European Union
Health Policy
Fall 2022
link.infini.fr/ehp-2022
Outline

- An overview of the **issues at stake**
- Quick reminders on **policy analysis**
- Introduction to **health policy** and politics
- Instructions for **course assignments**
Critical issues
Figure 1.  Life Expectancy at Birth and Total Health Expenditure—percent of GDP in 2004. Source: OECD Health data
Évolution de la structure par risques des prestations de protection sociale


Note : Les ruptures de série ont été mises en évidence, car elles affectent les délimitations entre les risques.
President-Elect Obama might struggle to implement his health-care campaign promises
Figure 3
Odds ratios of being in poor or fair health for the currently unemployed, by receipt of unemployment benefits for Germany (GSOEP) and the United States (PSID).
EU health policy
Investing in HEALTH

Health: a condition for economic prosperity and social cohesion
A LOOK AT HEALTH SYSTEMS IN THE EU

Average government expenditure on health and social protection

40% SOCIAL PROTECTION*
15% HEALTH
13% GENERAL PUBLIC SERVICES
11% EDUCATION
8% ECONOMIC AFFAIRS
4% PUBLIC SAFETY
3% DEFENCE
2% ENVIRONMENTAL PROTECTION
2% COMMUNITY AMENITIES
2% CULTURE AND RELIGION

* social protection covers pension and unemployment benefits

Growth in health expenditure vs GDP

Jobs in the health and social sectors
Health

27% PRIVATE AND HEALTH INSURANCE
73% PUBLIC HEALTH FINANCING

Jobs in the health and social sectors

ONE EMPLOYEE IN TEN WORKS IN THE HEALTH AND SOCIAL SECTOR

13,206,000
4,860,000
4,573,000
HUMAN HEALTH
SOCIAL WORK
RESIDENTIAL CARE
EU health policy
Policy analysis: Scientific inquiry

- **Description**: objective knowledge about the state of the material world
- **Explanation**: logical statements explaining a particular class of phenomena
- **Empirical focus**: public policy
Public policy: Definition

- “Anything a government chooses to do or not to do” (Dye)

- The conscious choice of governments to undertake a particular course of action (Howlett and Ramesh)
Public policy: Approach

- **Government** defines a range of **interventions** carried with **coercive powers** by any public unit of governance.

- “**Public policy**” and “**policy-making**” define these interventions and the **processes** that brought them into being.

- Our primary focus will lie in (1) the actions of **states** (‘methodological nationalism’), as well as in (2) the actions of the **European Union**.
Policy-making: Processes

- Impose decisions (exert **authority**)
- Allocate resources (**funding**)
- Provide incentives (**bargaining**)
- Develop institutions (**reform** governance)
- Prevent political losses (**blame avoidance**)
- Maximise political benefits (**credit-claiming**)
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Public policy: Correlates

- **Multiple levels of government** form a **governance** architecture over policy
- **Incentives** apply to elected decision-makers (office-**seeking**, office-**keeping**)
- **Complexity** makes public policy **nondeterministic** by nature
- **Non-decisions matter** as some actors have vested interests in the **status quo**
Policy analysis: Methods

- Specific **data** (qualitative, quantitative)
- Specific **analytics** (models, theories)
- Stance: **neutrality** (Max Weber-style)
  \neq journalism, advocacy

*Remember this slide* for when you will be presenting in this course
EU health policy
Figure 1
Overview of agencies and sources reporting on cervical cancer incidence and mortality in India

AGENCIES
- National Cancer Registry Programme of India (NCRP)
- International Agency for Research on Cancer (IARC)

DATABASES, REPORTS & SERIES
- Cancer Atlas of India
  - PBCR Report
  - NE-PBCR Report
  - Time trends Report
  - HBCR Report
- Cancer Incidence in Five Continents volumes (CI5)
- GLOBOCAN

SOURCES
- 105 major hospitals and pathology departments attached to medical schools; 12 PBCRs
- Ambillikai cancer registry (not registered under NCRP yet)

PBCR: Population Based Cancer Registry (NE-PBCR: north-east)
HBCR: Hospital Based Cancer Registry
Health policy: Definition

- Public interventions that aim at improving the health of individuals
- *Public* interventions, **not clinical**
- Quasi-universal bias towards ‘**good health**’
Health: Three dimensions

- **Health care** (controlled by doctors)
  Clinical acts; Technology; Biomedical research; Preventive medicine

- **Public health** (controlled by states)
  Actions on known causes of health and illness

- ‘**Life cycle**’ (shared control)
  Authorise or preclude decisions made by doctors and patients
Health: Evolution over time

- **Public health**: epidemiological transition (1950s); *most* of life expectancy (McKeown)
- **Health care**: asepsis (surgery), hospitals and health systems (18th–20th)
- **Medical ethics** (increasingly on the agenda)

Health policy is the development of this compound through **public interventions**
Course organization
Course organisation

- Opening lecture
- Student presentations

The lecture in the first hour will present essential facts and critical issues on a given policy aspect. The presentations in the second hour will explore specific points or case studies.
Oral presentations

- **Split the readings** and write article reviews of your sources to share between you
- **Structure your argument:** present the research question in the introduction, present your findings in 2–3 sections, and sum up
- Your presentation is **concise, synthetic, descriptive, factual and explanatory**
- Distribute a **handout** with outline and sources
Discussing presentations

- **Compare** the findings of both presentations, with regard to the session topic

- **What seems to explain the status quo?**
  Try to **identify** causes and variables

- **What seems generally true** overall?
  Try to **generalise** the findings

- **How would you research** the same topic?
  What would you **expect** to find out?
Last remarks

- **Stay informed:** check your *emails* regularly and catch up any missed class
- **Use class time:** provide feedback and ask all course-related questions *during class*
- **Work hard on presentations:** do your best at presenting *or discussing* them

Questions so far?
Everything you always wanted to know about European Union health policies but were afraid to ask (2019)

Download

English (PDF, 2.49 MB)

by Scott L. Greer, Nick Fahy, Sarah Rozenblum, Holly Jarman, Willy Palm, Heather A. Elliott and Matthias Wismar

2019, xii + 202 pages
ISBN 978 92 890 51 767
Price: CHF 40.00 / US$ 48.00
In developing countries: CHF 28.00
Order no. 13402147

What does the European Union mean for health? What can it mean for health?

This comprehensively revised second edition answers these questions. It provides a broad review and analysis of European Union public health policies to mid-2019. It begins by explaining the basic politics of European integration and European policy-making in health, including the basic question of how the European Union (EU) came to have a health policy and what that policy does. Thereafter, it moves on to the three faces of European Union health policy.
Updated 2022

Free online from the European Observatory on Health Systems and Policies

Copy available from our Google Drive folder link.infini.fr/ehp-2022
Before we start

- Go to link.infini.fr/ehp-2022

- **Check the Google Sheets document:** you should all be presenting (at least) twice in this course, as groups of 2+ students, for min. 10 and max. 15 minutes per presentation

- The group rules and detailed instructions for presentations are available from that document: **ask questions now** if you have any
EU political institutions
Overview

- **Institutional triangle**: Commission, Parliament, Council of Ministers / Council
- **Supranational, supreme judicial body**: Court of Justice of the European Union (CJEU)
- **European Central Bank** (Eurozone countries)
- **Agencies** and other treaty bodies
European Commission (COM)

- **Individual commissioners** from the Member States (MS), appointed by Parliament + Council

- **Organized into Directorates-General (DGs)**, the EU equivalent to departments/ministries

- **Controls the legislative agenda**: COM initiates all directive proposals

- **Most obvious health policy branch**: **DG SANTE** (Health and Food Safety) formerly **DG SANCO** (Health and Consumer Protection), est. 1999
Filter by

Topics
- Public health

Department type
- Any -

Main task
- Any -

Clear filters

Departments / Executive agencies (2)

TOPIES
Public health

EXECUTIVE AGENCY | CHAFEA
Consumers, Health, Agriculture and Food Executive Agency

DIRECTORATE-GENERAL | SANTE
Health and Food Safety

(removed, April 2021)
DG SANTE controls agenda items like

- Cross-border healthcare
  (0.1% of all EU-wide healthcare expenditure)
- Tobacco control
- Health of animals, crops, forests
- Pharmaceuticals and medical devices
  (obtained from DG Enterprise, now DG GROW)
COM mandates and health policy / 2

- **DG Employment**: occupational health and safety and cross-border social protection
- **DG Research and Innovation**: funding and orientation of biomedical research
- **DG Regional Policy**: management of structural funds (regional development aid)
- **DG Communication Networks**: major funder of health information technology
COM mandates and health policy / 3

- **DG Internal Market:** development and regulation of *internal market rules*
- **DG Competition:** development and regulation of *competition law and state aid*

And more indirectly: Trade, Agriculture, Environment, Europe Aid Development, Humanitarian Aid, Enlargement, …
European Parliament

- 705 MEPs elected by direct vote for 5 years, and organized into party groups
  
  *N.B. Brexit reduced the number of MEPs from 751*

- ‘First reading’ advantage – COM proposes legislation, EP amends it first

- Approves legislation by simple majority – i.e. absolute majority of MEPs
EP standing committees

Most relevant for health policy:

- Environment, Public Health, Food Safety
- Employment, Social Affairs (social security)
- Industry, Research, Energy (research)

… i.e. **ENVI**, **EMPL** and **ITRE**
At a glance
Infographic
13 February 2020

Size of political groups in the EP

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European Council(s)

- **Councils of Ministers** from all MS, organized into 10 topic areas **including Health**
- Approves or rejects first readings – which might trigger second reading and conciliation
- Approves legislation by **qualified majority** i.e. 15+ MS representing 65%+ of EU pop.  
  *(Brexit changed that too: QMV used to be 16+ MS)*
  also: reverse QMV to reject COM proposals
- **European Council** (heads of state)
"EU needs to be stronger not only for itself, but to contribute to a better world"

On 25 September, European Council President Charles Michel spoke, via video conference, at the United Nations General Assembly. "The EU is an actor for peace and progress, which wants to mobilise its influence and strength to make others more robust as well," he said.
Court of Justice of the EU

- **Supranational, supreme court** – application of rulings is direct and impossible to oppose

- **Treats cases brought by the EC** (implementation failure) **or by national courts** (domestic litigation, *preliminary reference*)

- **Rulings are binding** until overridden by new EU legislation, treaty change, or new ruling (case law approach)
EU Agencies

- European Centre for Disease Control (ECDC)
- European Food Safety Agency (EFSA)
- Executive Agency of Health and Consumers (CHAFEA), removed in 2021, replaced by HaDEA, Health and Digital Executive Agency · N.B. Executive Agency ≠ agency
- European Medicines Agency (EMA) moved from London to Amsterdam post-Brexit
Search for an agency

Map

Type of agencies

Keyword

Topic: Health

Type: 

Country: 

Search

European Agency for Safety and Health at Work (EU-OSHA)

European Centre for Disease Prevention and Control (ECDC)

European Chemicals Agency (ECHA)

European Food Safety Authority (EFSA)

European Foundation for the Improvement of Living and Working Conditions (Eurofound)

European Medicines Agency (EMA)

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

Consumers, Health, Agriculture and Food Executive Agency (Chafea)

IMI 2 Joint Undertaking (IMI 2 JU)
Next questions

- How did **EU integration** produce this? intergovernmentalism, neofunctionalism, neo-institutionalism, multi-level governance…
- **How does any of that operate effectively?** i.e. **law, budget, programs**, and politics
- **What about other policy stakeholders?** i.e. domestic governments, nongovernmental actors (e.g. industrial representatives)
Last word: a place where stakeholders meet
EHFG 2017
Health in All Politics - a better future for Europe

The discussions at the 20th EHFG aimed to dig deep, taking the technocratic concept of HiAP to the political level of policy implementation – Health in All Politics. Against a background of increasing populism and a post-truth era across Europe and beyond, the challenge to the EHFG on its twentieth anniversary is to build bridges between the different policy areas, guided by the European values of universality, access to good quality care, equity and solidarity.

Read more

ehfg.org/archive
EHFG 2021
Rise like a phoenix - Health at the heart of a resilient future for Europe

The COVID-19 pandemic has upended lives and radically altered the political landscape. While we continue to fight fires and look towards an uncertain future, amidst the ashes of this unprecedented crisis there lies an opportunity for renewal and rebirth. Health is having a rare moment in the political spotlight: now is the time to fight for solidarity, equity and transformation in health, within Europe and on the global stage.

Read more
26 - 29 SEPTEMBER | HYBRID CONFERENCE | BAD HOFGASTEIN

EHFG 2022: A moonshot for a true European Health Union
If not now, when?

Programme Overview  
25 Year Anniversary
Legal instruments
Legal instruments / 1

- Regulations: *directly applicable decisions*, e.g. agency (e.g. EMA) creation
- Directives: *transposable legislation*, with delays and other implementation bargains
- Declarative acts: *decisions* (binding) and *recommendations* (non-binding)
- Delegated and implementing acts: ‘*comitology*’ (COM) and *social partners*
Legal instruments / 2

- **Harmonization:** accept **EU standards** in replacement of national ones (e.g. hours of medical education)
- **Mutual recognition:** accept **goods, services, capital and people** from other MS (e.g. medical qualifications)
- **‘Country of origin’ principle:** accept **standards from other MS** (*Cassis de Dijon*)
Legal instruments / 3

- **Direct effect and precedence:** EU law is immediately and supremely enforceable.
- **Subsidiarity:** EU action occurs only if MS are not more capable players (principle of performance at the smallest possible unit).
- **Decentralization:** national courts and individuals can refer to the CJEU and bypass both the COM and the MS.
Scope of EU health mandate via *direct* powers
Article 6

The Union shall have competence to carry out actions to support, coordinate or supplement the actions of the Member States. The areas of such action shall, at European level, be:

(a) protection and improvement of human health;
(b) industry;
(c) culture;
(d) tourism;
(e) education, vocational training, youth and sport;
(f) civil protection;
(g) administrative cooperation.
Article 9

In defining and implementing its policies and activities, the Union shall take into account requirements linked to the promotion of a high level of employment, the guarantee of adequate social protection, the fight against social exclusion, and a high level of education, training and protection of human health.
Treaty of Lisbon (2007–9)

Art. 6 TFEU

[The Union shall]

support, coordinate or supplement the actions of the Member States

[in the]

protection and improvement of human health
A **high level of human health protection** shall be ensured in the definition and implementation of all Community policies... which shall **complement national policies**

[e.g. *tobacco/alcohol* control, quality control for *vaccines* via EMA; background: *BSE/vCJD crisis*]
FR - Notice d'utilisation

SHENGGUANG MEDICAL INSTRUMENT CO., LTD
East of Longshan Road, Jiaxian
Pingdingshan City
467000 Henan
China

EC
REP

Shanghai International Holding Corp. GmbH
(Europe) Eiffestrasse 80, 20537 Hamburg, Germany

TECHNIQUE DE PORT DU MASQUE :
Avant toute utilisation, inspectez le masque et assurez-vous:
Les masques chirurgicaux ont un sens à respecter.
Après avoir réalisé une friction hydro alcoolique des mains,
le saisir par la partie centrale externe.

4. Accrocher le masque :
passer les élastiques derrière
les oreilles

5. Modeler la barrette et
ajuster-la au contour du nez
avec vos deux index

6. Assurer l'étanchéité du
masque : le nez, la bouche et
le menton doivent être
recouverts

V1 12.05.20
Explicit scope limitation

Art. 152(5) TEC

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

[e.g. funding and price setting for healthcare, hospital equipment and staffing, medical workforce training]
Adhérent
ENVOI de MASSE le : 15/03/2005

INFORMATIONS ENVOI: 

INFORMATIONS relatives au médecin traitant

N° archivage N°Ident. Nom du médecin Dt décla. Dt fin Rel
00000000 DR 
Récupération le 16/08/2005 01 Valide : 0

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F11=Infos complémentaires F12=Retour
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</table>
‘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.’.
[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.
Legal scope

- **Art. 4, 6, 168(7) TFEU**: shared EU–MS competence applies only to **public health**, not **health services**, *although*—

- **Art. 168(4) TFEU** mentions binding legislation about **blood and organs** quality and safety (so, *some* very specific harmonization is allowed)

- **Other means of action** are mentioned: **recommendations**, and ‘soft law’ via the **Open Method of Coordination (OMC)** (‘programmatic’ power, e.g. State of Health in the EU)
Contributions from other mandates

- **Environment**: also framed as a way of ‘protecting human health’
- **Health and safety at work**: part of social policy objectives, where the **Open Method of Coordination** gets used, with potential application to health services
- **Consumer protection**: i.e. **food safety** for (internal market) consumers
Effective scope

- No formal power over health systems: welfare states are **national prerogatives**
- Wide mandate over freedom of movement: competitive nondiscrimination enforced for goods, services, capitals and individuals
  (‘second face’ of EU health policy = internal market)
- Regulatory impact over market regimes, i.e. taxation and macroeconomic policies
  (‘third face’ of EU health policy = fiscal governance)
Complicated consequences (Scharpf)

- **Constitutional asymmetry:** the *social* mandate of the EU is largely an indirect consequence of its *economic* one
- **Negative integration:** EU economic regulation proceeds by *removing barriers* to the internal market (a.k.a. liberalization)
- **Legitimacy issue:** no clear link between political *inputs* and policy *outputs*
EU actions in health

(2) Cross-border regulation
Cross-border public health powers

- **Joint procurement:** EU Member States can collectively buy health goods like vaccines. 2013 decision, first used 2016 to buy vaccines against pandemic influenza; also used for expensive drugs.

Historical background

- **Communicable disease crises**: HIV/AIDS (mid-1980s), BSE/nvCJD (peaked in 1993)
  Maastricht Treaty, 1992: “prevention of diseases, in particular the major health scourges”; EFSA, 2002

Figure 13.2  Communicable disease control history (excerpt)

Conceptual changes

- **‘All-hazards’ approach:** animal/human health plus **biosecurity** and **environmental threats**
  - e.g. chemical and nuclear accidents, natural disasters related to climate change

- **Precautionary principle:** EU can take action even when scientific evidence provided for risk assessment is inconclusive
  - e.g. BSE/nvCJD, Zika in 2015
Related issues

- **Vaccination**: no clear CJEU decision on whether EU citizens have a **right to be treated**
- **Restrictions in freedom of movement**: reliance on **WHO instruments** (IHR, PHEIC)
- **Liability for harm**: non-contractual liability of EU institutions — claims to compensation of damages fall to **Members States**
EU actions in health
(3) Indirect regulation
covered in Session 8
Bonus section

Where to learn more?

[ on top of the course handbook and various official EU websites ]
European Observatory on Health Systems and Policies

The Observatory supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.

Read more
A flavour of our upcoming #Eurohealth special edition on the COVID-19 Health System Response drawing on data from our HSR monitor: covid19healthsystem.org/mainpage.aspx

#WCPH2020
#COVID19inEurope

8:40 PM · Oct 14, 2020 · Twitter Web App
EHFG 2017
Health in All Politics - a better future for Europe

The discussions at the 20th EHFG aimed to dig deep, taking the technocratic concept of HiAP to the political level of policy implementation – Health in All Politics. Against a background of increasing populism and a post-truth era across Europe and beyond, the challenge to the EHFG on its twentieth anniversary is to build bridges between the different policy areas, guided by the European values of universality, access to good quality care, equity and solidarity.

Read more

ehfg.org/archive
EHFG 2021
Rise like a phoenix - Health at the heart of a resilient future for Europe

The COVID-19 pandemic has upended lives and radically altered the political landscape. While we continue to fight fires and look towards an uncertain future, amidst the ashes of this unprecedented crisis there lies an opportunity for renewal and rebirth. Health is having a rare moment in the political spotlight: now is the time to fight for solidarity, equity and transformation in health, within Europe and on the global stage.

Read more
Nutrition in Europe
Connections to health policy

- **Animal disease forms:** *zoonotic diseases* (bacteria, viruses, prions) ‘jump’ to human hosts as a consequence of promiscuity
- **Common diseases have** *dietary risk factors* (e.g. heart disease, cancer, dental health)
- **Animal health as an idiosyncratic concern:** EU action covers *animal health and welfare* (and also covers plant health)
Historical landmarks
Against the Grain
A DEEP HISTORY OF THE EARLIEST STATES
What could these historical relics possibly teach the wired, hyper-modernist residents of Diamond’s home village of Los Angeles? The question is not so preposterous. As he explains, *Homo sapiens* has been around for roughly 200,000 years and left Africa not much earlier than 50,000 years ago. **The first fragmentary evidence for domesticated crops occurs roughly 11,000 years ago and the first grain statelets around 5000 years ago**, though they were initially insignificant in a global population of perhaps eight million. More than 97 per cent of human experience, in other words, lies outside the **grain-based nation-states** in which virtually all of us now live. ‘Until yesterday’, our diet had not been narrowed to the **three major grains that today constitute 50 to 60 per cent of the world’s caloric intake: rice, wheat and maize**. The circumstances we take for granted are, in fact, of even more recent vintage than Diamond supposes. Before, say, 1500, most populations had a sporting chance of remaining out of the clutches of states and empires, which were still relatively weak and, given low rates of urbanisation and forest clearance, still had access to foraged foods. On this account, our world of grains and states is a mere blink of the eye (0.25 per cent), in the historical adventure of our species.
Historical landmarks

- **Wartime:** Spanish Civil War, WW2 show adverse health effects of **food rationing**
- **Totalitarianism:** further evidence of **human-engineered low-calorie diets** on children and adults in Nazi and Soviet camps
- **Post-WW2:** United Nations, Red Cross and Marshall Plan all factor in food shortages and **nutritional health monitoring**
### Table 1. Population goals for dietary recommendations in different countries of the European Region

<table>
<thead>
<tr>
<th>Component</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of total energy intake from:</td>
<td></td>
</tr>
<tr>
<td>Total fat</td>
<td>Less than 30–35%</td>
</tr>
<tr>
<td>Saturated fat</td>
<td>Less than 10%</td>
</tr>
<tr>
<td>Sugar</td>
<td>Less than 10%</td>
</tr>
<tr>
<td>Fruit and vegetables</td>
<td>More than 400–600 g per day</td>
</tr>
<tr>
<td>Salt</td>
<td>Less than 5–8 g per day</td>
</tr>
<tr>
<td>Body weight</td>
<td>BMI of 18–27</td>
</tr>
<tr>
<td>Physical activity</td>
<td>30 min moderate exercise per day</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>4–6 months(^a)</td>
</tr>
</tbody>
</table>

\(^a\) Many countries are revising their breastfeeding recommendations to 6 months, in accordance with World Health Assembly resolution WHA54.2 ([http://www.who.int/gb/EB_WHA/PDF/WHA54/ea54r2.pdf](http://www.who.int/gb/EB_WHA/PDF/WHA54/ea54r2.pdf), accessed 15 September 2002).

Source: *Food-based dietary guidelines in WHO European Member States* (29).
Contemporary policies
The interactive data visualization is available at OurWorldinData.org. There you find the raw data and more visualizations on this topic.
Share of the labor force working in agriculture


Licensed under CC-BY-NC-SA by the author Max Roser.
Number of people employed in agriculture since 1800

The total number of individuals in agricultural employment across select countries from the year 1800.

Source: Our World In Data based on Herrendorf et al. (2014)
Which EU regions had the highest harvested production of cereals?

1. Centre — Val de Loire (9.3 million tonnes)
2. Bayern (7.9 million tonnes)
3. Sud-Muntenia (7.3 million tonnes)
4. Castilla y León (6.7 million tonnes)
5. Niedersachsen (6.5 million tonnes)
6. Picardie (6.3 million tonnes)
7. Champagne-Ardenne (5.9 million tonnes)
8. Sud-Est (5.8 million tonnes)
9. Poitou-Charentes (5.4 million tonnes)
10. Vest (5.2 million tonnes)

(million tonnes, 2019 data)
Germany: NUTS level 1
Estimated total food waste in the EU, 2010 (kg per capita)

Data source: Technology options for feeding 10 billion people, STOA 2013.
Fig. 2. Lost years of healthy life in the European Region, 2000

Diseases with major nutritional determinants

- Malignant neoplasm (32%)
- Diabetes mellitus (5%)
- CVD (61%)
- Other disorders (21%)

Diseases in which nutrition plays a role

- Respiratory diseases (13.2%)
- Infectious and parasitic diseases (10.5%)
- Maternal conditions (1%)
- Congenital abnormalities (4.2%)
- Respiratory infections (6.8%)
- Oral diseases (1.1%)
- Neuro-psychiatric disorders (51.1%)
- Digestive diseases (9.5%)
- Nutritional endocrine disorders (2.6%)

Other disorders

- Musculoskeletal diseases (19%)
- Skin diseases (0.1%)
-Sense organ disorders (0.1%)
- Perinatal conditions (8%)
- Unintentional injury (45.9%)
- Genitourinary diseases (5%)
- Intentional injury (21.5%)
Fig. 3. Relationship of income to consumption of fresh fruit and vegetables and the share of income spent on food

\[\text{Consumption (grams per person per day)}\]

\[\text{Income spent on food}\]

\[\begin{array}{ccccccccc}
\text{Deciles}^a \text{ of net family income (per head)} \\
1 & 2 & 3 & 4 & 5 & 6 & 7 & 8 & 9 & 10 \\
\end{array}\]

\[\begin{array}{ccccccccc}
\text{Share of income (\%)} \\
0 & 5 & 10 & 15 & 20 & 25 & 30 \\
\end{array}\]

\[a\text{ 1 = lowest incomes; 10 = highest incomes.}\]
Contemporary policies

- **Large sci. evidence base** for effect of food on burden of disease, e.g. CVD, obesity, cancer
- **EU agency focus on food/feed safety** since General Food Law (2002), in the aftermath of foodborne infection scandals like BSE (1996) and E-coli (2011)
- **Comprehensive approaches** (by e.g. WHO) link agriculture, food safety, sustainable food policy and nutrition (‘from farm to fork’)


Fighting antimicrobial resistance: the AMR One-Health Network meets in Brussels on 15 October 2019

Health-EU Newsletter: EU-Health Award rewards initiatives that help young people get a healthy start in life

Presentation by European Commissioner for Health and Food Safety, Vytenis Andriukaitis.

BTSF training materials on African Swine Fever (ASF)

Training materials from the workshop in Luxembourg 23-25 September 2019 are now publicly available for further dissemination

Animal Welfare: Commission designates a second European Union Reference Centre
The European Union One Health 2018 Zoonoses Report

European Food Safety Authority and European Centre for Disease Prevention and Control (EFSA and ECDC)

Abstract

This report of the European Food Safety Authority and the European Centre for Disease Prevention and Control presents the results of zoonoses monitoring activities carried out in 2018 in 36 European countries (28 Member States (MS) and 8 non-MS). The first and second most commonly reported zoonoses in humans were campylobacteriosis and salmonellosis, respectively. The European Union (EU) trend for confirmed human cases of these two diseases was stable during 2014–2018. The proportion of human salmonellosis cases due to Salmonella Enteritidis was at the same level in 2018 as in 2017. Of the 27 reporting MS, 16 met all Salmonella reduction targets for poultry, whereas 11 MS failed meeting at least one. The EU flock prevalence of target Salmonella serovars in breeding hens, laying hens, broilers and fattening turkeys decreased during recent years but stalled in breeding turkeys. Salmonella results from Competent Authorities for pig carcasses and for poultry tested through National Control Programmes were more frequently positive compared with food business
Salmonella on the rise again, EU officials admit

By Sarantis Michalopoulos | EURACTIV.com

6 Feb 2018

An ECDC/EFSA report published in December 2017 found that Salmonella cases in humans have increased by 3% since 2014.
Salmonella on the rise again, EU officials admit

By Sarantis Michalopoulos | EURACTIV.com

6 Feb 2018

The incidence of Salmonella in humans almost halved between 2004 and 2009 but new figures show that it has re-appeared, causing worries for food producers and health workers, but also for EU policymakers.

Salmonella is a bacterium that can cause an illness called salmonellosis in humans. It’s commonly found in the intestines of healthy birds and mammals. In foods, it is most frequently found in eggs and raw meat from pigs, turkeys and chickens.

A recent case that caught the attention of policymakers and consumers came from French dairy giant Lactalis, which decided to withdraw 12 million boxes of powdered baby milk contaminated with salmonella from the supermarkets in 83 countries.

Similarly, it was reported in Germany last month that 20,000 tonnes of soy-based animal feed were found to be contaminated with salmonella in Bavaria and another 12 in Länder.

**The Formaldehyde issue**

EURACTIV also asked EFSA whether the ban of formaldehyde in animal feed could have contributed to the rise of salmonella cases.
Regulatory targets

- **Contaminants** (e.g. toxins)
- **Improvement agents**, incl. additives, processing aids, flavourings (e.g. aspartame)
- **Supplements**, incl. vitamins, mineral nutrients (e.g. iodine)
- **Novel foods** (e.g. GMOs)
- **Functional foods** (e.g. energy drinks)
GLYPHOSATE: 41 groups urge European Commission to put an end to use of unreliable industry studies.

#StopGlyphosate
Policy challenges

- **Food labels and dietary guidelines:** attaining *dietary targets* vs. alcohol, salt and sugar consumption patterns
- **Food safety:** *trade vs. (consumer) safety*, as with communicable disease control (e.g. trans fatty acids)
- **Sustainable agriculture:** *CAP rent* (focus on productivity and low prices) vs. organic farming and plant-based foods
Russian alcohol consumption down 40% since 2003 - WHO

Reputation for heavy drinking on the slide since Putin measures including curbs on alcohol sales

▲ Beer for sale at a Russian grocery store. Under Vladimir Putin, Russia has introduced a ban on shops selling any alcohol after 11pm and increases in the minimum retail price of spirits, Photograph: Artyom Geodakyan/Tass
Russian alcohol consumption down 40% since 2003 - WHO

Reputation for heavy drinking on the slide since Putin measures including curbs on alcohol sales

Labelling
Minimum retail price
Selling hours
Minimum age
Advertising
Taxation

▲ Beer for sale at a Russian grocery store. Under Vladimir Putin, Russia has introduced a ban on shops selling any alcohol after 11pm and increases in the minimum retail price of spirits, Photograph: Artyom Geodakyan/Tass
Multilevel governance, public health and the regulation of food: is tobacco control policy a model?

Abstract

Campaigns against risk factors for non-communicable diseases (NCDs) caused by smoking and obesity have become increasingly common on multiple levels of government, from the local to the international. Non-governmental actors have cooperated with government bodies to make policies. By analysing the policies of the World Trade Organization, the World Health Organization, the European Union, and the United Kingdom and United States governments, we identify how the struggles between public health advocates and commercial interests reached the global level, and how the relatively successful fight to ‘denormalize’ tobacco consumption has become a model for particular public health strategies. It highlights the need for a new approach that more fully integrates health and wellbeing into our food systems.
EU actions in health

(1) Direct action
Direct health objectives

- Public health: population-wide mandate in Maastricht (1992) and Lisbon (2009) treaties
- Environment: wide-ranging, from town planning to national energy supply
- Health and safety at work: e.g. legislation on sharp items in the workplace
- Consumer protection: e.g. food and drink labels about nutritional health claims

[consider also: organs, blood, tissues, cells]
‘Health in All Policies’ approach +
Together for Health (2008–13)
Investing in Health (2013)
As part of the Social Investment package, the Commission paper:

- Extends the EU Health Strategy by reinforcing its key objectives
- A healthy population and sustainable health systems are decisive for economic growth

- Establishes the role of health in the Europe 2020 strategy
- Recognises the contribution of health to prepare a job-rich recovery

- Reaffirms that health is a value in itself
- Makes the case that health is a growth-friendly type of expenditure

Investing in health is:
- Investing in health systems
- Investing in people’s health
- Investing in reducing inequalities in health
EU Health Programme 2014–2020

- **Highly limited budget:** €46 million per year, i.e. almost nothing \([\neq EU research funding]\)
- **Capacity-building effect:** program federates nongovernmental, EU-level actors
- **Cognitive effect:** diffusion of ‘good practices’, as with the **Open Method of Coordination**
- **Support from other groups**, e.g. working parties and **expert conferences**
Health for the EU in 33 success stories

A selection of successful projects funded by the EU Health Programmes
Together for healthy lives in Europe

EIT Health is a network of best-in-class health innovators backed by the EU. We deliver solutions to enable European citizens to live longer, healthier lives by promoting innovation. We connect the right people and the right topics across European borders, so that innovation can happen at the intersection of research, education and business – for the benefit of citizens.

We facilitate
At EIT Health, we facilitate innovation to improve the health of European citizens. In

We collaborate
We collaborate across European borders and bring stakeholders to the table. We

We create
The EIT Health network comprises best-in-class health innovators, who create

We educate
We want to improve health education, promote healthy lifestyles, and help health
but then

#UnitedAgainstCoronavirus
#StrongerTogether

europa.eu/global-response
Recent programmes

- **Health 2020**: WHO Europe strategy on reducing health inequalities and improving ‘leadership and participatory governance’

- **European Social Fund Plus (EFS+)**: should have replaced the EU Health Programme, making it part of **European Structural and Investment Funds (ESIF)** [COM(2018)382]

EU4Health 2021-2027 – a vision for a healthier European Union

EU4Health is EU’s response to COVID-19, which has had a major impact on medical and healthcare staff, patients and health systems in Europe. By investing €9.4 billion, therefore becoming the largest health programme ever in monetary terms, EU4Health will provide funding to EU countries, health organisations and NGOs. Funding will be open for applications in 2021.

♦ Areas of action

EU4Health will:

- boost EU’s preparedness for major cross border health threats by creating
  - reserves of medical supplies for crises
  - a reserve of healthcare staff and experts that can be mobilised to respond to crises across the EU
  - increased surveillance of health threats
- strengthen health systems so that they can face epidemics as well as long-term challenges by stimulating
  - disease prevention and health promotion in an ageing population
  - digital transformation of health systems
  - access to health care for vulnerable groups
- make medicines and medical devices available and affordable, advocate the prudent and efficient use of antimicrobials as well as promote medical and pharmaceutical innovation and greener manufacturing.
FAQ: What is the European Union doing about the COVID-19 pandemic?

The spread of the novel coronavirus is a challenge for states around the world. Member states of the EU have been particularly hard hit by the crisis. What are the EU institutions doing to stem the spread of the virus, provide medical care, and mitigate the economic consequences of the pandemic?

What are the leaders of the EU member states doing?
What is the job of the European Commission during the crisis?

It is important to realise that the European Commission has limited authority in the health sector. Basically, every member state is responsible for organising and financing its own health system.

The main job of the European Commission is to help member states weather the crisis and make recommendations for joint action. It has done much to coordinate the actions of member states during the crisis, e.g. in the fields of public health, transport, border protection, the internal market and trade. The aim was to coordinate actions and ensure that the virus could be fought as effectively as possible. The European Commission works with businesses and member states to improve supplies of medical equipment (including protective equipment) throughout Europe. And the Commission has drawn up a road map for the gradual easing of restrictions so as to enable member states to take a coordinated approach.

Additional information

European Commission information on the COVID-19 pandemic
Covid-19 measures (1)

- **Mobility:** information on travel restrictions, interoperability of contact tracing apps
- **Vaccine supply:** direct contracting with Pfizer and Moderna to acquire doses for all MS, recommendations on priority targets
- **Medical products:** funding and joint procurement procedure for rapid antigen tests, contract with Gilead for remdesivir, **strategic stock reserve** (rescEU)
In addition to the above countries, “Team Europe” – the European Commission on behalf of 27 EU member states plus Norway and Iceland – have also joined the COVAX Facility:

<table>
<thead>
<tr>
<th>Austria</th>
<th>Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>Italy</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>Latvia</td>
</tr>
<tr>
<td>Croatia</td>
<td>Lithuania</td>
</tr>
<tr>
<td>Cyprus</td>
<td>Luxembourg</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>Malta</td>
</tr>
<tr>
<td>Denmark</td>
<td>Norway</td>
</tr>
<tr>
<td>Estonia</td>
<td>Netherlands</td>
</tr>
<tr>
<td>Finland</td>
<td>Poland</td>
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<tr>
<td>France</td>
<td>Portugal</td>
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<tr>
<td>Germany</td>
<td>Romania</td>
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<tr>
<td>Greece</td>
<td>Slovakia</td>
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<tr>
<td>Hungary</td>
<td>Slovenia</td>
</tr>
<tr>
<td>Iceland</td>
<td>Spain</td>
</tr>
<tr>
<td></td>
<td>Sweden</td>
</tr>
</tbody>
</table>
Historically, crisis response and management has been the weak point of European action on health threats. Faced with urgent situations and domestic pressures, Member State governments have tended to revert to taking national measures, sometimes even against the interests of other Member States. The ECDC’s visibility is not matched with legal powers or capabilities to intervene, and even the Commission has limited ability to coordinate what Member States do. This was demonstrated all too clearly during the swine flu pandemic in 2009, when several Member States bought what influenza vaccine and antiviral medications they could, and declined to share. This episode gave rise to joint procurement as an EU policy instrument.  

Covid-19 measures (2)

- Health system funds: €6bn emergency fund (and tax breaks) to support acquisition of supplies, staff hires, mobile hospitals
- Research funding: €1bn reallocation from Horizon 2020 research programme
- Recovery plan and solidarity package: COM will borrow €806bn grants and loans on global markets to lend them to the MS (largest EU stim pack ever)
EU actions in health

(2) Cross-border regulation

covered in Session 5
7. Tobacco
<table>
<thead>
<tr>
<th>Product</th>
<th>Nicotine content</th>
<th>Suggested Rx</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarettes</td>
<td>1.1mg to 1.8mg per cigarette (22mg to 36mg/pack)</td>
<td>21mg patch QD x28 days <strong>plus</strong> NRT gum or NRT lozenge (4mg/2mg). Evaluate decrease patch dose monthly (PACT nurses to track?). May add Bupropion if no contraindications.</td>
</tr>
<tr>
<td>Cigars</td>
<td>13.3mg average</td>
<td>Patch and Short Acting NRT (4mg/2mg) based on # of cigars per day. May add Bupropion if no contraindications.</td>
</tr>
<tr>
<td>Mini-cigars (i.e. ‘Swishers or Dark Horse)</td>
<td>3.8mg per mini-cigar = 76mg/pack</td>
<td>42mg to 21mg (depending on # smoked) <strong>plus</strong> Short Acting NRT (4mg/2mg). May add Bupropion if no contraindications.</td>
</tr>
<tr>
<td>Pipe</td>
<td>5.2mg average per bowl</td>
<td>Patch and Short Acting NRT (4mg/2mg) based on # of bowls smoked per day. May add Bupropion if no contraindications.</td>
</tr>
<tr>
<td>Chewing/dipping can (i.e. Skoal, Copenhagen)</td>
<td>88mg per can of dip/chew</td>
<td>42mg Patch and Short Acting NRT (4mg/2mg). May add Bupropion if no contraindications.</td>
</tr>
<tr>
<td>Loose leaf pouch (i.e. Redman)</td>
<td>144mg per pouch</td>
<td>42mg Patch and Short Acting NRT (4mg/2mg). May add Bupropion if no contraindications.</td>
</tr>
<tr>
<td>Hookah (water pipe)</td>
<td>One 45-60 minute session = approximately one pack of cigarettes in nicotine and tar content</td>
<td>21mg Patch and Short Acting NRT (4mg/2mg). May add Bupropion if no contraindications.</td>
</tr>
<tr>
<td>Bidi’s (hand rolled cigarettes imported from India)</td>
<td>One bidi contains 3 to 5 times as much nicotine as a regular cigarette</td>
<td>Patch and Short Acting NRT (4mg/2mg) based on # of bidi’s smoked per day. May add Bupropion if no contraindications.</td>
</tr>
<tr>
<td>Kretek (Clove cigarette)</td>
<td>Little research available. Increased risk of acute lung injury, especially with asthma or respiratory infections.</td>
<td>Short Acting NRT (4mg/2mg) based on # of Kretek’s per day. May add Bupropion if no contraindications.</td>
</tr>
</tbody>
</table>

References available on request
Arrows indicate some (but not all) of the pathways by which these causes interact.
Figure 6: Deaths attributed to 19 leading risk factors, by country income level, 2004.
Figure 11: Percentage of deaths over age 30 years caused by tobacco, 2004.
2013 estimates: 100 million deaths in 20th century, 1B in 21st

Figure 11: Percentage of deaths over age 30 years caused by tobacco, 2004.

‘emerging markets’ for transatl. tobacco industry
Aspects of the issue

- **Ubiquitous use** of tobacco products (males and females) following mass production in early 20th c.

  Evidence of harm (1950s), incl. secondhand (1970s)

- **Change of position** from the World Bank, from tobacco subsidies (1950s) to tobacco control (1990s—)

- **Market concentration** in a few TNCs since 1990s
  (Philip Morris International, China National Tobacco Corporation, British American Tobacco, Japan Tobacco International, Imperial Tobacco)

- High levels of **industry lobbying** and trade disputes
scientific evidence and mass info. campaigns (adverts, public space)
tax increases
### Table 1.1 Top five tobacco growing countries, 2009

<table>
<thead>
<tr>
<th>Country</th>
<th>Raw Tobacco Production (tonnes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>3,067,928</td>
</tr>
<tr>
<td>Brazil</td>
<td>863,079</td>
</tr>
<tr>
<td>India</td>
<td>620,000</td>
</tr>
<tr>
<td>United States</td>
<td>373,440</td>
</tr>
<tr>
<td>Malawi</td>
<td>208,155</td>
</tr>
</tbody>
</table>


### Table 1.2 Top five cigarette exporting countries, 2009

<table>
<thead>
<tr>
<th>Country</th>
<th>Cigarette Exports (billion pieces)</th>
<th>Cigarette Production (billion pieces)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germany</td>
<td>181.11</td>
<td>225.00</td>
</tr>
<tr>
<td>Netherlands</td>
<td>115.35</td>
<td>115.30</td>
</tr>
<tr>
<td>Poland</td>
<td>89.49</td>
<td>142.86</td>
</tr>
<tr>
<td>United States</td>
<td>60.45</td>
<td>338.23</td>
</tr>
<tr>
<td>Indonesia</td>
<td>57.40</td>
<td>180.50</td>
</tr>
</tbody>
</table>

Towards a smoke-free world? Philip Morris International’s new Foundation is not credible

Smoking causes more than 7 million deaths each year and tobacco companies have known, since at least 1950, that their products are lethal and addictive. Now Philip Morris International (PMI) is committing nearly US$1 billion over 12 years to the Philip Morris Foundation for a Smoke-Free World that will “fund scientific research designed to eliminate the use of smoked tobacco around the globe.”

In a *Lancet* Viewpoint in this issue, the Foundation’s President Derek Yach argues it will support “an unwavering focus...to improve public health and human wellbeing.” What should we make of this?

Evidence from exposés and leaked documents offers no indication that the tobacco industry has become less cynical and dishonest over time. Indeed, a 2016 judgment in a challenge to the introduction of plain packaging in the English High Court concluded that the tobacco set agendas for scientists, and to generate divisions in the tobacco control community. There is nothing new about tobacco companies solemnly expressing concerns about smoking and health, while ignoring, attacking, or undermining the evidence. Indeed, in 1997 the Philip Morris Chief Executive Officer asserted that if presented with evidence that smoking caused lung cancer, he would “shut it [production] down instantly.”

In his Viewpoint, Yach seeks to justify the new PMI project by arguing that action to implement the FCTC has been too slow, and he states that the Foundation “supports and endorses implementation of all elements of the FCTC.” But this argument fails to pass the most elementary credibility test. The main obstacle to implementation of the FCTC (described in an internal PMI presentation as “a runaway train”) has been fierce
Meanwhile, globally

First WHO resolution on ‘limitation of smoking’

Further resolutions → FCTC + Tobacco-Free Initiative
Global policy instruments

**FCTC** (2003)

Control of supply and demand

**MPOWER** (mid-2000s)

Monitor tobacco use/industry
Protect nonsmokers
Offer cessation treatments
Warn consumers of consequences
Enforce bans on advertising
Raise tobacco taxes
## WHO FCTC TREATY PROVISIONS

### General and other obligations

<table>
<thead>
<tr>
<th>Article 2</th>
<th>Relationship between this Convention and other agreements and legal instruments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Article 5</td>
<td>General Obligations</td>
</tr>
<tr>
<td>Article 18</td>
<td>Protection of the environment and the health of persons</td>
</tr>
<tr>
<td>Article 19</td>
<td>Liability</td>
</tr>
</tbody>
</table>

### Demand reduction measures

<table>
<thead>
<tr>
<th>Article 6</th>
<th>Price and tax measures to reduce the demand for tobacco</th>
</tr>
</thead>
<tbody>
<tr>
<td>Article 8</td>
<td>Protection from exposure to tobacco smoke</td>
</tr>
<tr>
<td></td>
<td>- Protection in indoor workplaces</td>
</tr>
<tr>
<td></td>
<td>- Protection in public transport</td>
</tr>
<tr>
<td></td>
<td>- Protection in indoor public places</td>
</tr>
<tr>
<td>Article 9</td>
<td>Regulation of the contents of tobacco products</td>
</tr>
<tr>
<td>Article 10</td>
<td>Regulation of tobacco product disclosures</td>
</tr>
<tr>
<td>Article 11</td>
<td>Packaging and labelling of tobacco products</td>
</tr>
</tbody>
</table>

### Supply reduction measures

| Article 15 | Illicit trade in tobacco products                                                |
| Article 16 | Sales to and by minors                                                           |
| Article 17 | Provision of support for economically viable alternative activities              |
Figure 9.1 Structure of Global Governance in Tobacco Control

Cairney, Studlar and Mamudu 2009
Effects of FCTC adoption (Nikogosian and Kickbusch 2016)

- **Legislative measures** adopted in 80% ratifying countries (as of 2014)
- Revealed WHO **treaty-making capacity**
  First treaty adopted under WHO Art. 19
- Led to **additional protocol** (2013), monitoring reports
  Protocol to Eliminate Illicit Trade in Tobacco Products
- Demonstrated a change in **global health architecture**
  Proliferation of anti-tobacco stakeholders
Figure 2. Governance structure of the World Bank’s tobacco control programme. The World Bank’s Global Tobacco Control Programme is funded by a trust fund, which is financed by the Gates Foundation and the Bloomberg Philanthropies. The World Bank has implemented tax reforms in target countries since 2013. The decision-making authority is named the Consultative Group, which is chaired by the World Bank and participated by the representatives of the two donors. Progress reports and financial information are available on a secure website for the two donors. Abbreviations: BMGF: Bill and Melinda Gates Foundation, Bloomberg: Bloomberg Philanthropies. Sources: 29, 30.
Death rate from smoking, 1990
The annual number of deaths attributed to smoking per 100,000 people.

Source: IHME, Global Burden of Disease (GBD)
Note: To allow comparisons between countries and over time this metric is age-standardized.
Death rate from smoking, 2017

The annual number of deaths attributed to smoking per 100,000 people.

Source: IHME, Global Burden of Disease (GBD)
Note: To allow comparisons between countries and over time this metric is age-standardized.
Key ideational struggles

- **Science ‘skepticism’** (id. climate change)
- **Economics** (tax revenue, employment)
  Tobacco started as a source of income for roughly half of British colonists in the 1770s (wages could be paid in tobacco, and tobacco was used as a currency in Virginia)
- **Human rights** (liberty, individual responsibility)
  Global health (WHO) shift from regulating epidemic threats to regulating a freely available product
- **Security** (illicit trade, smuggling)
Number of daily smokers
Estimates of the total number of people who smoke cigarettes at least daily (across men and women of all ages).

EU actions in health

(3) Indirect regulation
Eaux troubles. Derrière ces figures, en loucedé, «la peur de l'étranger», ce vestibule de la haine où la xénophobie fait son lit. L'image du plombier polonais passe inaperçue. Jusqu'au 6 avril. Ce jour-là, l'ex-commissaire européen Frits Bolkestein vient à Paris s'expliquer lors d'une conférence de presse hypermédiatisée. Pince-sans-rire, il déclare souhaiter chez nous la présence de «plombiers polonais» pour faire du travail, parce que c'est difficile de trouver un électricien ou un plombier là où j'habite dans le nord de la France» (il possède une modeste maison de campagne à Ramoussies, près de Maubeuge). L'expression est parlante, ramassée et fait référence à la vie quotidienne. Du pain bénit pour les journaux télévisés. Elle fait tilt. Bolkestein évoque aussi la «nounou tchèque». Elle fait flop.
What are we talking about?

- **Health markets** are difficult to characterise due to **what is being commoditised**
- **Health systems** viewed as universally accessible services serving **population needs**
- **Health insurance** v. Single Market principles that limit **market distortion**
- **Health care services** among services removed from **Services Directive** (2006)
Shifting priorities and processes


- Patient mobility and cross-border care settled after years of discussion in 2011.
Three objectives (Koivusalo)

- Fiscal sustainability within Treaty limits: limits to state aids and public procurement
- Treating health care in trade and services negotiations while characterising it as a Service of General Interest (SGI ≠ SGEI)
- Regulating global pharmaceutical trade through WTO treaties (TRIPS) and other international treaties (e.g. TTIP)
Crucial Health v. Markets issues
<table>
<thead>
<tr>
<th>ECJ-code</th>
<th>Parties</th>
<th>Country of service</th>
<th>Country of insurance</th>
<th>Medical service/good</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-117/77;</td>
<td>Pierik I &amp; II</td>
<td>D</td>
<td>NL</td>
<td></td>
</tr>
<tr>
<td>C-182/78</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C-120/95</td>
<td>Decker</td>
<td>LB</td>
<td></td>
<td>Glasses</td>
</tr>
<tr>
<td>C-158/96</td>
<td>Kohll</td>
<td>D</td>
<td>L</td>
<td>Orthodontic treatment</td>
</tr>
<tr>
<td>C-160/96</td>
<td>Molennar</td>
<td>F</td>
<td>D</td>
<td>Long term care</td>
</tr>
<tr>
<td>C-368/98</td>
<td>Vanbraekel</td>
<td>F</td>
<td>B</td>
<td>Orthopaedic hospital treatment</td>
</tr>
<tr>
<td>C-411/98</td>
<td>Ferlini</td>
<td>L</td>
<td>(EC)</td>
<td>Discriminating billing</td>
</tr>
<tr>
<td>C-157/99</td>
<td>Geraets-Smits</td>
<td>D</td>
<td>NL</td>
<td>Inpatient Parkinson treatment</td>
</tr>
<tr>
<td></td>
<td>Peerbooms</td>
<td>A</td>
<td>NL</td>
<td>Coma therapy</td>
</tr>
<tr>
<td>C-385/99-1</td>
<td>Miller-Faur van Riet</td>
<td>D</td>
<td>NL</td>
<td>Denture/implantable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B</td>
<td>NL</td>
<td>Arthroscopic treatment</td>
</tr>
</tbody>
</table>

Wismar, *Eurohealth* 7(4), 2001
Indirect health regulation

- **EU-level enforceable principles**
  - Access and portability of health care
  - Service freedom for competitive health providers

  - Market regulation applies to (health) services

- **Result:** *supreme and direct* legal intervention through *judicial interdependence*
Freedom of movement

- Competition policy: free movement and antitrust regulation (COM + CJEU)
- Potential applications: health technology, contracted health professionals, privately funded health care
- Potential conflicts: cross-subsidies are discriminatory against internal market
Issue (1) Professional mobility

- **Principle:** trained health professionals should be able to work in any MS

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

- **Consequences:** more cross-country hiring of health workforce based on wage competition (e.g. Hungarian dentists)
Issue (2) Public procurement

- **Principle**: MS should not intervene against provider competition in national markets
- **Adaptation**: MS defend state compensation schemes (*BUPA* ruling, 2008)
- **Consequences**: insurance products providers can oppose state subsidies to national competitors (*Altmark* ruling, 2003)
Issue (3) Working times

- **Principle:** limited *number of hours* and defined breaks between shifts *(WTD, 1993)*
- **Adaptation:** substantial *cost increases* affected hospital and clinic staff
- **Consequences:** unintended *policy failure* with *negative externalities* on health services due to legal definitions of ‘on-call’ and ‘stand-by’ *(SIMAP and Jaeger rulings, 2000 and 2003)*
Issue (4) 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. in France, Spain and UK) expand to countries

- **Consequences:** expansion of cross-border services and ‘*medical tourism*’, esp. for expensive and/or badly covered services
Coping with Permanent, Aggravated Austerity in European Health Systems

First presented at the ‘Challenges for Europe’ workshop, Lille, 17 November 2016

Most of the references are in the course syllabus
Argument

1. The **mandate of the European Union over health policy** is an indirect but highly effective one

2. With the Global Fiscal Crisis, this mandate has turned the EU into a crucial driver of **health system reform**

3. This situation has reconfigured the politics of the welfare into **permanent, aggravated austerity** politics
Limits of EU health mandate

- **Explicit treaty provisions** make MS responsible of health care delivery, Council unanimity is required (Art. 207 TFEU), and harmonisation is ruled out (Art. 168 TFEU, ex-Art. 152(5) TEC) ([Hervey and Vanhercke 2010](#)).

- **Jurisprudential limits** to the treatment of *public* health services as economic in nature ([e.g. Watts 2004](#)).

- **Institutional diversity** of health care systems limits convergence of services and provision of goods to *beta*-convergence.
Gradual involvement

- Since 1957 – **Public health objectives** (Arts. 6, 168 TFEU) through small-budget initiatives and OMC-driven cognitive harmonization
- Since 1998 – **Negative integration** over ‘spot markets’ related to patient mobility, professional mobility, state aids and insurer competition (Greer and Jarman 2012)
- Since 2010 – **Economic surveillance** of health expenditure (largest component of MS soc. exp.)
Institutional shifts

- **Remapping of human health expertise** within EU institutions (DG SANCO + MARKT, ENVI) (de Ruijter 2016)

- **Private interest representation** of major incumbents (service providers, e.g. Franco-German complementary sickness funds via AIM) in Brussels (Greer 2009)

- **Variable integration of EU dimension** within national health departments / ministries / services, depending on initial level of departmental autonomy (Greer 2010)
Domestic reforms

- **Top-down structural reorganisation** of health systems at all levels of governance (state and providers)
- **Managerialism and competition mechanisms** within purchaser and provider markets (e.g. UK, Major + Blair)
- **Limited privatisation of health risks** through patient cost-sharing (Hacker 2004, Gingrich 2011, Jensen 2011)

Very general reform trends that apply to Bismarckian and Beveridgian health systems alike (Rothgang et al. 2010)
Reform context

- **Permanent austerity** since mid-1970s, though health care expenditure continued increasing *(Pierson 2001)*
- **Aggravated austerity** since Global Fiscal Crisis *(2008–9)* and Sovereign Debt Crisis *(2009–10)*
- **Severe cuts in public spending** followed by cuts in private health care consumption (primary care, pharmaceuticals)
- c. 2015 – **Negative or null growth** in real health care expenditure since c. 2010 *(Morgan and Astolfi 2015)*
Figure 1. Average OECD health expenditure growth rates in real terms, 2000 to 2011, public and total
Figure 2. Average annual growth in health spending across OECD countries, 2000–2011


Fig. 1. Change in GDP and change in government spending on health across country-specific recession and austerity periods. Cross-national variations in healthcare spending, by country-specific recession and austerity periods. 24 EU countries and the United States. Notes: Source: WHO Health expenditure database 2013 edition. EuroStat 2013 edition. Recessionary- and austerity-periods are defined in detail for each country in Web Appendix 1. Recession is defined as declining GDP (adjusted for inflation and purchasing-power) in consecutive years. Austerity is defined as declining government expenditure (adjusted for inflation and purchasing-power) in consecutive years. Data on small populations (i.e., Malta, Luxembourg, and Cyprus) excluded from the graphic. The US is included in this figure as a comparison but is not included in the other analyses in this paper.
EU involvement

- ECB + IMF macroeconomic conditionality for bailed-out MoU countries, e.g. Greece (see e.g. Fontan 2018)
- SGP + (TSG)EMU + European Semester fiscal surveillance for non-MoU countries, e.g. France
- **Structural funds** are conditioned to objectives above per 2014–20 ESIF rules (Baeten and Vanhercke 2016)
- Consequence: COM now operates as a **failed fiscal state** trying to cover MS expenses without means of taxation (Greer and Jarman 2015)
Application to Greece: A short history of Grexit

- 2009 – Greece reveals vastly underestimated deficit
- 2010 – First troika (COM, ECB, IMF) memorandum
  Greece starts ‘internal devaluation’ programme
- 2012 – Second memorandum
  Left-wing Pasok party eclipsed by radical-left Syriza
- 2015 – Third memorandum
  Syriza in power, organises austerity referendum
  Votes against, gets threatened with Grexit, complies
HEXP / GDP in selected OECD countries, 2009–15

- Greece: −1.8 percentage point* + see trend below
- Portugal: −1.1
- Spain: −0.5
- Italy: −0.2
- France: +0.1
- Germany: +0.1

* More than required by troika memoranda (6.0%)

OECD data, cited in Burgi 2017
Consequences on Greek health system (ESY)

- ESY created in 1983 on mixed pillars (Bev, Bism, priv)
- Performant despite low wages and long waiting lists

Example troika reform request

Cut **pharmaceutical spending** by half in 3 years (done)

Example system-wide consequences

Patient **pharma. co-payments 9 → 25%** of final price +
Limited state budget → Reduced imports
→ Shortages of prescribed drugs (e.g. insulin)
Consequences on Greek population

- Less unemployment benefits over shorter period
  → ~ 3 million uninsured (est. at 35% of total pop.)
  → introduction of health ‘coupons’ + basic min. income
- Increased attacks on vulnerable populations
  e.g. release of HIV status data (2012, abolished 2015)
  Stigmatisation of migrants, drug addicts, women
- Increased reliance on NGO assistance / internatl. help
  (all while having to deal with ~ 60,000 undoc. migrants)
Political consequences

- **Current reforms are not carried by broad consensus** but by minimum-winning elite coalitions (Pierson 2001)
- **Increased risk of health care politicization** through us-versus-them ‘Euroclash’ politics (Fligstein 2008)
  - Rich vs. Poor
  - Elite vs. People
  - Citizens vs. Foreigners
- **Adversarial politics** having no known positive effect on income growth, the situation is likely self-defeating
Political consequences, perfectly illustrated

Let’s give our NHS the £350 million the EU takes every week
Table 1.1  Impact of four different Brexit scenarios [continued]

<table>
<thead>
<tr>
<th>Financing</th>
<th>No Deal Brexit</th>
<th>Transition (the WA)</th>
<th>Backstop (NI Protocol)</th>
<th>Future relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reciprocal healthcare arrangements</td>
<td>No rights in place as legal framework ceases immediately.</td>
<td>Existing mechanism for coordination of social security continues, May</td>
<td>No provision for continued reciprocal arrangements for social security</td>
<td>Potential for some weaker form of reciprocal healthcare coordination than</td>
</tr>
</tbody>
</table>

Brexit

'It's like a death sentence': retired Britons in EU face loss of healthcare

Reciprocal scheme in which NHS reimburses cost of treatment will cease under a no-deal Brexit.
Thank you for your attention
Conclusive notes
administrative capacity, identifies authority, autonomy, and resources as three crucial dimensions of administrative capacity. An examination of the efforts to build administrative capacity after several recent public health crises (SARS, Avian Flu, MERS and COVID-19) shows that the EU has made only modest progress in granting such capacity to its supranational agency, The European Center for Disease Prevention and Control (ECDC). Despite the claims that COVID-19 was a new level of public health threat that demanded
We’ve covered

- **Health policy**, health systems, public health
- **Political institutions** and **legal instruments**
- **The EU health mandate**
- **EU health action**
  - Through **cross-border regulation**
  - Indirectly, through **market regulation**
  - Directly, esp. since **Covid-19**
- **Case studies** (thanks to all presenters)
Effective scope (1)

- No formal power over health systems: welfare states are national prerogatives

- Limited power in public health: mostly words (agenda-setting) and safety regulations → ‘first face’ of EU health policy = public health

As such, the EU looks like a weak player in health policy (at least until Covid-19).

However...
Effective scope (2)

- **Wide mandate over freedom of movement:** competitive nondiscrimination enforced for goods, services, capitals and individuals
  → ‘second face’ of EU health policy = **internal market**

- **Regulatory impact over market regimes,** i.e. taxation and macroeconomic policies
  → ‘third face’ of EU health policy = **fiscal governance**

From those angles, things are very different.
EU health policy after 2020

What it is:
- An impressive expansion of the fiscal resources for public health and civil protection
- A clear statement that the EU has a role in EU health protection and that EU health protection is important
- More effective EU agencies (EMA, ECDC...HERA?)
- More influence for EU ideas

What it isn’t:
- Redistributive between member states (no solution to problem of within the EU)
- Regulatory vis-a-vis a vis member state health policies
- Made permanent in politics or legislation- much of what happened is in the budget and can be changed at end of he current 7-year budget (MFF)
Complicated consequences (Scharpf)

- **Constitutional asymmetry:** the social mandate of the EU is largely an indirect consequence of its economic one

- **Negative integration:** EU economic regulation proceeds by removing barriers to the internal market (a.k.a. liberalization)

- **Legitimacy issue:** no clear link between political inputs and policy outputs
directly control the implementation of associated reforms.

In a preliminary opinion for a ruling on the OMT’s legality, the European Court of Justice’s general advocate emphasized that the importance of the ECB’s role in the Troika blurs the limits between fiscal and monetary policies.\(^\text{15}\) He concluded that it was fundamental for the ECB to end its involvement in the Troika immediately. In addition, an inquiry of the EP\(^\text{16}\) concluded that the ECB was widening the democratic deficit, because its participation in a vast array of reforms—including the liberalization of public health services and professions—extended beyond its monetary responsibilities.\(^\text{17}\) Given this conclusion, the EP advised the ECB to restrict itself to the role of ‘silent observer’ in the Troika. The reforms in which the ECB was involved were clearly backed by ‘expansionary austerity’ principles and were aiming to build market confidence through privatization, market flexibilization and budgetary cuts. Furthermore, the EP emphasized that although these reforms had minimal economic results, they triggered severe social and democratic disruptions (see also Stuckler and Basu 2013, chapter 5). Interestingly, it was the ECB and the European Commission, rather than the IMF, that advocated for the severity of these austerity measures (Blustein, 2015), as it was already the case for the Troika groups sent into Eastern and Central Europe in 2008 (Lütz and Kranke 2014). To conclude, the ECB’s determination to impose strict conditionality and

\(^{15}\) ECJ press release, 14 January 2015. The final ECJ judgement does not replicate the Advocate General’s arguments on the ECB’s participation in the Troika.

\(^{16}\) EP resolution, 13 March 2014. 2013/2277 (INI).

\(^{17}\) A member of the ECB’s staff who had been participating to these groups confirmed that the ECB has been consulted on these particular policy areas (interview 5).
"I'm afraid we only have ONE ventilator..."
Unclear future, although…

- Since 2016, alignment with UN Sustainable Development Goals (SDGs)
- Since 2020, additional funds for public health preparedness + emergency responses (HERA)
- No support for a European health system, even as a very distant goal
- No policy shift on market regulation and fiscal governance under either the global fiscal crisis or the Covid-19 pandemic
Health system diversity will remain...
Thanks again for your attention

Final things

- Make sure your presentation files (slides etc.) are available on Google Drive at
  link.infini.fr/ehp-2022
- Please fill in the feedback form available at
  link.infini.fr/ehp-2022-feedback

Last questions now!