During the COVID-19 pandemic, it has emerged that the EU lacks any substantive capacity in coordinating, let alone deciding, a European policy to confront the virus. Yet, the health response by the Member States has impacted some of the EU's fundamental freedoms, such as freedom of movement; moreover, the pandemic has had a great effect on the economic union and its rules. Evidently, health policy is yet another field where the process of European integration has created problems – in terms of interdependency – that need at some point to be dealt with by the Member States and the EU. As the following dossier shows, some of the groundwork has already been laid in the form of the EU Health Programme, which we are now going to analyse.

History of the EU Health Programme

According to Seychell and Hackbart (2013), the involvement of the European Community in health policy dates from the 1980s. Back then, it took the form of very specific initiatives, such as programmes to fight clearly identified diseases by coordinating national efforts (especially research, prevention, communication campaigns, and training of professionals). The first initiative took place in 1985, when the European Council launched the Europe against Cancer Programme with the help of an advisory committee of cancer experts. This resulted in a Commission-drafted action plan for 1987-1989. The initiative was considered successful, and was followed by a second action plan for 1990-1994. The success of the Europe against Cancer Programme allowed for the creation of analogous initiatives. The Europe Against AIDS Programme was established by the Council and the Ministers for Health of the Member States. This resulted in a 1991-1993 plan of action that was renewed in 1994 and in 1995. In 1996, a second action plan (1996-2000) was approved. In 1993, the Commission built a comprehensive framework to coordinate action in the field of public health and introduced it through the Communication of 24 November 1993. Following this, six additional action programmes were adopted, starting in 1996 and 1997 with the Community action on the prevention of drug dependence (1996-2000), the Community action on health monitoring, and the Community action on health promotion, information, education, and training (1996-2000). In 1999 three analogous Community actions were adopted in the fields of rare diseases, pollution-related diseases, and injury prevention. These covered the period 1999-2003.

Starting with the 2008 reform, the Health Programme became increasingly integrated within the EU policy

architecture

Eventually, these kinds of programmes ceased. In 2003, the EU decided to adopt a more comprehensive approach with the development of the first EU Health Programme (for 2003-2008). This was conceived as the main instrument for the implementation of the EU Health Strategy, with the aim of reducing the "increasing differences in health status and health outcomes between and within Member States." The programme was considered to "have provided clear European added value," even if the final evaluation underlined many flaws, above all the "lack of clear performance indicators" and "unclear objectives." Starting with the 2008 reform, the Health Programme became increasingly integrated within the EU policy architecture; this trend continued with both the 2014 reform and the European Commission's proposal for the 2021-2027 European Social Fund (ESF) and reform. In 2008, the Health programme was renewed through the EU Health Programme II (2008-2013). What made this programme novel was its integration into the Europe 2020 Strategy. It was also in line with the EU's 2008-2013 health strategy "Together for Health." The final evaluation (see also the final report), once again, highlighted how "the lack of explicit objectives and progress indicators in the programme's design was conducive to the proliferation of priorities." When the programme was renewed in 2014, in the shape of the EU Health Programme III (2014-2020), it became fully integrated into the Multiannual Financial Framework (2014-2020). It would follow a 7-year programming period in line with the other social funds. For 2021-2027, the Commission has proposed the incorporation of the Health Programme into the new ESF+. The programme, however, will retain its specificity and will pursue four distinct objectives: to strengthen crisis preparedness; along with health systems; to support EU legislation on public health; and to support integrated work. The health strand of the ESF+ will have a €413 million budget.

The Health Programme: policy goals and instruments

In terms of policy paradigms, the Health Programme III can be considered a social investment policy. The social investment paradigm, in fact, prescribes "investment in human capital and the objective of full labour market participation." Seychell and Hackbart (2013) explain how the "interplay between health and macroeconomic outcomes" (as outlined in the Staff Working Document on "Investing in Health") has informed the philosophy that underpins the programme. As the argument goes, "a population in good health is a prerequisite for smart, sustainable, and inclusive growth." To achieve this objective, investment is needed in three

areas: sustainable health systems, people's health, and the reduction of health inequalities. These three, in turn, "influence economic outcomes in terms of productivity, labour supply, human capital, and public spending." The philosophy so described, according to Seychell and Hackbart (2013), serves the purpose of reconciling two divergent needs. On the one hand, "health systems in Europe are at the core of its high level of social protection and they are a cornerstone of the European social market economy." On the other hand, the sustainability of these systems and "their ability to cope with the structural changes in demography and the shift in disease patterns affecting populations in Europe has increasingly come into question."

Investing in people's health is conducive to economic growth, because "the health status of individuals strongly influences their labour market participation."

Hence, the strategy of the Commission is two-pronged. The EU has mechanisms in place to ensure that Member States contribute to the macro-economic objective of financial sustainability through budgetary cuts, "including cuts in healthcare budgets." At the same time, "budget constraints should (…) be used as an opportunity to improve the value and effectiveness of healthcare spending." The mechanism in place to achieve this objective is the European Semester, during which the Country Specific Recommendations on health are presented. The Health Programme can facilitate the transition of health care systems by investing in a few crucial areas. The first relates directly to the financial sustainability objective, and requires the improvement of cost-efficiency through sound innovation and the introduction of advanced technological solutions. Second, investing in people's health is conducive to economic growth, because "the health status of individuals strongly influences their labour market participation." It allows them to remain "active and in better health for longer." Finally, the Health Programme has a definite market-correcting dimension, insofar as it strives to reduce health inequalities that are measured by the life expectancy of people with lower education and lower income; health care "can help reduce poverty." This objective tends to balance interventions that make health care sustainable: "fiscal consolidation measures applied to health systems should therefore not compromise the access of poor, disadvantaged populations to high-quality health care."
In terms of policy instruments, the Health Programme III is based on a large number of

different funding mechanisms, mainly grants (project, operating, and direct) to finance research projects or a specific set of activities over the accounting year. Other instruments include joint actions, which finance initiatives and actions with a clear EU added value. These are co-financed by authorities responsible for health, public sector bodies, and non-governmental bodies in the Member States.

How relevant is the Health Programme?

It should now be clear that the Health Programme is directed at a highly specialised group of professionals in the field of health care. However, for the programme to be successful, it has to have a strong profile amongst EU citizens. This was reiterated in the ex-post evaluation of the Public Health Programme (2003-2008): "health-related activities in the EU must have a high level of visibility and transparency and allow all stakeholders to be consulted and participate in order to promote better knowledge and communication flows." The "visibility of the Community as a promoter of the Health Programme" was one of the chief objectives of the cost-benefit analysis that formed the basis of the ex-post evaluation. The final results showed that "the dissemination effort [was] not always [targeting] all relevant stakeholders;" "the case studies revealed that in some cases the beneficiaries have made a considerable effort to disseminate project results," but that "in other cases, the dissemination efforts have not been targeted at all relevant stakeholders." The situation seemed to improve with the Health Programme II. As a matter of fact, its ex- post evaluation gave evidence of "a reasonable amount of coverage and visibility in terms of articles published in scientific journals." The report also highlighted how " initiatives such as the European Commission's Consumers, Health, Agriculture, and Food Executive Agency (Chafea) database and communication materials by the Directorate-General for Health and Food Safety (DG SANTE) have enhanced dissemination, but the diversity of target audiences renders systematic efforts to improve dissemination difficult;" "many communication materials are unwieldy, poorly presented or not accessible."
The evaluation's prescription for developing "a formal communication strategy to define communication objectives, actors, messages, audience, and channels" was actually implemented in the Health Programme III; the strategy also included a "full-time dissemination officer to oversee its implementation" and the publication of a new projects database "to enable new potential beneficiaries and the wider public" to learn about the programme.

Conclusion

The health policy of the EU, which is carried out for the most part through the Health Programme, is presently limited to improving the framework and fostering technological advancements in Member States' health care. In the past, the focus was on the efficiency of systems and their modernisation. The current pandemic might shift attention towards the coordination of prevention and containment of infection. In this sense, the EU health policy could be an asset in improving the aggregate health response of the Member States by creating networks and incentivising EU-wide cooperation between experts and national officials.

Photo credits Flickr CC: Jernei Furman