pour old wine so as to make it more drinkable" (Buchan, 1993). Swann's slightly more scholarly account makes a similar point. He describes the development of Community policy as neither steady nor smooth : "rather it has been ratchet-like with many examples of advance and spill-over from one...area to another...but with few examples of regression or spill-back" (Swann, 1992). This description reminds us of one of the key pressures - the general dynamic of unification - which led to the overall revision of the Treaty (see Section 2.3).

The rise of preventive policies

A second, and related, feature of the "landscape" or environment surrounding Article 129 is what Bomberg and Peterson have identified as the rise of preventive policies in the EC since the mid 1980s (in Mills, 1993). Examples of these policies - which "seek to eliminate or manage risks which could otherwise have adverse effects on human health or the environment" - are EC policies for the environment, consumers, research and development and social rights. A number of my interviewees (Atkinson, UK INT and Jukes, UK INT; see also Birt, 1993) pointed out how consistent such policies are with the new Article 129. Once again, the general dynamic of unification appears to be at work.

Furthermore, the fact that preventive policies developed more or less in tandem with the Single Market is no coincidence. As the implications of the Single Market began to "dawn", there was, for example, growing concern that the increased trade and economic activity generated could have an adverse impact on the environment and on public health. The ageing, and therefore shrinking, European workforce must be kept healthier, more productive and less at risk of accidents if Europe is to remain

competitive on the world stage. Thus there is a clear economic imperative for the emergence of preventive policies. In addition, it is evident that such policies have to be introduced by all member states - necessitating action at EC level - in order to avoid distortion of competition and of resource allocation within the internal market.

Coupled with the clear economic imperative is, arguably, a social democratic one also. A concern that all citizens of Europe should benefit from the process of economic integration also appears to have contributed to the rise of EC preventive strategies. Typically this is expressed in terms of developing the EC's human face, a "People's Europe" and "l'espace sociale". The way in which this wider social democratic concern took root, again from the mid-1980s onwards, is illustrated, for example, by the gradual broadening out of EC social policy beyond workforce and labour market issues (Atkinson, UK INT; Section 1.2 above; Swann, 1992; Hitiris, 1988 and Butt Philip, 1992). We see again that the strengthening and broadening out of the social policy and, indeed the preventive dimension of the Maastricht Treaty is consistent with developments already underway. It should come as no surprise, therefore, that the requirement to have at the heart of policy a high level of health protection looms large not only in Article 129 but also in, for example, Articles 129a (on consumer protection) and 130r (on Environment) of the Treaty.

Health related problems and challenges facing the member states

The ageing of the European workforce, coupled with falling birth rates, is but one of the health related problems and challenges which could affect the competitiveness of European industry. In addition the changing demographic structure will put increasing pressure on member states' health care systems. Other health related problems and challenges in the environment include increasing population mobility into the Community and between member states (this links to the changing international context discussed in Section 2.3), rising expectations about what health services can and should deliver and the general socio-economic problems of the Community, notably social exclusion. A number of my interviewees, notably Pritchard and Carroll (Pritchard, UK INT and Carroll, BRU DISS) argued that Article 129 should be seen as a response to these various health related problems. Taken together, they

have pushed public health right up the Community's agenda. For example, the vastly increased movement of people across Europe due to political changes and war, for example in the former Yugoslavia, has inevitably led to the spread of communicable disease, a problem which demands a public health response at EU level (Pritchard, 1994). In addition, because many of the major diseases and disorders affecting the people of Europe are related to lifestyle factors, it makes sense "to put more emphasis on health protection and disease prevention strategies", precisely as Article 129 is recommending (Collins, 1993a, Commission of the European Communities, 1993 and Commission press release of 24th November, "Prevention is Better than Cure"). The argument that Article 129 is a response to problems arising from a changing environment and clientele is also consistent with ideas in the policy analysis literature on information needs and issue search. If some of these ideas are applied in the context of this discussion, we can argue that existing and emergent health-related problems and challenges had become important enough to get on to the agenda, requiring "special government attention" and a "special apparatus" - in this case Article 129 - to treat them (Hogwood and Gunn, 1984).

Hogwood and Gunn also identify a number of circumstances - one or more of which is likely to apply - if an issue is to pass through the threshold and get on to the agenda. For example, the issue is likely to have reached crisis proportions and can no longer be ignored, or it is one which seems likely to have wide impact. Such predisposing factors, however, "do not guarantee politicization and access to the public policy agenda" (Hogwood and Gunn, 1984). It is important to be aware of the politics of agenda setting, whether at the national or at the European level. The next section therefore goes on to examine the political process in relation to Article 129.

2.5 The political process and system in relation to Article 129

This section, which continues to draw on Easton's and Barrett and Fudge's frameworks, focuses on inputs into the political process and the political system itself in relation to Article 129. The key players discussed are the member state governments, EC institutions (the Parliament and the Commission), non-governmental organisations and professional interest groups. The section also includes a discussion of a number of policy process issues raised by the wording of Article 129.

2.5.1 The member state governments

It has already been highlighted that the mechanism for Treaty revisions - the IGC - is a meeting of sovereign member states. Following a process of intergovernmental bargaining decisions are reached by the member state governments as to how the Treaty should be revised.

Clues as to the attitudes of the member governments towards the possible extension of Community competence into the sphere of public health are littered throughout the large number of official documents which appeared in the run up to and during the IGCs (see Corbett, 1993). For example, the European Council noted following its meeting in Rome on 14th and 15th December 1990 that "there is a wide recognition of the need to extend or redefine the Community's competence in specific areas" (Corbett, 1993, p.101). In this context it went on to ask the IGC to bear in mind, *inter alia*, "the health sector and in particular the combating of major diseases". In addition, the IGC received proposals for new provisions on public health from Portugal, Ireland, Spain, Italy, the Netherlands, Denmark and Germany (Corbett, 1993). This gives the impression that the majority of member state governments supported the inclusion of an Article on public health in the Treaty.

All my interviewees in fact went even further than this and said that the inclusion of Article 129 in the Treaty was unanimously supported by the member governments (Milligan, BRU DISS; Carroll, BRU DISS; Harlow, BRU DISS; Hayes, BRU DISS; Chapman, UK INT and Atkinson, UK INT). A number of reasons were put forward

for this unanimity. Carroll, for example, spoke of a general consensus that the "human face of the Community should be developed", while Milligan highlighted concern amongst the member states that, at European level, "health was untidy, with bits and pieces all over the place" (see Section 2.2). The view that a clearer focus for health policy in the Community was needed commanded general acceptance. Milligan also suggested that there was concern that the mixed competence basis (Article 235) of the EC's public health activities before Maastricht meant that they had a less than firm legal basis and were therefore susceptible to being challenged in the European Court of Justice (an example perhaps of the judicial dimension contributing to the policy making process). Similarly Community expenditure based on mixed competence was being subjected to increased scrutiny by the European Parliament. The implication here is that Article 129, which has put EC public health initiatives on a firm legal basis, is the member state governments' very pragmatic response to this climate of increased challenge and scrutiny.

Britain's stance on Article 129

Despite the air of unanimity, a number of my interviewees emphasised the need to probe beneath the "surface of general consensus" among the member state governments that the Community's competence should be extended into the field of public health. What is found at the deeper level are a range of different motivations and varying degrees of enthusiasm towards Article 129. Predictably, perhaps, Britain's stance was generally felt to be a minimalist one; in other words, its main motivation was to "tie down" the EC's competence by setting clear parameters in a new Treaty Article which - paradoxically perhaps - would limit rather than provide increased scope for EC activities in the field of public health (Milligan, BRU DISS; Harlow, BRU DISS and Hayes, BRU DISS). Atkinson described Britain as the member state displaying least enthusiasm, and offered two main reasons for this. First, at the time of Maastricht Treaty negotiations, Britain was in a minority of only three member states with a national health service funded out of general taxation. The other (then nine) member states have insurance based systems. Britain was therefore particularly keen that "harmonisation of the laws and regulations of the Member States" should be precluded by the Treaty, as harmonisation could mean Britain being forced to

switch to an insurance basis for the NHS. In addition, Britain was also concerned that any harmonisation could be extremely costly as it would presumably involve extensive investment in the southern member states' health services in order to "level them up" in terms of funding and standards to services in the northern states. Notwithstanding Britain's concern to limit the spread of Community public health competence for these two reasons, it should be noted that Britain's overall, perhaps slightly begrudging, support of Article 129 is consistent with the goals of its Health Presidency (July - September 1992) and also of its public health policy at the national level, as set out in the White Paper The Health of the Nation⁹ (Department of Health, 1992) (Atkinson, UK INT and Chapman, UK INT).

Set in a wider context, Britain's minimalist stance on Article 129 reflects the way in which it has always tended to view the relationship between the nation state (or national government) and the Community in zero-sum terms. In other words, "given a finite amount of authority or sovereignty, any increase in Community competence or authority has had to be matched by a diminution of similar power at the national level" (Swann, 1992). This contrasts with the view taken by other member states, for example Germany, associated with the maximalist stance, which tends to see the Community as a means of "collectively achieving objectives which are beyond the grasp of its members operating independently" (Swann, 1992). The validity of this viewpoint in relation to Article 129 is perhaps best illustrated by the need to take action at the EC level if the spread of communicable diseases across frontiers is to be controlled.

Another factor which helps to explain Britain's minimalist stance is its attitude towards the implementation of EC laws. Given that its implementation record is in fact one of the best, it seems reasonable to argue that Britain, when negotiating in the EC, tends to argue the "finer points precisely because there is a clear intention to

⁹ The White Paper is seen by most commentators as an important milestone in the reemergence of the public health perspective in British health policy. In addition, as Tremblay pointed out to me, the White Paper has played a key role in raising the profile of British public health expertise and has been commended as a model of good practice by the World Health Organisation (Tremblay, BRU DISS).

implement any decisions taken while other states, on occasion, find it easier to be reasonable in the Council because they either do not appreciate the problems of implementation or because they do indeed intend to avoid them" (Swann, 1992 and see also Mazey and Richardson, 1993).

The significance of the wording of Article 129

According to my interviewees, the actual wording of Article 129 also reveals the different attitudes and concerns of the member states. In keeping with its minimalist stance, Britain was particularly vigorous in negotiating the inclusion of phrases which describe the Community's role in terms of "encouraging cooperation" and promoting coordination between member states. Linked to this, Britain pushed hardest for the phrase precluding "any harmonisation of the laws and regulations of the Member States" : the principle of subsidiarity writ large (Nicholas, UK INT and Atkinson, UK INT). According to Nicholas, France was keen that Community action towards the prevention of diseases should be focused on the "major health scourges": the word "scourge" is a literal translation of the French "fleau". Its inclusion illustrates France's preference for large scale, overarching programmes, for example Europe Against Cancer which has its roots in the French Presidency of 1986. According to Article 129, one major health scourge which is to be a priority area of action for the Community is "drug dependence". This apparently came to be included as a result of pressure from the Italians (Tremblay, BRU DISS).

Also of interest when examining the wording of Article 129 is the way in which it actually evolved through successive Treaty drafts. The process of evolution could be interpreted as illustrating the course the negotiations took, and, by extension, which member state governments exerted particular influence at different stages. (Three of the versions of Article 129 which appeared during the IGC negotiations are reproduced in Appendices F, G and H). It is striking that neither of the two phrases already highlighted - the one which precludes harmonisation of the laws and regulations of the Member States and the one about drug dependence - appears in the Dutch Presidency's first draft version of the Treaty published on 24th September 1991 (Appendix G) (the public health title was unchanged from the Luxembourg Presidency

draft of 18th June 1991 : see Appendix F). However, just a month before the Maastricht summit, a phrase ruling out harmonisation does appear in the second Dutch Presidency Draft Union Treaty Working Document of 8th November 1991 (Appendix H). Interestingly, however, the phrase on drug dependence is still nowhere to be seen. From this it can be inferred that Britain had to negotiate long and hard - almost to the bitter end - before agreement to rule out any harmonisation was reached. The specific mention of drug dependence - a concession to the Italians - found its way into Article 129 with less than a month to go to the Maastricht summit in December 1991.

This brief discussion of some aspects of the wording of Article 129 illustrates - almost par excellence - that the "politics of the EC is the politics of bargaining, compromise and incrementalism" (Bomberg and Peterson in Mills, 1993). Lindblom's descriptive model of incrementalism, which embraces notions of "partisan mutual adjustment", consensus-seeking and "muddling through" (Hogwood and Gunn, 1984), is very helpful when it comes to developing an account of the type of political setting for the negotiations shaping Article 129.

In addition, the ambiguity of certain important phrases in Article 129 should not surprise us given that policy is "often very unclear, confused or ambiguous" (Barrett and Fudge, 1981). A number of commentators point out how certain key phrases such as "public health" and "prevention" could be interpreted in a variety of ways according to the particular cultural and linguistic context (Ashton, 1992, Sheldon, 1993 and Ham and Tremblay, 1993). Such ambiguity would certainly be berated by those advocating a rational approach to policy making and implementation. This approach would stress, for example, the need for absolute clarity of definition and to express policy goals clearly, relating means to ends (see Barrett and Fudge's discussion of Sabatier and Mazmanian's 'recipe book' approach to implementation). Before we resort to similar criticism of Article 129, however, we need to appreciate what might lie behind its looseness of definition and linguistic ambiguities. Atkinson thought it most likely that it suited the Treaty negotiators **not** to include a precise definition in the Article of such key phrases as "public health" and "prevention". He

went on to refer to the likelihood of a need to "muddy the waters a bit to keep everyone on board" (Atkinson, UK INT). Similarly, Atkinson considered the failure to define the phrase "incentive measure" - which appears not only in Article 129 but also in the Articles on education and culture - as another drafting compromise.

What this serves to illustrate - to return to our discussion of rational and incremental models of policy making - is that there may be "many good reasons for ... ambiguity" (Barrett and Fudge, 1981). For even when it is technically possible to define policy goals unambiguously, political processes involving compromise between key actors and their interests are likely to undermine initial clarity. If we subscribe to the view that implementation is about "getting something done" or performance as opposed to "conformance with policy" (Barrett and Fudge, 1981), we are more likely to find the drafting compromises of Article 129 perfectly acceptable. After all, to reflect again on Atkinson's comment, such compromises appear at least to have kept all the member states on board and provided the basis for increased and more concerted Community action in the sphere of public health.

While it is important to acknowledge the pivotal role of the member state governments not only in getting Article 129 included in the Maastricht Treaty but also in determining, by a process of bargaining, compromise and incrementalism, the final wording of the Article, it is important not to lose sight of the role played by other players. The next section examines the influence exerted by two Community institutions, the European Parliament and the European Commission.

2.5.2 EC institutions

The European Parliament

The discussion in Section 2.3 has already highlighted that the Parliament was at the forefront of agenda setting for the IGCs, pressing, for example, for the enlargement of Community competences. The question now to be addressed is whether the Parliament specifically sought the extension of Community competence into the field of public health.

Of my interviewees who felt able to comment on this, the majority felt that the Parliament had called for this particular extension of EC competence. To begin with, the Parliament had pressed in the past for truly preventive policies in the name of both the internal market and the general improvement of the quality of life in Western Europe. The latter point illustrates Parliament's view of itself as a Parliament for the **whole** Community, eager to add a human face to Community activities (Carroll, BRU DISS) and to raise its profile by "landing more goodies on health" (Hayes, BRU DISS). The Parliament's long track record in health matters means that it would have been entirely natural for it to have supported the inclusion of Article 129 in the Treaty - a question once again of continuity in rather than change of policy (Milligan, BRU DISS and Pritchard, UK INT; see also Commission of the European Communities, 1993 and Collins, 1993a). Linked to this, as Hayes pointed out, the Parliament's Committee on the Environment, Public Health and Consumer Protection (chaired by the Scottish MEP Ken Collins) is one of the most powerful and popular Parliamentary Committees. There is also a flourishing Parliamentary Intergroup on health - interestingly serviced by the European Public Health Alliance - which has had considerable success in pursuing action within the Parliament and in influencing MEPs (Hayes, BRU DISS and Mulcahy, BRU DISS). Overall the influence of these "health withinputs" was felt by those who were interviewed to have been considerable.

An examination of the literature seems to confirm the picture of the Parliament having an important role in pushing preventive strategies on to the EC's agenda, and, by extension, in securing the inclusion of Article 129 in the Maastricht Treaty. However the motivation for doing so is argued to go beyond an altruistic concern to develop a Citizen's Europe. Both Bomberg and Peterson and Buchan attribute the Parliament's, and indeed the Commission's, zeal in promoting the extension of Community competence to new fields to their own self interest (Bomberg and Peterson in Mills, 1993 and Buchan, 1993). Expanded powers in, for example, the field of public health mean more power for EC institutions in European policy making. This has strong resonances with Public Choice and New Right accounts of officials and bureaucrats deliberately adopting "bureau maximising strategies". As far

as the European Parliament is concerned, the crowning achievement in relation to Article 129 is arguably the co-decision process applying to this, and indeed to other new competences (see Section 2.3).

The final source to be drawn on in considering the role of the Parliament in relation to Article 129 is the documentary evidence, namely European Parliament Resolutions leading up to and during the IGCs (These are reproduced in Corbett, 1993). If the account so far is accurate, one would expect these Resolutions to contain statements in support of an extension of Community competence into the field of public health. The opposite, however, appears to be the case. No reference to public health can be found in the Parliament's detailed proposals¹⁰. However, in its statement responding to the Maastricht Treaty (European Parliament Resolution of 7th April 1992 : the Martin IV Report), the Parliament clearly states that it welcomes the wider scope of Community competences, and that it called for the new Title on public health, *inter alia*, to be included before the IGCs (Corbett, 1993, p.486). From this the tentative conclusion can be drawn that although the Parliament does not appear to have set out formally in written Resolutions its wish to see a new public health competence, it nonetheless supported the inclusion of Article 129 before and during the IGC negotiations, perhaps seeking to exert its influence through less formal channels like written proposals or the parallel inter-institutional conference (see Section 2.3). The conclusion has to remain tentative, however, because an exhaustive review of the IGC documentation has **not** been carried out. Nonetheless the documents which have been examined do underline the fact that major and controversial issues - for example monetary union, foreign and defence policy, the powers of Community institutions and decision-making processes within the Community - were under consideration at the IGCs. It may well have seemed more important to the Parliament to focus on these in its written Resolutions than on the "smaller fry" of new Community competences in areas such as public health.

¹⁰ The proposals which have been examined are those leading up to the IGCs (on 14th March 1990 (Martin I Report), 16th May 1990 (Herman Report on economic and monetary union), 11th July 1990 (Martin II Report) and also the Resolution issued during the IGCs (on 10th July 1991).

The European Commission

The idea of each EC institution seeking to expand its powers is relevant not only to the Parliament but also, as has already been hinted, to the Commission. As we have already seen, preventive strategies expand the powers not only of the Parliament but also of the Commission, and thereby serve their self interest. In addition, EC institutions are keen to put themselves "at the vanguard of a movement (partly self-created) to improve the quality of life in Europe and make European governments responsive to new social concerns and life styles" (Bomberg and Peterson in Mills, 1993).

The picture emerging from the literature of the Commission actively supporting the development of EC preventive strategies is borne out by what the people I spoke to said about the role of the Commission in relation to Article 129. A number suggested that the establishment of a Public Health Unit within DGV in the late 1980s (see Appendix I) signalled the start of a concerted push by the Commission not only to increase its own influence in the public health sphere but also to "tidy up the rag bag" of EC health-related initiatives and to put them on a firmer legal basis (Milligan, BRU DISS; Harlow, BRU DISS; Hayes, BRU DISS and Birt, 1993). In this sense, the Public Health Unit of DGV can be seen as an important "withinput" to the policy making process. However it is important to recognise that the Unit's objectives may not be shared by all other parts of the Commission. In other words, the Commission is unlikely to "think" and act "monolithically" in all policy areas. Mulcahy, for example, highlighted the large degree of conflict between different parts of the Commission in certain policy areas (Mulcahy, BRU INT). The conflict often highlighted is of the Commission's efforts, on the one hand, to tackle cancer through the Europe Against Cancer programme and, on the other, its policy of subsidising tobacco farmers in the southern rim member states. Mulcahy went on to suggest that the discussions about Article 129 could well have polarised the "health" and "anti-health interests" within the Commission and their respective lobbies.

Notwithstanding the likelihood of conflict within the Commission over the area of health policy, the "majority view" which seems to have emerged overall is that

Community competence should be extended into the field of public health. Interestingly, however, this view cannot be clearly detected in the Commission documents reproduced in Corbett (1993)¹¹ In none of these documents does public health receive a specific mention. Instead other themes - for example a single Community, ensuring unity and coherence in the Community's international action, strengthening democratic legitimacy and improving the effectiveness of the institutions - tend to predominate. Again one has the sense that Commission, like the Parliament, had bigger fish than public health to fry when it came to formally committing its proposals for the Political Union IGC to paper. However, once again this is offered as a very tentative conclusion as only a small selection of Commission documents published in the run up to and during the IGCs have been examined. If we turn to other sources, for example the January 1991 edition of The European Citizen published by the European Citizen Action Service (ECAS)¹², a different picture emerges. Here ECAS specifically refers to Commission IGC proposals for a legal basis "to coordinate action to combat diseases of significant importance, for which the cure or reduction is beyond the capacity of single Member States". In particular, a firmer foundation is needed for action "to combat cancer, AIDS, cardiovascular disease and drug abuse" (European Citizen Action Service, 1991a and 1991b). So while the range of Commission documents reproduced in Corbett do not refer to a new competence in public health, ECAS's statement here indicates that Commission proposals to this effect were circulating in the public domain.

2.5.3 Non-governmental organisations and professional interest groups

The mention of ECAS moves us on to a consideration of the role of non-governmental organisations (NGOs) and professional interest groups - for example the British Medical Association and the Royal College of Nursing - in pressing for the inclusion of Article 129 in the Maastricht Treaty. Commentators generally agree that

¹¹ Corbett reproduces the Commission Opinion on Political Union of 21st October 1990, the Commission Proposal on the Social Dimension, and Commission Amendments to Luxembourg Presidency "Non-paper" on political union of 12th April 1991.

¹² ECAS is an "umbrella organisation" set up in 1990 to advise, inform and strengthen the position of voluntary sector non governmental organisations in relation to EC institutions. It has set as its initial priority areas culture and education, health and social welfare and civic rights (Butt Philip, 1991).

European institutions - for example the Commission and Parliament - are quite open and accessible to outside interests (Mills, 1993 and Mazey and Richardson, 1993). Direct lobbying of EC institutions has been described as the Eurotransnational route for influencing EC policy. The other important route is the national one whereby groups seek to influence member state governments in order to influence the Council of Ministers and, by extension, the IGC process. In this particular context, professional interest groups would tend to use the national rather than the Eurotransnational route (Greenwood, Grote and Ronit, 1992).

The general consensus among interviewees was that - with one exception explored below - the role of NGOs and professional interest groups in getting Article 129 included in the Maastricht Treaty was limited. Two main reasons were given for this. The first - relating to NGOs - was that there were few health pressure groups with an identity separate from ECAS actually in existence when discussions about the revision of the Treaty got underway in late 1989 / early 1990 (Harlow, BRU DISS; Hayes, BRU DISS and Mulcahy, BRU INT). This view is confirmed by the literature on EC wide pressure groups (see, for example, Butt Philip, 1991 and Harvey, 1992). This literature highlights that while agriculture, the food industry, industrial and commercial interests have been well-represented at EC level in terms of numbers, funding and overall influence for some time, the so-called "non-economic interests" - for example environmental and health groups - appeared relatively late on the Brussels scene. The European Public Health Alliance (EPHA), for example, while officially formed in September 1991 from a network of health organisations then in ECAS, did not, in the words of Andrew Hayes, "really get going" until after the Maastricht Treaty (Hayes, BRU DISS). The same can be said of the European Heart Network, formerly the International Heart Network (Mulcahy, BRU INT). However, as we shall see in Section 2.6, these, and similar groups, are working hard to influence the sort of initiatives now coming forward under Article 129.

The second reason given for the limited influence of NGOs and professional interest groups in bringing about the extension of EC competence into the public health field was to do with their tendency to campaign on specific, well-defined issues rather than

for a general extension of EC powers, such as that represented by Article 129. This was highlighted by both Milligan and Atkinson in relation to lobbying at Eurotransnational and national level respectively (Milligan, BRU DISS and Atkinson, UK INT). Atkinson, for example, described the Department of Health's "disappointment" at the lack of any lobby - for example a health profession one - at national level seeking to influence general Community public health policy. This is not to say, however, that the Department has not been lobbied on more specific issues; for example the British Medical Association has for a long time called for a ban on tobacco advertising (see Sections 2.1 and 2.4) (Nicholas, UK INT). In addition it has made strong representations for a health audit approach to policy making to be adopted at EC level. Arguably the clause in Article 129 which states that "health protection requirements shall form a constituent part of the Community's other policies" is consistent with the health audit concept.

In similar vein, Harvey argues that "few voluntary organizations present an interest in large-scale political objectives" (Harvey, 1992). To illustrate this, he identifies a mere handful of voluntary groups which made a contribution on the EC's future social policy objectives by forwarding submissions to the intergovernmental conference which met over 1990-1 and which matured as the Treaty of Maastricht. Those that did were ECAS, the European Women's lobby, the Churches' Committee on Migrants in Europe and the Free Legal Advice Centres (Ireland). ECAS, for example, provided an important focal point for the demands of Citizen's Associations on the EC Treaty through its VOICE campaign (Voluntary Organisations in a Citizen's Europe). Amongst its specific demands was that Community competence should be extended into the field of public health. The clarity of ECAS's overall campaign, coupled with its frequent contact with Commission officials and MEPs, for example during the European Citizen's week it organised in September 1991, lead one to conclude that ECAS was an important source of pressure for the inclusion of Article 129 in the Maastricht Treaty (European Citizen Action Service, 1991b).

It is more difficult to draw definitive conclusions about the part played by professional interest groups in getting Article 129 into the Treaty. Overall, however, their interest and their influence seem to have been limited.

One important NGO which, to use a phrase from Article 129 itself, can be described as a "competent international organisation in the sphere of public health", is the World Health Organisation (WHO). Given the Commission's long and extensive track record of cooperation with the WHO, one might expect the WHO to have been a source of pressure for the inclusion of Article 129 in the Maastricht Treaty. The one person I spoke to who felt able to comment on this in fact took me by surprise when he implied that the WHO's influence during the IGC stage was in fact limited (Harlow, BRU DISS). Harlow also indicated that the initiatives now being worked up to implement Article 129 are relatively free of formal WHO influence. He attributed this to the Commission's wish to appear capable of taking its own initiatives and also to move away from WHO-type approaches which tend to be very medically oriented. At the informal level, however, Harlow conceded that the Commission is influenced by the WHO. Just as national governments rely on organised interests for their expertise and for the implementation of policy, so too, given the small size and limited expertise of the Public Health Unit of DGV¹³, we can expect the WHO to exert considerable - albeit informal - influence (Greenwood, Grote and Ronit, 1992).

This brief discussion of the influence of the WHO brings us on to a consideration of the "implementation stage", or the steps now being taken to develop initiatives based on Article 129 which is, after all, only the starting point. What has happened since February 1992 is the subject of the next section.

¹³ The Public Health Unit of DGV currently consists of some twenty permanent Commission staff and detached (seconded) national experts, plus a number of contract and support staff. However, the overall number varies according to the work to be done (Source : private correspondence dated April 14th 1994 with Dr W J Hunter, Health and Safety Director, DGV).

2.6 The implementation of Article 129

This section examines what has been done, and by whom, since the Maastricht Treaty was signed in February 1992, to strengthen the Community's influence and to develop its programmes in the sphere of public health. A number of policy process issues highlighted by the "implementation stage" of Article 129 are also discussed. In Barrett and Fudge's model (see Section 2.4), the implementation stage equates to the organisational system through which policy is mediated and executed.

2.6.1 Developments since February 1992

The Community's formal acquisition of a new competence in public health in February 1992 triggered a flurry of activity as the Council of Ministers, Community institutions and interest groups all set about seeking to influence the agenda emerging from Article 129. During the second half of 1992, for example, the Health Council of Ministers examined fundamental questions concerning the future course of Community action in the area of public health. Influenced by the goals of Britain's Health Presidency, discussion took place on the need to develop greater coherence and clearer priorities for public health and an appropriate framework for existing public health programmes. Also influencing the Council's deliberations was a Commission working paper entitled "Public Health" (SEC 92 1866, published in October 1992). As well as taking stock of Community public health initiatives to date, this paper emphasised several broad themes for future work. These were cooperation, complementarity, subsidiarity, health protection and preventive measures (Commission of the European Communities, 1993 and Collins, 1993a).

In May 1993 of the following year, the Council of Health Ministers produced a resolution urging the Commission, "as quickly as possible, to submit proposals for an action programme in the field of public health". The resolution set out a clear framework and principles to guide the Commission's work (Commission of the European Communities, 1993 and Collins, 1993). Within days of the publication of this resolution, the European Parliament held a public hearing on June 3rd of its Committee on the Environment, Public Health and Consumer Protection. The Public

Hearing was later followed by a parliamentary resolution setting out the Parliament's ideas and priorities for future Community action in the sphere of public health (Collins, 1993a). Because of its long standing interest in health and the introduction of the new co-decision procedure applying to public health, the Parliament can be expected to be a key player in shaping initiatives based on Article 129.

Five months later, in November 1993, the Commission published its own communication on the framework for action in the field of public health (Commission of the European Communities, 1993). The key recommendations of this document - for example concerning the principles that should guide Community action and the programmes which should be developed - have already been summarised in Section 2.2.

Not all the programmes identified by the Commission in its November 1993 framework document are, however, to be taken forward. At its meeting in June 1995, the Health Council of Ministers finally reached political agreement on just four programmes - public health promotion, information, education and training; cancer; AIDs and other communicable diseases and drugs dependency - which are to be implemented over a five year period starting in October 1995. The budget for the four programmes is £137 million, an allocation which was apparently reduced to leave a margin for the forthcoming proposal on Health Data and Indicators (Health Service Journal, 1995 and Department of Health, 1995e).

2.6.2 Policy process issues

As has already been highlighted, it is not only the Community institutions which have been active in seeking to shape future public health initiatives based on Article 129. From my discussions with interviewees and during the Brussels study tour it became apparent that Article 129 triggered a rush of papers and lobbying as key NGOs and professional interest groups sought also to influence the emergent public health agenda (see, for example European Public Health Alliance, 1992 and 1994; Institution of Environmental Health Officers and European Public Health Alliance, 1993; Standing Committee of Nurses of the EC, 1993). Indeed, Margaret Mulcahy of the European

Heart Network remarked that the Commission openly "trawled around" for ideas for its November 1993 framework document. Barrett and Fudge's description of the policy action relationship as a "process of interaction and negotiation" seems appropriate in this context (Barrett and Fudge, 1981). In addition we are again reminded of two linked characteristics of the policy process as it appears to operate at European level. The first of these is the relative openness of EC institutions to interest groups (Mills, 1993 and Mitchell, 1993). The reasons for this, which have already been alluded to in Section 2.5, include the Commission's own limited administrative capacity and limited expertise in the area of public health (Mills, 1993). This leads to "structural dependencies" within policy networks, for example for resources, expertise and implementation (Mills, 1993 and Mazey and Richardson, 1993). It therefore seems entirely possible that Commission officials, for example, despite their wish to appear to be taking the initiative and acting independently, will be drawn into "quasi-clientelist relationships with the limited number of groups which are really able to keep pace with and respond to Commission proposals" (Mazey and Richardson, 1993 and, for a more general exploration of the concept of clientelism, see Richardson and Jordan, 1979).

The mention of policy networks highlights a second important characteristic of the policy process at European level. A number of commentators have argued that EC decision making is fragmented into different sectors, "each with its own distinctive range of actors, imperatives and Treaty bases" (Mills, 1993). Furthermore, it has been suggested that this fragmentation, coupled with the increasingly technical nature of EC decision-making, offers "potentially greater opportunities for the formation of policy networks than at national level" (Sidjanski and Ayberk, 1987, quoted in Mitchell, 1993). Thus the relevance of the concept of policy networks may be even greater at European level than it is at national level.

For all the apparent openness of the Commission to ideas from interest groups when drafting its Framework document, there is one area - highlighted to me by a number of my interviewees - which it seemed determined to keep off the Community's public health agenda. Notable by its omission from the list of priority areas for future EC

action (see Section 2.2) is cardiovascular disease¹⁴. Atkinson pointed out that the recommended areas for action in the Framework document do not flow logically from the Commission's own analysis. This clearly identifies heart disease as a major cause of death in the Community and even goes so far as to state that it is "an appropriate target for action" (Commission of the European Communities, 1993). However, it is excluded from the final list of priority areas on the basis that the Community cannot "add sufficient value". This assertion was vigorously questioned by my interviewees (Atkinson, UK INT; Mulcahy, BRU INT and Hayes, BRU DISS). Instead they pointed to the "hidden hand" of the agricultural and commercial lobby, for example the food industry, whose interests are likely to be adversely affected by concerted EC action tackling heart disease. What this perhaps illustrates is that pressure groups differ markedly in their ability to influence decisions in their policy community or network. From this it can be argued that pluralism does not provide a completely adequate theory of power. As Ham has put it, "in particular, the strength of producer groups and the relative weakness of consumer groups cast doubt on the pluralists' argument that any group can make itself heard effectively at some stage in the decision-making process, and that no one group is dominant" (Ham, 1992b). Or, to put it in more general terms, the exclusion of cardiovascular disease from the agenda - both that of the Commission and that of the Health Council - serves to underline that "the pressure group world is not fluid and competitive, but hierarchical, stratified and inegalitarian" (Cawson, 1982). Very importantly, policy can be argued to involve inaction - in the sense of deliberate decisions not to act - as well as action, although the latter is much more difficult to pin down and analyse (Hogwood and Gunn, 1984 and Hecló, 1972). What fails to get on to the agenda is therefore highly significant.

The idea of policy as inaction, often discussed in a national context, thus seems to be relevant when it comes to analysing the Eurotransnational level as well. Other conclusions about the policy process at these two levels are drawn together in the final part of this Paper.

¹⁴ As we have already seen, the "priority area" of cardiovascular disease does not feature either in the four programmes the Health Council decided to take forward when it met in May 1995.

PART THREE: CONCLUSION

3.1 Future research

Given the "newness" of the EU's public health competence, it is perhaps not surprising that the answers to many questions about the future scope and impact of EU public health activities have yet to emerge. For example, it is too early to say whether the past constraints on public health policy arising from the absence of a clear legal basis have now effectively been removed. Will the self-limiting ordinance - Article 129's clause precluding harmonisation of the laws and regulations of the Member States - be a major obstacle? Can prevention be entirely separated from the functioning of health services? How will this key term, and others, be interpreted and how will the interpretation adopted impact on future policy? Will the clause relating to health protection be used to challenge some of the conflicts or mismatches glaringly evident in Community policy? (see tobacco example cited in Section 2.5). Another important area for future work is the way in which the role and influence of Community institutions in the sphere of public health may change as a result of the new codecision procedure. More generally, will the enlargement of the Community lead to the appointment of a Commissioner for health and thus to an end of the fragmentation of responsibility for health between different Directorates General of the Commission?

Although these questions go beyond the scope of this research, they could form the basis of future work on the EU's developing public health role. What this concluding section seeks to do, however, is to summarise the main findings and themes which have emerged from the work undertaken to date. The first part of the summary uses the framework provided by the three research questions identified in Section 1.1.

3.2 Main findings and themes of the research

In relation to the first question, it has been found that a wide range of EC initiatives had an impact on the NHS and health policy during the period 1973 (the year of

Britain's accession to the Community) to 1992, when the Maastricht Treaty was signed. These initiatives do not add up, however, to a coherent Community health policy for this period. Instead they are best seen as by products of policies in other areas. The policy areas identified in Ham's framework, and explored in detail in this Paper, are the Single European Market, which has given rise to the majority of the initiatives, the social dimension and research and information technology.

The EC initiatives affecting the NHS and health policy since 1992 suggest that a high degree of continuity with, rather than radical departure from, past initiatives will characterise future policy. However the impact of policies which have already been implemented looks set to intensify; for example we can expect to see increasing mobility of persons, goods and services in the health context as the Single Market becomes established. Overall, it seems highly unlikely that the EC will seek to develop a concerted health policy to bring its influence to bear on the funding and delivery of member states' health services. Indeed, "harmonisation of the laws and regulations of the member states" is specifically precluded by Article 129 of the Maastricht Treaty.

Other factors which all but rule out the "Europeanisation" of health policy are the heterogeneity of policy regimes in the member states, the entrenched view of health as an area of exclusive national competence and the EC's limited institutional and financial capacity. Furthermore, comparative analysis highlights a range of reasons why the development of an optimal structure for a health care system will always remain an elusive task (Hsiao, 1992 and Culyer and Meads, 1992). What comparative work also highlights, however, is that the problems faced by health care delivery systems in the industrial world are familiar and strikingly similar, and that policy instruments for tackling these problems are being drawn from the same relatively narrow range (Section 2.2). For these reasons, then, it is possible that member states' health care systems may converge more in the future.

Given that it has been the regulations made for other sectors which have tended to have repercussions for health services, it is tempting to see the Article on public

health in the Maastricht Treaty almost as a "bolt from the blue", or at least as a radical new departure for the EU. However, a central argument of this research has been that Article 129 also represents a high degree of continuity with the past; in this context past EC public health initiatives and policies concerned with prevention and with strengthening the "human face" of the Community. It can also be seen as a logical and pragmatic response to the problems and pressures affecting member states' health care systems. More generally, Article 129 is consistent with the general dynamic of unification, the implications of the Single Market and the changing international context.

These pressures in the "environment" provide an important backdrop for examining the politics of setting and shaping the agenda for and during the Maastricht Treaty negotiations. The key players in relation to Article 129 were found to be the member state governments, the Parliament and the Commission. With the exception of the European Citizen Action Service, non-governmental organisations and professional interest groups seem to have had little influence, or did not campaign specifically for an extension of EC competence into the field of public health.

3.3 The policy process at the Eurotransnational and national levels

The examination of the role and interaction of the key players in relation to Article 129 highlighted that certain aspects of the policy process are as much in evidence at the Eurotransnational level as they are at national level. For example, the stance adopted by different member states, the wording of Article 129 itself, and the way this wording evolved through successive Treaty drafts reveals a politics of "bargaining, compromise and incrementalism" (Mills, 1993). Similarly, the seemingly deliberate ambiguity of certain phrases in the Article highlights that political processes at Eurotransnational level as well as at national level involve compromise between key actors and their interests. The underlying motivation of the Commission and the Parliament in seeking expanded powers in the area of public health - argued by a number of commentators to be more to do with self-interest than with an altruistic concern to improve the quality of life of the Community's citizens - accords with

New Right accounts of bureau-maximising strategies. Notwithstanding the increased influence and role of, say, the Commission in the area of public health, the limited institutional and financial capacity of Directorate General V means that structural dependencies - for example for resources and expertise - within the public health policy network are inevitable. Such structural dependencies are also to be found in national policy networks. It would seem, however, that not all interests in the policy network developing around Article 129 are able to exert equal influence. The exclusion of cardiovascular disease from the Commission's list of priorities for action and from the programmes the Health Council has decided to take forward highlights that, at Eurotransnational as much as at national level, policy can involve inaction - in the sense of a deliberate decision not to act - as well as action. What this also hints at is the diversity within and between the different institutions which comprise the EC. This is illustrated, for example, by conflict between the different parts of the institutions representing what could be termed "health" and "anti-health" interests (the latter grouping would include supporters of the policy of tobacco subsidies). So Community institutions such as the Commission cannot be thought of in monolithic terms.

Examples of differences between the policy process at Eurotransnational and national levels seem to relate to degree and complexity. On degree, Mazey and Richardson argue that there is greater openness and accessibility to outside interests at Eurotransnational than at national level. They also suggest that the increasingly technical nature of EC decision making offers potentially greater opportunities for the formation of policy networks than at national level. Finally, as far as complexity is concerned, there is the idea that the policy process at European level is even more complex than at national level. The complexity is captured in Mazey and Richardson's description of "a vast and proliferating range of groups, conflicting national interests, a strongly sectorised but small bureaucracy, unpredictable agendas and changing decision rules" (Mazey and Richardson, 1993). This raises the fundamental question of how the EU is most accurately conceptualised. Should it be seen predominantly as a vehicle for intergovernmental collaboration, or as "a community with significant capability of its own of generating policy making processes"? (Greenwood, Grote and

Ronit, 1992; see also Keohane and Hoffman, 1991). The answer to this question would seem to depend in part on the policy sector and on the decision rules governing that sector. For example, the introduction of codecision with the Maastricht Treaty means that the power of the Parliament has been considerably enhanced in some policy sectors. It is therefore important to adopt a disaggregated approach which analyses individual policy domains. Such an approach recognises that the policy process is different within different domains (Altenstetter, 1992 and Greenwood, Grote and Ronit, 1992). In addition, how the Community is conceptualised cannot be separated from the wider debate about the type of Europe that is envisaged. Will it be the "superstate" or the intergovernmental model which will prevail in the future, or is this dichotomy an oversimplification? Certainly the debate about the future model arouses much controversy in domestic politics and will no doubt continue to do so at both national and Eurotransnational levels in the run up to the next IGC, scheduled for 1996. The Maastricht Treaty could only ever have been a staging post on the way to this IGC, when critical issues to do with the Community's role and powers into the next century have to be confronted. Given the sheer difficulty of the issues and the number of players involved in the highly complex European political process, it seems unlikely that the tensions and contradictions of integration - which have arguably been there from the very early days of the European project - will be swept away in 1996.

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APPENDICES

TITLE X

PUBLIC HEALTH

Article 129

1. The Community shall contribute towards ensuring a high level of human health protection by encouraging cooperation between the Member States and, if necessary, lending support to their action.

Community action shall be directed towards the prevention of diseases, in particular the major health scourges, including drug dependence, by promoting research into their causes and their transmission, as well as health information and education.

Health protection requirements shall form a constituent part of the Community's other policies.

2. 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 useful initiative to promote such coordination.
3. The Community and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.
4. In order to contribute to the achievement of the objectives referred to in this Article, the Council:
 - acting in accordance with the procedure referred to in Article 189b, after consulting the Economic and Social Committee and the Committee of the Regions, shall adopt incentive measures, excluding any harmonization of the laws and regulations of the Member States,
 - acting by a qualified majority on a proposal from the Commission, shall adopt recommendations.

BRUSSELS STUDY TOUR PROGRAMME**European Health Management
Brussels, Belgium
11th - 13th April 1994****Monday 11th April 1994**

0900 - 0930	Introduction and welcome: Sydney Allman
1000 - 1100	European Health: the issues: Mike Tremblay
1130 - 1230	Seamus Carroll, Cabinet of Commissioner Padraig Flynn
1330 - 1500	Pharmaceuticals and Medical Devices: Fernand Sauer, DGIII
1530 - 1700	Medical Informatics: Thomas Sommer, DGXIII
1700 - 1800	June Milligan UKREP Health
	Free Evening

Tuesday 12th April 1994

0830 - 0930	Discussion
0930 - 1100	Procurement of Services: George O'Brien, DGIII
1100 - 1230	Public Health: Mike Harlow, DGV
1430 - 1530	Research: Anthony Dickens, DGXII
1530 - 1630	Labour mobility and qualifications: Laxmi Reilly, DGIII
1630 - 1730	Public Health Policy: Ken Collins, MEP*
1800 - ?????	Reception

Wednesday 13th April 1994

0830 - 0900	Discussion
0900 - 1100	Public Health: Andrew Hayes, European Public Health Alliance
1130 - 1230	Portability of health and social security benefits for migrant workers: Peter Altmaier, DGV
1230 - 1500	Understanding Health in Europe: strand discussions: Mike Tremblay and others
1500	Course ends

*NB Ken Collins cancelled his session. The course was therefore not addressed by an MEP.

LIST OF PEOPLE INTERVIEWED

Name	Position/job title	Organisation	Date of Interview
Mrs Margaret Mulcahy	General Secretary	European Heart Network	Tuesday 12th April 1994
Ms Karen Chapman	Executive Secretary	Eurolink Age	Wednesday 27th April 1994
Ms Sallie Nicholas	Secretary, European Committee	British Medical Association	Wednesday 27th April 1994
Mr Graham Jukes	Director of Professional and Technical Services	Institution of Environmental Health Officers	Thursday 28th April 1994
Mr Phylip Pritchard	European Officer	Royal College of Nursing	Tuesday 3rd May 1994
Mr Paul Atkinson	Civil Servant, International Relations Unit	Department of Health	Tuesday 3rd May 1994

Provisions in the EEC Treaty which directly or indirectly affect health

Article	Summary
2	Sets out the duty of the Community to raise the standard of living. This Article is relevant to health because of the widely acknowledged link between poverty and ill health (see for example Department of Health and Social Security, 1980 and Whitehead, 1988)
36	Allows restrictions on imports and goods in transit, in order to protect the health and life of humans
43	Deals with agricultural policy which can have an impact on human health
48	Ensures freedom of movement for persons, including patients and health workers. Specifically, this Article provides for the abolition of discrimination based on nationality in employment. Similarly, Article 7 states that nationals of another member state "may not be discriminated against on grounds of nationality, either in law, administrative practice, or in fact" (Hughes, 1992)
51	Provides that the Community shall adopt such measures in the field of social security, including health-related benefits, as are necessary to provide freedom of movement for workers (Hughes, 1992)
52 - 58	Concern the right of establishment, that is the right to work in another country on an employed or self-employed basis
59	Establishes the freedom to provide services, including health services, across frontiers
85 - 88	Provide for freedom of contract, for freedom to choose an occupation and practise a profession in any member state and also for freedom of competition. Hermans' interpretation of these Articles is that the principles of free enterprise and free competition apply to health care (Hermans, 1992)
100A	(a SEA Treaty amendment) - States that all proposals establishing the internal market for products, for example harmonisation measures, must have a high level of health protection as a basis. A number of important initiatives affecting health-related products such as blood products and pharmaceuticals, have now been launched using Article 100A as a basis (Collins, 1993a)

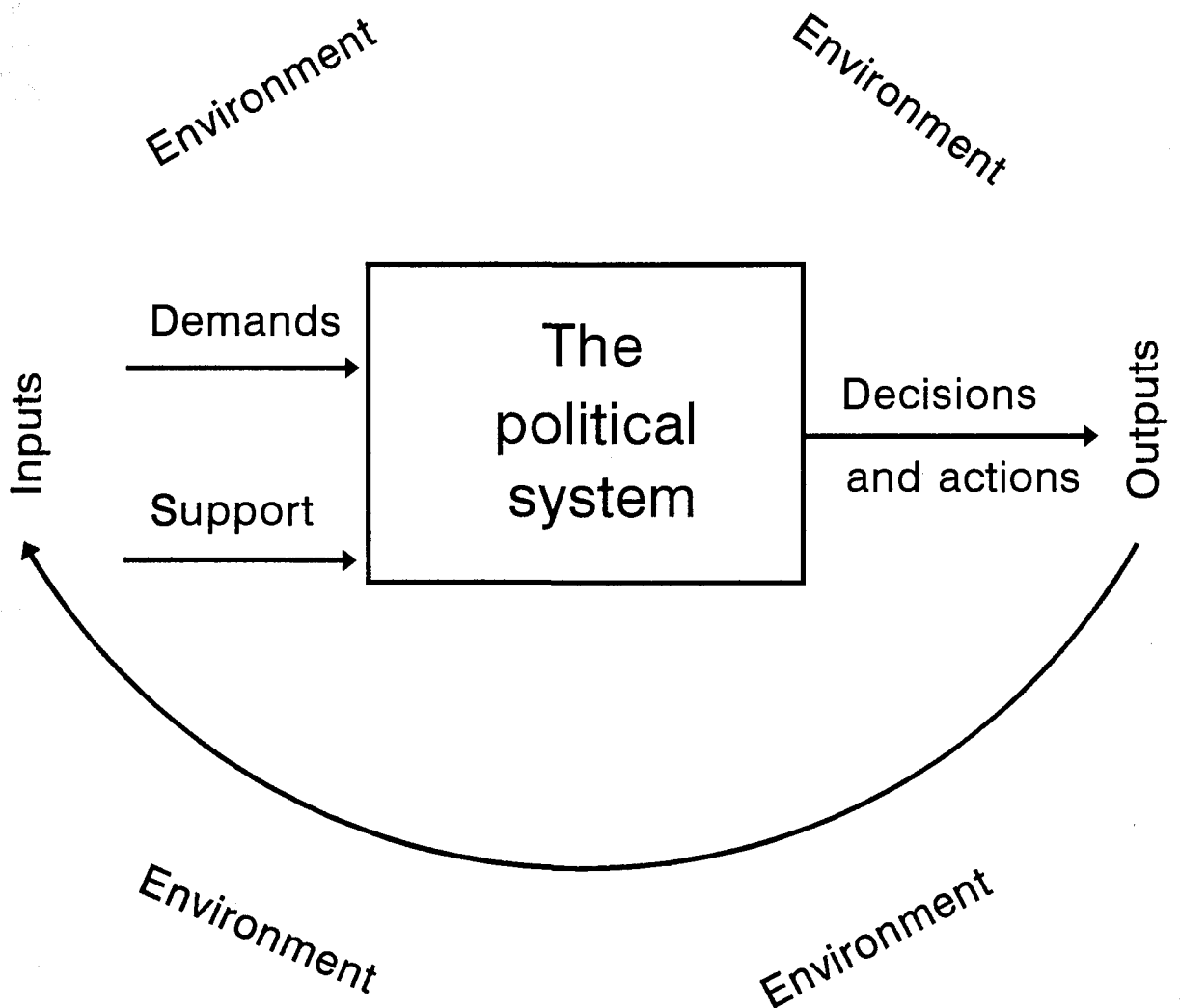
117 - 118 and 118A	Concern health and safety at work. Articles 117 - 118 were given additional impetus by Article 118A of the Single European Act (SEA). Article 118A of the SEA states that "member states shall pay particular attention to encouraging improvements, especially in the working environment, as regards the health and safety of workers, and shall set as their objectives the harmonisation of conditions in this area, while maintaining the improvements made". Significantly the SEA also introduced the qualified majority voting (QMV) system for health and safety matters.
130f - q	Cover research, including health research
130r and s	Extend the Community's competence into the area of environmental protection, underlining that the protection of human health is the ultimate goal of measures based on this new competence.
155	Also provides a basis for issuing recommendations related to health protection. This Article has been used, for example, for issuing recommendations on a European list of occupational diseases.
235	This Article allows for the Council to take decisions after merely consulting the Parliament, "if action by the Community should prove necessary to attain, in the course of the operation of the common market, one of the objectives of the Community and this Treaty has not provided the necessary powers". This Article provides the basis for proposals for decisions and regulations of various health-related issues such as information to the general public and training of the health professions in the context of the Europe Against Cancer programme, the setting up of a Health and Safety at Work Agency, and the creation of a European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). These initiatives are based on mixed competence, that is to say they are partly within the terms of Article 235, and "partly by agreements between Health Ministers as representatives of the member states meeting within the Council" (Health Committee of the House of Commons, 1992).

Source : Commission Communication on the Framework for Action in the Field of Public Health

Commission of the European Communities, 1993.

EASTON'S SIMPLIFIED MODEL OF A POLITICAL SYSTEM

Source: Easton (1965a)



Source: Ham, C. (1992) Health Policy in Britain
Basingstoke: MacMillan

**EXTRACT FROM LUXEMBOURG PRESIDENCY DRAFT TREATY
ON THE UNION OF 18TH JUNE 1991**

Title XVII — Public Health

Sole Article

1. The Community shall contribute towards ensuring a high level of human health protections by encouraging cooperation between the Member States and, if necessary, lending support to their action. Community action shall be directed towards the prevention of diseases, while paying particular attention to combatting major health scourges. Health protection demands shall form a constituent part of the Community's other policies.

2. 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 all appropriate steps to promote such coordination.

3. The Community and the Member States shall foster cooperation with third countries and the appropriate international organizations in the sphere of public health.

4. The Council, acting by a qualified majority on a proposal from the Commission in cooperation with the European Parliament and after consulting the Economic and Social Committee, shall adopt the action programmes necessary to attain the objectives referred to in this Article.

EXTRACT FROM DUTCH PRESIDENCY DRAFT TREATY
OF 24TH SEPTEMBER 1991

Title XV — Public health

Title XVI — Culture

(no change from Luxembourg Presidency draft)

**EXTRACT FROM DUTCH PRESIDENCY WORKING DRAFT
OF 8TH NOVEMBER 1991**

Title XVII — Public health

Sole Article

1. The Community shall contribute towards ensuring a high level of human health protection by encouraging cooperation between the Member States and, if necessary, lending support to their action. Community action shall be directed towards the prevention of diseases, in particular the major health scourges, especially by promoting research into their causes and their transmission, as well as health information and education.

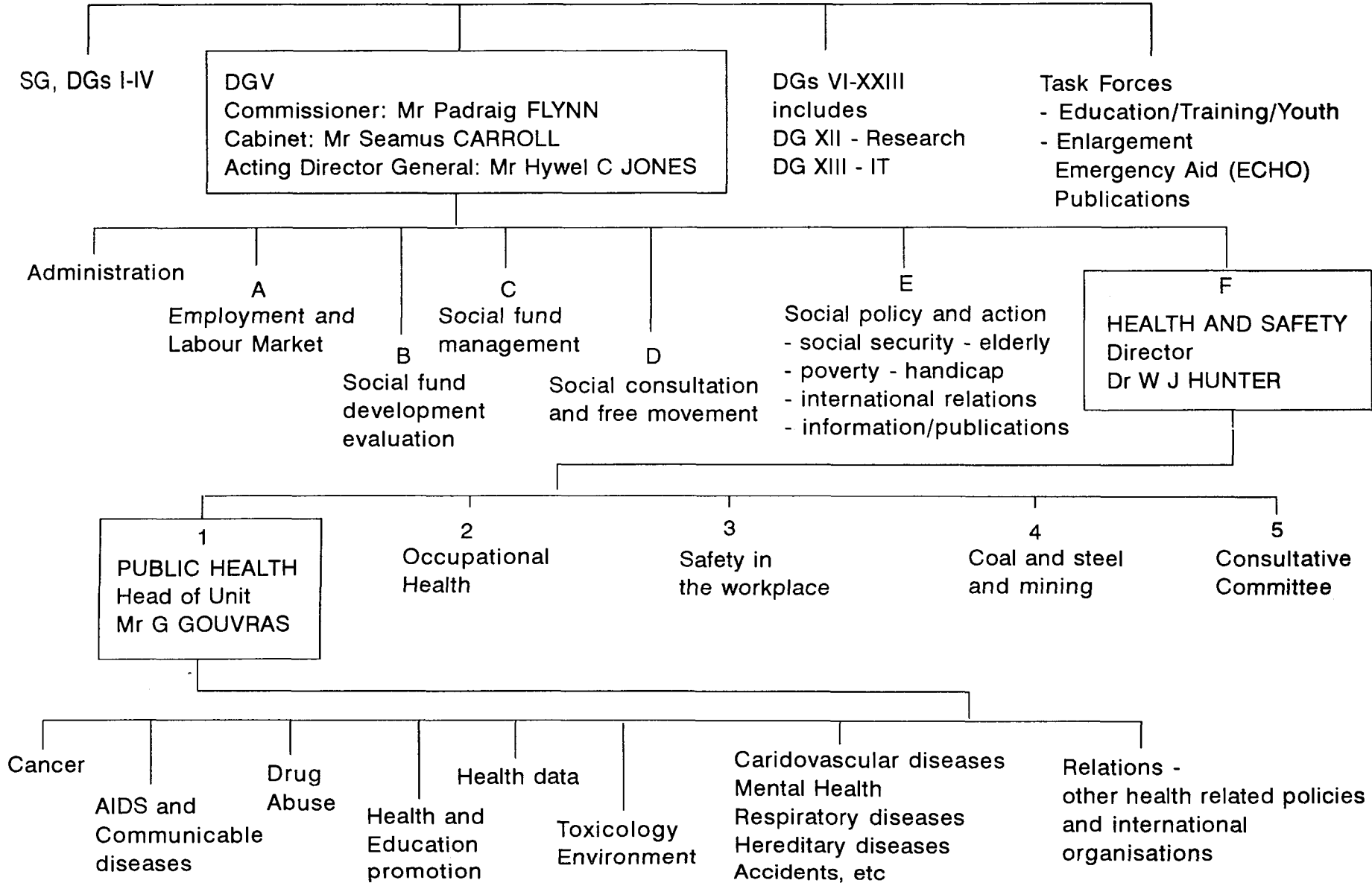
Health protection demands shall form a constituent part of the Community's other policies.

2. 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 all appropriate steps to promote such coordination.

3. The Community and the Member States shall foster cooperation with third countries and the competent international organizations in the sphere of public health.

4. Without prejudice to the other provisions of this Treaty, the Council, acting in accordance with the procedure referred to in Article 189c and after consulting the Economic and Social Committee and the Committee of Regions, shall, in order to contribute to the achievement of the objectives referred to in this Article, adopt recommendations and incentive measures, to the exclusion of any harmonization of the legislative and regulatory provisions of the Member States.

PUBLIC HEALTH IN THE EUROPEAN COMMISSION:
THE STRUCTURE OF DGV
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