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Sébastien Duyck, Sébastien Jodoin, Alyssa Johl

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Isabell Büschel
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Isabell Büschel

The correlation between climate change and human health

In line with Simon Caney’s affirmation that any account of climate change (CC) impacts that ignores its implications for people’s enjoyment of human rights is fundamentally incomplete and inadequate,1 we try in this chapter to outline the link between CC and human health2 and to demonstrate that CC has a human rights impact, especially with regard to the rights to the protection of health and to equal treatment of persons in Europe.

Climate-borne threats for the population of Daredevil’s health: true concerns in a ficticious case

December 2020. As a sad record this year, the Kingdom of Daredevil, Member State of the European Union (EU), registers 55,000 premature deaths among its citizens due to bad air quality in association with extreme heat waves. It is established that repeated air pollution peaks associated with ground-level ozone lead to respiratory deficiencies and premature deaths.3 In the case of the Kingdom of Daredevil, the number of premature deaths has almost doubled since 2016. Researchers argue that there is a correlation with CC, as on the one hand heat peaks have been increasing by 5.5 degrees Celsius over the past half century and private investment into sustainable housing (for example, in the form of adequate isolation against heat and cold) could not be unblocked since the 2008 crisis severely hit the country’s economy and households. On the other hand, road traffic has been steadily increasing and the government still favours the use of diesel vehicles over alternatively fuelled cars and trucks. On top of that, unemployment affects all levels of society, especially young professionals whose qualifications do not match the needs for skilled workforce in both natural and social sciences in order to adequately address the sanitary, scientific and legal challenges of CC. Because of wrong or short-term-view political choices particularly in the fields of environment, health, energy and transport the Kingdom of Daredevil failed to build resilience in the face of pathologies linked to extreme air pollution and heat levels.
Demonstrated risks for human health provoked by climate change

Admittedly, not all climate-related changes are negative for human health. Milder temperatures will lead to less cold-related fatalities and a more comfortable indoor environment during winter. Also, the productivity of outdoor workers is expected to increase because of milder winters, and more precipitation will promote agriculture and food production.4 However, it is undisputable that CC largely constitutes a threat to human health in Europe.5 This threat may be caused by direct effects on human health, e.g., changes in the incidence of allergic diseases6 or diseases transmitted by insects (mosquitoes and ticks), and by indirect effects, such as changes in water and air quality, or the impacts from extreme weather conditions.7 Since 1998, floods have caused some 700 deaths within the EU, the displacement of approximately half a million people and at least €25 billion in insured economic losses.8 Cold temperatures are expected to lead to an increase in suicidality. Combined with coronary thrombosis (possibly leading to stroke) and respiratory disorders, they also contribute to other types of excess winter deaths, together with other factors such as influenza, social class and per capita gross national product.9 There are serious concerns and evidence that CC could amplify existing mental disorders and especially addictions and suicide rates.10 On top of that, wrong energy policy choices and unaffordable electricity tariffs may cause fuel poverty, which in turn may negatively affect individuals’ health and well-being.

Climate change as a cause for health inequalities

Under the abovementioned circumstances, inequalities are likely to be caused by the effects of CC on populations’ health across Europe, having as consequence violations of the rights to the protection of human health and to equal treatment provided for by Articles 35 and 20–26 of the Charter of Fundamental Rights of the European Union (CFREU),11 as well as national constitutions. Such violations may be caused by either inequity in the exposure to health risk or uneven coverage of health care costs related to the effects of CC.

Inequitable exposure to health risks

Differences across European Member States due to geography, demography and levels of sustainable development12 may exacerbate the uneven distribution of health impacts caused by CC among populations and regions. As a consequence, vulnerable population subgroups are likely to be hit more severely in some Member States of the EU than in others: children, elderly, people with chronic disease and socially/economically disadvantaged individuals.13 For example, mortality increases during heat waves from 7.6% to 33.6%.14 The EuroHEAT project demonstrates that mortality is even higher when ozone levels are high, especially among the elderly (75–84 years).15 Winter mortality is higher in countries with a warmer winter climate due to housing standards that are not thermally efficient to retain heat. An increase in premature deaths during winter is observed in Portugal (28%), Ireland and Spain (each 21%), the UK (18%), Greece (18%) and Italy (16%), whereas the populations of Finland, Germany and the Netherlands are far less exposed to this health risk due to housing standards that are prepared for cold climate.16 Besides the question of ethical justifiability of this challenge to equal treatment, there is a legal issue with regard to effectiveness in respect of the right to protection of human health and equal treatment. According to Article 35, sentence 2 of the CFREU, “a high level of human health protection shall be ensured in the definition and implementation of all the Union’s policies and activities”. As Member States are legally bound by the respect of the principles of
Are Europeans equal?

primacy of EU law and of loyal cooperation, this high level of human health protection must be reflected in national policies and laws. If it is established that “a high level” of human health protection does not necessarily mean the highest attainable level, another question is whether it is tolerable and legal that this level differs across Europe’s regions. As long as there is no common EU legislation on patients’ rights other than the directive on cross-border healthcare, there is no legal guarantee for equality in access to healthcare. Consequently, differing premature death rates for identical risks related to CC, such as extreme temperatures or excess air pollution levels, are currently causing differences in treatment of EU citizens according to the place where they live and work.

Coverage of country-specific climate change–related health expenses

In the face of CC, a phenomenon that is universal and affects without exception the various geographic zones of the EU, the health expenses that it causes or contributes to are being covered according to national health insurance schemes. In other words, coverage for treatment of allergies or cardiovascular disorders provoked by exposure to pollen, nitrogen dioxide and particulate matter and/or by extreme weather events differs from one Member State to another. Even though the sufferings from CC are similar across countries, access to treatment and cost coverage are different due to the principle of subsidiarity that prevails in the definition and implementation of public health policies within the EU according to Article 168, paragraph 1, sentence 2 of the Treaty on the Functioning of the European Union. Due to the restricted competences attributed to the EU in this area, the Commission’s role has traditionally been limited to supporting the EU Member States’ efforts to protect and improve the health of their citizens and to ensure the accessibility, effectiveness and resilience of their health systems. However, the EU can be considered empowered to legislate to tackle climate-related health issues based on Articles 191 to 193 of the Treaty on the functioning of the EU. According to these provisions, EU environmental policy should contribute to pursuing the objectives of preserving, protecting and improving the quality of the environment; protecting human health; prudently and rationally utilising natural resources; and promoting measures at the international level to deal with regional or worldwide environmental problems, in particular combating climate change. There is an urgent need for EU legislation to be adopted on these grounds given that CC-related migration to and within EU territory will increasingly stress Member States’ health care systems.

How has the EU so far been addressing the challenge of health inequalities caused by CC?

EU adaptation policies as a means to combat health inequalities

The following measures are highlighted among those which the EU has adopted to address and prevent health inequalities in the framework of adaptation policies to CC:

a Decision no. 1386/2013/EU of the European Parliament and of the Council of 20 November 2013 on a General Union Environment Action Programme to 2020 ‘Living well, within the limits of our planet’. This 7th Environment Action Programme sets at its paragraph 2.1(c) as one of the priority objectives to “safeguard the Union’s citizens from environment-related pressures and risks to health and well-being”. In the Annex, the Union commits to “transforming itself into an inclusive green economy that secures growth and development, safeguards human health and well-being, reduces inequalities” (point 10) and to “update targets in line with the latest science and seek more actively to ensure synergies with other policy objectives in areas such as climate change, mobility and transport,
biodiversity” (point 47). While the European Commission recognizes that enhancing climate resilience can have important benefits for public health, it stresses at the same time the need for adequate management of the synergies and potential trade-offs between climate-related and other environmental objectives. Taking the example of air quality, it alerts about the risk that switching to certain lower carbon emission fuels such as biofuels in response to climate-related considerations could lead to substantial increases in particulate matter and dangerous emissions. This is because currently most biofuels are produced from land-based crops, which causes concern over increased consumption of biofuels requiring agricultural expansion at a global scale, in turn leading to additional carbon emissions (this effect is called Indirect Land Use Change, or ILUC). In this respect, the EU’s policy of using biodiesel for transport is bad practice, as it is set to increase Europe’s overall transport emissions by almost 4% instead of cutting CO₂ emissions, which is equivalent to putting around 12 million additional cars on Europe’s roads in 2020. In London, medical doctors recently called for a ban on diesel vehicles to stop this cause of premature deaths.

In the Communication “A Budget for Europe 2020”, the European Commission commits to mainstreaming CC into overall Union spending programmes and to direct at least 20% of the Union budget to climate-related objectives. According to Directorate-General “Climate Action” of the European Commission, at least 20% of the EU budget for 2014–2020 – as much as €180 billion – should be spent on climate change–related action. To achieve this increase, mitigation and adaptation actions are to be integrated into all major EU spending programmes, in particular cohesion policy, regional development, energy, transport, research and innovation and the Common Agricultural Policy. Furthermore, it is foreseen that the EU’s development policy also contributes to achieving the 20% overall commitment, with an estimated €1.7bn in 2014–2015 and €14bn over the years 2014–2020 for climate spending in developing countries.

Regulation no. 282/2014 on the establishment of a Third Programme for the Union’s action in the field of health (2014–2020) is meant to, “in particular in the context of the economic crisis, contribute to addressing health inequalities . . . through actions under the different objectives and by encouraging and facilitating the exchange of good practices” (Recital 10). The sharing of information and lessons learned across countries and sectors concerns, for example, behavioural strategies such as clothing, drink, food; scheduling daily work; seasonal migration; food safety and water quality. Furthermore, health education and training is to be promoted with respect, for example, to urban/spatial planning, building design, natural cooling systems etc.

In the Roadmap to a Resource Efficient Europe, the European Commission invites Member States’ governments to phase out environmentally harmful subsidies (EHS), with tax reductions or exemptions being one example (point 3.4). Whereas this Roadmap is not of a binding legal nature itself, it serves as a strategy document intended to achieve the EU’s climate commitments laid down in binding legal acts over which the European Commission enjoys power of enforcement. As one step in the direction of phasing out EHS can be considered the 2016 report by the German Environment Agency revealing a paradox in national government policy, namely showing that subsidies granted by the German government are worth €57 billion work against climate policy.

Outlining remarks

As of today, the health impact of CC is insufficiently addressed by research. Only seven research projects have been funded by the EU between 2004 and 2010 about public health knowledge.
on extreme weather events, such as heat waves and cold spells and their environmental consequences (e.g. floods, wildfires, air pollution). Can Europe afford, on moral, economic and legal grounds, to not grant sufficient funding today to address tomorrow’s consequences of CC on human health?

Notes


6. Climate and associated land-use change will affect the range of allergenic species and the timing and length of the pollen season, and plant productivity and pollen production may be increased by elevated CO2 levels, which is expected to lead to at least the doubling of sensitization to ragweed across Europe from 33 million currently to 77 million people by 2041–2060, I. R. Lake et al., ‘Climate Change and Future Pollen Allergy in Europe’, Environmental Health Perspectives (2016) 1, at 5.


11. The CFREU is the catalogue of fundamental rights of the EU. It was solemnly proclaimed by the heads of state at the Nice European Council on 7 December 2000. Since the entry into force of the Treaty of Lisbon on 1 December 2009, it became part of EU primary law, meaning that it has the same binding legal effect on EU institutions and national governments as the EU treaties themselves. Its content is consistent with the European Convention of Human Rights adopted by the Council of Europe in 1950.


13. CC is likely to alter health inequalities and to affect in an uneven manner especially ‘children, those working outdoors, the elderly, women and people with a pre-existing illness’: European Commission, supra note 4, at 7.
Isabell Büschel

15 Ibid.
16 European Commission, supra note 9.
17 Court of Justice of the EU, Dow AgroSciences e.a. / Commission, T-475/07, Rec. p. II-5937, Decision of 9 September 2011, point 149: “the Community institutions are bound by their obligation, under the first subparagraph of Article 152(1) EC, to ensure a high level of human health protection. That high level does not necessarily, in order to be compatible with that provision, have to be the highest that is technically possible (Case C-284/95 Safety Hi-Tech [1998] ECR I-4301, paragraph 49)”, I. Büschel, ‘Les rapports entre santé et libertés économiques fondamentales dans la jurisprudence de la Cour et du Tribunal de Première Instance des Communautés Européennes’ (8 October 2009) (Thèse pour le doctorat en droit public, Aix-Marseille University).
20 According to the principle of subsidiarity, enshrined in Article 5 of the Treaty on EU, decisions are taken as closely as possible to the citizen and the EU does not take action (except in the areas that fall within its exclusive competence), unless it is more effective than action taken at the national, regional or local level.
21 “Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health.”
22 Migration related to CC to the extent that it contributes to tensions over scarce resources, land loss and border disputes, conflicts over energy sources, tensions between those whose emissions caused CC and those who will suffer the consequences of CC, political radicalisation in weak or failing States: Paper from the High Representative and the European Commission to the European Council, Climate Change and International Security (14 March 2008), S113/08, section II, available online at www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/reports/99387.pdf.
Are Europeans equal?


35 A list of these EU-funded projects is available online at http://ec.europa.eu/health/climate_change/extreme_weather/flooding/index_en.htm.