ESPOL
EUROPEAN SCHOOL OF POLITICAL AND SOCIAL SCIENCES

European Union Health Policy

François Briatte

Fall 2023

Course contents

Course material

link.infini.fr/ehp-2023 (Google Drive)

- Course **syllabus**
- Course **handbook(s)** (for reference)
- Course **readings** (for e.g. dissertation research)
- Course **slides**
- **Presentation readings**
- **Student presentations** (folder to upload material)

Course handbook

ch. 1 · Introduction

ch. 2 · The European Union

ch. 3 · Public Health

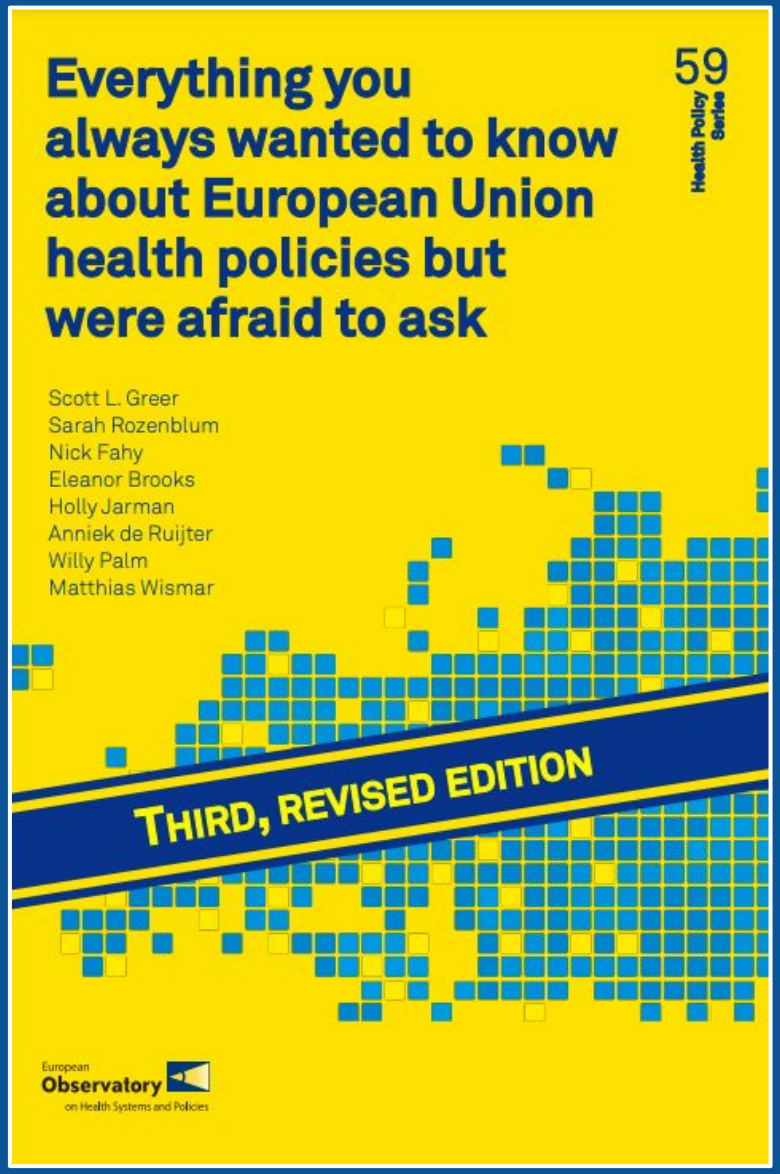
ch. 4 · EU Action for Health

ch. 5 · EU Market

ch. 6 · Fiscal Governance

ch. 7 · Global Health

Free to download



Coursework instructions

Grading scheme

- 80% **presentations**
  - If you present only once, 60% presentation
    20% **memo** (2-page document summarising the presentation to a policy-maker, to be uploaded with the presentation before our last class)
  - If you present twice, 40% per presentation
    (no final memo)
- 20% **attendance and participation** (class-level)

How to present

- Read and apply the **detailed instructions**
- Aim at **12–15 minutes** (at most)
- Upload **slides and handout** (both in PDF) in advance
  - Slides should be concise and readable
  - Handouts are ‘presentation booklets’
  - Both include your names and references
- Use **notes**, and do not read them

Student work ethics

- Coordinate within your **group**
- Distribute work fairly, and **do not free-ride**
- Naturally, **do not miss presentation day**
- Observe deadlines

I do not police groups. Same group, same grade

All other School regulations apply


QUESTIONS?

European Union Health Policy

Fall 2023

link.infini.fr/ehp-2023

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

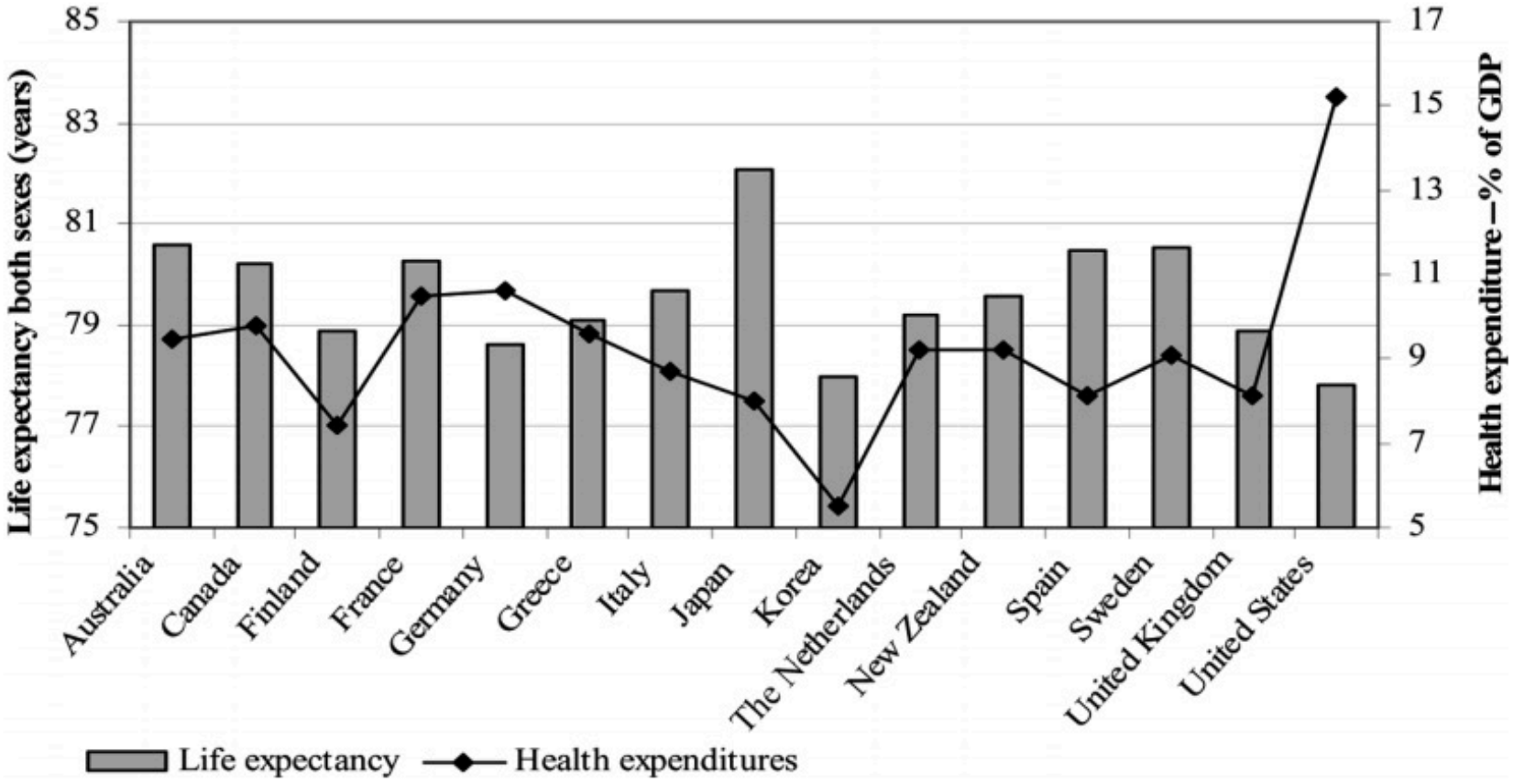
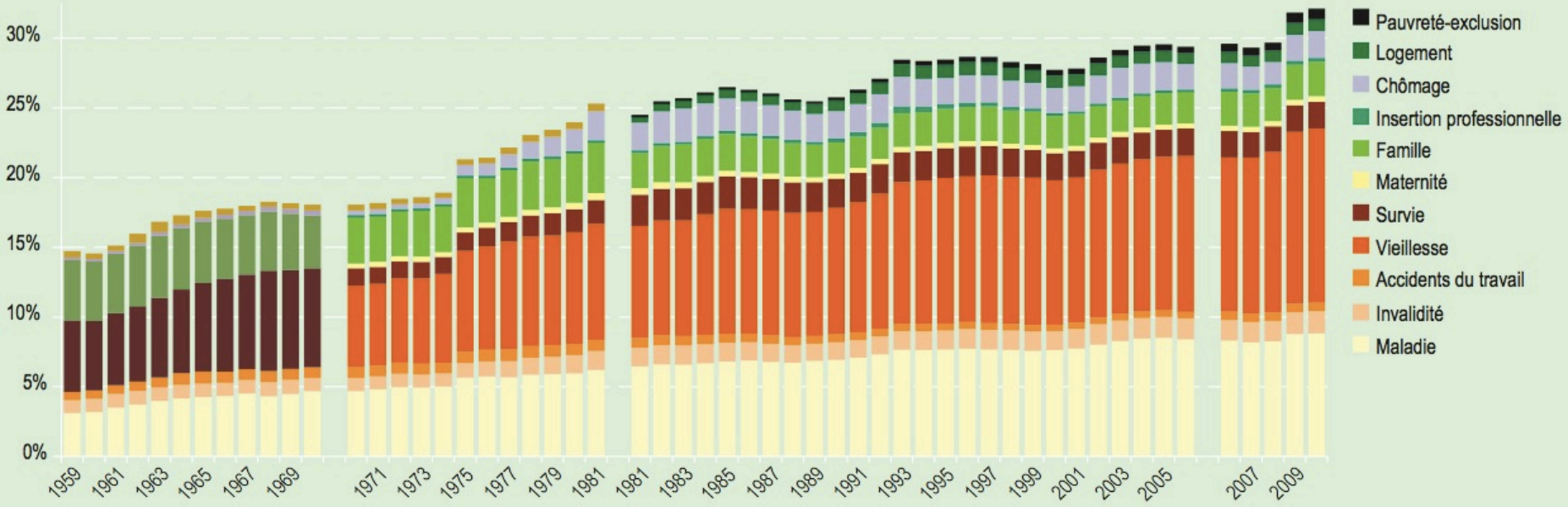


Figure 1. Life Expectancy at Birth and Total Health Expenditure—percent of GDP in 2004. Source: OECD Health data

GRAPHIQUE 4

Évolution de la structure par risques des prestations de protection sociale



Sources • DREES-CPS, base 1970 (1999-1970 et 1970-1981), 2000 (1921-2006) et 2005 (2006-2010).
Note • Les ruptures de série ont été mises en évidence, car elles affectent les délimitations entre les risques.

AP Photo/Morry Gash

President-Elect Obama might struggle to implement his health-care campaign promises

New Roma Health Report confirms health inequalities (04.09.2014)

The EU-funded report examines existing data on the health of Europe's largest ethnic minority and confirms health inequalities, such as the fact that Roma people have shorter life expectancies. The report also examines how this data from Member States were compiled.

Share

All highlights

EU health policy

Health: a condition for economic prosperity and social cohesion

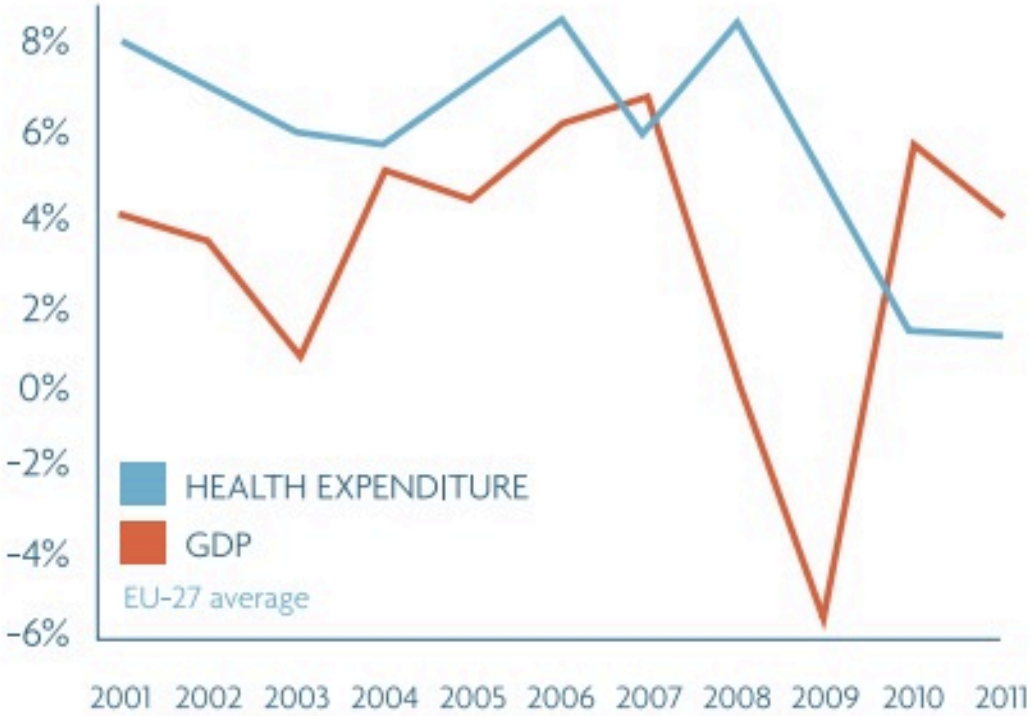
A LOOK AT HEALTH SYSTEMS IN THE EU

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 AMENTIES
2% CULTURE AND RELIGION

* social protection covers pension and unemployment benefits

Growth in health expenditure vs GDP



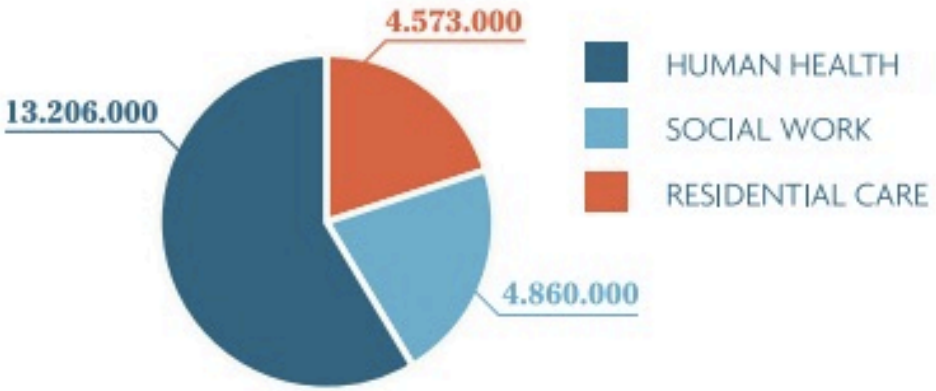
Jobs in the health and social sectors

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

EU health *policy*

Policy analysis: Scientific inquiry

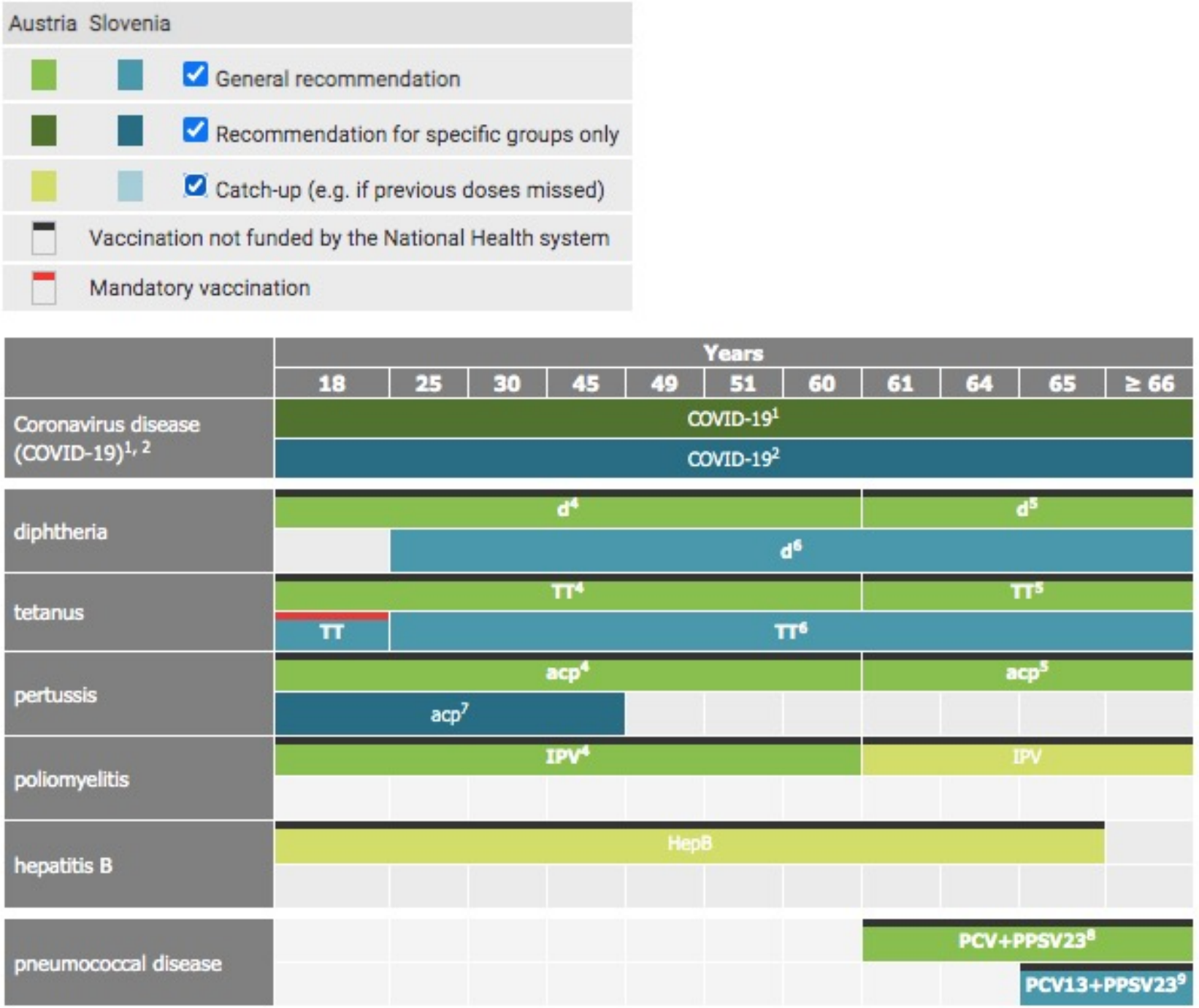
- **Description**: **objective** knowledge about the state of the material world
- **Explanation**: **logical** statements explaining a particular class of phenomena
- **Empirical focus**: **public policy**

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**


Austria Slovenia
General recommendation
Recommendation for specific groups only
Catch-up (e.g. if previous doses missed)
Vaccination not funded by the National Health system
Mandatory vaccination
Years
18
25
30
45
49
51
60
61
64
65
≥ 66
Coronavirus disease (COVID-19)[1, 2]
COVID-19[1]
COVID-19[2]
diphtheria
d[4]
d[5]
d[6]
tetanus
TT[4]
TT[5]
TT
TT[6]
pertussis
acp[4]
acp[5]
acp[7]
poliomyelitis
IPV[4]
IPV
hepatitis B
HepB
pneumococcal disease
PCV+PPSV23[8]
PCV13+PPSV23[9]

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**

Public policy: Research

- Wide universe of **policy areas**, with considerable **overlap** between them
- Unifying characteristic: ***S*tate-*s*ociety interactions** (Löwi)
  - **distributive**: *S* provides to a subset of *s*
  - **redistributive**: *S* allocates between several *s*
  - **regulatory**: *S* adjusts multiple-*s* relations
  - **constituent**: *S* creates the rules of its action

Policy analysis: Methods

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

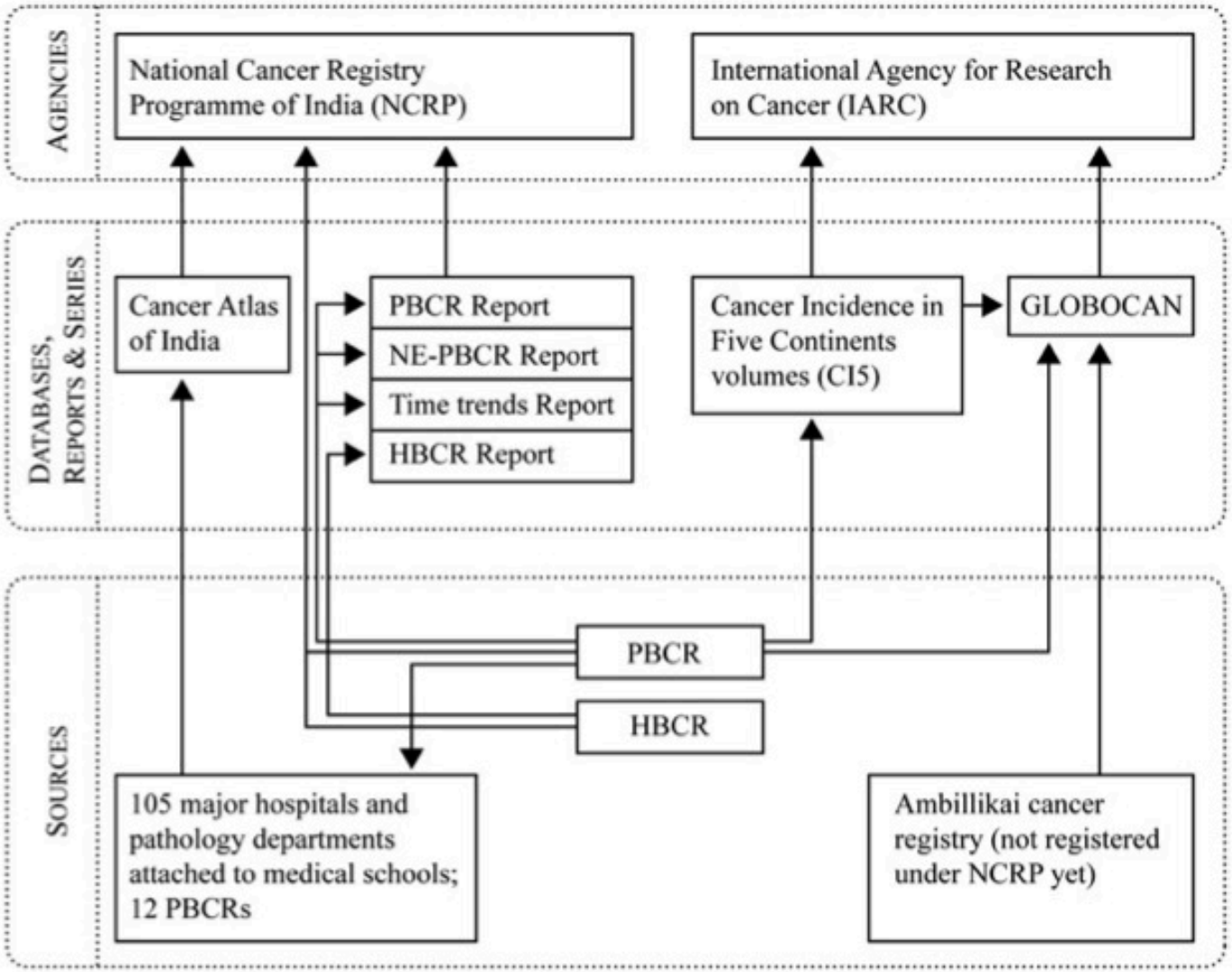
Remember this slide for when you will be presenting in this course (and check the final slide for more instructions re: presentations)

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**)

EU *health* policy

Figure 1
Overview of agencies and sources reporting on cervical cancer incidence and mortality in India



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


BUNDESMINISTERIUM
FÜR GESUNDHEIT


ITFoM
FUTURE OF MEDICINE


OECD


Maastricht University


MSD


EUROPEAN
SCIENCE
FOUNDATION


BUREAU OF HEALTH PROMOTION
DEPARTMENT OF HEALTH, TAIWAN


GLOBAL HEALTH EUROPE
A Platform for European Engagement in Global Health


Roche


Pfizer


MPIMG


FOPI
Forum der forschenden pharmazeutischen Industrie


AMGEN


OAK

Health policy: Definition

- **Public interventions that aim at improving the health of individuals**
- *Public* interventions, **not *clinical***
- Quasi-universal bias towards '**good health**'

RÉPUBLIQUE FRANÇAISE
Liberté Égalité Fraternité

Santé publique France

MANGER BOUGER

mangerbouger.fr

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** (18^{th}–20^{th})
- **Medical ethics** (increasingly on the agenda)

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

Health: Political dimension

- Interventions in health policy combine several dimensions of the act of **government**
- When **democratically elected**, office holders will seek election or re-election
- As a latent component of **public opinion**, health can become very salient in the presence of **pain and loss**

Agnès Buzyn convoquée par la CJR en vue d'une mise en examen pour « mise en danger de la vie d'autrui »

Health politics: Attention

"Leaders in general government are always mindful of their last election, as well as the next one, and frequently explore opportunities to achieve higher office. They observe that most of their constituents […] usually accord very high priority to health policy **only when they perceive significant, usually unanticipated, threats** to their health or the health of persons close to them" (Fox)

Health policy: Current challenges

- **Welfare states are in crisis**
  - Increasing **costs**, scarcity of **resources**
  - Access, Equity, Costs, Quality, Choice: (the health care 'quadrilemma')
- **Population control is contested**
  - **Locus** of responsibility
  - Construction of **target groups**
  - Degree of **coercion**
- **Biosecurity**

Health policy: A final paradox

"Health policy is pathological […]. Our neurosis consists in knowing what is required for good health […] but not being willing to do it. Government's ambivalence consists in […] telling people how to be healthy and […] paying their bills when they disregard this advice. Psychosis appears when government persists in repeating this **self-defeating play**." (Wildavsky)

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

· · · Any questions so far?

Bonus

Student presentations

`link.infini.fr/student-presentations`

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EUROPEAN SCHOOL OF POLITICAL AND SOCIAL SCIENCES

EU Institutions Involved in Health Policy

EU Health Policy

Lecture 2

Before we start

- Go to `link.infini.fr/ehp-2023` and check the Google Sheets document on presentations
- You should be presenting (at least) once as groups of 2+ students, for 10 to 15 minutes
- All rules and instructions for presentations can be found at the bottom of that document

Please ask questions now if you have any


European
Commission


CVRIA


European Parliament

EUR-Lex

Access to European Union law

QUICK SEARCH

SEARCH

Search tips

Need more search options? Use the Advanced search

Pause

EU law

- Treaties
- Legal acts
- Consolidated texts
- International agreements
- Preparatory documents
- EFTA documents

EU case-law

- Case-law
- Reports of cases
- Directory of case-law

National law and case-law

- National transposition
- National case-law
- JURE case-law

Information

- Themes in focus

Overview

- **Institutional triangle** · Commission (COM), Parliament (EP), 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


Naar
een
energie-unie
Vers une
Union
de l'énergie
Towards
an
Energy Union

European Commission (COM)

- **Individual commissioners** from Member States (MS), appointed by Parliament + Council
- Organized into **Directorates-General** (DGs), EU equivalent to departments/ministries
- Controls the **legislative agenda**: the Commission initiates all directive proposals
- Most obvious **health policy branch**: **DG SANTE** (Health and Food Safety)

  formerly **DG SANCO** (Health and Consumer Protection), est. 1999

2023

European Commission

English

Departments and executive agencies

Directorate-general | SANTE

Health and Food Safety

DG SANTE is responsible for the EU Commission's policies on health and food safety.

announced in September 2021

Service | HERA

Health Emergency Preparedness and Response Authority

HERA anticipates threats and potential health crises, through intelligence gathering and build
necessary response capacities.

2020

European Commission

EN English

Home > Departments and executive agencies

Departments and executive agencies

Filter by

Topics

Public health

Department type

- Any -

Main task

- Any -

Departments / Executive agencies (2)

TOPICS Public health ⊗

removed in April 2021

EXECUTIVE AGENCY | CHAFEA

Consumers, Health, Agriculture and Food Executive Agency

DIRECTORATE-GENERAL | SANTE

Health and Food Safety

COM health policy / 1

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 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** · handling of **structural funds** (regional development aid)
- DG **Communication Networks** · major funder of **health information technology**

COM 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 (EP)

- **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. an absolute majority of MEPs
- Organised in **groups** rather than parties

At a glance

Infographic

13 February 2020

European Parliament

Size of political groups in the EP

	EPP	S&D	Renew Europe	ID	Greens/ EFA	ECR	GUE/ NGL	NI	Total
DE	29	16	7	11	25	1	5	2	96
FR	8	6	23	23	13		6		79
IT	8	18	1	29		6		14	76
ES	13	21	9		2	4	6	3	* 58
PL	17	8				27			52
RO	14	11	8						33
NL	6	6	7	1	3	4	1	1	29
BE	4	3	4	3	3	3	1		21
CZ	5		6	2	3	4	1		21
EL	8	2				1	6	4	21
HU	13	5	2					1	21
PT	7	9			1		4		21
SE	6	5	3		3	3	1		21
AT	7	5	1	3	3				19

EP standing committees

Most relevant for health policy are

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

… a.k.a. **ENVI**, **EMPL** and **ITRE**

→ most likely targets of **lobbying** efforts

Charles Michel, President of the European Council

In the news

25 September 2020 | Press release

"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

27 September 2020 | News

"We need the United Nations more than ever"

1-2 October 2020 | Meeting

Special European Council postponed to 1 and 2 October

European Council(s) (EC)

- **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 population

  *N.B. **Brexit** changed that too: QMV used to be 16+ MS*

  *Also uses **reverse QMV** to **reject** COM proposals*

- 'European Council' is the one for **heads of state**


CVRIA
COUR DE JUSTICE
DE L'UNION
EUROPÉENNE

Court of Justice of the EU

- **Supranational, supreme court** — application of rulings is *direct* and *impossible to oppose*
- **Treats cases brought by the European Commission** (MS implementation failure) **or by national courts** (via domestic litigation or preliminary reference)
- **Rulings are binding** until overridden by new EU legislation, treaty change, or new ruling

  → **case law** approach

EU health-focused agencies / 1

- **European Centre for Disease Control** (ECDC)
- **European Food Safety Agency** (EFSA)
- ~~Executive Agency of Health and Consumers~~

  *CHAFEA was removed in 2021 and replaced by **HaDEA**, the Health and Digital Executive Agency · N.B. Executive Agency (programme management) ≠ Agency*
- **European Medicines Agency** (EMA)

  *moved from London to Amsterdam post-**Brexit***

EU health-focused agencies / 2

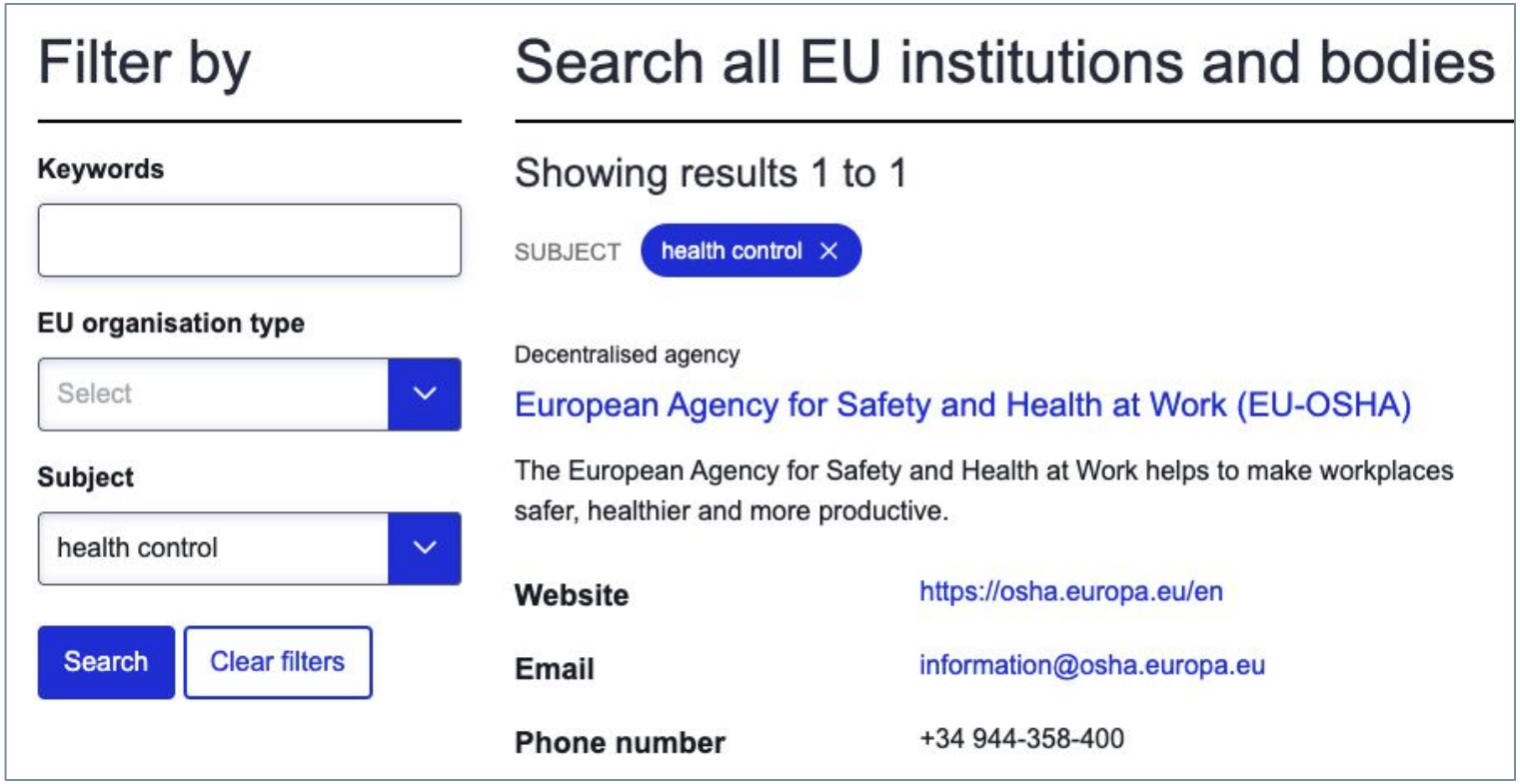
- **European Chemicals Agency** (ECHA)
- **European Health Emergency Preparedness and Response Authority** (DG HERA)

  *created post-**Covid-19** in September 2021, on the model of the U.S. Biomedical Advanced Research and Development Authority (BARDA) · **actually a DG**, currently headed by a former director of now-dissolved DG MARKT*

  → more on HERA when we get to communicable disease control

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

Overall, these institutions form a relatively small but **extremely specialized bureaucracy** that finds itself embedded in a **large, fragmented policy community**, and in a **unique political system** that emphasizes **accountability**, **transparency** and **budget control**



- How did the **EU policy system** emerge?
  → theories of **EU integration**
- How does it **operate** effectively?
  → **laws**, **budgets**, **programs**, and **politics**
- How **legitimate** is the EU policy system?
  → **input** (democracy), **output** (policies) and **throughput** (transparency and deliberation)
- What about **other policy stakeholders**?
  i.e. domestic governments, nongovernmental actors (e.g. industrial representatives)


QUESTIONS?


10’ BREAK

ESPOL
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EU Health Mandate and Legal Instruments

EU Health Policy

Lecture 3

EUR-Lex

Access to European Union law

QUICK SEARCH

SEARCH

Search tips

Need more search options? Use the Advanced search

Pause

EU law

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EU case-law

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- JURE case-law

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12008E006

Consolidated version of the Treaty on the Functioning of the European Union - PART ONE: PRINCIPLES - TITLE I: CATEGORIES AND AREAS OF UNION COMPETENCE - Article 6

Official Journal 115 , 09/05/2008 P. 0052 - 0053

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.

Text

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.

Top

Table of contents

Art. 6 TFEU (Treaty of Lisbon, 2007–9)

[The Union shall…]

support, coordinate or supplement

the **actions of the Member States**

[in the]

protection and improvement of human health

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-vou
Les masques chirurgicaux ont un sens à respecter.
Après avoir réalisé une friction hydro alcoolique des mai
le saisir par la partie centrale externe.

le haut (baguette) et passer les doigts dans les élastiques (côté bleu légèrement brillant à l'extérieur)

blanc) est à a
bouche

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

SONEST
HYGIÈNE | INDUSTRIE

Importateur : Sté SONEST
4 rue Gay Lussac 67201 Eckbolsheim (France)
www.sonest.fr • contact@sonest.fr

Norme EN 14683 + 2019 AC

ISO 9001:2015

Masque sans latex hypoallergénique

Efficacité de filtration
bactérienne > 98% et
résistant aux éclaboussures

Fabrication :
BARI KBK GROUP LTD
Fabriqué en UE - BULGARIE

Certificat CE disponible sur
demande à contact@sonest.fr

CE

101210CT

3 760322 110005

visuels non contractuels

SONEST
HYGIÈNE | INDUSTRIE

Importateur : Sté SONEST
4 rue Gay Lussac 67201 Eckbolsheim (France)
www.sonest.fr • contact@sonest.fr

Norme EN 14683 + 2019 AC

ISO 9001:2015

Masque sans latex hypoallergénique

Efficacité de filtration bactérienne > 98% et résistant aux éclaboussures

CE

101210CT

3 760322 110005

Fabrication :
BARI KBK GROUP LTD
Fabriqué en UE - BULGARIE

Certificat CE disponible sur demande à contact@sonest.fr

visuels non contractuels

Art. 152(1) TEC (Treaty of Amsterdam, 1997–99)

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***

Art. 152(5) TEC (Treaty of Amsterdam, 1997–99)

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. healthcare **funding** and price setting, hospital **equipment** and **staffing**, workforce **training***

** MEDECIN TRAITANT **

UT : VICTOR38
DATE : 25/07/06

[redacted]

15/03/2005

[redacted] né(e) le [redacted]

[redacted]

[redacted]

[redacted]

La Mutuelle Des Etudiants
Agence de Grenoble Centre-Ville
Sécurité Sociale centre 601 LMDE
28 cours J. Jaurès - 38000 Grenoble
www.LMDE.com

rmations relatives au médecin traitant

ti.	Nom du médecin	Dt décla.	Dt fin Rel
[redacted]	DR [redacted]	[redacted]	
01		Validé : O	

Fin

F11=Infos complémentaires F12=Retour

LIBELLE	BASE	TAUX SALA
Salaire de base		
Prime d'ancienneté		
Rémunération brute forfaitaire (ICCP comprise)		
SANTE		
Sécurité Sociale-Maladie Maternité Invalidité		
Décès		
Complémentaire Incapacité Invalidité Décès		
Complémentaire santé		
ACCIDENTS DU TRAVAIL-MALADIES PROFESSIONNELLES		
RETRAITE		
Sécurité Sociale plafonnée		
Sécurité Sociale déplafonnée		
Complémentaire Tranche 1 (Régime unifié)		
FAMILLE		
ASSURANCE CHOMAGE		
Chômage		
AUTRES CONTRIBUTIONS DUES PAR L'EMPLOYEUR		
CSG déductible de l'impôt sur le revenu		
CSG/CRDS non déductible de l'impôt sur le		

Constraints repeated in Art. 168(7) 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.'.

Art. 207 TFEU (ex Art. 133 TEC)

[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**

Explicit scope limitations

Arts. 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 mentioned: **recommendations** and 'soft law' via **Open Method of Coordination** (OMC)

'programmatic' power · e.g. State of Health in the EU

Legal instruments (1)

- **Regulations: directly applicable measures**, such as agency creation or renewing existing regulations
- **Directives: transposable legislation**, with delays and other implementation bargains (COM *v.* MS → CJEU)
- **Declarative acts: decisions** (binding), **opinions** (non-binding) and **recommendations** (non-binding)
- **Delegated and implementing acts: 'comitology'** (COM) and **social partners** (e.g. safety standards)

Contributions from other mandates

- **Environment** · understood as a way of **'protecting human health'**
- **Health and safety at work** · part of a wider set of social policy objectives, which rely on the **Open Method of Coordination**, with potential application to health services (e.g. needles ↔ sharp objects)
- **Consumer protection** · **food safety** for (internal market) consumers

Effective scope (as seen today)

- **No formal power over health systems** · welfare states, and within them healthcare funding and health services, are national prerogatives
- **Limited power in public health** · mostly words (agenda-setting) and safety regulations

  → **'first face'** of EU health policy = **public health**

From that angle, the EU looks like a weak player in health policy.
However…

Effective scope (as we will see later)

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

  → **'second face'** of EU health policy = **internal market**

- **Regulatory impact on** , which ultimately affects taxation and macroeconomic policies

  → **'third face'** of EU health policy = **fiscal governance**

Legal instruments (2)

- **Harmonization:** accept **EU standards** in replacement of national ones (e.g. hours of medical education)
- **Mutual recognition:** accept **goods** (health products), **services** (health insurance), **capital** and **people** (health workers) from other Member States
- **'Country of origin' principle:** accept **standards from other Member States** (*Cassis de Dijon* ruling)

Legal instruments (3)

- **Subsidiarity:** EU action occurs **only if MS are not more capable players** (principle of performance at the smallest possible unit)
- **Direct effect and precedence:** EU law is **immediately** and **supremely** enforceable
- **Decentralization:** national courts and individuals can **refer to the CJEU** directly (and bypass both the Commission and the Member States)


QUESTIONS?


10’ BREAK

ESPOL
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EU Health Action
(1) Direct Action

EU Health Policy
Lecture 4

Health mandate (see last session)

- **Public health** · **population-wide mandate** in Maastricht (1992) and Lisbon (2009) treaties

  Also remember earlier point re: organs, blood, tissues, cells

- **Environment** · **wide-ranging** programmes, from city planning to national energy supply
- **Health and safety at work** · regulation of the **workplace**, e.g. legislation on sharp items
- **Consumer protection** · e.g. food and drink labels about **nutritional health claims**

Legal instruments

- **Regulations: directly applicable measures**, such as agency creation or renewing existing regulations
- **Directives: transposable legislation**, with delays and other implementation bargains (COM *v.* MS → CJEU)
- **Declarative acts: decisions** (binding), **opinions** (non-binding) and **recommendations** (non-binding)
- **Delegated and implementing acts: 'comitology'** (COM) and **social partners** (e.g. safety standards)

Constraints and consequences

- **Legal restriction** through Art. 168 TFEU
  (and through more general subsidiarity principle)
- **Budget constraint** · EU budget capped at 1.5% of EU gross national income (2% since Covid-19)

→ *Consequences*

- **Proliferation of 'paper-only' health programmes** with limited actual impact on MS policies
- **Indirect implication of EU banks** (ECB, EIB) via monetary/lending policies (more on that later)

Past positions

‘Health in All Policies’
(HiAP, 1999, 2006)

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 contribtion 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

‘success stories’

stakeholder networks

eit Health

HOME ABOUT REGIONS PROGRAMMES NEWS & VIEWS EVENTS PARTNERS OPPORTUNITIES

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

cross-country comparisons

THE STATE OF HEALTH IN THE EU

POOLING EXPERTISE, STRENGTHENING KNOWLEDGE.

ec.europa.eu/health/state

Health at a Glance: Europe

2022
2020
2018
2016
2014

This biennial publication presents a set of key indicators of health status, determinants of health, health care resources and activities, quality of care, health expenditure and financing in 35 European countries, including the 28 European Union member states, 5 candidate countries and 3 EFTA countries. The selection of indicators is based largely on the European Community Health Indicators (ECHI) shortlist, a set of indicators that has been developed to guide the reporting of health statistics in the European Union. It is complemented by additional indicators on health expenditure and quality of care, building on the OECD expertise in these areas. Each indicator is presented in a user-friendly format, consisting of charts illustrating variations across countries and over time, a brief descriptive analysis highlighting the major findings conveyed by the data, and a methodological box on the definition of the indicator and any limitations in data comparability.

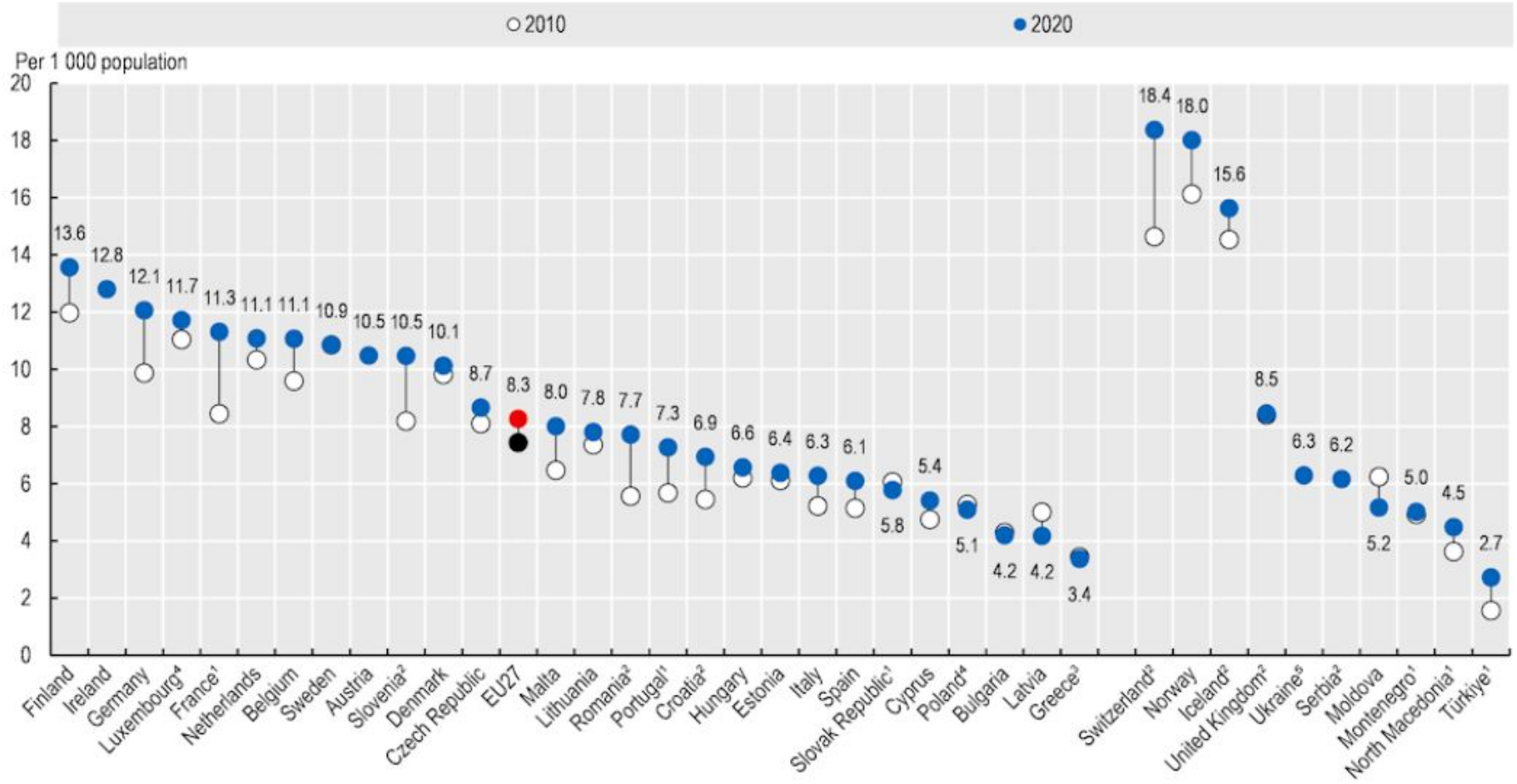
Less

English

Related Content: | Related Databases:

Biennial | ISSN: 23056088 (online) | https://doi.org/10.1787/23056088

Figure 7.16. **Practising nurses per 1 000 population, 2010 and 2020 (or nearest year)**

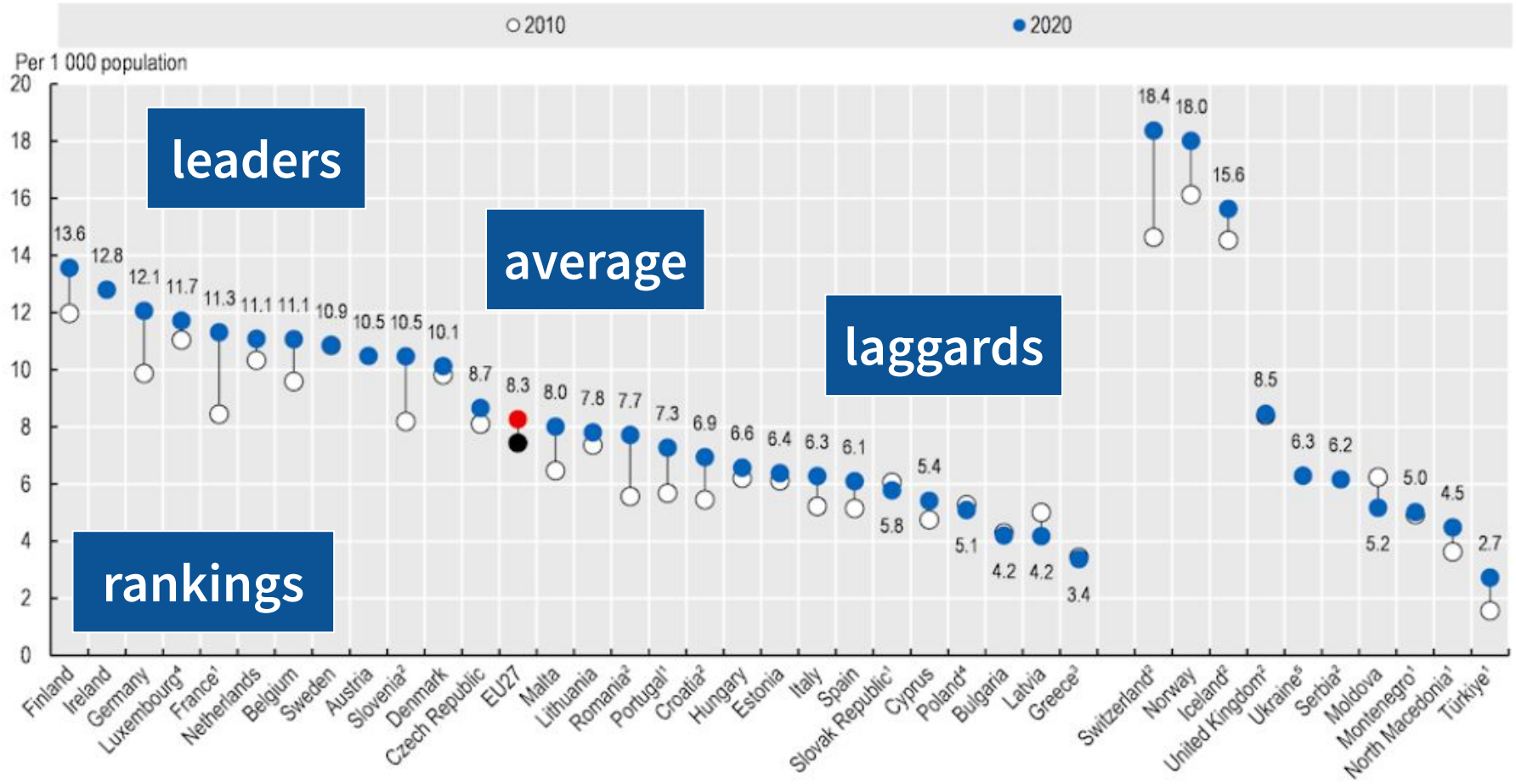


Note: The EU average is unweighted. 1. Data include not only nurses providing direct care to patients, but also those working in the health sector as managers, educators, researchers, etc. 2. Associate professional nurses with a lower level of qualifications make up 70% or more of nurses in Croatia, Romania and Serbia; about 60% in Slovenia; about 33% in Switzerland and Iceland; and about 20% in the United Kingdom. In Switzerland, most of the growth since 2010 has been in this category. 3. Greece reports only nurses employed in hospitals. 4. The latest data refer to 2017 only. 5. The latest data refer to 2014 only.

Source: OECD Health Statistics 2022; Eurostat Database; WHO National Health Workforce Accounts for Moldova and Ukraine.

benchmarks

Practising nurses per 1 000 population, 2010 and 2020 (or nearest year)



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Source: OECD Health Statistics 2022; Eurostat Database; WHO National Health Workforce Accounts for Moldova and Ukraine.

comparisons

common knowledge

best practices

lesson-drawing

cognitive harmonization

Health at a Glance: Europe 2022

STATE OF HEALTH IN THE EU CYCLE

OECD

European Commission

EU Health Programme, 2014–2020

- **Highly limited budget** · €46 million per year, i.e. almost nothing — unlike EU **research funding**
- **Capacity-building intent** · meant to federate **nongovernmental**, **EU-level** actors

  → working parties, expert conferences
- **Cognitive intent** · diffusion of ‘good practices’, as with the **Open Method of Coordination**

  → final move left to MS governments

but then…

28.12.2020

FAQ: What is the European Union doing about the COVID-19 pandemic?

EU member states work together to tackle the challenge of the coronavirus
© picture alliance/AP Photo/Francisco Seco

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

  [COM also issued **recommendations** on priority targets]
- **Medical products** · strategic **stock reserve** (rescEU), funding and **joint procurement** procedure for rapid antigen tests, contract with Gilead for remdesivir


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:

(UK also joined)

Austria	Ireland
Belgium	Italy
Bulgaria	Latvia
Croatia	Lithuania
Cyprus	Luxembourg
Czech Republic	Malta
Denmark	Norway
Estonia	Netherlands
Finland	Poland
France	Portugal
Germany	Romania
Greece	Slovakia
Hungary	Slovenia
Iceland	Spain

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.[77]

77 European Commission (2019). Memo. Framework contracts for pandemic influenza vaccines 28 March 2019. Available at: https://ec.europa.eu/health/sites/health/files/preparedness_response/docs/ev_20190328_memo_en.pdf.

€ 9.4 billion

European Commission

All topics | Health Programme | EU4Health | Investment plan | Structural funds

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.

€ 9.4 billion

Fun fact

Right before Covid-19, the EU was considering *not* having an actual health programme

The plan was to replace it with the European Social Fund Plus (EFS+), as part of European Structural and Investment Funds (ESIF) [COM(2018)382]

‘This is more than a recovery plan’

€ 806 billion

This girl is supposed to be you, presumably leaping out of the pandemic

Covid-19 measures (2)

- **Health system funding** · **€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** · Commission borrowed **€806bn grants + loans** on global markets to lend them to the MS (largest EU stim pack ever)


QUESTIONS?


10’ BREAK

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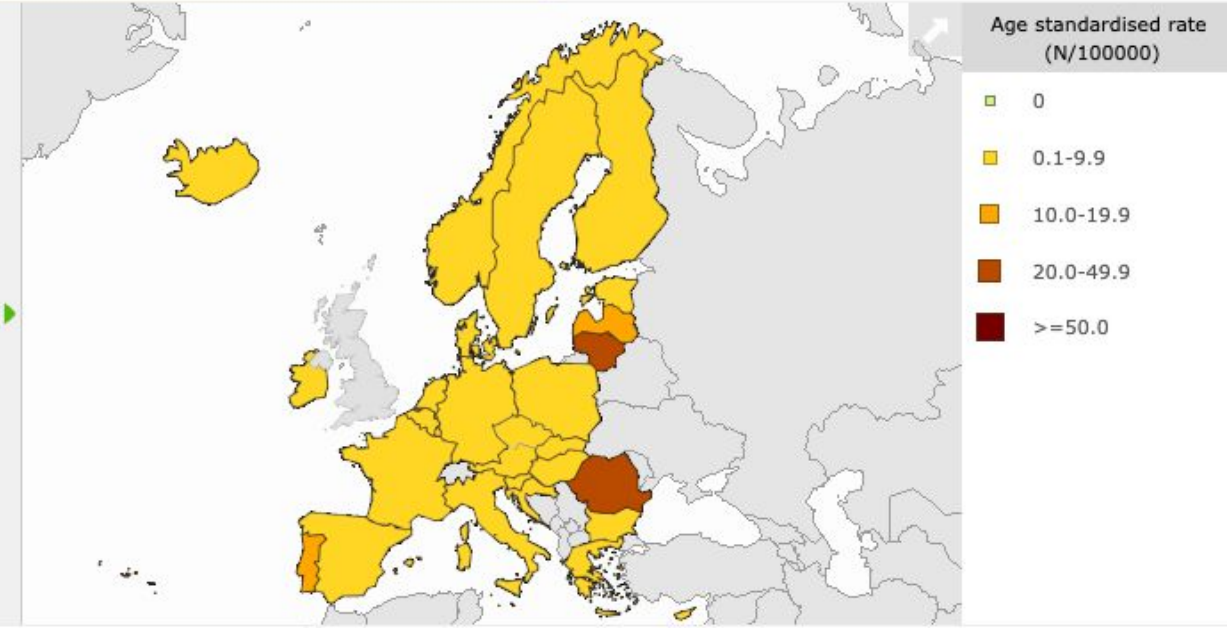
EU Health Action
(2) Cross-Border Action

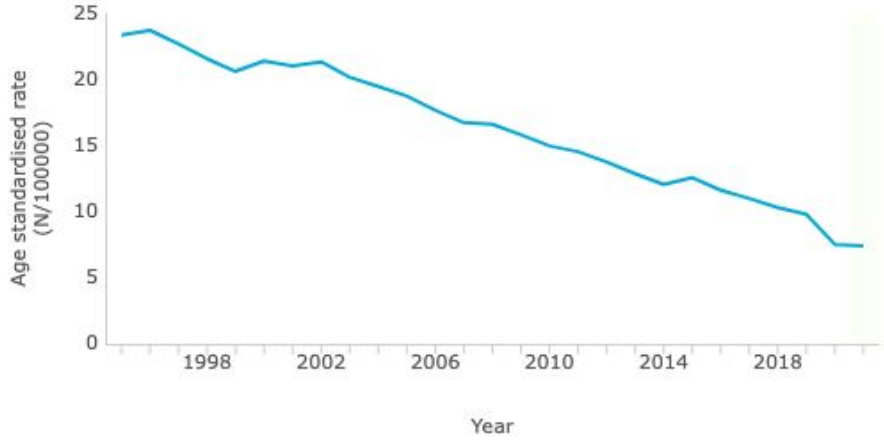
EU Health Policy
Lecture 5

Surveillance Atlas of Infectious Diseases

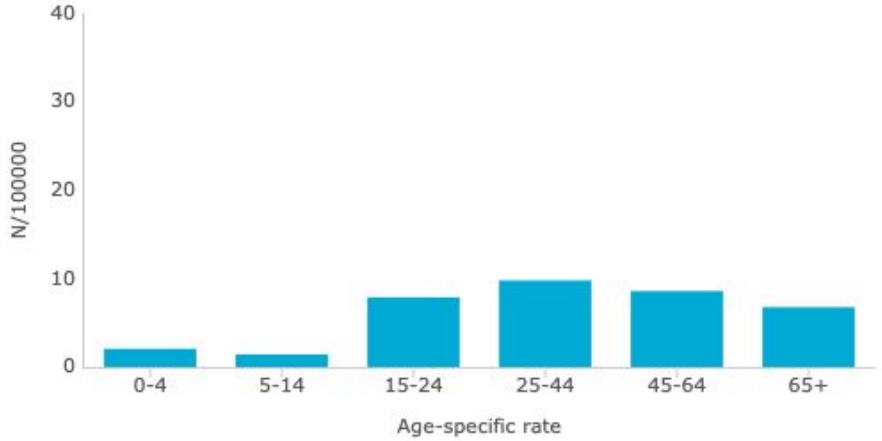
Tuberculosis | All cases | Age standardised rate | 2021

Region	Age standardised rate (N/100000)
EU/EEA	7.41
Austria	4.46
Belgium	8.00
Bulgaria	9.48
Croatia	3.52
Cyprus	5.36
Czechia	3.28
Denmark	3.66
Estonia	8.18
Finland	2.91
France	6.71
Germany	4.86
Greece	2.06





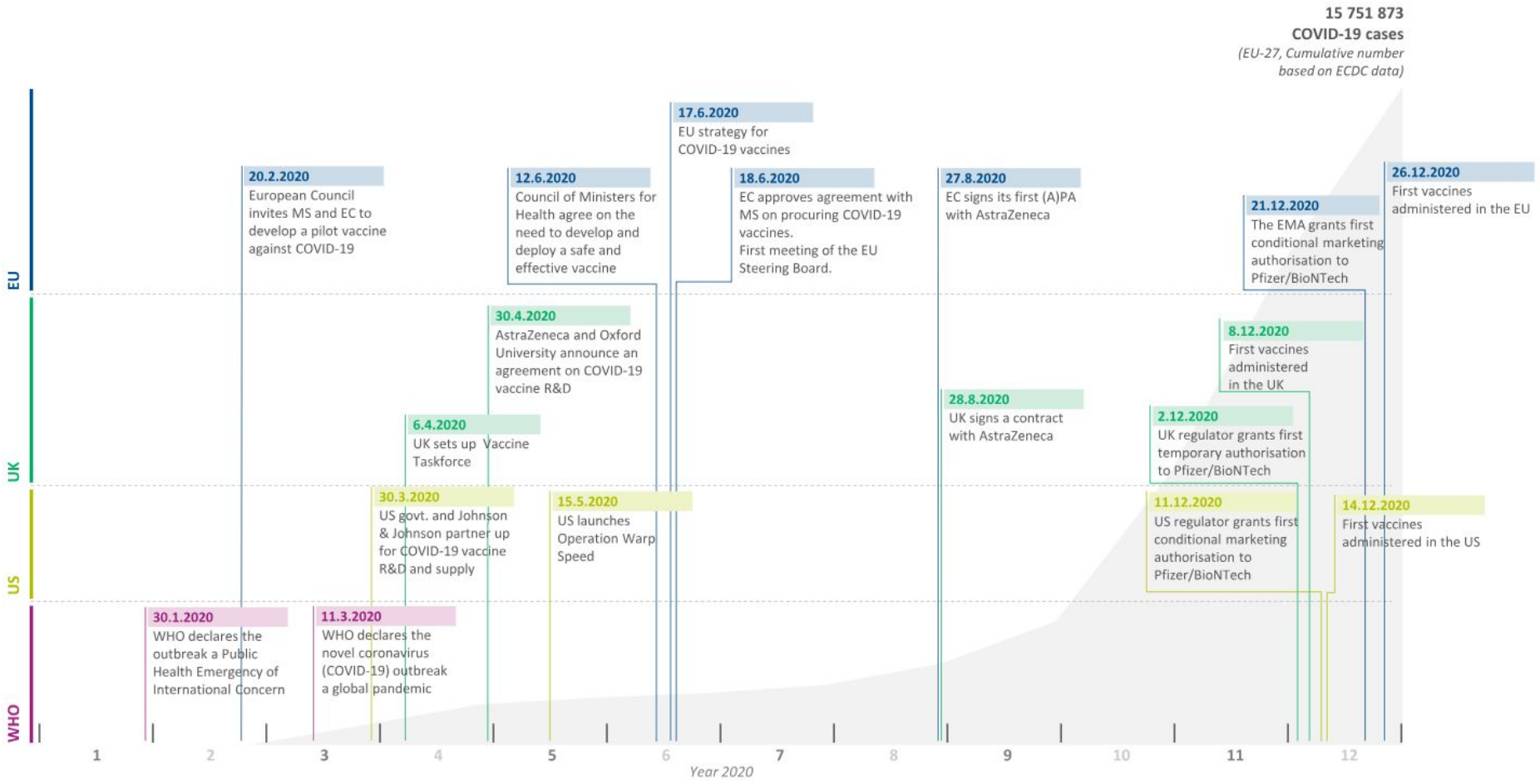
Age-specific rate



Europe is closing borders amid coronavirus outbreak. They may be hard to reopen.

March 17, 2020 at 4:45 p.m. EDT

A line of trucks trying to enter Poland from Briesen, Germany, stretches 25 miles on Tuesday. (Sean Gallup/AFP/Getty Images)



‘The EU noted the importance of vaccine development early on in the pandemic, but started its **procurement process**… later than the UK and USA’ — **European Court of Auditors, 2022**

Cross-border public health powers

- **Communicable disease surveillance** · ECDC (2004) and Health Security Committee (2001) missioned with **monitoring epidemic threats**

  Initial EWRS surveillance network est. 1998, gained importance with anthrax 2001 and SARS 2003 alerts

- **Joint procurement** · since 2013, EU Member States can **collectively buy health goods** like vaccines

  First used 2016 to buy vaccines against pandemic influenza · also used for expensive drugs

Historical background

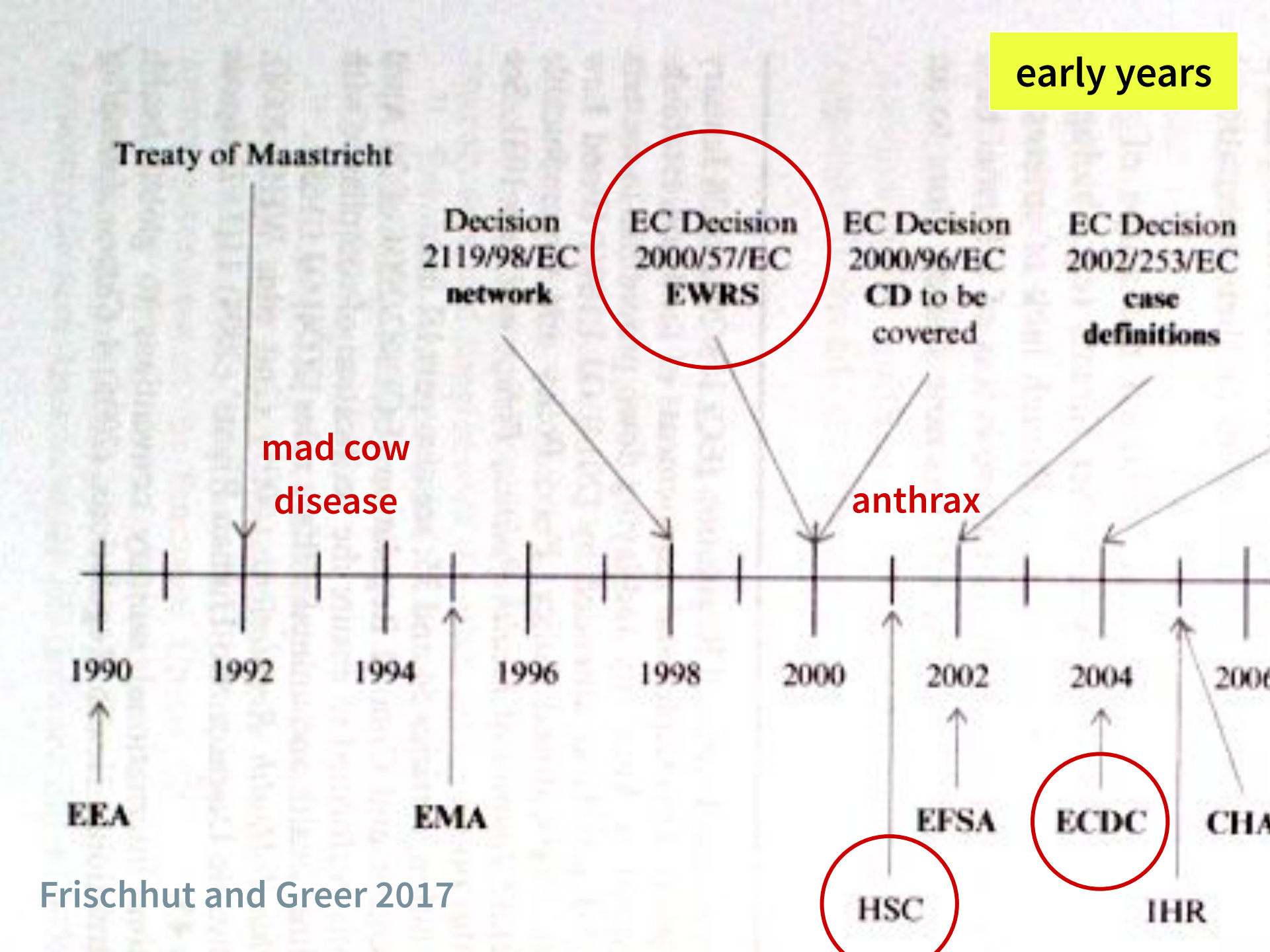
- **Communicable disease crises** · **HIV/AIDS** (mid-80s), **BSE/nvCJD** (peaked in 1993)

  → 'prevention of diseases, in particular major health scourges' in Maastricht Treaty (1992) + EFSA (2002)

- **Revised International Health Regulations** (IHR) in 2005 following **SARS** (2003)

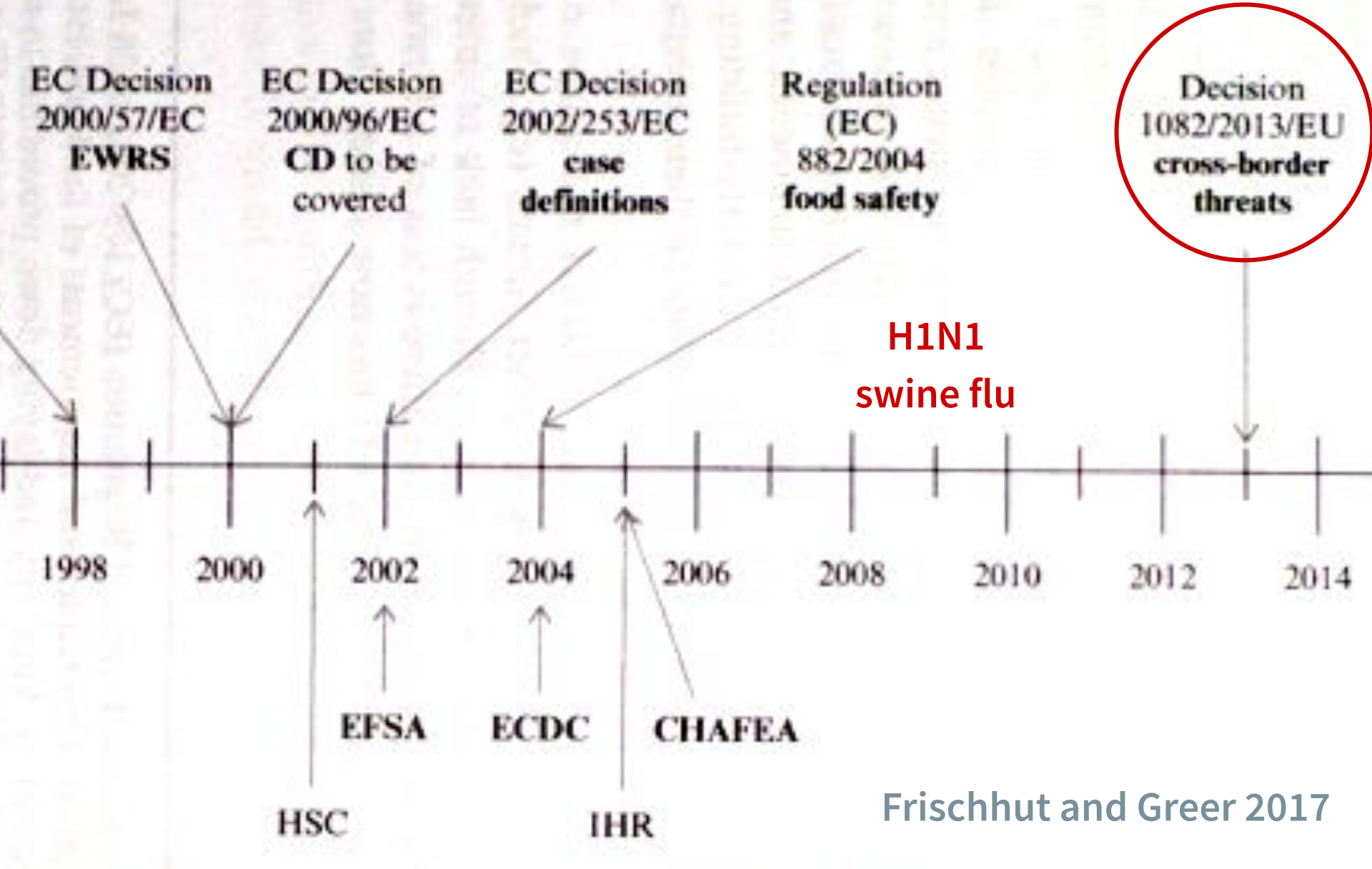
  Other critical/focusing events: **anthrax** (2001), **H5N1** avian flu (2004), **H1N1** swine flu (2009), **Ebola** (2014), **Zika** (2015), and of course **Covid-19** (2020)

early years



Frischhut and Greer 2017

pre-Covid-19



Frischhut and Greer 2017

Major conceptual policy shifts

- **'All-hazards' approach** · animal/human health plus **biosecurity** and **environmental threats**

  e.g. chemical and nuclear accidents

  natural disasters ↔ climate change

- **Precautionary principle** · EU can take action even when scientific evidence for **risk assessment** is inconclusive (contrast to the US)

  e.g. BSE/nvCJD, beef hormones, GMOs

Major pre/post-Covid-19 policy shifts (1)

- **Pre-Covid** · Health Security Committee supported only by a Decision (2013) · ECDC staff-constrained, limited to risk assessment (no operational capacity)
- **Post-Covid** · **Regulation** (≠ Decision) on cross-border threats **as part of** a **'European Health Union'**

  → higher status for Health Security Committe

  → expanded mandates for EMA and ECDC

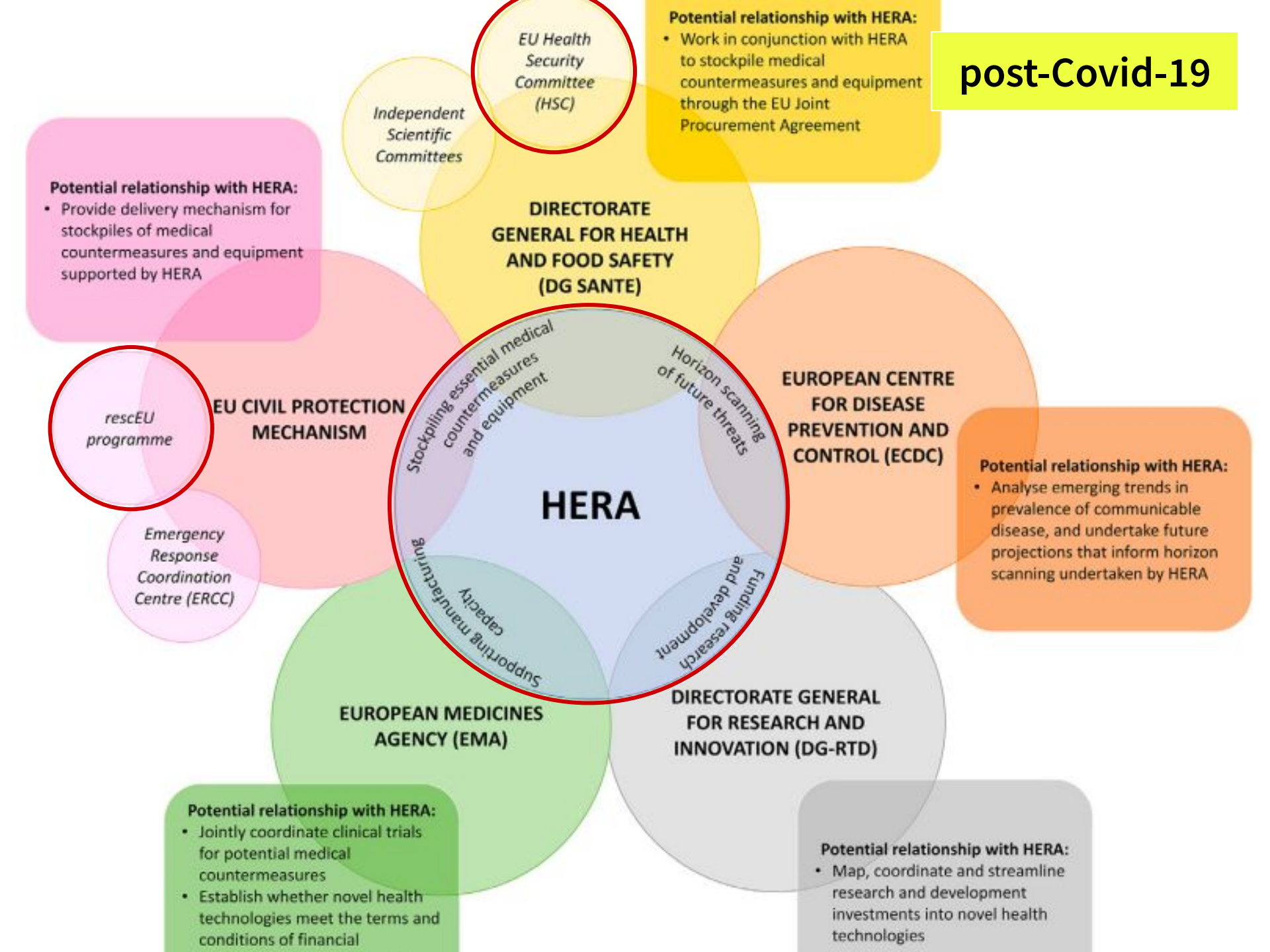
  → explicit means for Commission to declare EU-wide **public health emergencies** (akin to IHR/PHEIC)

Major pre/post-Covid-19 policy shifts (2)

- **HERA** · **Health Emergency Preparedness and Response Authority** with Commission DG status and €1bn/yr budget (on top of rescEU + EU4Health)
- **EU Vaccines Strategy** · includes **distribution rules** on per-capita basis to guarantee **equitable access**

N.B. **Vaccine market authorization** remains possible through either MS agencies or, as more generally observed, through EMA approval (shared competency)

Vaccine use remains MS-controlled · who gets which vaccine and when is *not* harmonized (MS prerogative)


post-Covid-19
EU Health Security Committee (HSC)
Independent Scientific Committees
Potential relationship with HERA:
• Work in conjunction with HERA to stockpile medical countermeasures and equipment through the EU Joint Procurement Agreement
Potential relationship with HERA:
• Provide delivery mechanism for stockpiles of medical countermeasures and equipment supported by HERA
DIRECTORATE GENERAL FOR HEALTH AND FOOD SAFETY (DG SANTE)
rescEU programme
EU CIVIL PROTECTION MECHANISM
Emergency Response Coordination Centre (ERCC)
Stockpiling essential medical countermeasures and equipment
Horizon scanning of future threats
HERA
Supporting manufacturing capacity
Funding research and development
EUROPEAN CENTRE FOR DISEASE PREVENTION AND CONTROL (ECDC)
Potential relationship with HERA:
• Analyse emerging trends in prevalence of communicable disease, and undertake future projections that inform horizon scanning undertaken by HERA
EUROPEAN MEDICINES AGENCY (EMA)
DIRECTORATE GENERAL FOR RESEARCH AND INNOVATION (DG-RTD)
Potential relationship with HERA:
• Jointly coordinate clinical trials for potential medical countermeasures
• Establish whether novel health technologies meet the terms and conditions of financial
Potential relationship with HERA:
• Map, coordinate and streamline research and development investments into novel health technologies

Related legal issues

- **Vaccination** · no clear CJEU decision on whether EU citizens have a **right to be treated**
- **Restrictions in freedom of movement** · reliant on **WHO instruments** (IHR/PHEIC) until today

  → untested effectiveness of Regulation 2022/2371
- **Liability for harm** · non-contractual liability of EU institutions → **claims to compensation** of damages fall to Members States


QUESTIONS?


10’ BREAK

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Nutrition in Europe and EU Food Policy

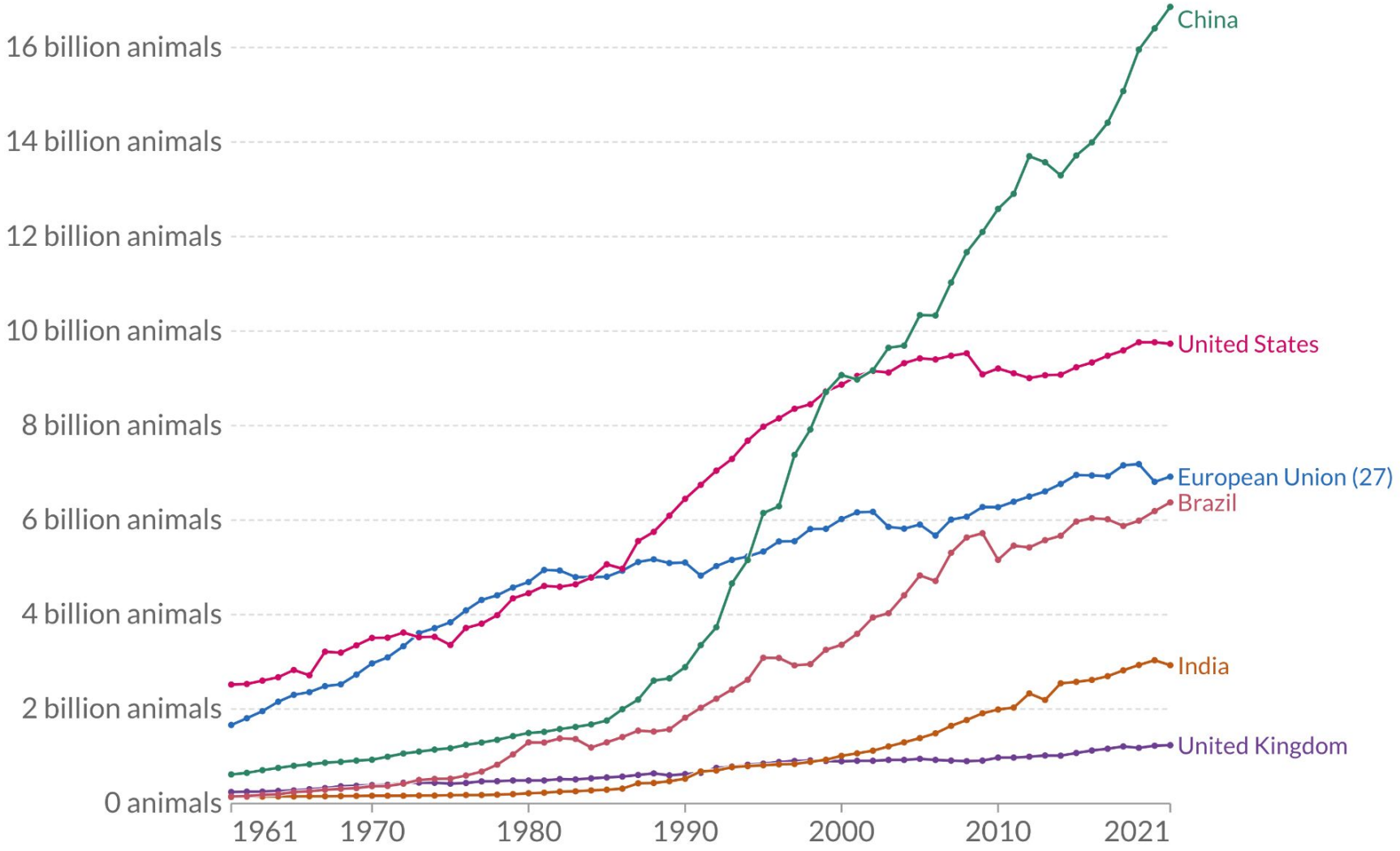
EU Health Policy

Lecture 6

Number of land animals slaughtered for meat per year, 1961 to 2021

This data is based on the country of production, not consumption.

Our World in Data

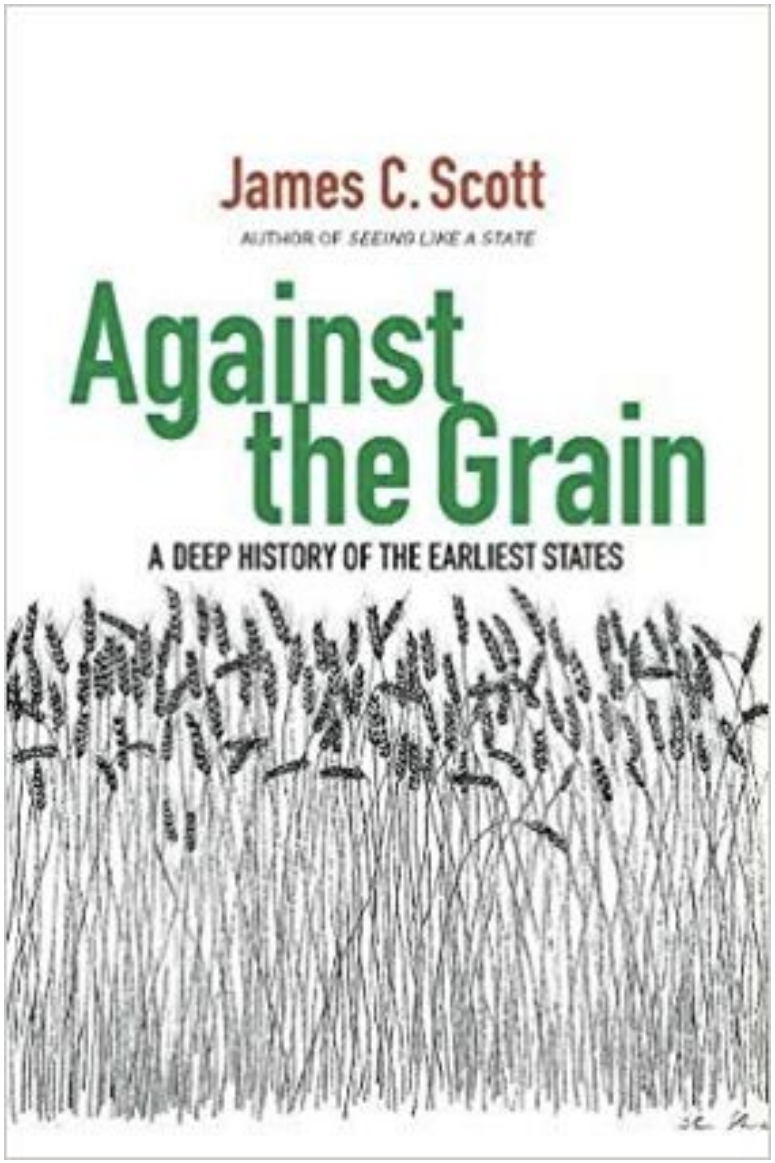


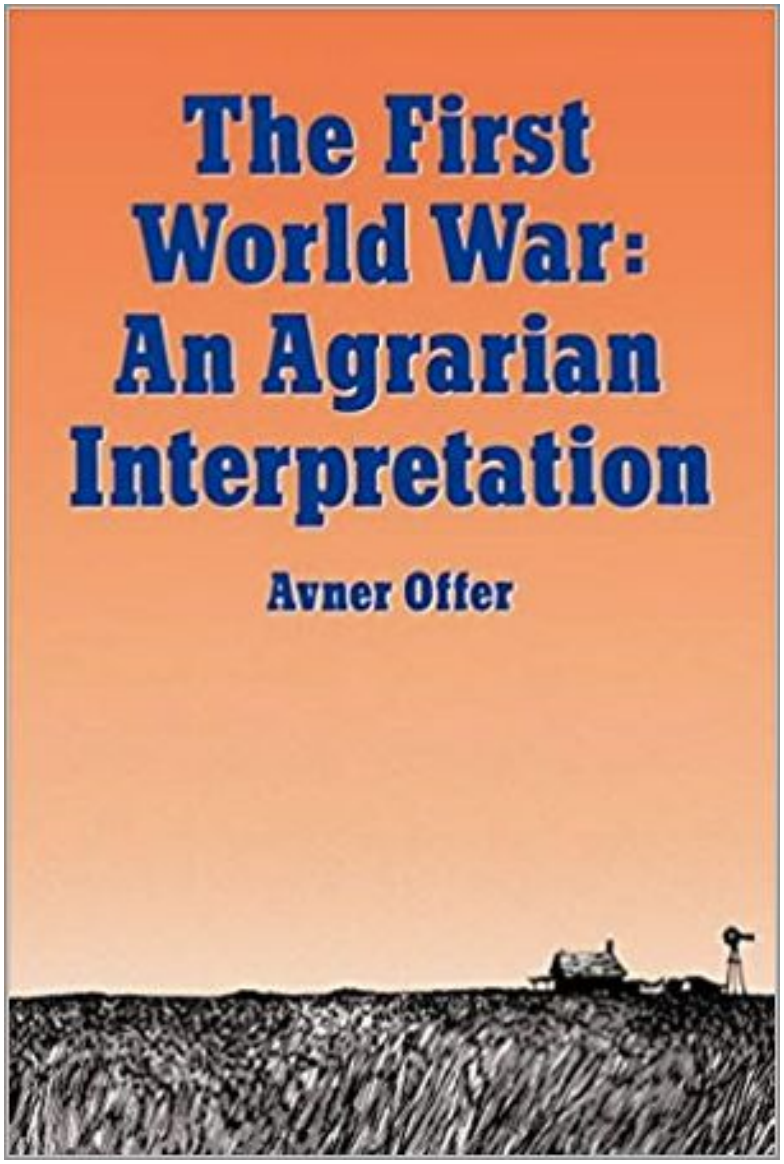
Source: Food and Agriculture Organization of the United Nations

Connections to health policy

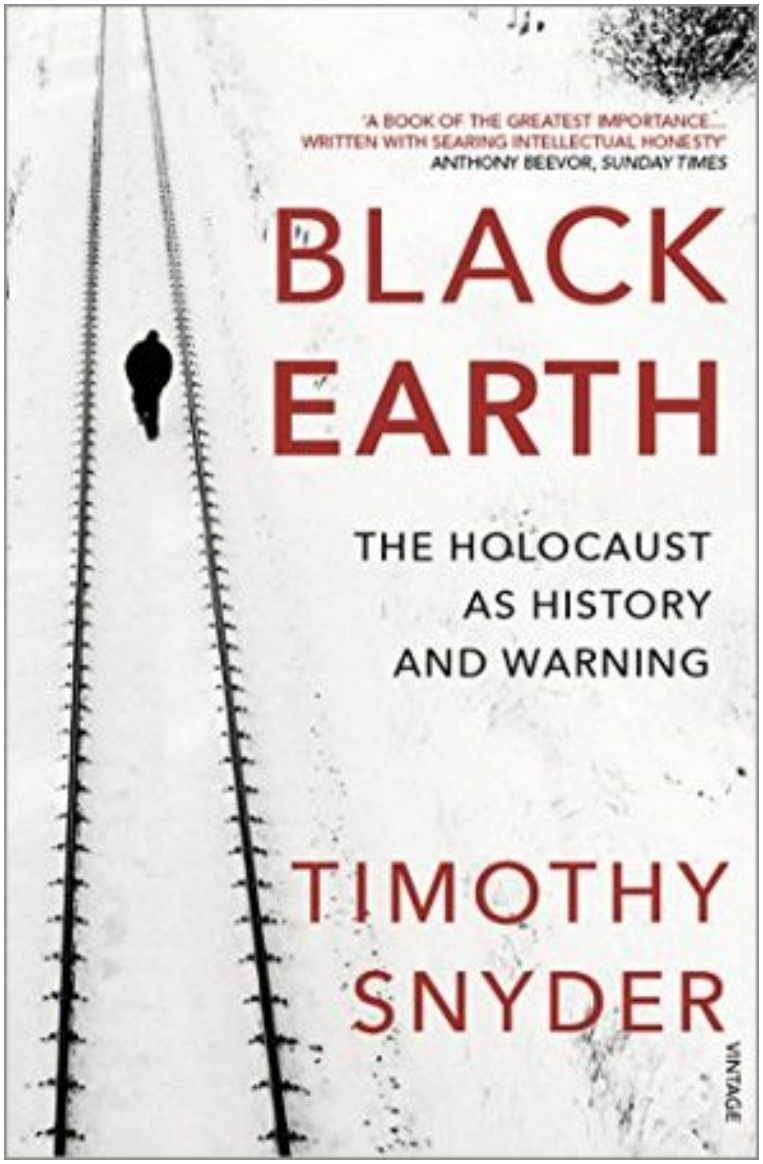
- **Common human diseases** have **dietary risk factors** (e.g. heart disease, cancer, dental health)
- **Animal disease forms** · **zoonotic diseases** (bacteria, viruses, prions) 'jump' to human hosts as a consequence of promiscuity
- **Animal health as a concern in itself** · EU action covers **animal health and welfare** (and plant health)

Historical landmarks


James C. Scott
AUTHOR OF SEEING LIKE A STATE
Against the Grain
A DEEP HISTORY OF THE EARLIEST STATES



'… Germany like Britain had to make sure that it could be supplied with food and raw materials which implied also a buildup of a navy and **stronger control over the agricultural neighbors who produced food**, mostly in the East (Russia or what is today the Ukraine), and in the Balkans…'



'… (You can see there, if you wish, the seeds of the **food driven *Lebensraum* doctrine**, a point recently made by Timothy Snyder.)'

(Branko Milanović)

On Snyder's book/argument, see **Richard Evans' review**

Holodomor famine in Ukraine, 1932-33

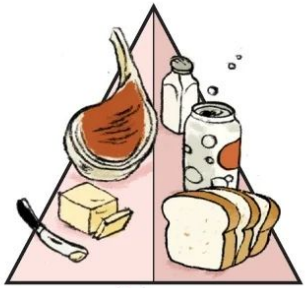
Historical landmarks

- **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**

USE SPARINGLY:
RED MEAT & BUTTER
REFINED GRAINS: WHITE BREAD, RICE & PASTA
SUGARY DRINKS & SWEETS
SALT

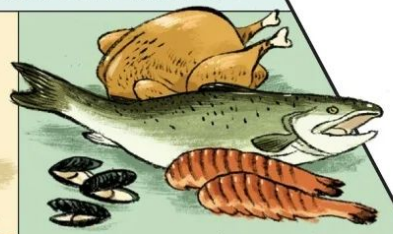
OPTIONAL: ALCOHOL IN MODERATION
(Not for everyone)

DAILY MULTIVITAMIN
PLUS EXTRA VITAMIN D
(For most people)



DAIRY (1–2 servings a day) OR
VITAMIN D/CALCIUM SUPPLEMENTS

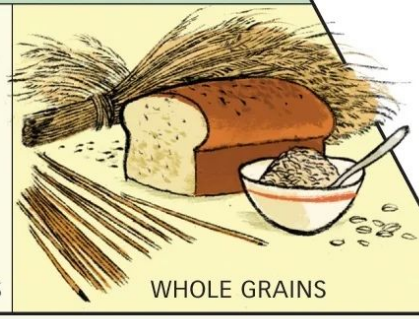
NUTS, SEEDS, BEANS & TOFU



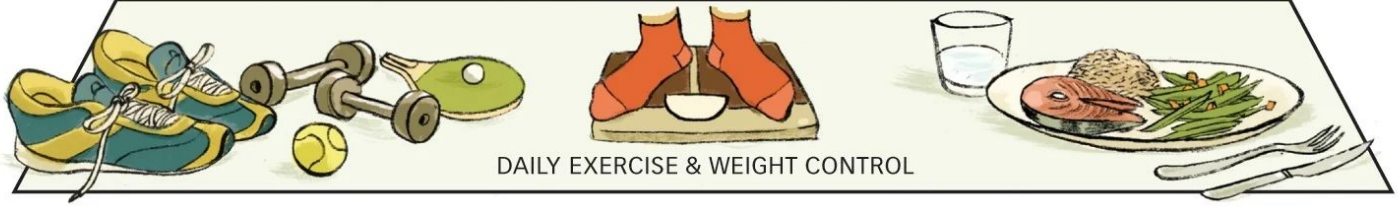
FISH, POULTRY & EGGS

VEGETABLES & FRUITS

HEALTHY FATS/OILS



WHOLE GRAINS



DAILY EXERCISE & WEIGHT CONTROL

HEALTHY FATS/OILS:
OLIVE, CANOLA, SOY, CORN,
SUNFLOWER, PEANUT
& OTHER VEGETABLE OILS;
TRANS-FREE MARGARINE

WHOLE GRAINS:
BROWN RICE,
WHOLE WHEAT PASTA,
OATS, ETC.

Contemporary policies

Fig. 2. Lost years of healthy life in the European Region, 2000

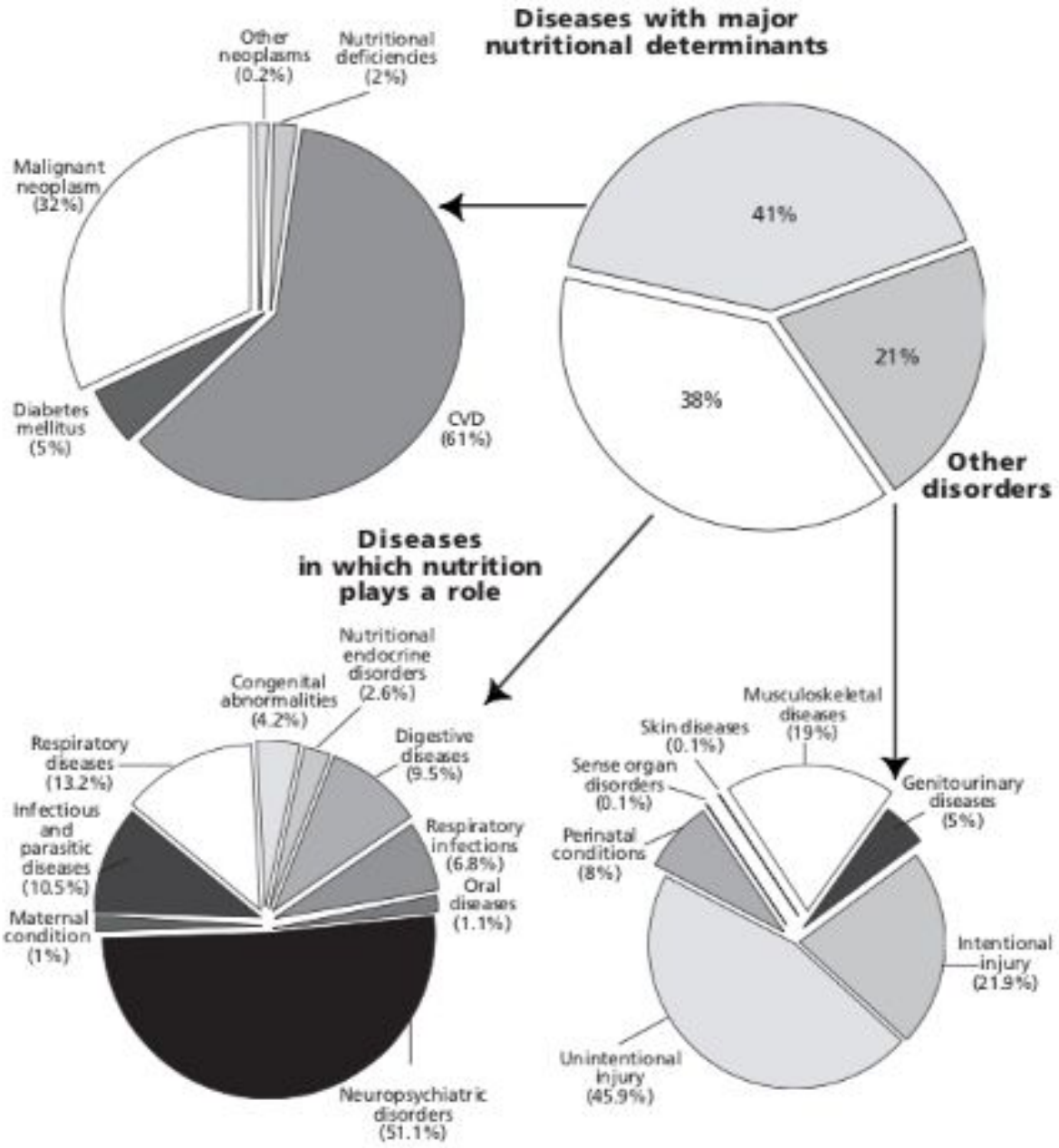
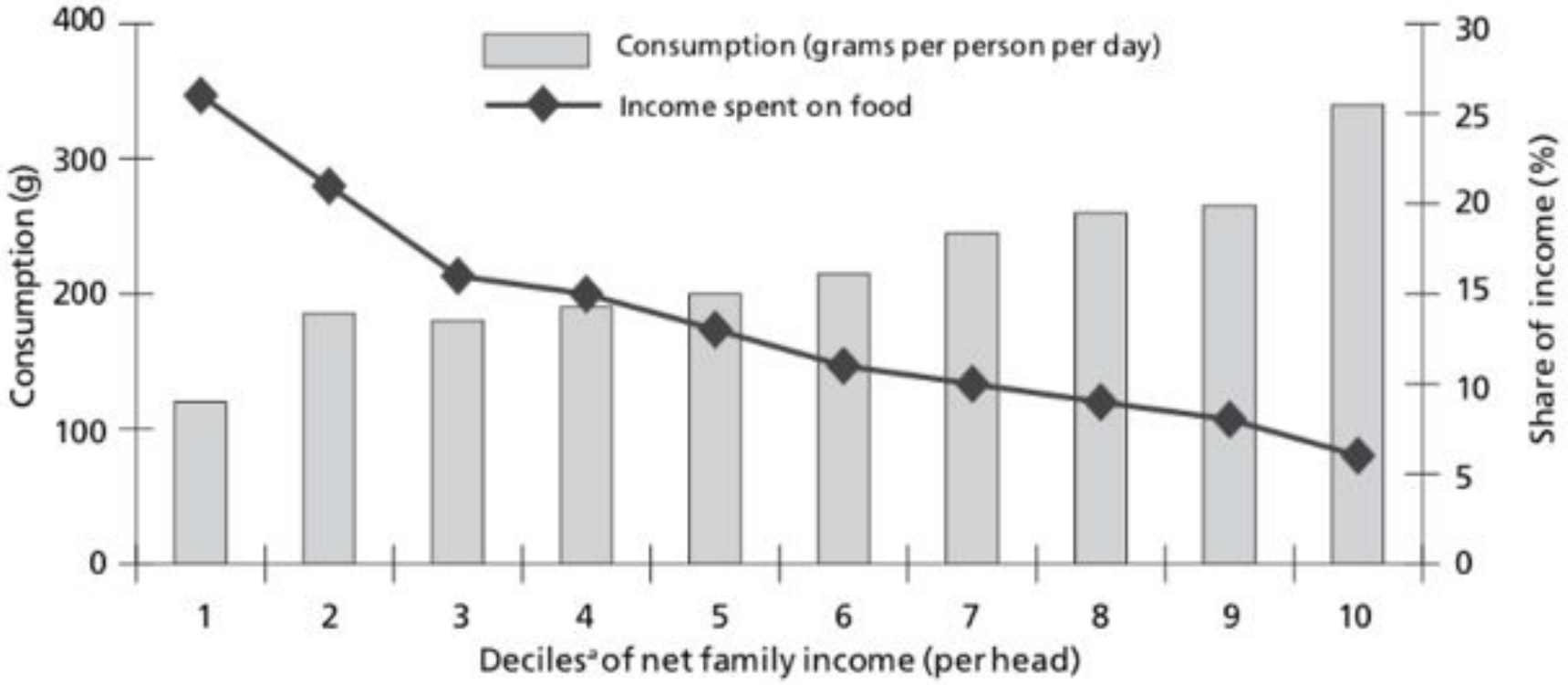
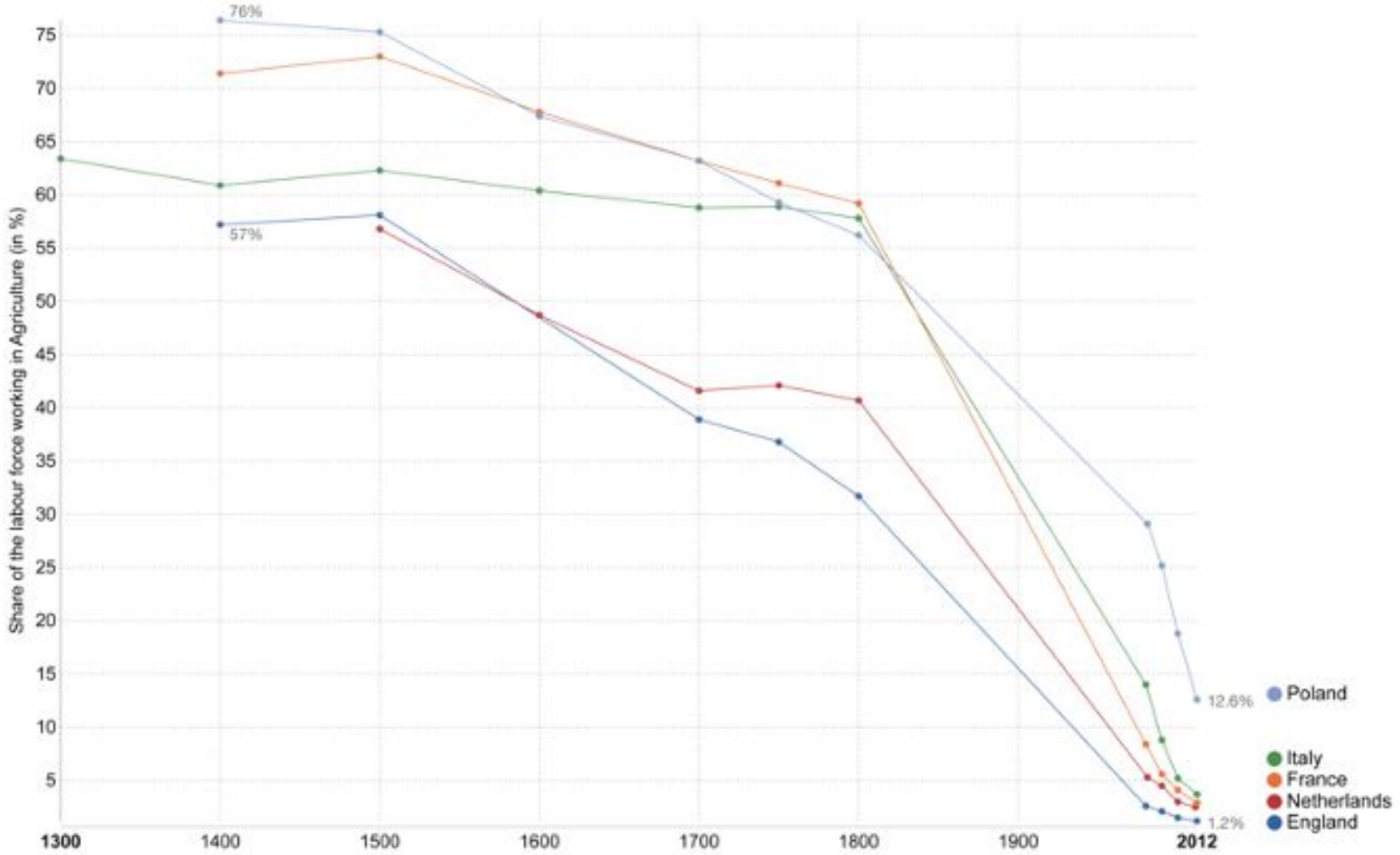


Fig. 3. Relationship of income to consumption of fresh fruit and vegetables and the share of income spent on food



[a] 1 = lowest incomes; 10 = highest incomes.

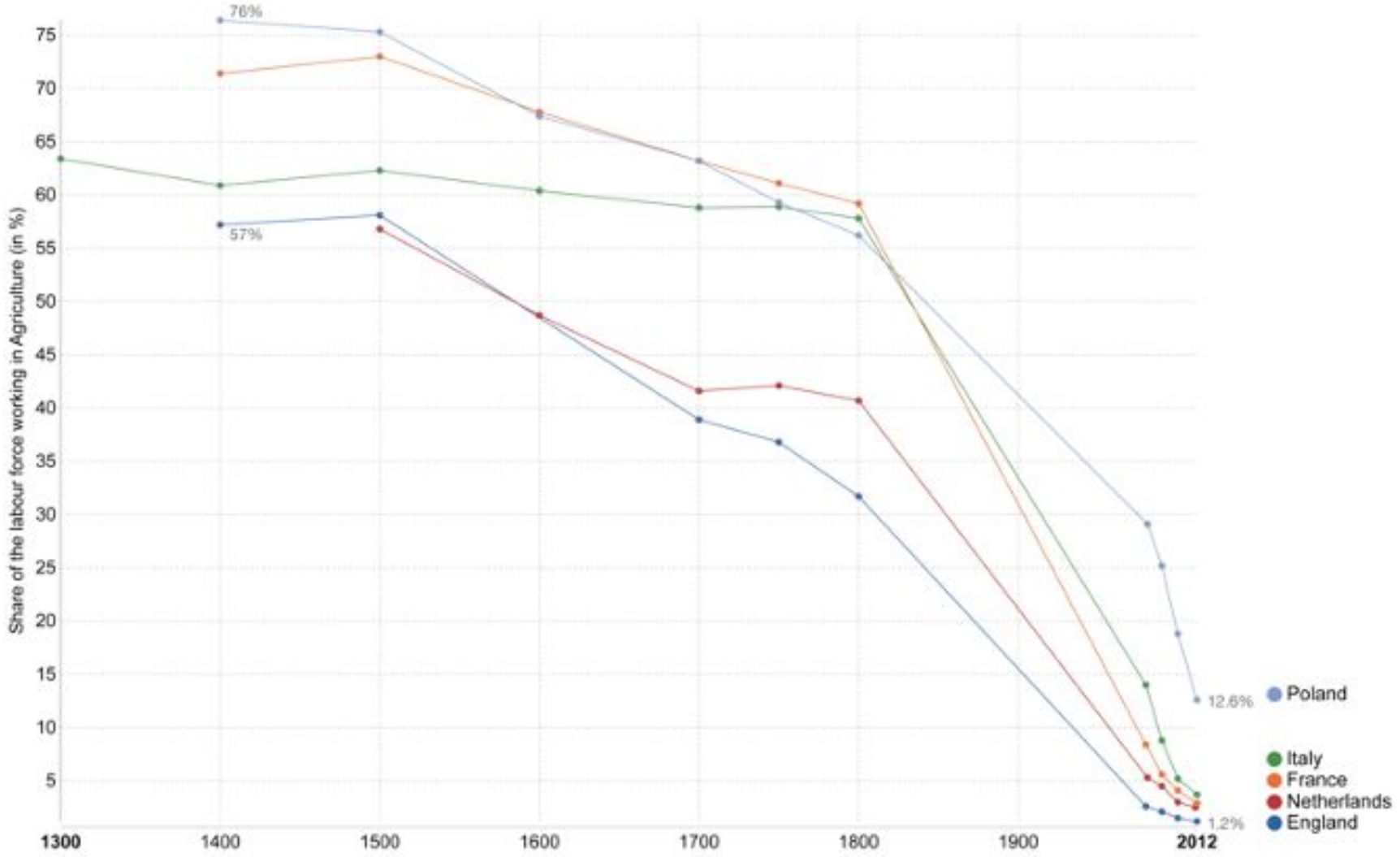
Our World in Data



Data source: Pre 1800 is from Allen (2000), "Economic Structure and Agricultural Productivity in Europe, 1300-1800". Newer data from the World Bank.
The interactive data visualization is available at OurWorldinData.org. There you find the raw data and more visualizations on this topic.

Our World in Data

Share of the labor force working in agriculture, since 1300 – By Max Roser



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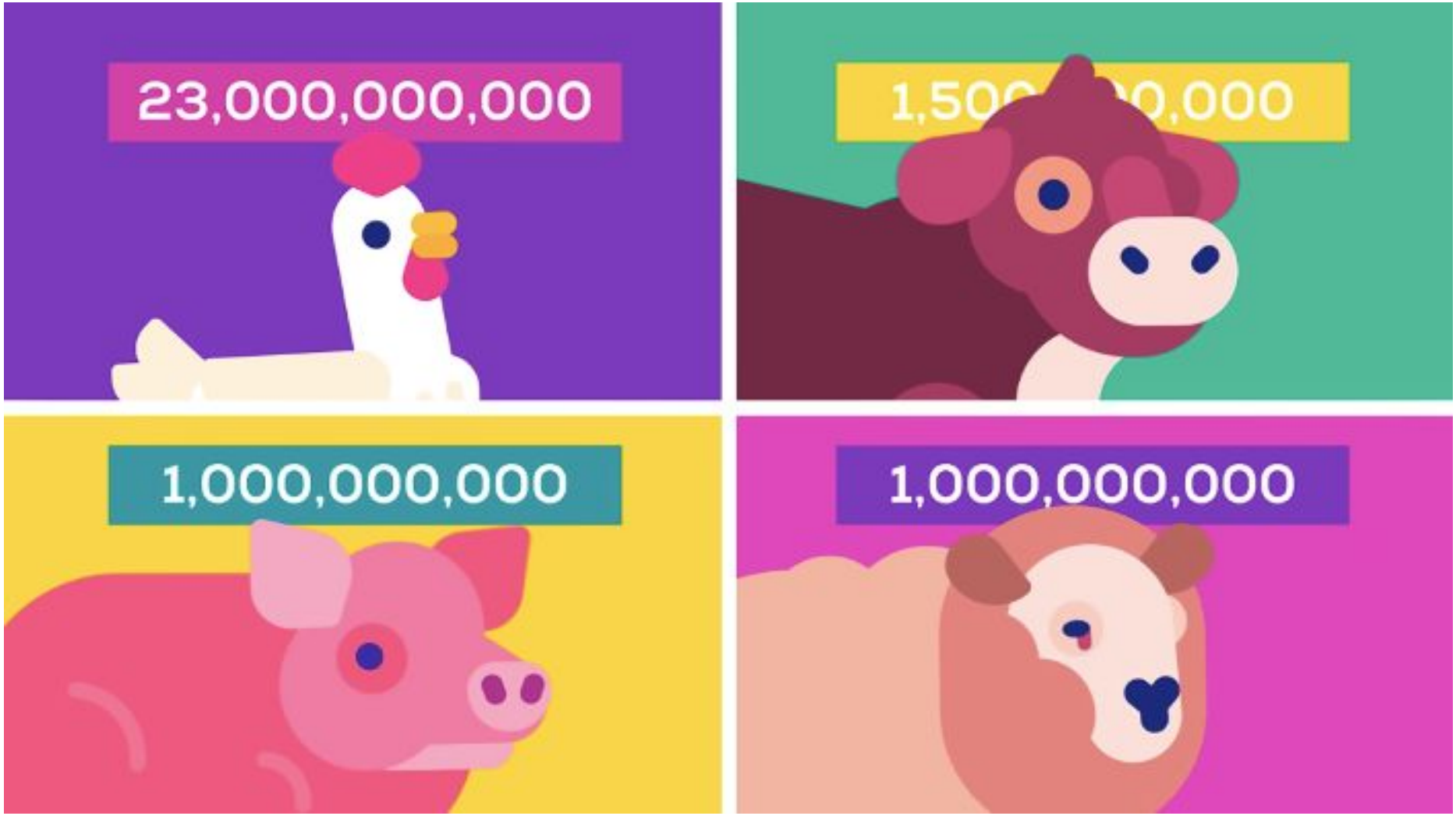
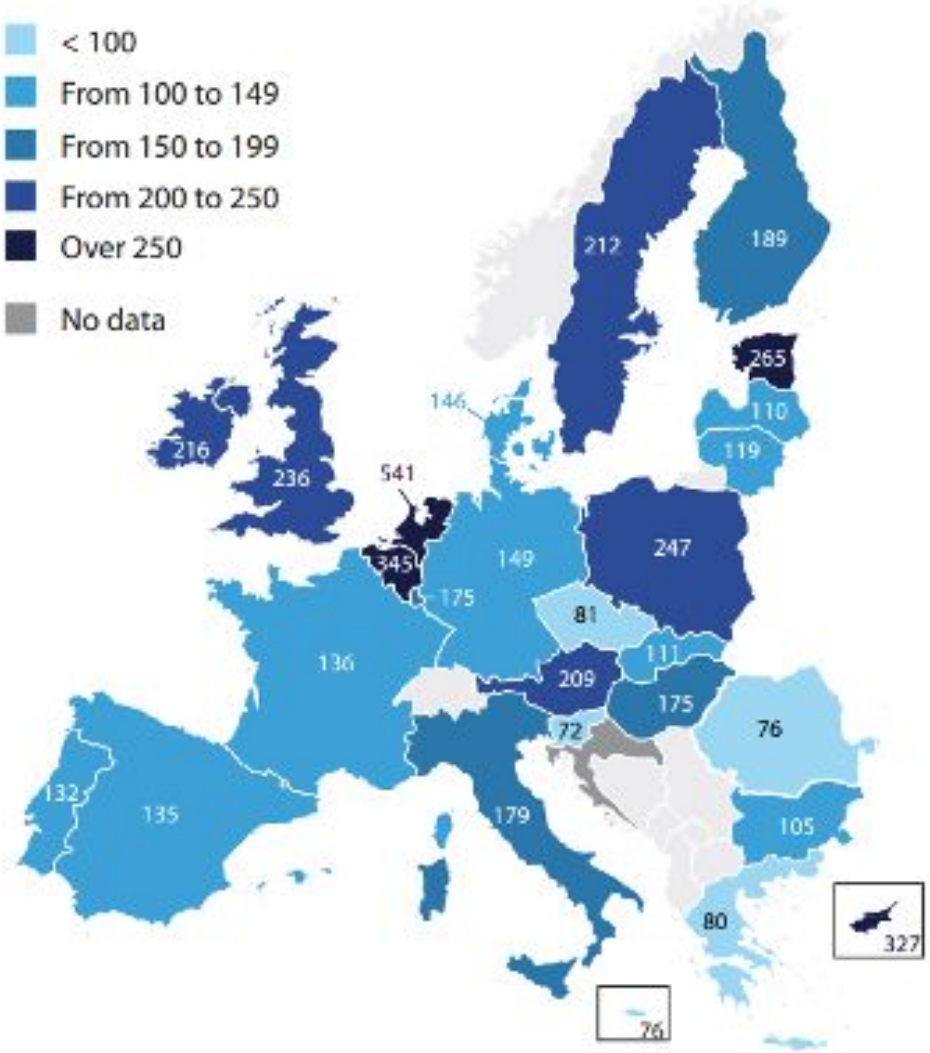
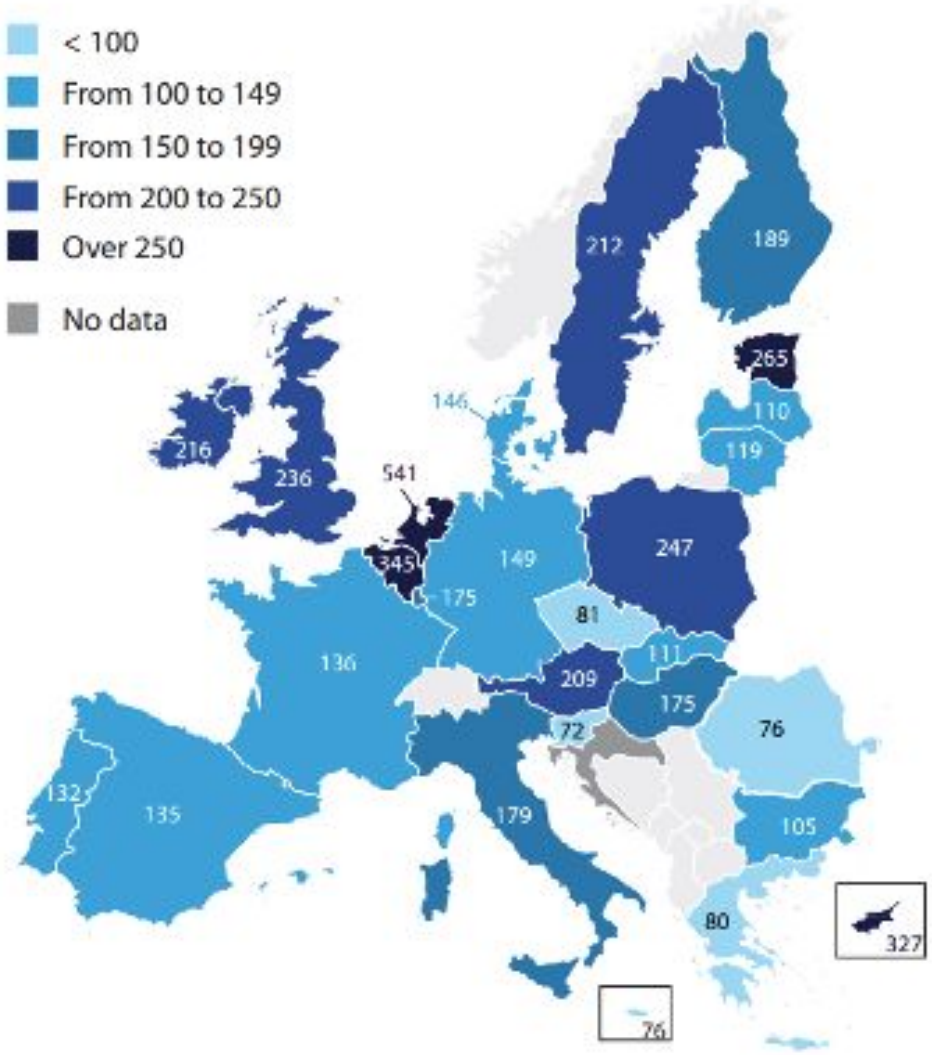

23,000,000,000
1,500,000,000
1,000,000,000
1,000,000,000

Which EU regions had the highest harvested production of cereals?

(million tonnes, 2019 data)
Germany: NUTS level 1


< 100
From 100 to 149
From 150 to 199
From 200 to 250
Over 250
No data
212
189
265
146
110
119
216
236
541
247
345
149
175
81
111
136
209
175
76
72
132
135
179
105
80
327
76

Estimated total food waste in the EU, 2010 (kg per capita)



Data source: Technology options for feeding 10 billion people, STOA 2013.

Contemporary policies

- **Large scientific 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')

Regulatory targets

- **Contaminants** (e.g. toxins)
- **Improvement agents**, including additives, processing aids, flavourings (e.g. aspartame)
- **Supplements**, including vitamins and 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** · reaching **dietary targets** *vs.* limiting alcohol, salt and sugar consumption patterns
- **Food safety** · **trade vs. (consumer) safety** (e.g. trans fatty acids), as with communicable disease control
- **Sustainable agriculture** · **CAP rent** (focus on productivity and low prices) *vs.* organic farming and plant-based foods


Iceland
Finland
Russia
Sweden
Norway
Estonia
Latvia
Lithuania
Denmark
Kazakhstan
Ireland
United Kingdom
Russia
Belarus
Netherlands
Poland
Germany
Ukraine
Belgium
Lux.
Czech Rep.
Slovakia
Moldova
France
Austria
Hungary
Georgia
Azerbaijan
Armenia
Romania
Croatia
Serbia
Bosnia Herz.
Bulgaria
Italy
Spain
Portugal
Albania
Turkey
Greece
Cyprus

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

Journal of Public Health Policy
June 2019, Volume 40, Issue 2, pp 147–165 | Cite as

Multilevel governance, public health and the regulation of food: is tobacco control policy a model?

Authors | Authors and affiliations

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Original Article
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QUESTIONS?


10’ BREAK

ESPOL
EUROPEAN SCHOOL OF POLITICAL AND SOCIAL SCIENCES

Tobacco Control and Lobbying in the EU

EU Health Policy

Lecture 7


Iceland
Finland
Russia
Sweden
Norway
Estonia
Latvia
Lithuania
Denmark
Kazakhstan
Ireland
United Kingdom
Russia
Belarus
Netherlands
Poland
Germany
Ukraine
Belgium
Lux.
Czech Rep.
Slovakia
Moldova
France
Austria
Hungary
Georgia
Azerbaijan
Armenia
Romania
Croatia
Serbia
Bosnia Herz.
Bulgaria
Italy
Spain
Portugal
Albania
Turkey
Greece
Cyprus

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

e 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

Labelling

Minimum retail prices

Selling hours

Minimum age

Advertising restrictions

Taxation

~~Prohibition~~


~~Prohibition~~
Labelling
Minimum retail prices
~~Selling hours~~
Minimum age
Advertising restrictions
Taxation
SMOKING CAUSES MOUTH CANCER
SMOKING CAUSES LUNG CANCER
SMOKING CAUSES BLINDNESS
WARNING
Brand
Variant

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

Product	Nicotine content
Cigarettes	1.1mg to 1.8mg per cigarette (22mg to 36mg/pack)
Cigars	13.3mg average
Mini-cigars (i.e. 'Swishers or Dark Horse)	3.8mg per mini-cigar = 76mg/pack
Pipe	5.2mg average per bowl
Chewing/dipping can (i.e. Skoal, Copenhagen)	88mg per can of dip/chew
Loose leaf pouch (i.e. Redman)	144mg per pouch
Hookah (water pipe)	One 45-60 minute session = approximately one pack of cigarettes in nicotine and tar content
Bidi's (hand rolled cigarettes imported from India)	One bidi contains 3 to 5 times as much nicotine as a regular cigarette
Kretek (Clove cigarette)	Little research available. Increased risk of acute lung injury, especially with asthma or respiratory infections.

***Highly* addictive substance**

Other products containing alkaloids: caffeine, cocaine

Used in smoking cessation treatments (NRT) to relieve withdrawal symptoms

Also present in recent smoking products, e.g. **'electronic cigarettes'**

Arrows indicate some (but not all) of the pathways by which these causes interact.

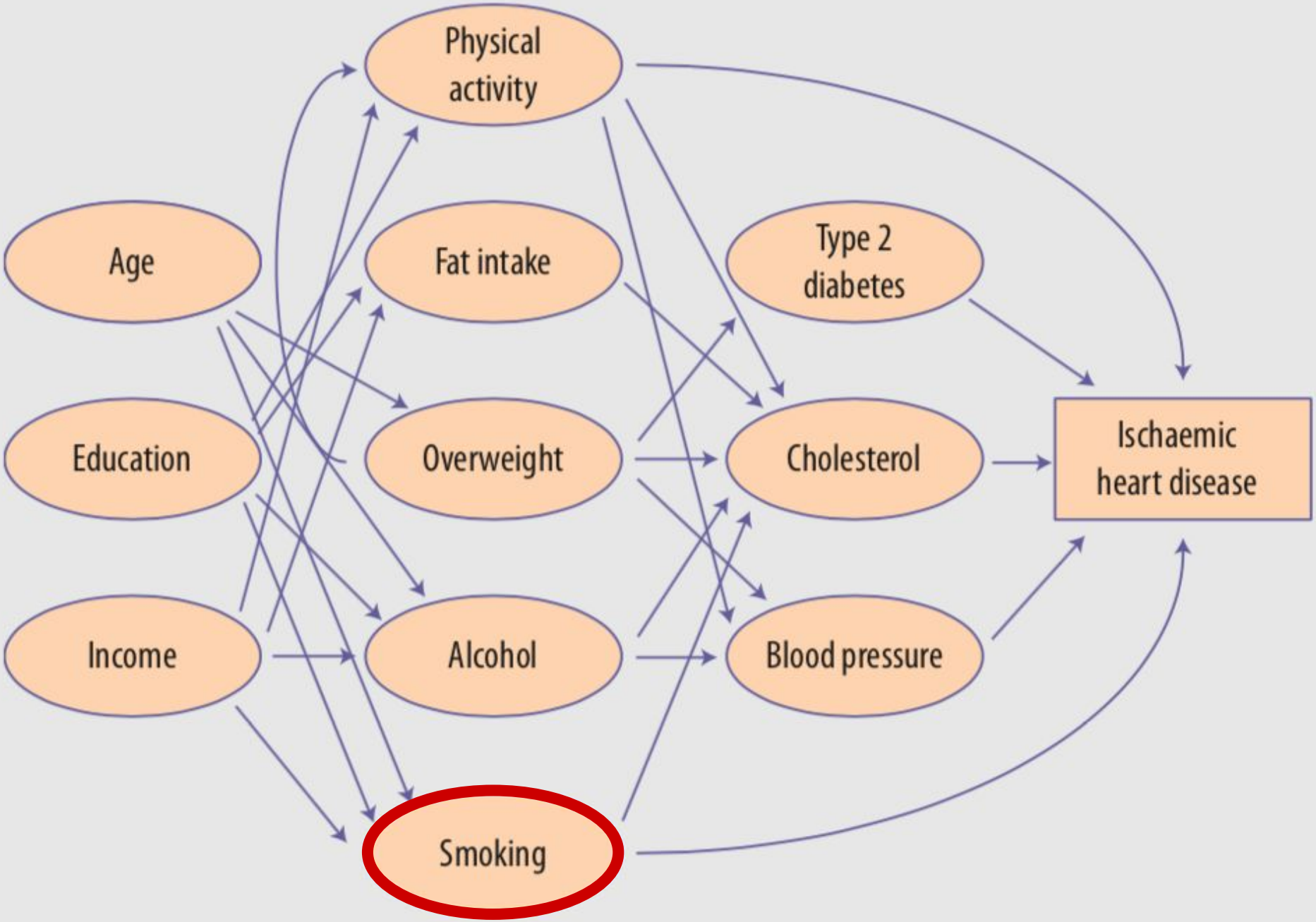
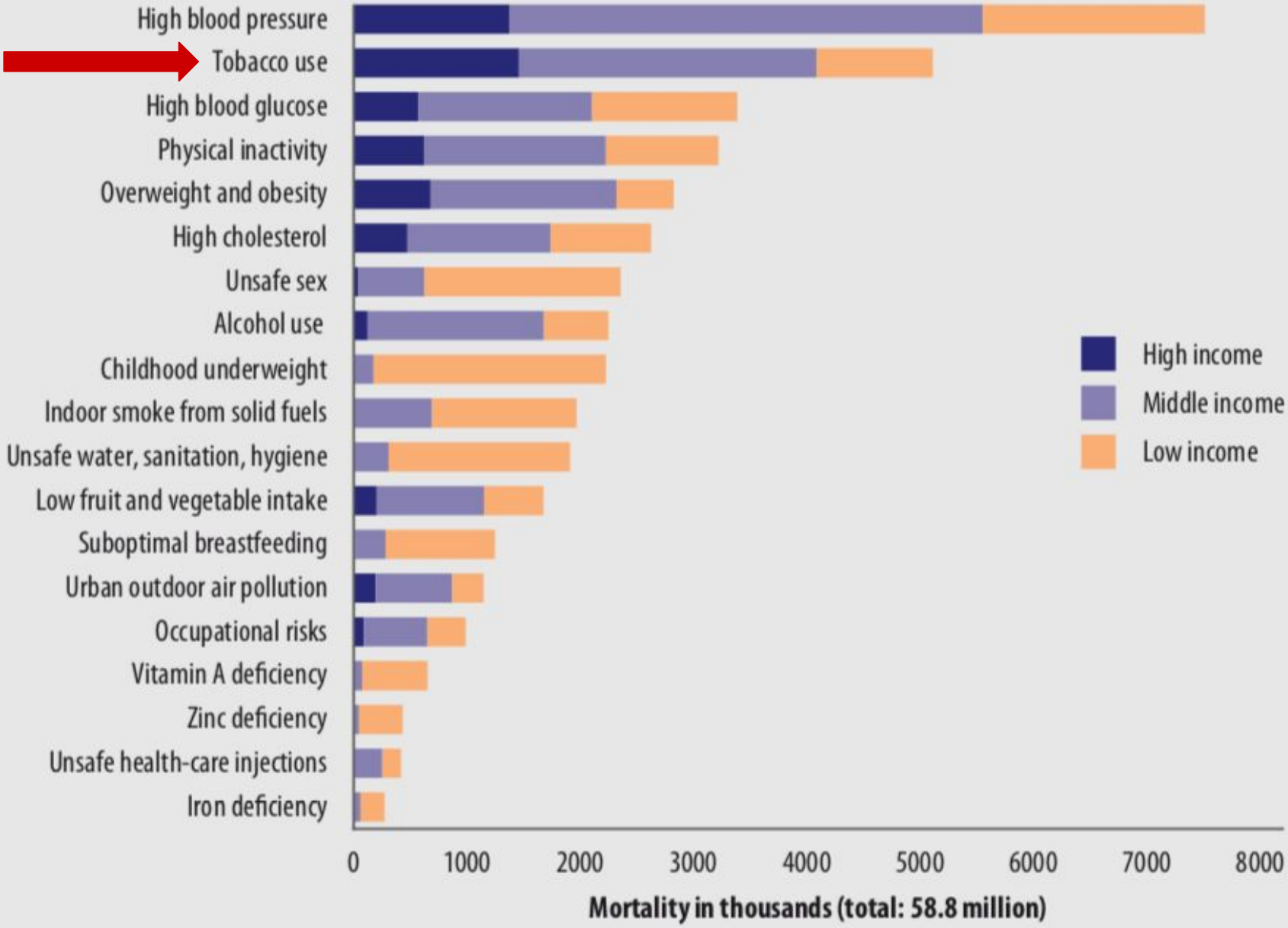
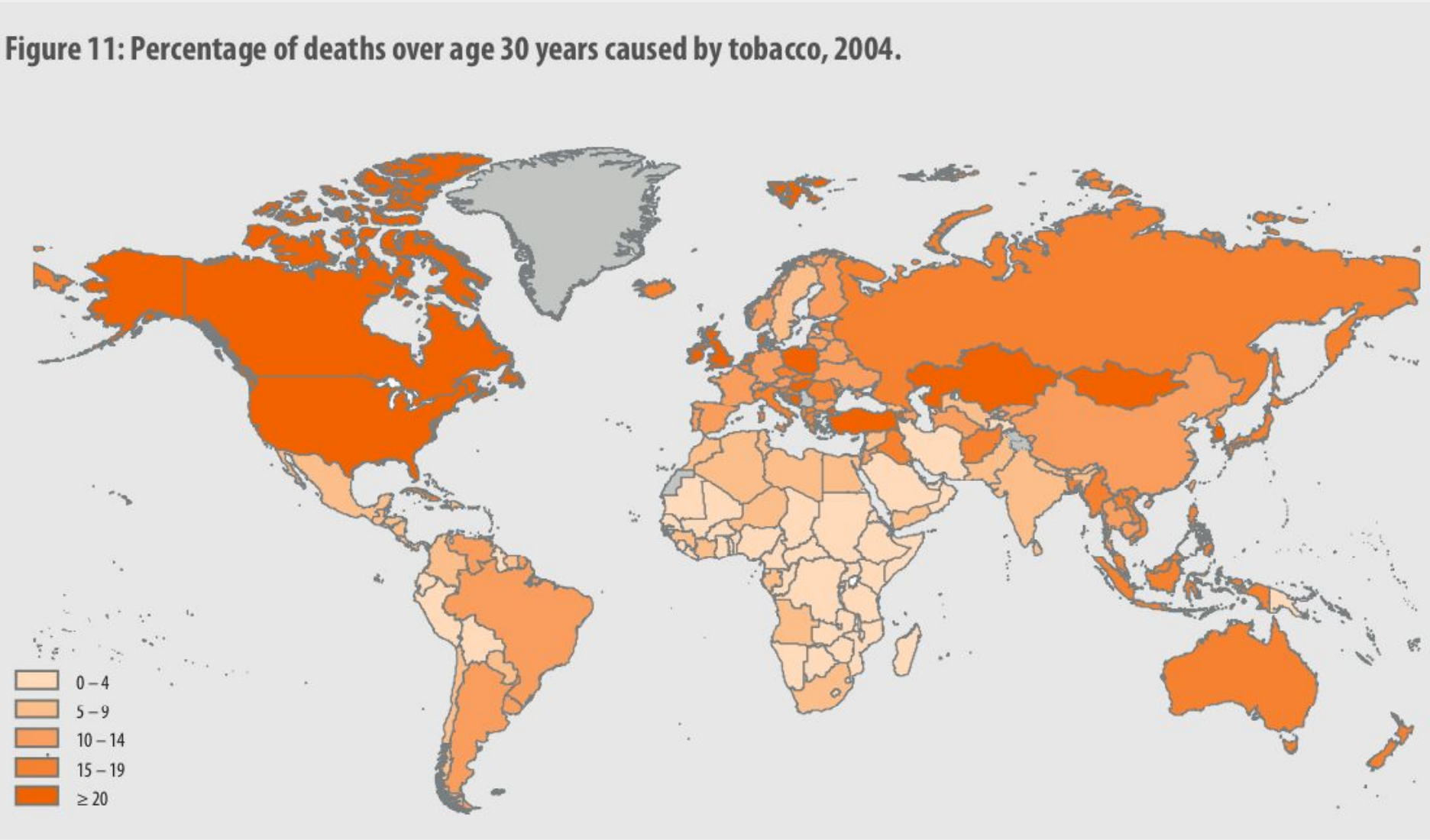


Figure 6: Deaths attributed to 19 leading risk factors, by country income level, 2004.

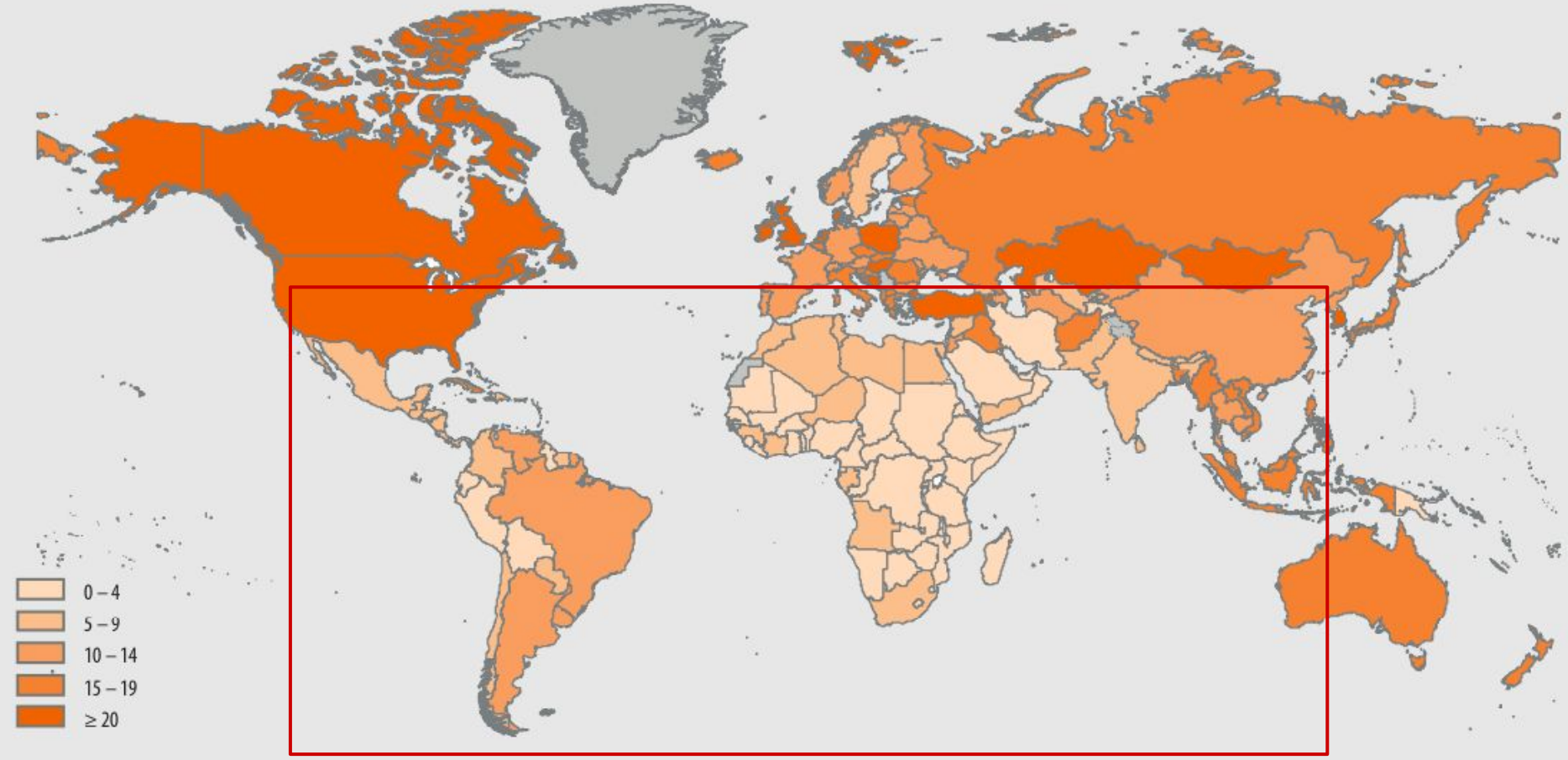


100 million deaths in 20th century, **1 billion deaths** in 21st



(2013 estimates)

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



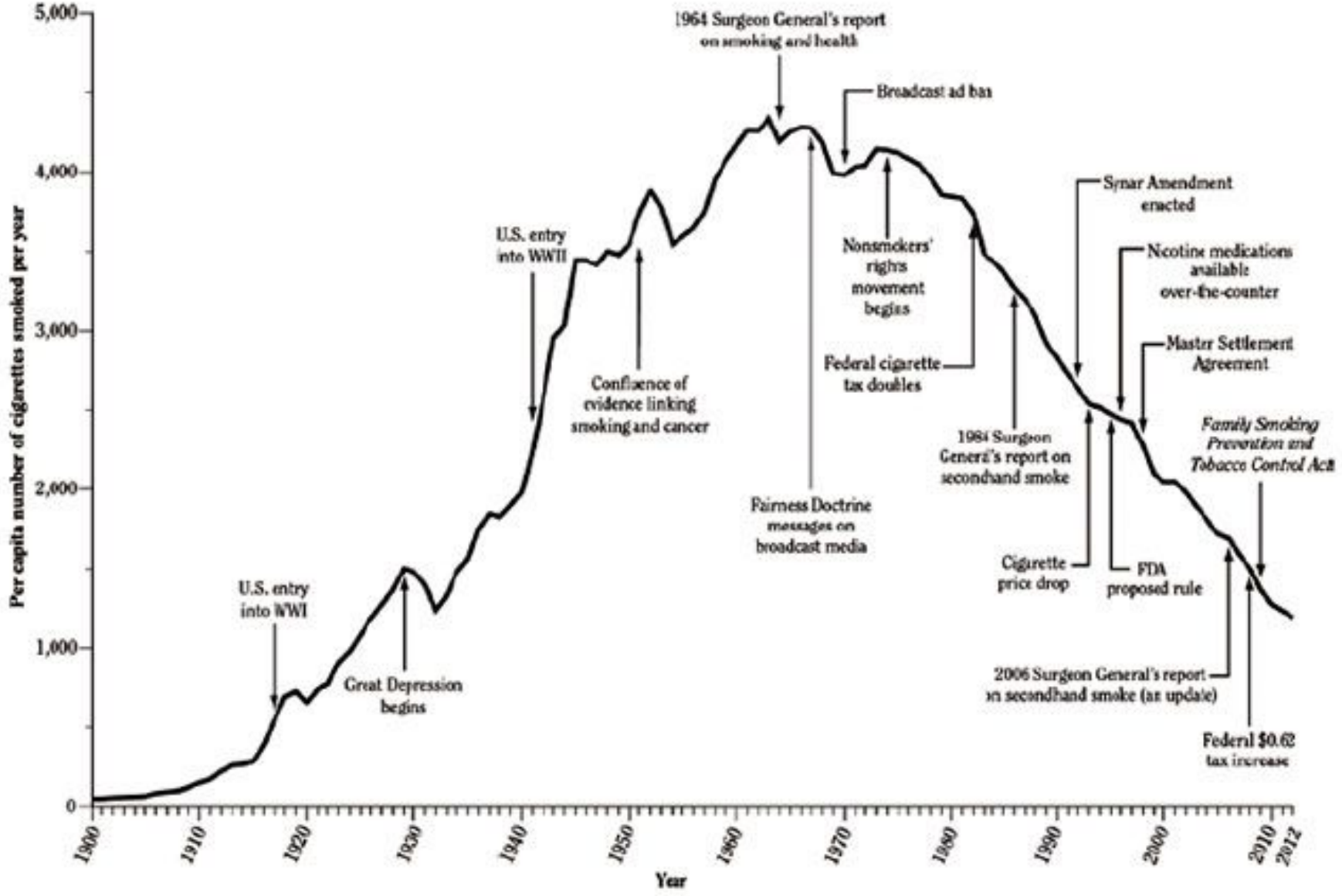
‘emerging markets’ for transnational tobacco industry

Aspects of the issue

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

  Evidence of harm (1950s), incl. secondhand (1970s)
- **Change of position** at 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

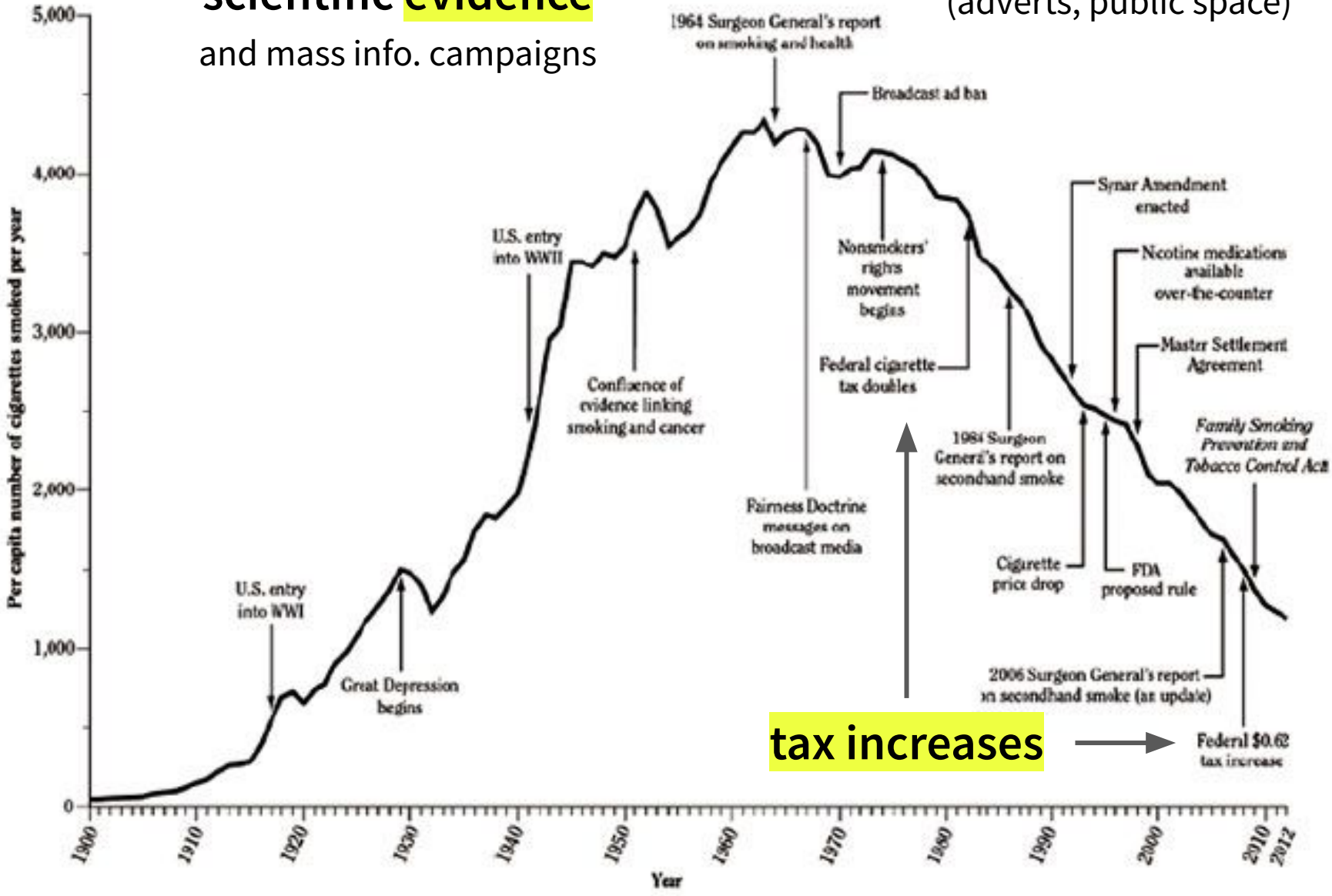

Per capita number of cigarettes smoked per year
5,000
4,000
3,000
2,000
1,000
0
1900
1910
1920
1930
1940
1950
1960
1970
1980
1990
2000
2010
2012
Year
1964 Surgeon General's report on smoking and health
Broadcast ad ban
Synar Amendment enacted
Nicotine medications available over-the-counter
Master Settlement Agreement
Family Smoking Prevention and Tobacco Control Act
U.S. entry into WWII
Confluence of evidence linking smoking and cancer
Nonsmokers' rights movement begins
Federal cigarette tax doubles
1984 Surgeon General's report on secondhand smoke
Fairness Doctrine messages on broadcast media
Cigarette price drop
FDA proposed rule
2006 Surgeon General's report on secondhand smoke (an update)
Federal $0.62 tax increase
U.S. entry into WWI
Great Depression begins

scientific evidence

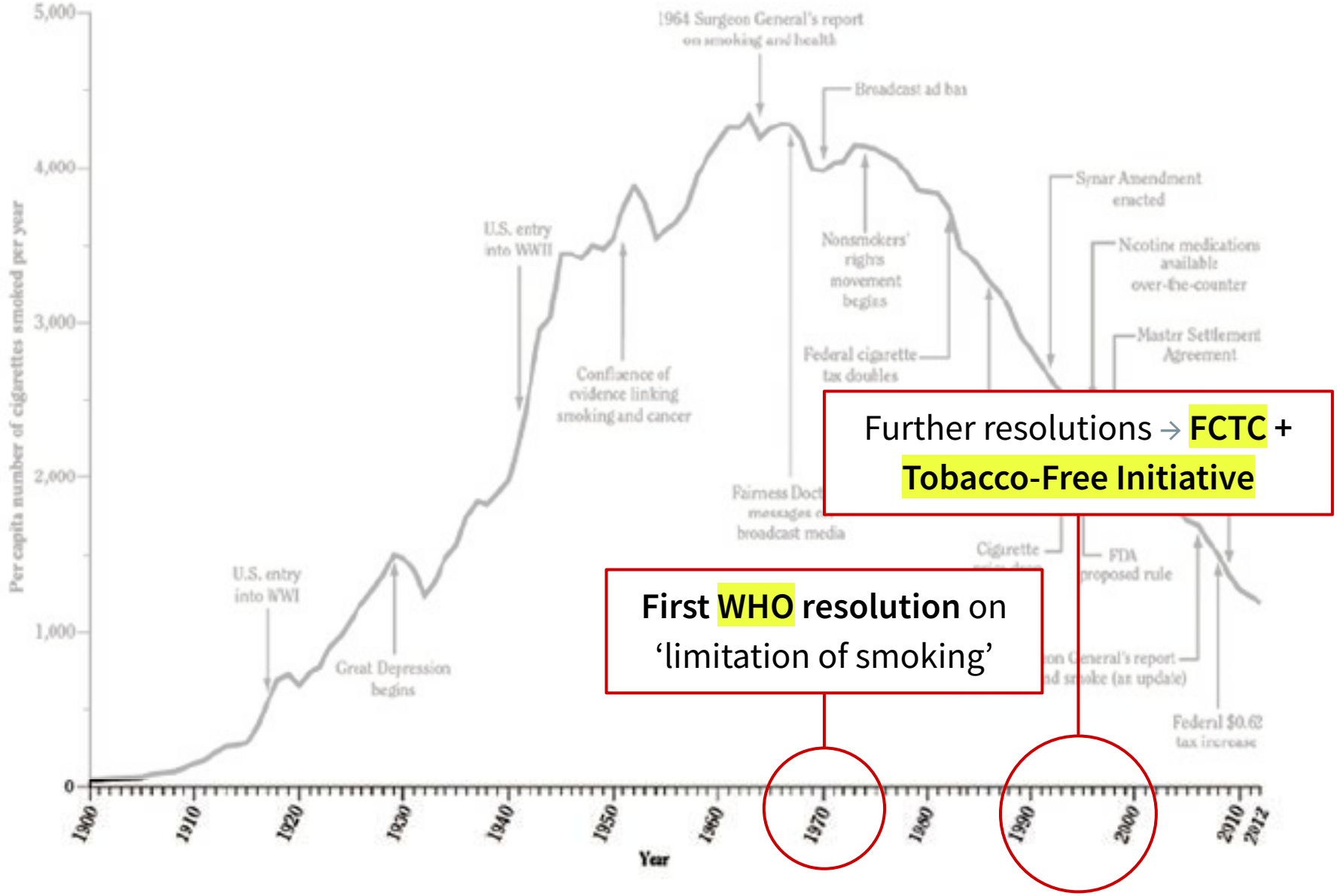
and mass info. campaigns

local bans

(adverts, public space)



tax increases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1900
1910
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2010
2012
Year
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U.S. entry into WWII
Confluence of evidence linking smoking and cancer
U.S. entry into WWI
Great Depression begins
Fairness Doct
broadcast media
Cigarette
FDA proposed rule
Federal $0.62 tax increase
Further resolutions → FCTC + Tobacco-Free Initiative
First WHO resolution on 'limitation of smoking'

Global policy instruments

FCTC (2003)

Control of supply and demand

MPOWER (mid-2000s)

Monitor tobacco use/industry

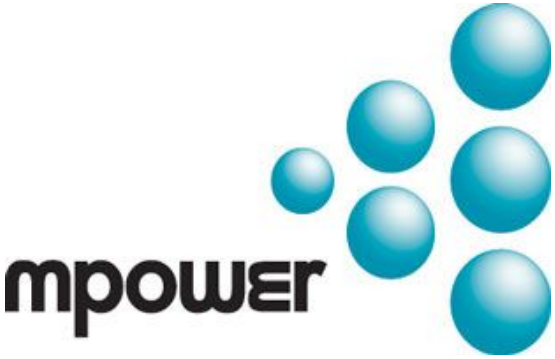
Protect nonsmokers

Offer cessation treatments

Warn consumers of consequences

Enforce bans on advertising

Raise tobacco taxes



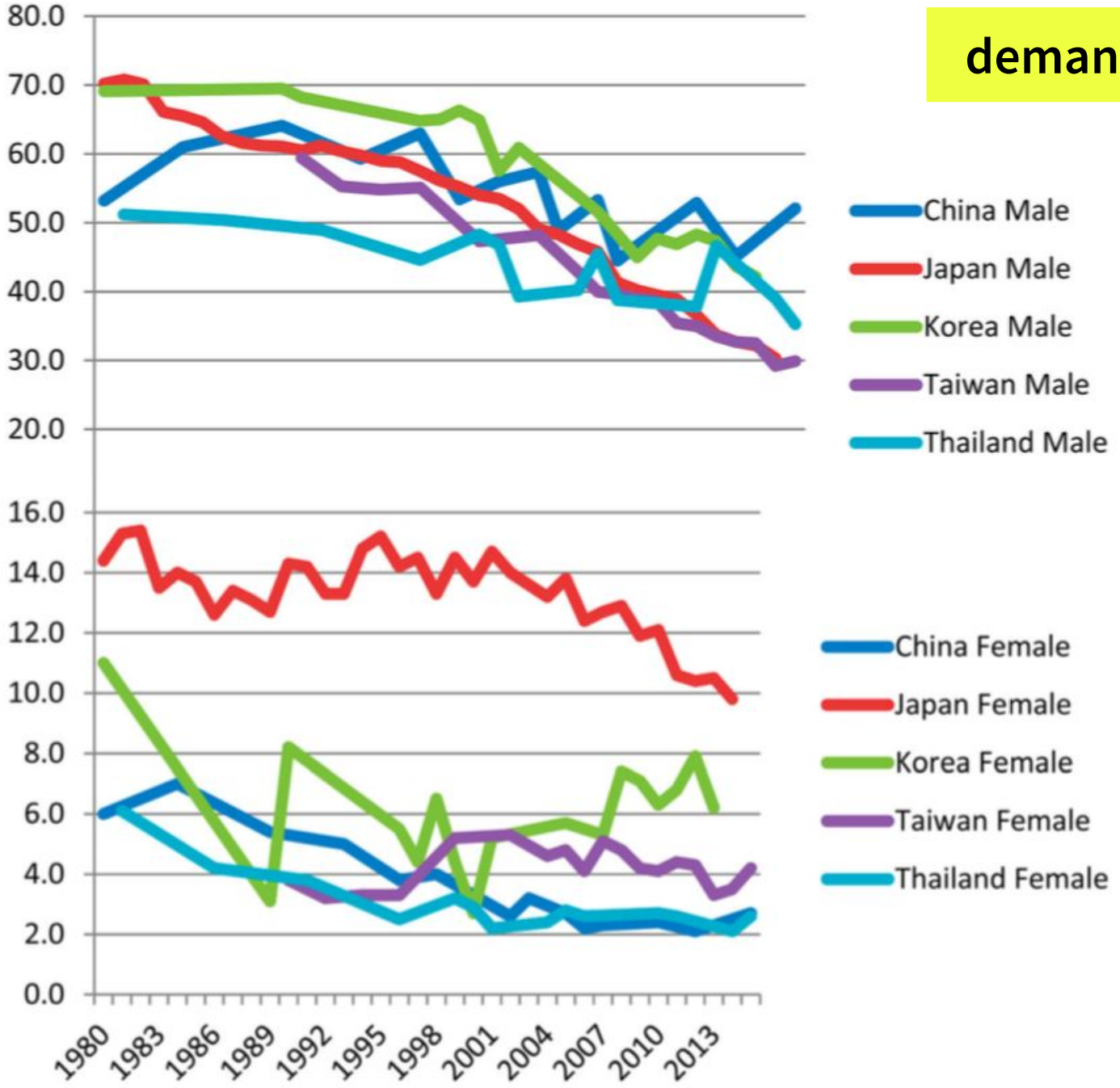
Effects of FCTC adoption (Nikogosian and Kickbusch 2016)

- **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** (on illicit trade, 2013) and to FCTC/MPOWER monitoring reports
- Demonstrated a change in **global health governance**

  → Proliferation of anti-tobacco stakeholders

demand-side


80.0
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60.0
50.0
40.0
30.0
20.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
1980
1983
1986
1989
1992
1995
1998
2001
2004
2007
2010
2013
China Male
Japan Male
Korea Male
Taiwan Male
Thailand Male
China Female
Japan Female
Korea Female
Taiwan Female
Thailand Female

supply-side

TABLE 1.1 *Top five tobacco growing countries, 2009*

Country	Raw Tobacco Production (tonnes)
China	3,067,928
Brazil	863,079
India	620,000
United States	373,440
Malawi	208,155

Source: Eriksen et al. 2012.

TABLE 1.2 *Top five cigarette exporting countries, 2009*

Country	Cigarette Exports (billion pieces)	Cigarette Production (billion pieces)
Germany	181.11	225.00
Netherlands	115.35	115.30
Poland	89.49	142.86
United States	60.45	338.23
Indonesia	57.40	180.50

Source: Eriksen et al. 2012.


LUCKIES
RED
LUCKY
STRIKE
IT'S TOASTED
Lobbying
kills

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

Pat Greenhouse/The Boston Globe via Getty Images

See Editorial page 1715
See Correspondence page 1733
See Viewpoint page 1807

Smoking causes more than 7 million deaths each year[1] 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".[2] In a *Lancet* Viewpoint in this issue, the Foundation's President Derek Yach argues it will support "an unswerving focus…to improve public health and human wellbeing".[3] 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.[4] 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,[9] 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".[10]

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".[3] 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"[11]) has been fierce

Key ideational struggles

- **Science** (*vs.* 'skepticism', as with e.g. climate change)
- **Economics** (tax revenue, employment)

  'Fun fact' — tobacco emerged as an income source for U.S. 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)


QUESTIONS?


10’ BREAK

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EUROPEAN SCHOOL OF POLITICAL AND SOCIAL SCIENCES

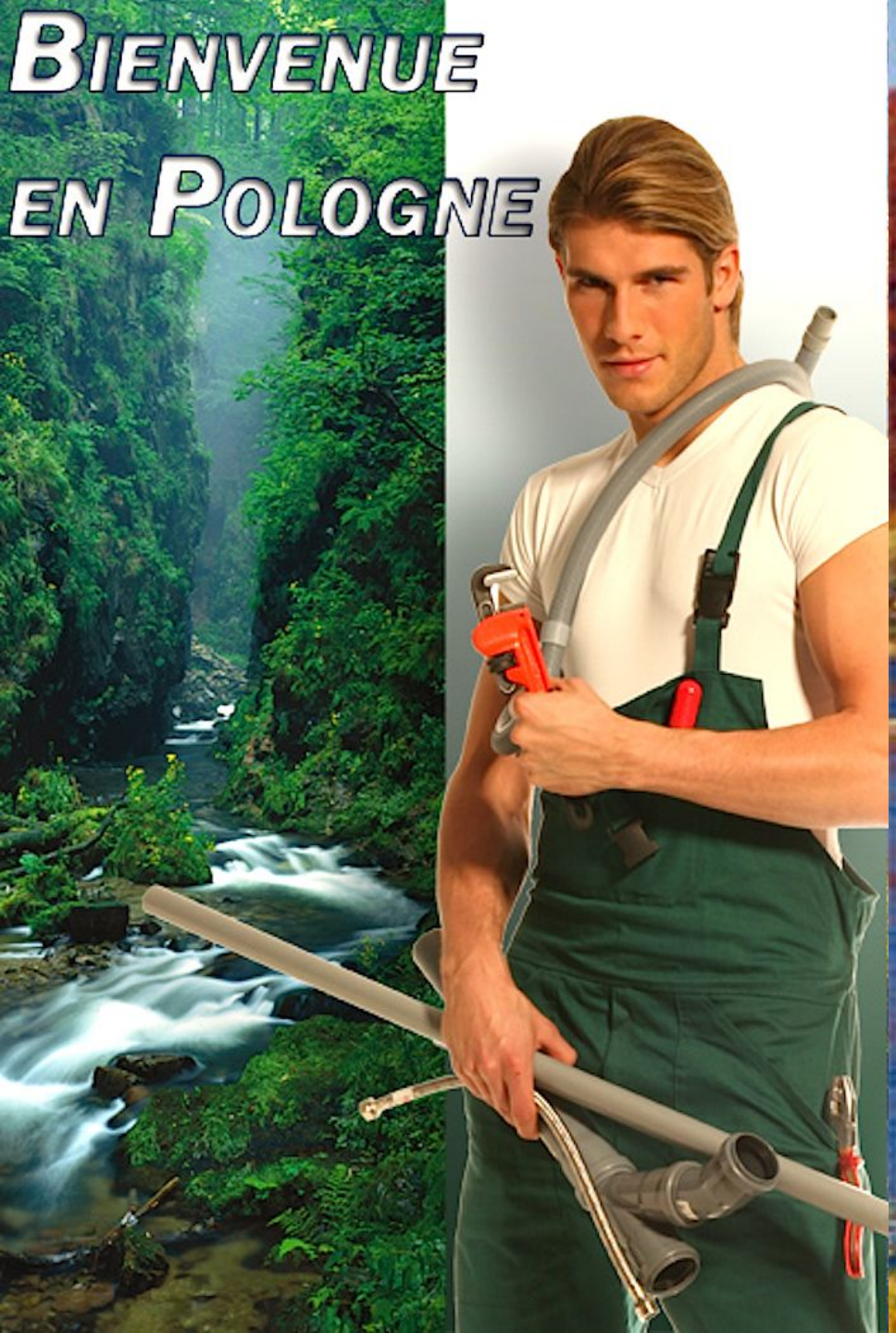
EU Health Action
(3) Indirect Regulation

EU Health Policy
Lecture 8

Protest against the Internal Market Directive, 2006

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.

Bienvenue en Pologne



Pologne: Je t'attends

What are we talking about?

- **Health *systems*** · viewed as **universally accessible** services serving **population needs**
- **Health *insurance*** · often **state-sponsored** ≠ Single Market principles that limit **market distortion**
- **Health care *services*** · among those removed from **Services Directive** (2006)
- **Health *markets*** · hard to characterise due to what is being **commodified** (workers? drugs? patients?)

COM-level positions

- ***Together for Health*** (2007) white paper focused on **public health**, despite losing focus in the title of the final document
- ***Health for Growth*** (2014–2020), focused on health services, expressed **conflicted goals** — health care financing *v*. **Treaty obligations**
- **Patient mobility and cross-border care** settled after years of discussion in 2011

EU-level policy goals (Koivusalo)

- **Fiscal sustainability within Treaty limits** · limits to **state aids** and **public procurement**
- **Including health care in trade/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)

CJEU indirect health regulation

- **EU-level enforceable principles**
  - → Health care should be **portable**
  - → Health providers should be **competitive**
- ***Kohll* and *Decker* rulings** (1995–1996)
  - → **Market regulation applies to (health) services**
  - → Confirmed by subsequent decisions (1998–2006)

    incl. *Watts* (2006) for NHS-style health systems

EU legal principles

- **Subsidiarity:** EU action occurs **only if MS are not more capable players** (principle of performance at the smallest possible unit)
- **Direct effect and precedence:** EU law is **immediately** and **supremely** enforceable
- **Decentralization:** national courts and individuals can **refer to the CJEU** directly (and bypass both the Commission and the Member States)

EU market principles

- **Harmonization:** accept **EU standards** in replacement of national ones (e.g. hours of medical education)
- **Mutual recognition:** accept **goods** (health products), **services** (health insurance), **capital** and **people** (health workers) from other Member States
- **'Country of origin' principle:** accept **standards from other Member States** (*Cassis de Dijon* ruling)

ROLE OF THE ECJ IN THE DEVELOPMENT OF EUROPEAN HEALTH POLICY

ECJ-code	Parties	Country of service	Country of insurance	Medical service/good
C-117/77; C-182/78	Pierik I & II	D	NL	
C-120/95	Decker		LB	Glasses
C-158/96	Kohll	D	L	Orthodontic treatment
C-160/96	Molennar	F	D	Long term care
C-368/98	Vanbraekel	F	B	Orthopaedic hospital treatment
C-411/98	Ferlini	L	(EC)	Discriminating billing
C-157/99	Geraets-Smits Peerbooms	D A	NL NL	Inpatient Parkinson treatment Coma therapy

Wismar, *Eurohealth* 7(4), 2001

Freedom of movement

- **Competition policy** · **free movement** and **antitrust regulation** (COM + CJEU)
- **Applications** · health **technology**, contracted health **professionals**, privately funded **health care**
- **Conflicts** · **cross-subsidies** are discriminatory against internal market competitors

Health *v.* Markets issues

Issue (1) Professional mobility

- **Principle** · trained **health professionals** should be able to work in any Member State
- **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** · Member States should not intervene against **provider competition** in national markets
- **Adaptation** · defence of **state compensation** schemes by Member States (*BUPA*, 2008)
- **Consequences** · insurance product providers can **oppose state subsidies** to national champions (*Altmark*, 2003)

Issue (3) Working times

- **Principle** · limited **number of hours** and defined breaks between shifts (WTD, 1993)
- **Adaptation** · substantial **cost increases** for hospitals (increased clinical staff)
- **Consequences** · unintended policy failure with **negative externalities** on health services due to legal definitions of ‘on-call’ and ’stand-by’ (SIMAP, 2000, and *Jaeger*, 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


QUESTIONS?


10’ BREAK

ESPOL
EUROPEAN SCHOOL OF POLITICAL AND SOCIAL SCIENCES

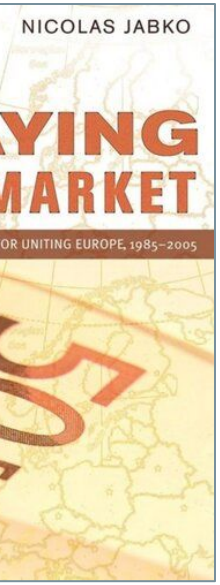
EU Health under Permanent Austerity

EU Health Policy

Lecture 9


NO TO AUSTERITY
Nein zu Sparmassnahmen
Severe austerity : return to sender
NO T
OXI
ACLVB
ABVV
CGSLB
FGTB
CES/ETUC

EU political economy, 1980s–90s



marketization

de-regulation of goods, capitals, labour, services

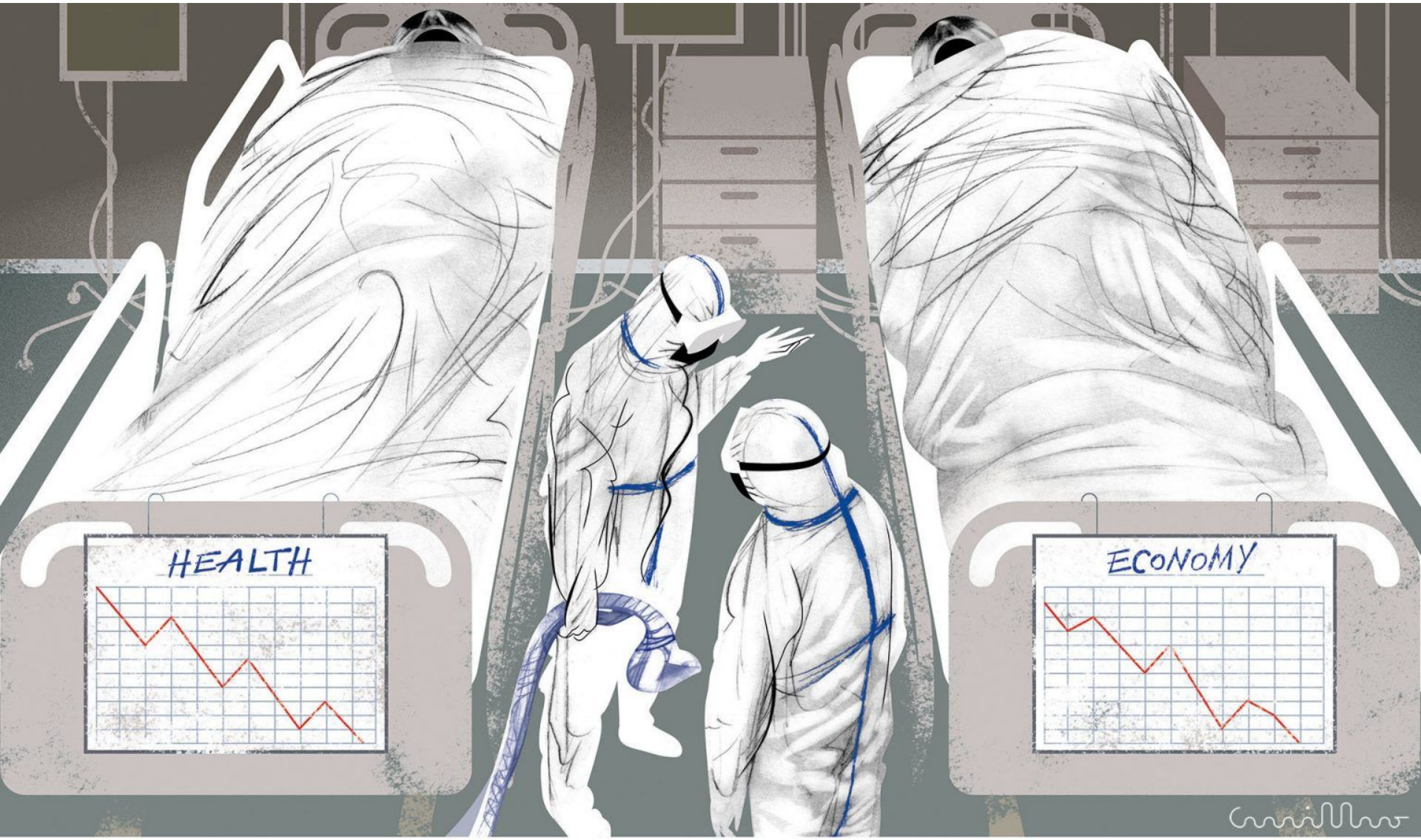
→ new liberalized internal markets

e.g. transport, energy

federalization

re-regulation at EU level: CJEU, ESF, EMU

→ ‘freer markets, new rules’



“I’m afraid we only have ONE ventilator...”

How health and austerity met

Effective scope of EU health policy (Sessions 3–5)

- **No formal power over health systems** · welfare states, and within them healthcare funding and health services, are national prerogatives
- **Limited power over health standards** · mostly agenda-setting and safety regulations

→ **'first face'** of EU health policy = **public health**

N.B. Covid-19 measures have only marginally changed that 'face' of EU health policy so far

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 (towards more than one kind of system)

Effective scope of EU health policy (Sessions 8–9)

- **Wide mandate over freedom of movement**, entailing competitive nondiscrimination for **goods, services, capitals and individuals**

  → **'second face'** of EU health policy = **internal market**

- **Regulatory impact on governmental expenditure**, affecting taxation and macroeconomic policies

  → **'third face'** of EU health policy = **fiscal governance**

Gradual involvement of EU into health policy (1)

- Since 1957 – **Public health objectives** (Arts. 6, 168 TFEU) through small-budget initiatives and cognitive harmonization

  → **'first face'** of EU health policy = **public health**

- Since 1998 – **Negative integration** of health services through patient mobility, staff mobility and insurer competition (Greer and Jarman 2012)

  → **'second face'** of EU health policy = **internal market**

Institutional shifts at EU and MS levels

- **Remapping of human health expertise** within EU institutions (DG SANCO + MARKT, ENVI) (de Ruijter 2016)
- **Private interest representation** of service providers, e.g. Franco-German complementary sickness funds via AIM, in Brussels (Greer 2009)
- **Variable integration of EU dimension** within national health ministries / services, depending on initial level of departmental autonomy (Greer 2010)

Gradual involvement of EU into health policy (2)

- Context since *c.* 1970 — **Permanent austerity** in health systems and other welfare sectors, in the form of cost containment reforms and managerialization
- Since 2010 – **Economic surveillance** of health expenditure (largest component of MS soc. exp.) in the aftermath of the Global Fiscal Crisis (2008)

  → **'third face'** of EU health policy = **fiscal governance**

  (still in place post-Covid-19)

Context and consequences

- **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)
- **Cuts in public spending**, followed by lower private health care consumption (e.g. primary care, drugs)
- **Negative or null growth** in real health care exp. from *c.* 2010 to 2015 (Morgan and Astolfi 2015)

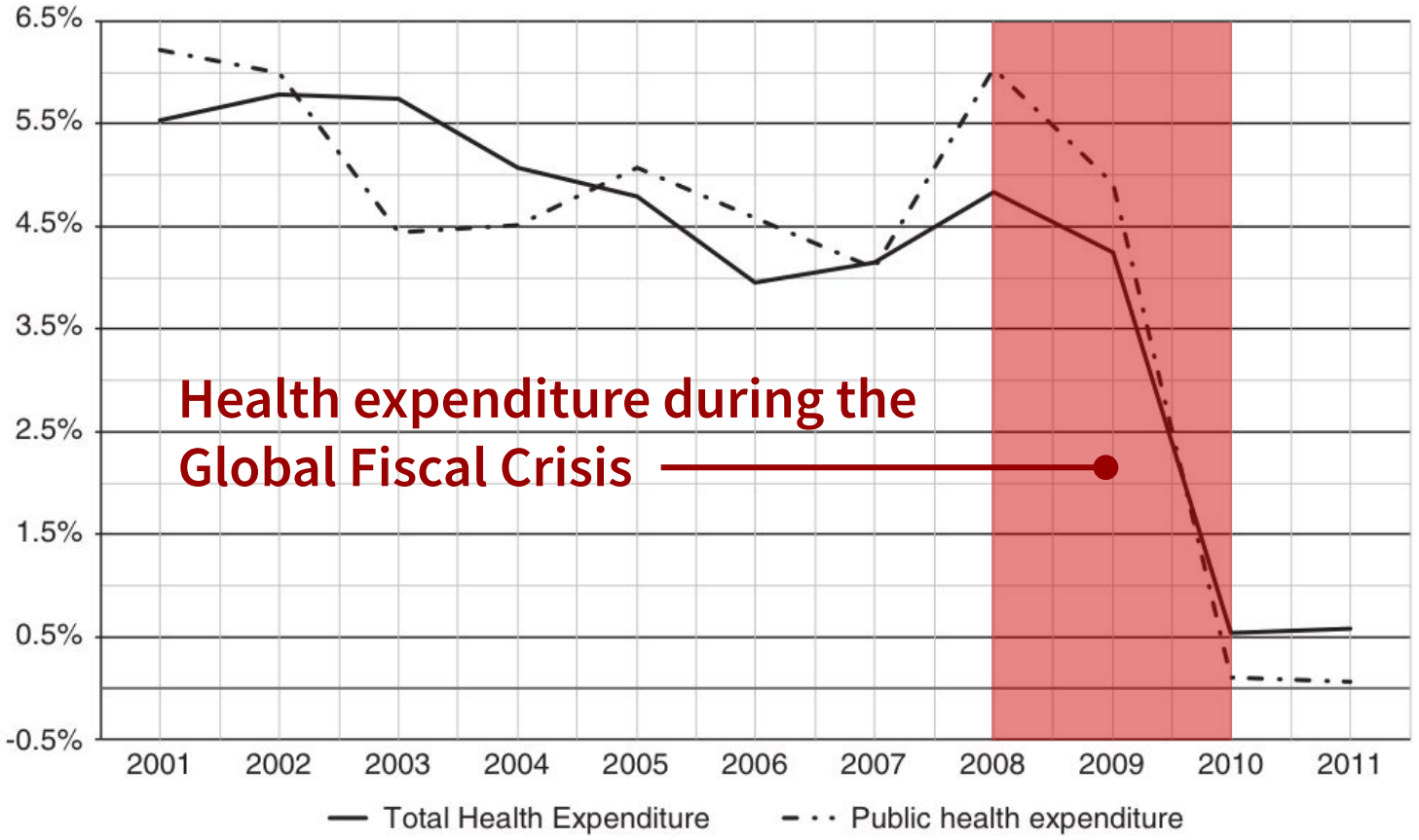


Figure 1. Average OECD health expenditure growth rates in real terms, 2000 to 2011, public and total
Source: OECD (2013).

Morgan and Astolfi 2015

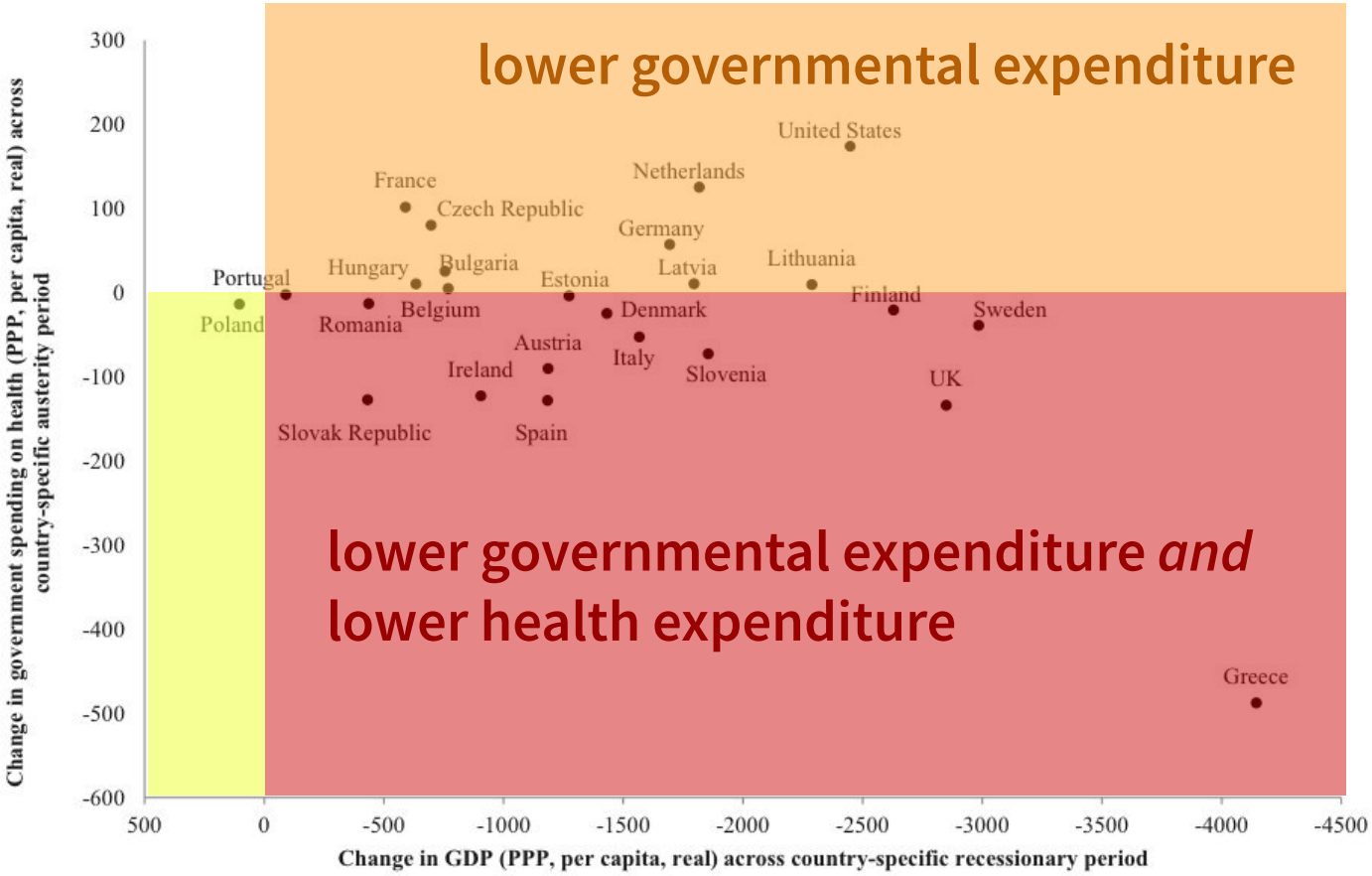


Fig. 1. Change in GDP and change in government spending on health across country-specific recession and austerity periods. Cross-national variations in healthcare spending, by country-specific recession and austerity periods, 24 EU countries and the United States. *Notes:* Source: WHO Health expenditure 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 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.

Reeves *et al.* 2014

Healthcare reforms since *c.* mid-1970s

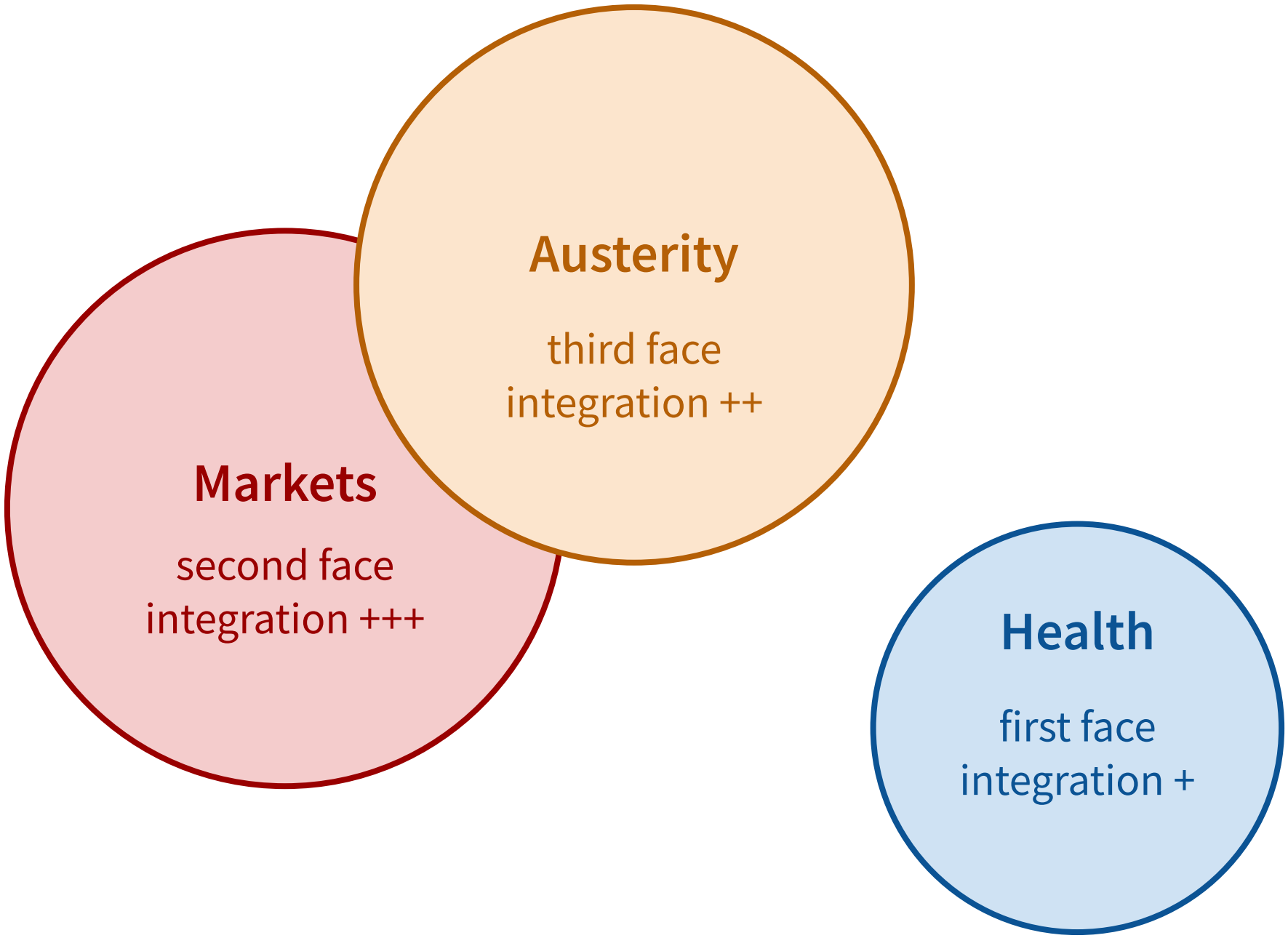
- **Top-down structural reorganisation** of health systems at all levels (state and providers)
- **Managerialism and competition mechanisms** within purchaser/provider markets (e.g. UK, Major + Blair)
- **Limited privatisation of health risks** through patient cost-sharing (Hacker 2004, Gingrich 2011,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

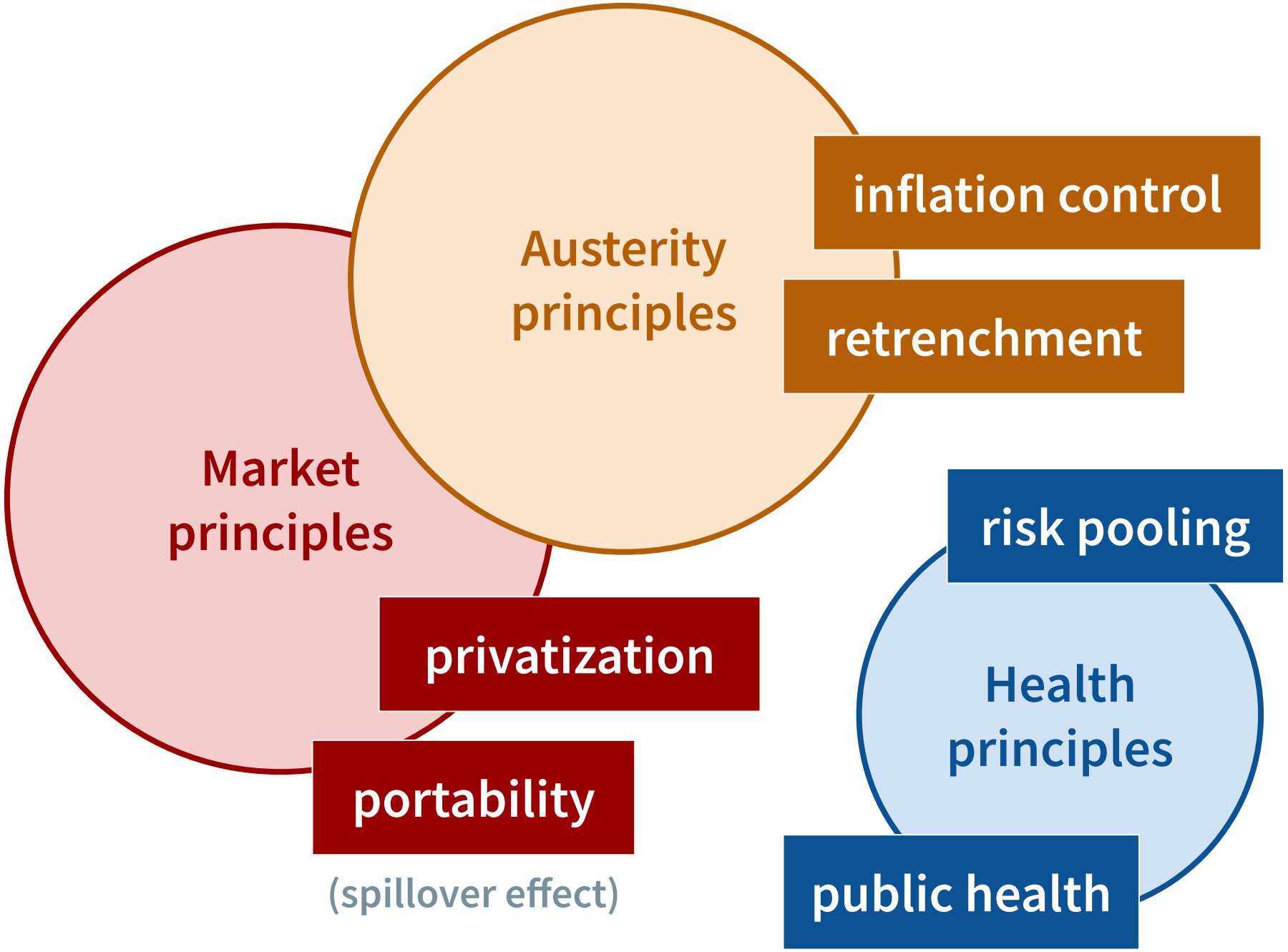
All reform trends apply to Bismarckian and Beveridgian health systems alike (Rothgang *et al.* 2010)

EU reform drivers since *c.* 2010

- ECB + IMF **macroeconomic conditionality** for bailed-out MoU countries, e.g. Greece (e.g. Fontan 2018)
- **Fiscal surveillance** for non-MoU countries, e.g. France, via SGP + (TSG)EMU + European Semester
- **Structural funds** are conditioned to objectives above per 2014–20 ESIF rules (Baeten and Vanhercke 2016)

→ EU operates as a **failed fiscal state** trying to balance MS expenses without means of taxation (Greer and Jarman 2015)


Austerity
third face
integration ++
Markets
second face
integration +++
Health
first face
integration +


Austerity principles
inflation control
retrenchment
Market principles
privatization
portability
(spillover effect)
risk pooling
Health principles
public health

LSE

banks also have policy agendas

The EU and the inevitability of immigration

0 comments

About the author

Sergio Scandizzo is Head of Internal Modelling at the European Investment Bank.


QUESTIONS?


10’ BREAK

Closing thoughts

Keeping up with EU health policy

European Observatory on Health Systems and Policies
a partnership hosted by WHO

- **EU Health Observatory**
- Policy-focused journals like ***Eurohealth*** (see syllabus)
- Biomedical and public health journals

  e.g. ***European Journal of Public Health***

  Lancet Regional Health Europe

- EU institutions and **WHO Europe**
- **European Health Forum Gastein**
- EU-focused think tanks

World Health Organization

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16-07-2020

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18-09-2020

Achieving Person-Centred Health Systems: Evidence, Strategies and Challenges
16-07-20

The Changing Role of the

European Observatory
@OBShealth

📢Coming soon...

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

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- The road towards developing a European Health Union
- Universal Health Coverage in the EU
- Building a true labour market for health workers
- Creating European public goods in health
- Supporting countries with implementing health system reforms
- One Health through the lens of the SDGs
- Europe's role in global health

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Volume 28 | Number 3 | 2022

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SERIES VIEWPOINT | VOLUME 9, 100192, OCTOBER 2021

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Shaping EU medicines regulation in the post COVID-19 era

Marco Cavaleri • Fergus Sweeney • Rosa Gonzalez-Quevedo • Melanie Carr

Open Access • Published: October, 2021 • DOI: https://doi.org/10.1016/j.lanepe.2021.100192

Abstract

The EU Medicines Regulatory Network (EMRN), comprised of the European Medicines Agency (EMA), the medicines regulatory authorities of the Member States and the European Commission (EC), is operating amid a complex crisis that has positioned regulators centre stage due to their key role in the development, approval and safety monitoring of vaccines and treatments for COVID-19. Here we consider the EMA's and EMRN's response to the pandemic and some of the early learnings that will help reshape

EUROPEAN INTEGRATION 27.09.2023 | Björn Hacker

More or less crisis-proof

So far, the EU has reacted to major crises in an ad hoc manner. For the future, Europe must be better prepared, especially in addressing social issues

EUROPEAN HEALTH FORUM GASTEIN

CONFERENCE PROJECTS & EVENTS YFG ABOUT US GET INVOLVED REGISTER

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

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Photos
Videos
Webcasts

Twenty Years

Aniversary Edition - European Health Forum Gastein

In 2017, the European Health Forum Gastein celebrated its 20th anniversary. On this page, we want to take you on a journey back in time – explore the history of our Forum, European health policy, and the interlinkages between both.

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Health, Human Rights, Politics and Populism

Understanding and countering threats posed by populism and market-driven healthcare

11:30-12:15 | #EmpowerHealth #EPHA30

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Jonathan Kennedy
Reader in Politics and Global Health, Centre for Public Health and Policy, Queen Mary University of London
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Director General for the European Institute of Women's Health, previous EPHA President
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Going beyond EU health policy

- Effects in **Member States**
  (incl. subnational units)
- Applicability of lessons learnt to **other regional integrations**
  e.g. ASEAN, NAFTA

  → see **Greer *et al.* 2022** (*JHPPL*)
- Role of EU in **global health**

  → see **Greer *et al.* 2022**
  (*Everything…*), ch. 7


EU Global
Health Strategy
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Thanks for your attention and efforts during this course

Feedback welcome