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Is the health of the Single Market under threat?

By Marie-Hélène Fandel

Background

A significant increase in the rate of 'non-communicable' diseases – mostly lifestyle-induced – has prompted warnings that the impact of unhealthy living on Europe's public finances could be "as bad as climate change".

Amid all the evidence of rising obesity, increasing alcohol consumption and continued high levels of smoking (which remains the third biggest cause of death in Europe), there is mounting concern that the casualty of all this may not just be our waistlines, hearts, lungs and government budgets.

The Single Market also needs to be safeguarded to avoid the risk of fragmentation as Member States and the EU increasingly intervene to tackle lifestyle risks.

EU governments have responded to the growing concern about the impact of unhealthy lifestyles on individuals, on national budgets and on the economy as a whole, by focusing on the prevention of chronic diseases – i.e. on public health rather than health systems *per se* – and by striving to influence people's behaviour while trying to avoid accusations of excessive 'nannying' or 'meddling'.

Each Member State has devised its own recipe for changing behaviour, using a mixture of traditional 'ingredients' ranging from communications' campaigns targeted at youngsters, warning labels and fiscal incentives, to restrictions on advertising alcohol and cigarettes or advertising unhealthy foods during children's television programmes, smoking bans in public and/or workplaces, or even limits on the use of trans-fats.

What the EU can do for your health

It is not only the EU's 27 governments which are taking action: the Union itself is increasingly playing a role in this area, despite the strict limits on its powers to intervene on health issues.

The Barroso Commission recently sought to influence the debate by producing "vision papers" on promoting healthy diets and physical activity, on nutrition and obesity, and on sport. In January 2007, former Health Commissioner Markos Kyprianou presented a Green Paper entitled 'Towards a Europe free from tobacco: policy options at EU level' which advocated a comprehensive public smoking ban across Europe.

In April 2008, his successor Androulla Vassiliou delivered a speech to the European Alcohol and Health Forum (EAHF) in which she underlined the need to curb alcohol drinking in Europe and stop alcohol advertising being targeted at young people.

She also hinted at possible regulatory action if the EAHF (a voluntary body made up of business and non-governmental organisations which is committed to taking action through self-regulation) does not succeed in reaching its objectives.

Ms Vassiliou has also announced that the European Commission is aiming to draw up a joint action plan by 2009 to fight cancer. According to the World Health Organisation's Regional Office for Europe (WHO Europe), cancer rates could theoretically be reduced by 40% through changes in lifestyle behaviours.

These recent examples demonstrate the increasing role being played by the EU in the field of health policy – and the European Commission's willingness to act. Indeed, it is obliged to do so in many cases because, despite its limited competences in this area, health has permeated almost all policy fields and the Union now plays a role in many closely-connected issues.

The EU Treaties state that the Community "supports and complements" the Member States in improving the working environment and protecting workers' health and safety – a goal which has been a key driver behind the growing number of bans on smoking in public places.

EU action also complements other national policies aimed at improving public health, preventing illnesses and avoiding pandemics.

For example, in the event of an outbreak of avian flu or foot and mouth disease, the EU has to act swiftly to halt, contain or prevent contamination, given the increased risk of such diseases spreading in a border-free Single Market.

Protecting public health in the Internal Market is also an important aspect of EU consumer policy, which has resulted, for example, in EU-wide food safety standards and rules on labelling to ensure customers are provided with comprehensive information on the content of food products and on genetically modified (GM) foods or foods containing GM ingredients.

A regulation on the use of nutrition and health claims made for food was also adopted in December 2006, harmonising the rules governing the use of terms such as "low fat", "light" or "high fibre" to prevent consumers from being misled. More recently, the Commission proposed introducing compulsory front-of-pack labelling for a set of nutrients including fat, salt and sugar, as part of the anti-obesity drive.

The health of the Single Market

Single Market 'harmonisation' remains the most important aspect of EU intervention in the health policy field.

One area of EU activity which illustrates not only the link between health, lifestyles and the Single Market, but also the complexity of this issue, is the regulation of tobacco advertising in the Union.

Advertising tobacco on television has been outlawed under the 'Television without Frontiers' Directive since 1989. Nine years later, the EU attempted to impose an almost total ban on all forms of advertising and sponsorship of tobacco products through legislation, but the European Court of Justice (ECJ) ruled that this exceeded the Union's Internal Market powers and encroached on health policy, which is matter for individual Member States.

The issue came to the fore again when David Byrne (the first European Commissioner to combine the health and consumer protection portfolios) proposed a new Directive aimed at introducing an EU-wide ban on advertising cigarettes in newspapers and magazines, and on the Internet, and the sponsorship of events or activities involving or taking place in several Member States.

This was opposed by Germany, which argued that, once again, the EU was exceeding its powers under the Treaty's Internal Market provisions (Article 95) and took the case to the ECJ.

This time, the Court's Advocate-General argued that the legal basis used for the Directive was correct and that the law was "appropriate for putting an end to the divergent development of national rules in this field". The Advocate-General's opinion was not binding, but it probably played a role in Germany's decision to drop the case.

This amounted to a recognition of the Union's role in health policy insofar as it relates to safeguarding the Single Market, thus opening up new opportunities for EU action.

State of play

The picture is complicated by the fact that Member States have the right to introduce national measures in pursuit of public health objectives which may have an impact on the free movement of goods within the Single Market.

These not only include restrictions on alcohol and tobacco, but also on products high in fat, sugar, or salt. This could potentially affect any food product from non-alcoholic drinks, canned food, snacks, sweets, cereals and

even bread to goods incorporating bio- or nanotechnologies.

This debate is hardly new: Member States have always been able to restrict the free movement of goods on health grounds under Article 30 of the Treaty, which allows them to impose quantitative restrictions on imports to protect public health.

This right reflects a recognition that, in line with the subsidiarity principle, it is up to individual Member States to decide how best to protect their citizens' health.

But it is also open to abuse for domestic political reasons and to promote narrow national interests – as happened, for example, when some EU countries extended their bans on imports of British beef until long after the Union had decided that mad cow disease had been brought under control and no longer posed a risk to human health.

Even when governments have good intentions, the restrictions can be excessive. For example, the Rosengren ECJ ruling overturned a Swedish government ban on private individuals importing alcohol drinks. The government argued that the measure was designed to limit alcohol consumption, but the Court ruled that it could not be justified on public health grounds because it was neither proportionate nor effective.

Restrictions which affect a large number of products and manufacturing processes can also cause confusion on the market. For example, Denmark led the way in capping the use of trans-fats (which can clog arteries and cause heart disease) in processed food, and this was soon followed by voluntary measures in the UK. However, to date, other EU Member States have not taken any action in this area.

Furthermore, national restrictions introduced on health grounds often start with good intentions, but can impact on the Single Market in the same way as requirements outlawed by the ECJ in the seminal *Cassis de Dijon* ruling of 1979.

Instead of requiring approval of each national product before it can be sold in another EU country, the Court ruled then that any product which could be lawfully marketed in France could lawfully be sold in all other Member States. This is a principle well worth protecting for the sake of the health of the Single Market.

The exceptions provided for under Article 30 can clearly be invoked, but only if they are proportionate and effective to protect public health. However, the term "proportionate" is open to interpretation and, in the absence of an EU-wide framework, the ECJ may increasingly be effectively asked to decide between the health of citizens and that of the Single Market.

In part because of overlapping responsibilities, therefore, EU intervention in the public health arena tends to be uneven and patchy.

So where should the Union act, and what exactly should it be doing?

Prospects

Above all, the EU needs to take good care of the Single Market and prevent it from fragmenting over health issues. This requires a coherent framework for setting the scientific criteria and boundaries on what restrictions can be imposed on health grounds.

This is becoming evermore important as health-related goods and services are increasingly being traded across borders, and the "goods of the future" are increasingly incorporating bio- and nanotech processes whose impact on health is either unknown or disputed.

Genetically Modified Organisms (GMOs) are a case in point. France has, for example, taken a tough stance on this issue and recently invoked the precautionary principle when it introduced a ban on planting a GM corn crop – the only one commercially used in France. President Nicolas Sarkozy suggested, however, that this did not mean the end of GM crop cultivation in France, but rather that more funds would be allocated to national research.

This issue is bound to resurface at forthcoming Agriculture Council meetings or when the Commission publishes a new assessment of the GM corn crop concerned, based on an evaluation by the European Food Safety Agency (EFSA), due in October.

Austria, Denmark, Greece and Luxembourg have also been battling with the Union for years for the right to maintain their national bans on various types of GMO which are generally allowed on EU soil. Such bans were justified by the governments concerned partly on the basis of available scientific evidence, and partly on political choices.

EU divisions over this issue have also led to problems with the World Trade Organization,

and the Commission is now considering how to deal with this.

The debate over 'Frankenstein foods' could also get even hotter if and when the public become more aware of nanotechnologies.

Traditionally used in electronics and computers, nanotech can now also be found in food and drinks including nutritional supplements, slimming products, canola oil or chocolate drinks.

In the United States – a country arguably more open to new technologies – nanotech is already facing growing public opposition, signalling that the 'nano-honeymoon' may well be over: the more consumers learn about the nature and potential risks of nanotech applications, the more risk-averse they become.

More independent scientific evidence is therefore crucially needed to separate political from science-based decisions. The EFSA could be a possible conduit for more research and evidence- gathering, but the resources allocated to this so far appear modest.

Developing a more effective policy mix

Heavy-handed regulation from Brussels is not necessarily the only, or indeed the best, way forward. Efforts to combat lifestyle risks should also provide avenues for cooperation between industry, civil society and EU institutions in the form of self- and especially co-regulation.

To take just one example of how effective this approach can be: an EU initiative on diet, physical activity and health launched by Commissioner Kyprianou in 2005 appears to have proved instrumental in developing an EU-wide pledge to halt the marketing of junk food to children under 12 by the end of 2008. This pledge is expected to be honoured by major food companies which account for 50% of food and drink advertising in Europe.

Many global companies are also pre-empting a possible all-out 'war' on fat, salt and sugar by changing their recipes and offering 'healthy choice' products. The EU could surf this wave and propose higher pan-European standards through self-regulation.

However, a higher degree of EU cooperation and even harmonisation is needed, as there is often a limit to how effective purely national restrictions on health grounds can be.

In the UK, for example, cigarettes are heavily taxed, but Europe's increasingly mobile consumers buy them in less-heavily taxed countries whenever they can. As a result, about 30% of the cigarettes smoked in the UK are not purchased domestically, considerably undermining the impact of national 'nicotine taxes'.

The Lisbon Treaty recognises the importance of health for the sustainability of Europe's public sectors, and calls on Member States to cooperate more closely.

Such cooperation should be strengthened, particularly when it comes to exchanging best practices. All the EU Member States are using the same policy instruments to stem the development of preventable illnesses, especially cancer and heart disease. What is missing at EU level is adequate information about the actual impact of policies designed to change individual behaviours.

Developing an EU-specific body of science-based evidence on the main existing determinants of health could thus contribute to evaluating Member States' claims and make it clearer whether decisions at national level are being made primarily on scientific or political grounds.

Preventive action should also be better structured. In particular, rapid alert systems would facilitate information exchange between Member States and help to define EU-wide measures to restrict the marketing or use of 'high-risk' products.

EU Single Market policy could also make a more positive contribution to public health.

If a Member State finds it legitimate and lawful to restrict a specific product or manufacturing process, this should be explored and potentially applied in other countries, applying the logic of the *Cassis de Dijon* case the other way round: i.e. if a product is not good enough for a Frenchman or woman, why should it be OK for a German?

In other words, the EU has to raise its game by improving its capacity to gather and develop a European body of scientific evidence and by developing a more effective policy mix.

Otherwise, modern Europeans' lifestyles may end up damaging not only their health but also that of the Single Market.

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