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Outline

• EU integration

• EU institutions
  • Political decision-making
  • Judicial decision-making

• Discussion
  • Integration theories
  • Euro adoption in Poland
European Integration
History

• **Long-term** (economic and cultural)
  from 10th century onwards
  
  • State formation
  
  • Nationalism
  
  • Imperialism

• **Short-term** (political and institutional)
  from 1945 onwards
Origins

- **Intellectual elites:** (19th century)
  - Perpetual peace (Kant)
  - Popular union (Hugo)
  - Mercantilism

- **World Wars:** (Age of Extremes)
Origins, post-WW1

- **Intellectual circles**: Paneuropa (1923)
  - Competitive equilibrium (USA, USSR, UK)
  - Industrial pacts (FR, DE)
  - Gradualism

- **Political initiatives**:
  - Kellogg- Briand Pact (1928)
  - League of Nations (1919-1946)
Origins, post-WW2

- **Elite-driven process:** Churchill, Monnet, Schuman
- **US support:** Marshall Plan, NATO
- **Political origins:**
  - European Movement
  - Treaty of London (*Council of Europe*)
  - Christian Democrats
European Coal and Steel Community

- **Franco-German cooperation:** Monnet Plan, Schuman Declaration (9 May 1950),

- **Treaty of Paris (1951):** ECSC joined by France, Germany, Italy, Benelux; rejected by UK

- **Supranational organisation:** High Authority, Parliamentary Assembly, Court of Justice

- **Economic interdependence:** ‘de facto solidarity’ through economic ≠ political means
European Economic Community

- **European Defence Community**: failed ratification by French Parliament (1950–4)

- **Messina Conference (1955)**: common markets and energetic cooperation

- **Treaty of Rome (1957)**: EEC between ‘The Six’
  - **Freedom of goods**, people, services and labour
  - **Nuclear energy** (Euratom)
European integration

- **Membership expansion** from 6 to 27 states, with forthcoming plans to integrate Croatia

- **Treaty expansion** from Messina to Maastricht and from Rome to Lisbon

- ‘**Creeping competence’** of judicial and political institutions over policy-making

  - Commission, Parliament and Court of Justice
  - Council and Council of Ministers
L'élargissement européen de 1973

1973 : la C.E.E. s'élargit au Royaume-Uni, à l'Irlande, au Danemark. 9 membres.

L'élargissement européen de 1981


L'élargissement européen de 1986

1986 : Espagne et Portugal entrent dans la C.E.E. ce qui fait alors 12 états membres.

Les adhésions de 1995 à l'U.E.

Les candidatures à l'entrée dans l'U.E.

Or le préambule du Traité de Rome stipule que l'Union Européenne a pour vocation de s'ouvrir à d'autres états européens. Après la chute du Rideau de Fer, 10 pays est-européens font donc successivement acte de candidature.

Les limites orientales de l'U.E.

Plus à l'est, l'élargissement de l'Union s'arrête aux frontières ouest de l'Ukraine, de la Biélorussie et de la Moldavie, c'est à dire à peu près sur la limite ouest de l'ex-URSS.
Treaty expansion

- **Single European Act (1987):** qualified majority voting (QMV) on internal market expansion

- **Maastricht Treaty (1992):** Treaty of the European Union (TEU) with three policy pillars
  - **Pillar 1:** European Monetary Union (EMU) and European Central Bank (ECB)
  - **Pillar 2:** ‘Foreign and Security Policy’
  - **Pillar 3:** ‘Justice, Freedom and Security’
Treaty expansion

- **Amsterdam Treaty (1997):** extensions of EU policy reach over Pillar 3 (justice, immigration)
- **Nice Treaty (2001):** revised decision-making rules (QMV, Commission, Convention)
- **Constitution:** launched in 2002, stalled after negative referenda in 2005 (FR, NL), ratified in 2007
- **Treaty of Lisbon (2012):** fusion of Pillars 1 and 3, increased EU powers (QMV, Commission, Parliament)
European Institutions
Ambiguous categories
supranational
intergovernmental
judiciary
representative

Not shown on figure
EMU/ECB governance
COREPER/Comitology
Ministerial EU offices
Parliamentary parties/groups
European Commission

- ‘Brussels’ — College of 27 commissioners elected on 5-year mandates, with a president

- **Not a government:** no responsibility to Parliament, no election by either citizens or legislature

- **Legislative initiative:** formal agenda-setting power and decisive policy influence at all stages in Pillar 1

- ‘Extensive’ bureaucracy: small but active networks of committees to smooth out decision-making
Council of the European Union

● ‘Council of Ministers’ — 9 groups of 27 national ministers, covering the main policy areas

● **Intergovernmental power:** balances supranational influence from the Commission and Parliament

● **Legislative domination:** transposes EU law and controls trade and justice policy

● **Competitive fragmentation:** unequal influence of Ministers and Councils with integration objectives
European Council

- ‘Council’ — 27 heads of Member States, meeting four times a year at summits, with a president

- **Wide policy control:** influences the agenda, monitors implementation, troubleshooting

- **Rotating governmental presidency:** 6-month mandate for EU representation by one Member State

- **Wide political control:** initiates intergovernmental conferences (IGC) to activate treaty revision
European Parliament

- ‘Strasbourg’ — 736 MEPs with 5-year mandates, elected on national procedures since 1979

- Rise to influence: successive claims granted to increased powers within the ‘institutional triangle’

- Parliamentary dynamics: parliamentary groups, high (MEP) turnover, low (electoral) turnout

- Symbolic controls: expenditure (non-compulsory), appointment (president of the Commission)
European Court of Justice

- ‘ECJ/CJEU’ — supranational court of national judges elected in office for 6 years by their governments
- Judicial review: extensive jurisprudential reach over violations and lack of implementation of EU law
- Preliminary rulings: national courts refer cases to ECJ judges and therefore largely determine its reach
- Treaty Base: Commission is ‘guardian of treaties’ but ECJ defines precise scope and consequences
Balance of power (1) Politics

- **Intergovernmental balance:** Member States defend their interests over EU and over each others’

- **Partisan politics:** centre of gravity at domestic level, absent of a collective electoral identity

- **Collective action:** business interests and NGOs are far more influential than organised labour

- **Public opinion:** wide-ranging ‘democratic deficit’ argument, used by ‘Euroskeptic’ players
Balance of power (2) Policy

- **Within-triangle consensus primes:** complex decision rules but common consensus culture

- **Small states hold considerable influence:** QMV and equal representation induce pluralistic power

- **Large states pay or receive more:** net financial contributions do not match allocations (CAP/SOC)

- **EU weighs in international trade:** representation at WTO and other free trade agreements
Balance of power (3) Law

- **Policy initiation**: formal power of the Commission, who attends all other decision-making meetings.

- **National implementation**: discretion of Member States over the transposition process.

- **Judicial review**: extensive scope of ECJ rulings in defining exact EU attributions and prerogatives.

- **Market internationalization**: EMU/ECB governance links with ECJ rulings and Commission policy.
Concepts of European integration

- **Europeanization**: interplay between EU-level policymaking and domestic political orders
  - Policy *convergence*?
  - Policy *transfer/learning*?

- **Judicialization**: construction of judicial authority through dispute resolution and lawmaking

- **Governance**: social processes that adapt institutions to the interests of their constituents
Theories of EU integration

- **Liberal intergovernmentalism**: periodic clashes of national interests by rational state agents (CAP)

- **Neofunctionalism**: spillover effects created by feedback loops within legal and policy systems (ECJ)

- **Neoinstitutionalism**: path dependence as a historical result of institutional sunk costs (EMU)

- **Constructivism**: shared mental sets and collective imaginaries with normative influence (EBM)
Note: the course syllabus says ‘EU and global finance regulation’ (Quaglia 2011) here, but we will use recent research data discussed with Solveig Werner instead.
Euro adoption in Poland

- **Economic performance:** adopting the euro might buffer future crises—or not

- **Popular support:** elite-mass communication might provide leverage for (or against) adoption

- **Treaty requirement:** Poland is legally bound by its accession treaty to enter the EMU

- **Timing:** accidental logics (plane crash, elections…), elite perceptions and domestic politics
Present perception of economic crisis on the national economy

Future perception of economic crisis on the national economy

Delta perception of economic crisis on the national economy

Percentage in support of stopping Euro adoption

Source: Special Eurobarometer 71.1 (2009). Horizontal line at average.
Preference regarding the speed of the Euro adoption process

Crisis national repercussion: Delta

Euro adoption: preferred speed

Thank you for your attention

f.briatte@ed.ac.uk

P.S. Full sources and credits appear in the syllabus.
Health Care and Public Health in the European Union

François Briatte
May 2011
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<tr>
<td>Total population</td>
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<td>393,367,000</td>
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<td>Gross national income per capita (PPP Intl. $)</td>
<td>2,460</td>
<td>40,745</td>
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<td>Life expectancy at birth m/f (years)</td>
<td>62 / 64</td>
<td>78 / 83</td>
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<tr>
<td>Probability of dying under five (per 1,000 live births)</td>
<td>76</td>
<td>4.5</td>
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<tr>
<td>Total health expenditure per capita (Intl. $)</td>
<td>109</td>
<td>3333</td>
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<td>Total health expenditure as % of GDP</td>
<td>4.9</td>
<td>9.8</td>
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### Selected objectives

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<th>WHO SEAR</th>
<th>Prevalence in India</th>
<th>WHO Europe</th>
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<tr>
<td>Malaria</td>
<td>1.5 million</td>
<td>Prison health</td>
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<tr>
<td>HIV/AIDS</td>
<td>2.4 million</td>
<td>Maternity health (inequities)</td>
</tr>
<tr>
<td>TB / MDR-TB</td>
<td>3.3 million</td>
<td>Chronic illness</td>
</tr>
<tr>
<td>Tobacco</td>
<td>≈ 28% males</td>
<td>Mental health</td>
</tr>
<tr>
<td>Reproductive health</td>
<td>Perinatal mortality ≈ 48.5 per 1,000</td>
<td>“World Heart Day”</td>
</tr>
<tr>
<td>Environmental health</td>
<td>clean water ≈ 88%</td>
<td>Health systems</td>
</tr>
<tr>
<td></td>
<td>sanitation ≈ 31%</td>
<td></td>
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</tbody>
</table>
Outline

• **Comparative statics**

• **Health politics** in the European Union:
  
  • **Health systems** policy
  
  • **Public health** policy

• **Discussion:**
  
  • Health policy in transition countries
Introduction

Comparative statics
HIV prevalence

worldmapper.org
Cholera deaths
Alcohol consumption
Women smoking
Men smoking
Diabetes prevalence

worldmapper.org
Variability

- Environmental quality
- Epidemiological trends
- Health system capacity
- Political economy of health services
- Social inequalities in health
- Global health authority
- Bioethics
Epidemiological trends (1)

• **Outbreak epidemics**: infectious diseases that become widespread in a given population, often not limited to a single area
  - Leprosy (6th–13th); Plague (14th–18th); Cholera
  - Tuberculosis; Syphilis; HIV/AIDS; MDR/XDR-TB

• **Latent epidemics**: chronic diseases that become widespread in ageing, affluent populations after the epidemiological transition
Epidemiological trends (2)

- **Relationship to low wealth:** promiscuity, poverty, lack of education, absence of health support

- **Relationship to high wealth:** lifestyle factors, nutrition paradox, psychosomatic factors

- **Historical patterns** reflect the effects of globalisation and its effects on industrialisation, wealth, migration and lifestyles.
“Expensive health care is not always the best”
OECD press release, August 2009
Loss in HDI by component and region
UN Human Development Report 2010
Interdependence

- **Globalised patterns:**
  - **Epidemiological** (infectious and chronic)
  - **Liberalism** (political and economic)

- **Diffusion processes:**
  - **Isomorphism:** coercive, mimetic and normative
  - **Policy diffusion:** learning, transfer, convergence
  - **Rescaling:** global leadership and stewardship
Interdependence in the EU

- EU-level policy-making
- EU-level policy coordination
- EU-level lawmaking (supreme and direct)
Health systems policy

in the European Union
# Health systems in Europe

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<th>Characteristics</th>
<th>Bismarckian</th>
<th>Beveridgian</th>
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<td>Entitlement</td>
<td>Professional</td>
<td>Residential</td>
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<tr>
<td>Funding</td>
<td>Contributions</td>
<td>Taxation</td>
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<tr>
<td>Cost control</td>
<td>Insurance funds</td>
<td>State</td>
</tr>
<tr>
<td>Service control</td>
<td>Mixed</td>
<td>Public</td>
</tr>
<tr>
<td>Representatives</td>
<td>AT, BE, <strong>DE</strong>, FR, LU</td>
<td>DK, FI, <strong>GB</strong>, IE, SE</td>
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**Residuals:** Liberal (NL, CH) and Southern-Continental systems (ES, GR, IT, PT).
Common challenges

- **Increasing costs:**
  - Demographics (low incidence)
  - Technological advances (high incidence)

- **Fiscal strain:**
  - Permanent austerity (stagflation)
  - Monetarism (inflation control)

- ‘Welfare crisis’: retrenchment policies and politics
Regulatory reforms

- **Universalization**: coverage for all citizens
- **Distributed financing:**
  - **State participation** (Bismarckian systems)
  - **Patient cost-sharing** (both systems)
- **Market integration:**
  - **Internal markets**, PPPs / PFIs
  - **Cost-efficiency**
Variability in political salience
Scope of EU mandate

- No formal decision power over health systems: health is an EU objective, but welfare states are considered national prerogatives.

- Wide mandate over freedom of movement: competitive nondiscrimination is enforced for goods, services, capitals and individuals.

- Regulatory impact over market regimes: Macroeconomic, taxation and regulation policies are deeply shaped by EU law and agreements.
Initial EU health mandate

• **Article 152(1) EC:** “A high level of human health protection shall be ensured in the definition and implementation of all Community policies… which shall complement national policies.”

• **Article 152(5) EC:** “Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care.”
Treaty of Lisbon (2010–12)

- **Article 2E:** “[The Union shall] support, coordinate or supplement the actions of the Member States [in the] protection and improvement of human health”

- **Article 188(c):** “[The Council shall] act unanimously … in the field of trade in social, education and health services, where these agreements risk seriously disturbing the national organisation of such services and prejudicing the responsibility of Member States to deliver them.”
From Art. 152 EC to 168 TFEU

127) Article 152 shall be amended as follows:

(a) in paragraph 1, second subparagraph, the word ‘human’ shall be replaced by ‘physical and mental’ and, at the end of that subparagraph, the following shall be added: ‘, and monitoring, early warning of and combating serious cross-border threats to health’;

(b) in paragraph 2, at the end of the first subparagraph, the following sentence shall be added: ‘It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas.’;

(c) in paragraph 2, the following shall be added at the end of the second subparagraph: ‘, in particular initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation. The European Parliament shall be kept fully informed.’;
From Art. 152 EC to 168 TFEU

5. The European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, may also adopt incentive measures designed to protect and improve human health and in particular to combat the major cross-border health scourges, measures concerning monitoring, early warning of and combating serious cross-border threats to health, and measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol, excluding any harmonisation of the laws and regulations of the Member States.

(e) the second subparagraph of the current paragraph 4 shall become paragraph 6 and paragraph 5, renumbered 7, shall be replaced by the following:

7. Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them. The measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.
Freedom of movement

- **Competition policy** is reflected in free movement and antitrust regulation decisions by the European Commission and the European Court of Justice.

- **Potential applications** concern health technology (pharmaceuticals, medical devices), contracted health professionals, privately funded health care.

- **Potential conflicts** arise with risk adjustment and cross-subsidies in health systems, if considered discriminatory against internal market behaviour.
Macroeconomic coordination

- **Economic and monetary integration** shapes (mostly by restricting) state options in fundraising.

- **Deregulation** further supports cross-border service circulation and constrains demand-side measures.

- **Safety regulations** apply to (harmonise) employment, environmental and public health law.

- **Constitutional asymmetry problem**: ‘EU market protection’ is unmatched by ‘EU welfare’
Judicial interdependence

- EU-level legal principles
  - Access and portability of health care
  - Service freedom for competitive health providers
  - Market regulation applies to (health) services
- Turning point in EU law (supreme and direct)
Issue (1): Patient mobility

- **Principle**: EU citizens should be able to access health services and be provided coverage regardless of their residence.

- **Adaptation**: cross-border coordination complexes between regions (e.g. ES, UK) expand to countries.

- **Consequences**: expansion of cross-border services and ‘medical tourism’ (especially when services are expensive and lowly covered) is possible.
Issue (2): Professional mobility

- **Principle:** trained health professionals should be able to work in any EU Member State

- **Adaptation:** skills and language ability tests for medical and paramedical practitioners

- **Consequences:** increased cross-country hiring of health workforce based on wage competition (e.g. UK, India and Philippines; Hungarian dentists)
Issue (3): Public procurement

- **Principle:** EU Member States should not intervene against provider competition in national markets.

- **Adaptation:** Member States have to defend state compensation schemes (*BUPA* ruling, 2008).

- **Consequences:** Insurance products providers can oppose state subsidies to national competitors (Art. 86(2) and 87 EC, *Altmark* ruling, 2003).
Issue (4): Working time

- **Principle:** limited number of hours, defined breaks between shifts (Working Time Directive, 1993)

- **Adaptation:** substantial cost increases affected hospital and clinic staff

- **Consequences:** unintended policy failure with negative externalities on health services due to the legal definitions of ‘on-call’ and ‘stand-by’ (SIMAP and Jaeger rulings, 2000 and 2003)
Negative integration and ‘spot markets’

- Removes obstacles to ‘spot markets’:
  - Patient and professional mobility (circulation)
  - Insurers and providers expansion (competition)

- Carries threats for health system sustainability:
  - Risk pooling (equity), financial balance (solvability)

- Paradox: equitable health systems contribute to economic growth while being threatened by it
Contextual responses

• **Lags in directive transposition**: achieve minimal compliance and engage into intense lobbying

• **Market protections for welfare services**: attempt to insulate “Services of General Interest” *(failed)*

• ‘Soft law’ approaches:
  - High Level advocacy groups
  - Open Method of Coordination (OMC)
National responses

• Weak cases: countries with low and institutionally limited ministerial resources for health policy have a low capacity to deviate significantly from EU health policy coordination (e.g. France, Germany).

• Strong cases: countries with highly coordinated ministries with sufficient authority to lead national responses can substantially deviate from EU health policy coordination (e.g. UK–England).
‘Soft law’ approaches

- **Funding** for research and services collaboration (residual budget but substantial effects)

- **Coordination** between specialised agencies independent from the Commission (≈ 28 total)

- **Learning** from (and lobbying from within) the Open Method of Coordination in Health (est. 2000)
  
  - Incentives: uncertainty, penalty default for failure
  
  - Conditions: absence of prescriptive hierarchy
EU-level funding

- Biomedical research grants
  - Increased collaboration between research groups
  - Increased standardization of research protocols
- Clinical research networks
  - Resource-pooling among European clinicians
  - Standard-setting by EU-level clinical committees
- Professional networks
EU-level coordination

- **Pharmaceuticals** (EMEA, est. 1993): single market operator with expert knowledge

- **Food safety** (EFSA, est. 2002): created post-BSE crisis

- **Common issues:**
  - Varying levels of authority
  - Permeability to private interests

- **Disease surveillance** (ECDC, est. 2004) · next section
EU-level learning

- **Health priority-setting** (outcomes)
  - High level of health, low amenable mortality
  - **Spillover effects**: quality-of-life, gender equality

- **Health systems governance** (reform)
  - Benchmarks and best practices
  - **Spillover effects**: health system hybridization
Conclusions on health systems policy

• **Is the treaty base adequate?** Should the European Union retain or reform its legal base, given the impact on health systems policy?

• **Is the market approach adequate?** Should the European Union focus on harmonizing markets or health outcomes?

• **Is the political stance adequate?** Should the European Union produce hard or soft law, given the legitimacy of its ‘judicial democracy’ institutions?
Public health policy
in the European Union
Scope of EU mandate

- **Legal foundations**
  - Initial: occupational health, consumer protection
  - Acquired: disease surveillance, priority agendas

- **Political foundations**
  - Intermediate positioning between states and IGOs
  - Discrete legal base for public health & health care
  - Limited authority of DG SANCO over DG MARKT
Additional factors

- **Renewed priority**: Art. 6 TFEU place public health protection highest in lexicographic order

- **Subsidiarity**: national prerogatives in health care services remain in place

- **Proportionality**: internal market law cannot serve public health objectives

- **Industrial lobbying**: additional litigation and directive contention at the national and EU levels
Additional involvement

- **Environmental policy:** air and water quality, waste disposal, noise pollution, nuclear safety (DG Env.)

- **Research policy:** public health research frameworks, EUROSTAT information system (DG Res.)

- **Agricultural policy:** nutritional health (misbalance) in the Common Agricultural Policy (CAP, DG Agr.)

- **Biosecurity:** ‘Freedom, Justice, and Security’ include illicit drugs and tobacco smuggling (DG Just.)
Specific programmes

- **Early initiatives**: priority-setting in relation to (or in replacement to) national agendas
  - Europe Against Cancer (1987–)
  - Europe Against AIDS (1991–)
- **Current initiatives**: priority-setting for global action
  - EU presidencies (e.g. cancer, Estonia 2008)
  - EU Public Health Frameworks (2003–8, 2008–13)
Case (1) Tobacco control

- **Early initiative** with wide variations in resource and EU support over time (1987, 1992, 2008)

- **Product regulation directives:**
  - labeling (1989), smokeless tobacco (1992), tar yield, 1990 (revision directive, 2001; *lobbied*)
  - advertising (1989, 1998, 2003; *watered down*)
Case (2) Communicable disease control

- **Historical basis:** International Sanitary Conferences and Regulations, c. 1850 (cholera)

- **WHO compliance:** International Health Regulations, c. 1969– (revised 2005)

- **Limited restrictions:** movements of goods & people

- **Disease surveillance:** from c. 1990 (*Legionella*) onwards (anthrax, 2001; SARS, 2002; H1N1, 2009); **ECDC** (est. 2004) with reference to WHO, U. S. CDC
Shared sovereignty

- **WHO FCTC**: split leadership between Commission and Member States in the 1999–2003 negotiations

- **WHO Europe**: possibility to advance a European agenda outside of European borders

- **Main dilemmas:**
  - policy coherence
  - lobbying and legitimacy
Conclusions on EU public health policy

• **Is the EU public health regime adequate?** How much more (or less) could and should be achieved, within (or outside) the bounds of the treaty base?

• **Is EU-level policy-making adequate?** How much is gained in supranational coordination and lost in permeability to industrial lobbying?

• **Is EU global health leadership adequate?** How far could and should EU/WHO arrangements span?
Summary: EU health policy-making

- EU policies contain market-enhancing, market-correcting and market-cushioning policies that frequently contradict each other.

- The implementation of these policies reflects the constitutional asymmetry between market efficiency and social protection at the EU level.

- Strategies to establish constitutional parity in the ‘European Social Model’ are unclear in the current legal and political context.
Discussion

Health policy in transition countries
Post-1990 reforms

- **Past situation:** fragmented system with vertically integrated financing and provision, providing universal coverage at low costs

- **Regime shift:** compulsory health insurance funds (‘from Beveridge to Bismarck’) neither systematic or successful with cost containment

- **Managerial reforms:** quality of care and cost-benefit assessments are limited at purchaser-level
Thank you for your attention

f.briatte@ed.ac.uk

P.S. Full sources and credits appear in the syllabus.
French Politics

François Briatte
May 2011
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<tr>
<td>Regional units</td>
<td>28 states 7 territories</td>
<td>22 regions 100 districts</td>
</tr>
<tr>
<td>Parliamentary seats</td>
<td>545 (curr.) 552 (max.)</td>
<td>577</td>
</tr>
</tbody>
</table>
Outline

- **Introduction:** Fifth Republic Institutions (and other fragments of modern French political history)

- **Policy and politics:**
  - State capacity
  - Europeanisation

- **Discussion:** French market governance and internationalization under Nicolas Sarkozy
Introduction

Fifth Republic Institutions
Long-term regime (in)stability

• Succession of monarchies with stable borders:
  • Monarchy (1814/30–48); Revolution (1789, 1848)
  • Colonial Empire (1804–15, 1852–70)

• Institutionalised nation-state central government:
  • Republic (1792–1804, 1848–52, 1870-1940)
  • Vichy Regime (1940–46)
  • Post-war Republic (1946/58–today)
Long-term identity traits

- **Religious denominations and practice:**
  - 51% non-believers, 42% Catholics
  - Separation of Church and State: *laïcité*

- **State centralisation and devolution:**
  - Extensive bureaucracy and central concentration
  - Extensive delegated prerogatives to local units
Current regime stability

- **Extended presidential power:**
  - Extensive constitutional prerogatives
  - Elected by direct universal suffrage (1962)

- **Diminished parliamentary power:**
  - Single-member district vote, with ‘double offices’
  - Subordinated to presidential power (1958, 2000)

- **Bipolarized party system** (video)
Current identity traits

- **Educational system**:  
  - Largely public, central, egalitarian  
  - Challenged over social mobility and reproduction

- **State involvement**:  
  - Pro-active on taxation, welfare, industrial policies  
  - Challenged over decreasing electoral support
Liberté • Égalité • Fraternité

RÉPUBLIQUE FRANÇAISE

(视频)
State/Society conflicts

- ‘Mai 68’ (1968)  
- Death penalty abolition (1981)  
- ‘No to an EU Constitution’ (2005)  
- ‘Émeutes de banlieues’ (2005)  
- Stigmatizing the Roma (2010)  
- …
Immigration

- **Change in migration patterns** (1960–70s): from European to (North) African countries (video)

- **Change in public perceptions** (1980–90): from complementarity to zero-sum with French workers

**Political context:**

- Algerian War (1954–1962); Extreme-right (1983–)

- Racial inequalities and mass xenophobia
Politics

- **Organizations**: multiple parties, trade unions and interest groups, active but with weak membership

- **Protest**: demonstrations, disobedience and defiance (with varying support for each of them)

- **Courts**: important role in making part of the ruling elite, well, ineligible

- **Media**: constant scrutiny of political horse races, low with rather low policy content
State capacity and Europeanisation
State entrepreneurship

- **Frozen welfare state** (*sécurité sociale*): Resilient (path-dependent) measures in social and employment policies protect insiders

- **Industrial planning** (*dirigisme*): ‘National champions’ benefit from legal, economic and political protection

- **Bureaucratic workforce** (*grands corps*): Top civil servants share the culture and mindsets of political and economic elites
Limits to interventionism

- **Global liberalism**: ‘national champions’ are up for grabs on global financial markets and can emancipate both their workforce and their capitals.

- **European integration**: the EMU/EC/ECJ triumvirate exerts strong constraints in competition and macroeconomic policy.

- **Budget limits**: ‘grands projets’ are largely a thing of the past due to limited spending.
Limits to welfare support

- **Initial model**: Bismarckian self-managed funds based on social contributions preferred to Beveridgian universalism by post-war trade unions.

- **Reform attempts**: overall failure to control social expenditure, and yet *several successful reforms* after the ‘Juppé plan’ failure (*defrosting without benefits*).

- **Employment**: ‘35 heures’ (reverse Reaganomics) mythology vs. ‘CPE’ (magical activation) mythology.
European stewardship

• **Historical fit:**
  - Mitterrand initiatives (Maastricht, EMU, SEA)
  - Counter-reaction (Constitution)

• **Top-down strategies:** ‘adapt, ignore, reject’

• **Bottom-up strategies:** ‘create, reform, upload’

• **Electoral strategies:** blame Brussels (*scapegoating*)
Discussion

French market governance and internationalization
Thank you for your attention

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