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European Union health policy after the pandemic: an opportunity to tackle health inequalities?

Eleanor Brooks

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Abstract

COVID-19 has exposed and exacerbated the health inequalities across and between European Union member states. It has also raised the profile of EU health policy and highlighted the value of European cooperation in health. Early failures to respond adequately, coupled with this increased salience, have given rise to a series of initiatives designed to strengthen and expand the EU's role in health. This presents an opportunity to address the imbalances in the EU's institutional and legal structure which prevent it from addressing health inequalities more effectively. Drawing on changes underway in the public health, internal market and fiscal governance elements of EU health policy, this paper explores the potential for the post-pandemic EU health policy framework to better support the reduction of health inequalities.

Keywords

EU; Health; COVID-19; Inequalities; Integration; Social determinants of health

Health inequalities in the European Union (EU) exist both across and between member states. Across individual member states, the gap in life expectancy between people with the highest and lowest levels of education is, on average, seven years for men and three years for women (OECD and EU 2020: 115). Older people report the greatest proportion of unmet medical need in Croatia and Greece; unmet needs are more commonly experienced by younger people in Denmark (European Commission 2019: 32). Problems in ensuring access to the health system for rural and peripheral communities are reported by more than half of countries (European Commission 2019: 36). Between member states, health inequalities are equally stark. Preventable mortality in Hungary, Latvia and Lithuania is more than twice the EU average and, in Bulgaria and Cyprus, ‘...a sizable group of the population are still excluded from [universal healthcare] coverage’ (European Commission 2019: 16; 32). The proportion of total health spending devoted to preventive healthcare – a crucial component of action to tackle health inequalities – varies from more than four per cent in Italy to one per cent in Slovakia (European Commission 2019: 17).

Mapping the links between these (pre-existing and long term) inequalities and inequalities in the manifestation of COVID-19 is difficult. A broad review of national COVID-19 experiences reveals some counterintuitive and chance results. Member states considered weak in terms of pandemic preparedness did unexpectedly well in the initial months of the crisis – Hungary, Czechia and Bulgaria being good cases in point (Löblová, Rone and Borbáth 2021). Others with comparatively strong health systems were victims of timing, experiencing early outbreaks that pre-dated much of the emerging scientific knowledge of the disease and, therefore, suffering more acutely (see Peralta-Santos, Saboga-Nunes and Magalhães (2021) on the cases of Italy and Spain, for instance). Nevertheless, it is clear from the wider picture that COVID-19 has affected those worst off the most, reflecting and exacerbating existing health inequalities (Bambra et al. 2020; Marmot and Allen 2020).

In addition to reducing individual wellbeing and economic productivity, health inequalities undermine core EU values such as equality, non-discrimination, solidarity and justice (EuroHealthNet 2019). Yet, the EU’s capacity to directly address these inequalities is limited. This is largely because they are driven by long term disparities in access to the social determinants of health (SDoH). These include the health system but are mostly found outside of it and concern education, income, housing, access to the natural environment and other features of the circumstances in which we grow, live, work and age (CSDH 2008). Though its extensive market and fiscal powers mean that it shapes much of the wider health environment within its member states, the EU’s explicit health powers are narrow and do not cover the SDoH; the distribution of early-childhood care, education, housing, and employment are the responsibility of national governments. Consequently, much of the EU action that affects health inequalities is either indirect, unintentional, or designed without an explicit health objective.

The COVID-19 pandemic, and the increased attention to the EU’s role in health that has followed it, present an opportunity to address this challenge and push health inequalities up the EU agenda. Change is underway in some of the governance frameworks that structure the EU’s influence over the SDoH, with the potential to increase the EU’s ability to proactively and coherently address health inequalities. Since early 2020, the EU has created a new Health Programme with an unprecedented budget, offered a reinterpretation of the scope of public health as an EU concern, and adopted a recovery package with the potential to support long term structural reform. These developments are in their early stages but will change the way in which the EU shapes – both directly and indirectly – national health policies and the health of Europeans. This paper explores the implications of this evolving health policy framework for health inequalities. It first introduces a framework for understanding health inequalities and their determinants, and outlines the mechanisms by which the EU influences these determinants. It then describes the changes underway in the aftermath of COVID-19, including the EU4Health Programme, the European Health Union initiative, the Commission’s reinterpretation of the public health derogation under EU law, and the Next Generation EU (NGEU)

recovery package. Within these, it identifies opportunities and potential avenues through which the EU might better tackle inequalities in health. The paper concludes with a brief discussion of the future of health (inequalities) policy in the EU.

HEALTH INEQUALITIES AND EU HEALTH POLICY

Health is experienced on a social gradient. Rates of all-cause mortality are higher in more deprived areas than in less deprived areas, a pattern now being replicated for mortality resulting from COVID-19 (Marmot and Allen 2020). For those at the lower end of this gradient, COVID-19 is being experienced as a *syndemic* – ‘a co-occurring, synergistic pandemic that interacts with and exacerbates their existing [chronic diseases] and social conditions’ (Bambra et al. 2020: 965). Individuals at the lower end of the social gradient are more likely to suffer from clinical risk factors associated with COVID-19, such as diabetes, heart disease, asthma and obesity. These risk factors arise from a lack of access to the SDoH – i.e. to an adequate level of income, quality education, quality housing, green spaces and healthcare services. Moreover, the direct risk posed by being a key worker or living in densely populated housing, for instance, falls disproportionately on disadvantaged groups. In sum, the burden of COVID-19 and its negative effects are being exacerbated by the interaction and accumulation of existing inequalities (Bambra et al. 2020). What is causing these inequalities and what can EU health policy do about it? Forster, Kentikelenis and Bambra (2020) identify three major determinants of health inequalities in Europe: access to universal healthcare (UHC), economic policy that supports healthy work, job security and income stability, and wider policies that increase access to the SDoH and promote social equality. Whilst EU law and policy influences each of these determinants, the extent to which such influence is significant, intentional and coherent varies considerably, as does the extent to which each is recognised as a part of, or even relevant to, health policy.

The EU’s formal health mandate – that with which it can explicitly and directly act to improve health – is limited. Member states have successfully utilised the treaties to curtail EU action on health and have done so by drawing a distinction between *public health*, on the one hand, and *healthcare*, on the other. Article 168 TFEU gives the EU some exclusive powers in the area of public health. These include a mandate to regulate the safety of pharmaceuticals, medical devices, and blood, tissues and organs. By contrast, its powers in the field of healthcare – referring to the treatment of individuals and the organisation of the health system, rather than the health of the population as a whole – are explicitly curtailed by Article 168(7) TFEU. This careful protection of national prerogatives in healthcare means that, for example, whilst the EU is the sole regulator of the safety of medicines, it has no direct role in decisions about how medicines are purchased, allocated or distributed within a system of UHC. Indeed, though the EU encourages and supports the development of UHC systems, it does so via predominantly soft policy mechanisms, since healthcare provision is a national responsibility.

Whilst it has been fairly easy for member states to curtail the EU’s direct powers in health, limiting its indirect impact on health has proven near impossible. Most of the SDoH are found far beyond the health system and, consequently, the EU policies acknowledged to have the greatest impact upon health fall outside of the scope of Article 168 TFEU’s restrictions (Greer et al. 2019: 117). These include those that seek to improve health via regulation of the environment, health and safety at work, and consumer protection, as well as those that do not seek to influence health at all, but do so indirectly. The latter are found in agriculture, trade, competition, internal market, non-discrimination, employment and a host of other policy domains, where EU powers are often strong. Whilst policies on environment, health and safety at work and consumer protection are generally recognised as part of EU health policy and have an explicit health objective, the latter are not. The EU is formally required to take the health impact of such policies into account, but health actors are not centrally involved in

their development. Moreover, some of these powers enable the EU to directly challenge national health policies. The internal market mandate provides that, where a national policy presents a barrier to the free movement of goods or services, it can be struck down by the Court of Justice of the EU, with potentially damaging effects upon health (the challenge to Minimum Unit Pricing policies for alcohol are a good example of this risk; see Alemanno 2016; Bartlett 2016).

An area that is far removed from public health but is – perhaps unexpectedly – increasingly understood as ‘part of’ health policy is the EU’s extensive economic and fiscal governance framework. The EU adopted a complex structure for the surveillance of member states’ budgets, expenditure and economic policy in the aftermath of the economic crisis that engulfed the continent in the late 2000s. Since health is a large and expensive item in national budgets, it is logically included in this framework, which is implemented via a policy coordination cycle known as the European Semester. The result is that the EU has unprecedented influence over national spending on health, and other sectors/services relevant to health inequalities (Baeten and Vanhercke 2017). Early Semester cycles treated health as an expense, within a broad austerity agenda, but subsequent experience indicates that this framing has been undermined, primarily by health interests (Greer and Brooks 2021). Though its recommendations remain non-binding for most member states and its consideration of health remains secondary, the European Semester is now one of the most important health policy levers that the EU possesses.

In sum, the formal health powers assigned to the EU in the treaties do not tell us much about the reality of how health policy has developed or how the EU influences health inequalities (de Ruijter 2019). As alluded to in the preceding paragraphs, it is more useful to understand EU health policy as having three faces (Greer 2014): one comprised of direct and explicit public health policy, a second based on the EU’s market-making and regulatory competences, and a third rooted in the fiscal governance framework. These three faces give the EU a patchwork of direct and indirect influence over the SDoH, and thus over health inequalities within and between its member states.

RESPONDING TO COVID-19: CHANGES IN EU HEALTH POLICY

The EU’s performance in the first weeks and months of the crisis was as could be expected, given the uneven set of policy competences described in the previous section. An initial period of panic and uncertainty saw governments look inwards, closing borders, guarding supplies and eschewing coordination (not to mention solidarity) with EU partners. This soon subsided, as the necessity of collective action became clear, allowing the EU to play a greater role (Brooks, de Ruijter and Greer 2021). In some instances, this revealed significant weaknesses in the EU’s capacities. The civil protection and health emergencies systems, for example, offered as much as their mandates and resources allowed, but this was shown to be insufficient in the face of a crisis on the scale of COVID-19. A common medical stockpile did not exist, the European Centre for Disease Prevention and Control (ECDC) struggled against a curtailed mandate that precludes its involvement in risk management, and the mechanism for joint procurement of medicines failed to deliver timely results (de Ruijter et al. 2021; Paces and Weimar 2020). By contrast, in other areas, the added value of collective action was starkly apparent. The EU marshalled significant funds, both in the short term – via initiatives like the European instrument for temporary Support to mitigate Unemployment Risks in an Emergency (SURE) – and in the longer term – via the NGEU recovery plan. In the months which have followed, successful measures have been gradually institutionalised, whilst failings have prompted new initiatives to strengthen the EU’s health competence. The result is a marked increase in health integration (Brooks and Geyer 2020). The following sections use the three faces framework to present the changes in EU health policy that have taken place in the aftermath of COVID-19, and their potential implications for health inequalities.

Changes in the First Face of Health Policy: The EU4Health Programme and the European Health Union

The first face of EU health policy has traditionally been rooted in its Health Programme, which was first established in 2003. This was due to lose its dedicated funding stream and instead be absorbed into a wider European Social Fund within the new EU budget for 2021. However, the pandemic highlighted both the necessity of coordinated action and the risks associated with inequalities between health systems. In May 2020, the Commission reversed its pre-COVID decision to disband the Health Programme and, when presenting its revised multi-annual financial framework for the 2021-2027 period, included within it a new programme, called EU4Health. Most significantly EU4Health has a budget of €5.3 billion, more than 10 times as much as the previous programme. While much of EU4Health's work will focus on crisis response and communicable diseases, the regulation stipulates that a minimum of 20 per cent of the funds must be reserved for health promotion and disease prevention activities (European Union 2021), and the work programme foresees action to strengthen health systems, improve access to healthcare and strengthen the data infrastructure to support better policy-making (European Commission 2021a).

EU4Health contributes to the wider European Health Union (EHU) initiative. The EHU was announced by Commission President Ursula von der Leyen in her State of the European Union address in September 2020. The full extent of its goals is, as yet, unclear but the initial package of legislative proposals seeks to strengthen the EU's role in health. They reinforce the mandate of the ECDC, extend the remit of the European Medicines Agency (EMA) and reform the EU health security framework. The EHU also links to a revision of the EU civil protection mechanism, and is supported by a new EU Pharmaceutical Strategy, Vaccine Strategy and the EU4Health Programme. More recently, it has been supplemented by a new Health Emergency Preparedness and Response Authority (HERA), designed to prevent, detect and respond to health emergencies (European Commission 2021b). In sum, EU4Health and the EHU mark a significant, integrative step forward in EU health policy.

The EU's formal health powers remain unchanged in the post-COVID period, but its competences are being expanded via secondary legislation, for instance in the strengthening of the mandates for the ECDC and the EMA. Moreover, the scope and ambition of its work on health has increased considerably, and health inequalities are identified as a key theme with the new initiatives. The EU4Health Regulation commits the EU to reducing health inequalities as both a general and a specific objective of the programme (European Union 2021: Article 3; Article 4). The Pharmaceutical Strategy targets access to medicines and the ECDC's strengthened capacity for data collection may help to support better mapping of inequalities across Europe. Successful utilisation of these tools to address inequalities will require linking with other frameworks – such as the European Semester, the structural funds and the European Pillar of Social Rights (see below) – and the political will to act upon the EU's commitment to a preventative, rather than a curative, model of health (EuroHealthNet 2021). Moreover, the implications of the EHU for health inequalities remain unclear. For the moment, it seems primarily to be framed as a European health *security* union; further 'building blocks' – specifically targeting health promotion and disease prevention activities – would need to look quite different from those adopted to date, in order to create a more holistic public health union.

Changes in the Second Face of Health Policy: Reinterpreting the Public Health Derogation

The second face of EU health policy is found where health meets the market; it concerns the free movement of health goods (such as pharmaceuticals, laboratory equipment, personal protective equipment), health services and health professionals. This free movement came under immediate pressure during the COVID-19 crisis and the EU's early response focused on challenging national decisions to close borders, restrict exports and stockpile critical supplies. Some of these were overturned more quickly than others but, fairly soon, the EU was working towards common policy on

travel restrictions, contact tracing apps and the free movement of critical goods via green lanes, among other issues (Greer, de Ruijter and Brooks 2021). Simultaneously, it adopted a new Pharmaceutical Strategy to address weaknesses in the pharmaceutical market and supply chain, and a Vaccine Strategy to boost capacity for COVID-19 vaccine production. It introduced temporary relaxation in the frameworks on state aid and anti-trust law, which ensure a 'level playing field' in the internal market, to allow governments to support national businesses, employers and sectors (Biondi and Stefan 2020). It also postponed the introduction into force of the new medical devices regulation, giving device manufacturers space to focus on the production of urgently needed equipment and treatments (Greer et al. 2022).

The EU's powers as regulator of the market are exclusive and comprehensive; as such, major change is not foreseen here. However, within its efforts to restore the internal market, the Commission published a Communication in which it quietly laid the groundwork for a potential shift in the meaning of public health within EU law. Since the creation of the internal market, member states have enjoyed a health-related derogation to the principle of free movement. Now embodied in Article 36 TFEU, this derogation provides that a barrier to free movement – for example, a ban on the importation or exportation of a particular good – may be permitted under EU law where it can be shown necessary to protect public health. Historically, this provision has been interpreted as referring to *national* public health; i.e. a member state needs only to demonstrate that the measure is necessary and proportionate to protecting the health of its own population. However, in a March 2020 Communication responding to the growing number of national export restrictions on essential medical supplies to fight COVID-19, the Commission re-interpreted the public health exception. Whilst acknowledging member states' right to adopt trade restrictions where necessary to protect public health, the Communication suggests that the legality of restrictions adopted will be judged according to their impact upon 'the objective of protecting the health of people living in Europe' (European Commission 2020: annex II, note 2). This approach shifts the understanding of proportionality to require justification with reference to the health of the EU population as a whole, and not just the population of the relevant country. More fundamentally, '...it turns the internal market face on its head, by assuming that health is the objective and the market exists as an instrument to ensure health, rather than the traditional, reverse understanding of health as ancillary to the market' (Brooks, Rozenblum, Greer and de Ruijter 2022).

The reinterpreted derogation has yet to be tested. A Commission statement in this context is remarkable but has no legal effect until put before a court. However, the Commission used its reinterpretation to deem bans on the export of medical supplies needed to fight COVID-19 disproportionate, and successfully persuaded national leaders of this, removing barriers which would have greatly exacerbated inequalities in national responses to the pandemic. More fundamentally, tackling health inequalities requires a firm commitment to solidarity, and the Commission's reinterpretation frames public health squarely as a collective, European issue, rather than as an exclusive concern of the nation state (de Ruijter et al. 2020).

Changes in the Third Face of Health Policy: The Next Generation EU Recovery Plan

Arguably the most significant EU policy changes to have taken place in response to COVID-19 are those affecting fiscal governance, and thus the third face of EU health policy. A core pillar of the EU's response has been the mobilisation of funds; first to assist governments in their short-term responses, by re-purposing existing and unspent funds, and suspending EU-imposed limits on national expenditure, and second to support long term recovery. Short-term efforts have supported the SURE initiative, targeted at preserving employment, and an expansion of the European Solidarity Fund, to cover health emergencies. By far the more substantial response, however, has been the adoption of the renegotiated MFF and the NGEU recovery package.

NGEU provides €750 billion of additional funding to support recovery from the pandemic and mitigation of its economic impact. Its largest component is the Recovery and Resilience Facility (RRF), a fund to support reforms and investment in member states. Of the €672.5 billion available to national governments under the RRF, €360 billion is to be issued as loans and €312.5 billion will be issued as grants. The remaining €83.1 billion of the NGEU package is made up of various ‘top-up’ funds, designed to supplement specific EU programmes and priorities, such as rural development, transitions under the European Green Deal and civil protection. REACT-EU (Recovery Assistance for Cohesion and the Territories of Europe), for instance, tops-up the allocation for cohesion under the MFF and makes the structural funds envelope the largest single-policy grant instrument in the EU budget.

There are several important implications of these changes for health inequalities in Europe. Firstly, it has been crucial that, throughout the development of the EU’s fiscal response to the pandemic, the mistakes made in the aftermath of the economic crisis of the late 2000s were not repeated. Rather than framing EU support as contingent upon the implementation of an austerity agenda at national level, the RRF has been set up to provide loans and grants with minimal conditionality. Whilst it does not mutualise the debt of member states, it takes an unprecedented step in issuing common European debt and giving the Commission a central role in its distribution. As such, it is more likely to avoid the damage that was done by cutting public services and health expenditure in the early 2010s (Karaniolos et al. 2013; Quaglio et al. 2013), and instead embodies a sense of solidarity that was lacking during the last crisis (Greer, de Ruijter and Brooks 2021). A second important element of the fiscal policy changes is the increased budget allocation for the European Structural and Investment Funds (ESIF). The ESIF is the only direct fiscal policy tool that the EU has and, though funds are not ringfenced, in recent years there has been increased emphasis on its utilisation to support investment in health systems and address inequalities (Greer et al. 2022). ESIF funding for the 2021 to 2027 period is a little over €350 billion overall, with only a proportion of this being spent on health projects. This is small, relative to the objectives that it seeks to achieve – to support economic development and reduce inequality between regions – but any increase, coupled with more purposeful utilisation to improve health, should be seen as a positive development.

A third, and final, implication of the new fiscal policy structure concerns its potential to induce long term structural reforms that support a reduction in health inequalities. The RRF has a dual aim. It seeks to mitigate the impact of the pandemic, but to do so in a way which accelerates transition towards a green and digital economy. To this end, the Commission has sought to guide and steer the use of the funds from the outset. It has identified seven flagship areas for investment: clean technology and renewables, energy efficiency, sustainable transport, broadband services, digitalisation of public administration, data cloud and sustainable processor capacities, and education and training for digital skills. In addition to serving these priorities, national plans (outlining how a country will spend its portion of the funds) must demonstrate that a minimum of 37% of planned spending is dedicated to climate investments and reforms, and no less than 20% is earmarked to foster the digital transition. Finally, proposed spending plans should address the four dimensions – environmental sustainability, productivity, fairness and macroeconomic stability – outlined in the 2021 Annual Sustainable Growth Survey. In essence, the RRF seeks to bring the EU’s priorities together under one programme for structural reform. A full analysis of whether these priorities, and the actions taken in pursuit of them, contribute to a reduction in health inequalities is beyond the scope of this paper. However, the RRF offers an unprecedented resource, aimed not only at economic growth and productivity, but also at sustainability, resilience and inclusion.

EU HEALTH POLICY IN THE POST-COVID ERA: AN OPPORTUNITY TO TACKLE HEALTH INEQUALITIES?

The EU’s constitutional asymmetry – the imbalance in powers granted to the Union which favours economic and market integration over action to address social challenges – is more stark and more inhibiting to the fight against health inequalities than any other element of EU health policy (Greer et

al. 2019: 116). The SDoH are numerous, disparate and often beyond the EU's fragmented health mandate. There are two routes to addressing this impasse: one is fundamental treaty change; the other is an increase in the policy space available for tackling inequalities, under the current treaties, and accompanying political will to utilise this. Treaty change does not seem likely in the immediate future and is anyway argued by some to be unnecessary, given the potential health applications of competences that the EU already possesses (Guy 2020; Purnhagen et al. 2020). The changes to EU health policy that are underway in the aftermath of COVID-19, however, might yet constitute an increase in policy space. Within the 'core' of EU health policy, existing competences are being strengthened and expanded, and the scope and reach of EU health policy is being extended, with support from a greatly increased health budget. A free movement derogation reinterpreted to understand public health as a European, rather than a national, concern would strengthen the foundation of solidarity needed to tackle health inequalities, as well as rebalancing the relationship between market objectives and public health. The RRF marks an unprecedented step towards more solidaristic fiscal policy and the NGEU priorities contain more space for health investments and reforms than any previous EU instrument. Within all of these frameworks, access to healthcare, the importance of disease prevention and health promotion, and the fight against health inequalities are clearly identified as key themes. Moreover, beyond 'health policy proper', instruments like the Just Transition Fund, the Digital Europe initiative and the ESIF all present opportunities to address the SDoH and reduce health inequalities.

Uncertainties and challenges remain. It is not clear whether the EHU will be elaborated as something more than a new health security framework, or whether the European Semester will prove effective enough to drive long term structural reform at national level, given the range of priorities it is now responsible for implementing. To give another very specific example of an area where there is much more to be done, the EU's approach to trade negotiations continues to fall short of promises to protect governments' capacity to regulate for health protection, equity and access to care (Koivusalo, Heinonen and Tynkkynen 2021). A genuinely holistic approach to the SDoH is some way off but the post-COVID health policy landscape offers new opportunities in the fight against health inequalities.

AUTHOR DETAILS

Eleanor Brooks, School of Social and Political Science, University of Edinburgh, United Kingdom
[Eleanor.brooks@ed.ac.uk]

REFERENCES

- Alemanno, A. (2016). Balancing free movement and public health: The case of minimum unit pricing of alcohol in 'Scotch Whisky'. *Common Market Law Review*, 53(4): 1037-1063.
- Baeten, R. and B. Vanhercke (2017). Inside the black box: the EU's economic surveillance of national health care systems. *Comparative European Politics*, 15(3): 478-497.
- Bambra C., R. Riordan, J. Ford and F. Matthews (2020). 'The COVID-19 pandemic and health inequalities', *Journal of Epidemiology and Community Health*, 74: 964-968.
- Bartlett, O. (2016). Minimum Unit Pricing for alcohol may not be a proportionate public health intervention. *European Journal of Risk Regulation*, 7(1): 218-222.
- Biondi, A. and O. Stefan (2020). EU Health Union and state aid policy: with great(er) power comes great responsibility. *European Journal of Risk Regulation*, 11(4): 894-902.
- Brooks, E. and R. Geyer (2020). The development of EU health policy and the Covid-19 pandemic: trends and implications. *Journal of European Integration*, 42(8): 1057-1076.
- Brooks, E., S. Rozenblum, S. Greer and A. de Ruijter (2022). 'COVID-19 and EU health policy'. In M. Cini and N. Perez-Solorzano (eds), *European Union Politics*. 7th edition. Oxford: Oxford University Press: 421-435.
- Brooks, E., A. de Ruijter and S. Greer (2021). 'Covid-19 and European Union health policy: from crisis to collective action'. In B. Vanhercke, S. Spasova and B. Fronteddu (eds), *Social policy in the European Union: State of play 2020, facing the pandemic*. Brussels: European Trade Union Institute: 33-48.
- CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization.
- EuroHealthNet (2019). *Health inequalities in Europe*. Online: https://eurohealthnet.eu/sites/eurohealthnet.eu/files/publications/Health_Equity_in_the_EU_Factsheet_October_2019_A4_online%20version.pdf [accessed 2 October 2021].
- EuroHealthNet (2021). *Input at the EU4Health workshop 'Potential solutions for a healthier European Union'*. Online: <https://eurohealthnet.eu/publication/input-eurohealthnet-eu4health-workshop-%E2%80%98potential-solutions-healthier-european-union%E2%80%99-24> [accessed 6 October 2021].
- European Commission (2019). *State of Health in the EU Companion Report*. Luxembourg: Publications Office of the European Union. doi:10.2875/85326.
- European Commission (2020). Communication on a coordinated economic response to the COVID-19 outbreak. COM(2020) 112 final, 13.3.2020.
- European Commission (2021a). Annex to the Implementing Decision on the financing of the Programme for the Union's action in the field of health ('EU4Health Programme') and the adoption of the work programme for 2021. C(2021) 4793 final, 24.6.2021.
- European Commission (2021b). Communication Introducing HERA, the European Health Emergency preparedness and Response Authority, the next step towards completing the European Health Union. COM(2021) 576 final, 16.9.2021.
- European Union (2021). Regulation (EU) 2021/522 of 24 March 2021 establishing a Programme for the Union's action in the field of health ('EU4Health Programme') for the period 2021-2027, and repealing Regulation (EU) No 282/2014, OJ L 107, 26.3.2021, p. 1-29.

- Forster, T., A. Kentikelenis and C. Bambra (2020). *Health inequalities in Europe: Setting the stage for progressive policy action*. Dublin: TASC. Online: <https://www.feps-europe.eu/resources/publications/629:health-inequalities-in-europe-setting-the-stage-for-progressive-policy-action.html> [accessed 4 October 2021].
- Greer, S. (2014). 'The three faces of European Union health policy: Policy, markets, and austerity'. *Policy and Society*, 33(1): 13-24.
- Greer, S., N. Fahy, S. Rozenblum, H. Jarman, W. Palm, H. A. Elliot and M. Wismar. (2019). *Everything you always wanted to know about European Union health policies but were afraid to ask*. 2nd edition. Brussels: European Observatory on Health Systems and Policies.
- Greer, S., S. Rozenblum, N. Fahy, E. Brooks, H. Jaman, A. de Ruijter, W. Palm and M. Wismar (2022). *Everything you always wanted to know about European Union health policies but were afraid to ask*. 3rd edition. Brussels: European Observatory on Health Systems and Policies.
- Guy, M. (2020). 'Towards a European Health Union: What Role for Member States?'. *European Journal of Risk Regulation*, 11(4): 757–765. <https://doi.org/10.1017/err.2020.77>
- Karanikolos, M., P. Mladovsky, J. Cylus, S. Thomson, S. Basu, D. Stuckler, J. Mackenbach and M. McKee (2013). 'Financial crisis, austerity, and health in Europe'. *The Lancet*, 381(9874): 1323-1331. [https://doi.org/10.1016/S0140-6736\(13\)60102-6](https://doi.org/10.1016/S0140-6736(13)60102-6)
- Koivusalo, M., N. Heinonen and L. K. Tynkkynen (2021). 'When actions do not match aspirations - comparison of the European Union policy claims against what has been negotiated for health services, trade and investment'. *Globalization and Health*, 17(98): 1-11. <https://doi.org/10.1186/s12992-021-00739-8>
- Löbblöva, O., J. Rone and E. Borbáth (2021). 'COVID-19 in Central and Eastern Europe: Focus on Czechia, Hungary and Bulgaria', in S. L. Greer, E. J. King, A. Peralta-Santos and E. M. da Fonseca (eds), *Coronavirus politics: the comparative politics and policy of COVID-19*. Michigan: University of Michigan Press: 413-435.
- Marmot M. and J. Allen (2020). 'COVID-19: exposing and amplifying inequalities'. *Journal of Epidemiology and Community Health*, 74: 681-682.
- OECD and EU (2020). *Health at a Glance: Europe 2020*. Paris: OECD Publishing Press. <https://doi.org/10.1787/82129230-en>
- Paccès, A. M. and M. Weimer (2020). 'From Diversity to Coordination: A European Approach to COVID-19'. *European Journal of Risk Regulation*, 11(2): 283-296.
- Peralta-Santos, A., L. Saboga-Nunes and P. C. Magalhães (2021). 'A tale of two pandemics in three countries: Portugal, Spain and Italy', in S. L. Greer, E. J. King, A. Peralta-Santos and E. M. da Fonseca (eds), *Coronavirus politics: the comparative politics and policy of COVID-19*. Michigan: University of Michigan Press: 361-377.
- Purnhagen, K., M. Flear, T. Hervey, A. Herwig and A. de Ruijter (2020). 'More competences than you knew? The web of health competences for Union action in response to the COVID-19 outbreak'. *European Journal of Risk Regulation*, 11(2): 297-306. <https://doi.org/10.1017/err.2020.35>
- Quaglio, G., T. Karapiperis, L. Van Woensel, E. Arnold and D. McDaid (2013). 'Austerity and health in Europe'. *Health Policy*, 113(1): 13-19. <https://doi.org/10.1016/j.healthpol.2013.09.005>
- de Ruijter, A. (2019). *EU Health Law & Policy: The expansion of EU power in public health and health care*. Oxford: Oxford University Press.
- de Ruijter A., R. Beetsma, B. Burgoon, F. Nicoli and F. Vandembroucke (2020). *EU solidarity and policy in fighting infectious diseases: state of play, obstacles, citizen preferences and ways forward*. Research paper 2020-06, Amsterdam Centre for European Studies. Online: <http://dx.doi.org/10.2139/ssrn.3570550> [accessed 2 October 2021].