Health and Inequality[1]

Jappe Eckhardt

Cite as: Eckhardt, J. (2023), *Health and Inequality*, in: Moschella, M., Quaglia, L., & Spendzharova, A. (eds). *European Political Economy: Theoretical Approaches and Policy Issues.* Oxford University Press, pp. 284-304

Chapter summary

Until the beginning of the twenty-first century, health policy was neglected by most students of International Political Economy (IPE) and European political Economy (EPE). However, due to increased transnational risks to the political and economic well-being of citizens posed by pandemics such as Covid-19 and the rise in non-communicable diseases across the globe, the determinants of health started to spill over national borders. At the same time, because of the marketisation and privatisation of health care, private actors started to play a more prominent role in health policy. As a result, IPE/EPE scholars started to pay more attention to health as a field of inquiry. In this Chapter, I set out the main themes defining health policy as a growing field of scholarship within EPE using four theoretical approaches: Open European Economy Politics, Growth Models European Political Economy, Ideational European Political Economy and Critical and Feminist European Political Economy. I will also discuss potential avenues for future research.

[1] This version is an early draft from February 2023

Introduction

For most of the 20th Century, health was not on the radar of many EPE/IPE students. The focus of most EPE/IPE scholarship was primarily on those topics which are generally considered to be the key issue areas in the global economy such international trade and monetary affairs, the role of multinational corporations and economic development. This is not to say that health was ignored entirely by EPE/IPE scholars or IR scholars more broadly (see e.g. Thomas 1989; Navvaro 1977), yet for long health was deemed to primarily fall, not only within social policy, but the domestic sphere of national governments. As a result, health policy was studied almost exclusively by public health scholars and seen as a domestic issue, for which the responsibility fell on national and sub-national government. In case the "international" or "European" context was taken into consideration, this was done as part of a comparative analysis of national contexts.

The traditional absence of health from the IPE/EPE research agenda was understandable, as the topic was, until relatively recently, seen as beyond the boundaries of IPE/EPE scholarship. Health policy was for long regarded exclusively a matter of national governments taking care of their domestic populations. This is also true for the EU, the focus of this chapter. As Mossialos et al (2010: 45) note, health policy was until well into the 1990s "a highly constrained area of EU competence" and EU countries were extremely wary to delegate powers in this policy field to the European level. In the last two decades or so this situation has changed significantly. As a result of increased cross border risks to the political and economic well-being of countries posed by infectious disease outbreaks and pandemics such as Covid-19, both perceived and real, as well as the rise in non-communicable diseases across the globe, health policy and governance has gone through a process of transnationalization or, in the European context, Europeanization. And, as the determinants of health started to spill

over national borders and became transnational health issues, those working within the field of IPE/EPE have become increasingly interested in issues related to health. In this Chapter, I will discuss what the main academic debates are, using the four theoretical approaches discussed throughout this volume and highlight some avenues for further research.

Relevance of health and inequality as a field of inquiry

Any student of the EPE of health policy must invariably grapple with several key questions: a) whether health care is and should be predominantly publicly planned or subject to market forces? and b) what role the various state and non-state actors within the EU system of governance play? While historically the responsibility of organising health systems and health care fell on national governments, in practice, since the beginning of the 21st century, three powerful political and economic forces have played an influential role in changing the role of states in the field of health: marketisation, privatisation and globalisation.

First, we have witnessed a trend towards the *marketisation* of health care systems (see e.g. Jensen 2011). Although marketization has been interpreted in various ways, a recent paper by (Krachler et al 2021: 2) usefully defines it as 'the introduction or intensification of price- or cost-based competition among [health] service providers.' In other words, marketization refers to practices aimed at shifting the balance towards the use of market mechanisms to allocate health care resources. The literature has identified various practices states can/have use(d) to increase competition in health care systems. States can increase openness by loosening the rules excluding non-traditional providers. This often leads to a situation whereby public and private sectors remain intertwined, creating a "mixed market" system which includes public, for-profit, and non-profit providers (Kettl 2015). States can also introduce changes to payment systems or purchasing, allowing existing providers to fail,

expanding frameworks for performance management and evaluation, increasing patient choice, and competitive tendering competition between public and private sectors. Finally, states can increase or introduce *management autonomy in the public sector* by enhancing autonomy of health providers (e.g. public hospital autonomization), the creation of internal markets, and/or regulatory decentralization (Eckhardt and Lee 2019).

Second, there has been a related trend towards the *privatisation* of health care as a policy instrument to relieve perceived pressures on public finances by reducing the role of the state and to shift health care costs from public to private sources (Janssen and Van der Made 1990). Marketisation can under certain circumstances lead to privatisation, but the two processes are not the same (Krachler and Greer 2015). As explained above, marketisation is related to the introduction or intensification of cost or price-based competition, while privatisation refers to a change in ownership (Peedell, 2011). That is, under privatisation, non-state actors become increasingly involved in health provision, typically through a transfer of assets or the contracting out of certain health services. Examples of privatisation include the selling off of health care facilities like hospitals to private investors; the financing of health care through private insurance schemes and user fees; and the delivery of health services such as laundry, catering, cleaning, laboratory services and so forth through private providers (Eckhardt and Lee 2019). In low(er) income countries, constraints on domestic resources and health development assistance, alongside limited capacity of the public sector, have been rationales used by the World Bank, International Monetary Fund and other major donors to press governments to enact privatisation policies (McIntyre et al., 2006).

Third, there has been a trend towards the *globalization* of health. As indicated earlier, during most of the 20th Century, health policy was almost exclusively a matter of national

governments taking care of the health of their domestic populations. However, by the turn of the Century, many health-related issues had become globalized. There are various aspects related to the globalization of health worth mentioning here. Lee and Collin, 2014 (: 3) argue that, as s a result of globalization, the determinants of health circumvent, undermine and have become "oblivious to the territorial boundaries of states and, thus, beyond the capacity of individual countries to address through domestic institutions." The most obvious example of this are outbreaks of infectious diseases, which can spread across borders and become epidemics such as SARS or pandemics like Covid-19 (for a more in-depth discussion see Boxes 13.1 and 13.2). The spread of non-communicable diseases is also linked to globalization (Stephens et al. 2022). This trend also refers to other important health related aspects such as an increase in cross border mobility of health care professionals (Stillwel 2004), as well as an increase in the financing and service provision across national borders which in turn has led among other things to a surge in 'medical tourism' (Ile and Tigu, 2017).

These three trends have been the subject of much critical analyses by researchers within a diverse range of theoretical traditions. In the next four sections I will discuss the state of the art of the EPE research on health policy using the four schools of thought used in this volume: Open European Economy Politics; Growth Models European Political Economy; Ideational European Political Economy; Critical and Feminist European Political Economy.

Open European Economy Politics

As indicated in the Introduction to this Volume, this approach takes as a starting point that, to understand policy outcomes, one should first identify actors' preferences, which are shaped by their material interests. There are two strands of Open European Economy Politics literature: state centred explanations and society centred explanation. The general idea

behind the former body of work is that state interests, and the institutional setting in which policy decisions are taken in the EU, rather than the influence of business lobbies determines policy outcomes. Society centred explanations on the other hand place private interests at the heart of their analysis and suggest that the political tactics and impacts of corporate actors are key in understanding policy outcomes.

Let us start with state centred explanations. The starting point of this body of work is that interests of Member States is key in understanding the fact that the EU's role in health is narrow. That is, health policy currently still falls within the competence of the EU member states, which means that formally in areas such as health crisis response, pharmaceutical procurement and communicable disease control, the EU cannot do much more than support national policies and encourage coordination. Having said that, during the last two decades health has become an increasingly important issue area on the EU policy agenda and the organisation of health systems and health care has inevitably been affected by EU integration (Baute and De Ruijter, 2021; Földes, 2016; Martinsen and Vrangbæk, 2008). EU member states have traditionally resisted the delegation of health policy competences to the EU level because retaining control of health policies and systems is historically considered to be in the national interest. Although most EU member states remain warry of far-reaching harmonisation in this policy area until this day, shifts in preferences have taken place over time (Brooks and Greyer 2020). Member states with well-funded healthcare systems are typically more willing to discuss EU integration in health than those with underfunded and underperforming systems and bringing these different interests together in a more harmonized European framework has proven to be challenging but, through negotiations and compromise, progress has been made.

According to existing work, there are several factors which have led to the increasing impact of the EU upon health, which in turn has laid bare the stark divisions that exist between Member States's interests. Firstly, the EU has had a sustained and significant impact on health policy via the enforcement of the four freedoms (i.e. free movement of goods, services, people and capital), which form the cornerstones of the internal market and over which the EU enjoys considerable legislative power. That is, by targeting provisions of EU Member States favouring national businesses or citizens, the EU has forced the removal and re-regulating of national health policies from above. We have seen many instances of this over the years, including the regulation of professional qualifications for health workers, the provision of health services in other Member States, the authorisation of pharmaceutical products and patient mobility (Brooks et al 2020). However, member states do not automatically accept this process of, what Greer (2006) has called, "uninvited" Europeanization in EU health policy. As the case of the EU's patients' rights directive discussed in Box 13.3 shows, these debates often lead to long negotiations and compromise outcomes to balance the different positions and interests of the Member States. In case of the patient's right directive, such negotiations led to a water downed version of an internal healthcare market with considerably more control by national governments reinserted (Martinsen 2017).

The second factor which has led to an increase in EU's impact on health is the aforementioned trend towards the globalization of health. More specifically, a pattern has emerged since the end of the 20th Century in which, after each crisis with cross border public health implications, incremental but pivotal steps in the development and integration of EU health policy have been taken (Azzopardi-Muscat et al 2016; Földes, 2016). Brooks et al. (2020) describe various examples of such health crises and the EU's response. In the mid-1990s, the Bovine Spongiform Encephalopathy (BSE) crisis of had a significant impact on the EU. It led to an

amendment of the Treaty of Amsterdam in which it was agreed that the EU would get the power to harmonise Member State policies in areas of organs, substances of human origin, blood and blood derivatives, as well as in measures related to veterinary and phytosanitary affairs. A couple years later, as a reaction to the uncoordinated and inefficient European response to the SARS outbreak of 2003, EU member states agreed to create the European Centre for Disease Prevention and Control (ECDC), as well as to the establishment of Unit 3C within DG Health and Food Safety (DG SANTE). The former is a hub to coordinate health monitoring and data collection, while the latter allows the EU to better coordinate joint procurement for medical countermeasures. Although these initial changes certainly helped to better monitor and coordinate health crises responses, during the swine flu pandemic of 2009 (H1N1) many Member States reverted to protectionist approaches and appeared unwilling to share information on data and preparedness planning for health security threats, despite attempts from the European Commission to coordinate the crisis response. This in turn led to discussions and eventually the establishment of a formal EU Health Security Committee. This was seen as another step in the right direction. Yet, as the discussion in Box 13.2 on the Covid-19 policy response shows, a dangerously patchy health infrastructure continues to exist across Europe.

So far, we have mainly discussed the interests of public actors such as EU Member States and the European Commission. Yet, as the earlier discussion on marketisation, privatisation and globalisation already pointed out, we cannot understand health policy outcomes without also taking into consideration the interests and political role of private (or market) actors. This brings us to society centred explanations of policy outcomes. An understanding of the relative roles of public and private actors within the (global) economy lies at the heart of much scholarship on “classical” EPE/IPE issue areas such as trade policy (Milner 1988; Dür 2008;

Dür et al. 2020), as well as monetary and financial affairs (Frieden 1991; Underhill and Zhang 2008; Chalmers 2020). The ascendance of corporations as key actors in the policy making process has been a core focus of this literature. Private actors have become correspondingly prominent in the field of health and there is a burgeoning body of research on this topic (see e.g. Hawkins and Holden 2016; Hawkins et al. 2018; Milsom et al. 2021).

Corporations are important first and foremost because of their role in production and exchange of health-related goods and services within the global economy as well as at the EU level. Some companies develop, produce, and sell health-harming products such as tobacco or alcohol to consumers, while governments try to regulate these markets. In these instances, the interests of private and public interests may clash. An example in the EU context is the EU Tobacco Products Directive, which entered into force in 2014 and gave Member States two years to adopt legislation which forces tobacco companies to cover cigarette and roll-your-own tobacco packs for at least 65% with graphic health warnings with photos, text and cessation information (for a further discussion on tobacco control in the EU see e.g. Duina and Kurzer 2004; Kurzer and Cooper 2016). The legislation allowed countries to go beyond these minimum requirements by for instance introducing plain packaging, which requires companies to remove all promotional, marketing and advertising features on packs of tobacco but leaves the health warnings. This legislation was vehemently opposed by the tobacco industry (Curran and Eckhardt 2017). At the same time, other type of corporations develop, produce and/or distribute medicines, vaccines or therapeutic and diagnostic equipment, used in hospitals (which are often state owned/financed) to diagnose and cure people and, as discussed above, in many countries private actors provide health care services (Eckhardt and Lee 2019). In such instances the interests of public and private actors are usually much more aligned. The most obvious recent example is the joint effort by scientists, regulators, as well as

biotechnology and pharmaceutical companies, to develop a Covid-19 vaccine. These efforts enabled the European Medicines Agency (EMA) to approve the first vaccine (developed by BioNTech and Pfizer) in December 2020, which was only 9 months after the COVID-19 pandemic was declared (Cavaleri et al. 2021).

In addition to their role in production and exchange relations, private health actors are actively seeking to shape, formulate and implement health policies to further their interests. While business interests have of course always sought policy influence, their role in EU health policy has become even more important in recent years because of globalization, marketisation and privatization. In many sectors, globalisation has led to consolidation of ownership and domination by an increasingly few transnational corporations, which in turn has increased their political clout. The costs of staying on the sideline can be very high for these companies, as regulation/legislation can have severe negative consequences on their competitiveness (Buse and Lee 2005). To go back to the earlier example of the EU Tobacco Products Directive: legislation on (plain) packaging poses an explicit threat to tobacco industry promotional strategies by removing a key medium, particularly in a market like the EU where other forms of advertising are restricted, so tobacco firms had a clear incentive to lobby against this directive at the EU level as well as at the Member State level. Although they were unable to block the EU from adopting the Directive, their lobby campaign had success in that only a handful of Member States (UK, France and Ireland) decided to adopt more restrictive legislation by introducing plain packaging, while all other EU countries only implemented the minimum requirements (MacKenzie et al. 2018).

Growth Models European Political Economy

As is the case with other social policy fields, significant differences exist between the ways EU member states have organised public health, as well as between the institutional features underpinning health policies across Europe. These different institutional configurations are the result of variations in "underlying philosophies, legacies, normative aspirations and levels of economic development" (Földes, 2016: 297).

A logical starting point to study national institutional diversity among EU countries and its implications for European integration would be, as also suggested in the Introduction to this Volume, the Varieties of Capitalism (VoC) literature. However, there is surprisingly little work that has used a VoC lens to study institutional differences in health care systems across Europe. One notable exception is a recent article by Hornung and Bandelow (2021), which uses the classical VoC framework with its two ideal types of Coordinated Market Economies (CMEs) and Liberal Market Economies (LMEs), to analyse the conditions under which public health expenditures changed in EU member states after the GFC. The authors observe interesting variations between CMEs and LMEs in this regard. That is, being a CME turned out to be the most important condition for increased health care spending. The other important factor for such increased post-crisis spending, the authors find, was the presence of a left-wing government. Member States, which neither had left party participation in government nor an institutional frame of CME did not experience increases in public health expenditures.

One of the likely reasons for the fact that few scholars interested in health policy have used a VoC lens in their work, is the rather static and strictly dualistic character of the approach. If one looks at the existing instruments/typologies for grouping and comparing countries' health care systems (see e.g. de Carvalho et al 2021; Moola et al, 2021) and compare these to

typologies of market economies, it becomes apparent that countries do not always fall within the same cluster of countries.

Take for instance the typology of European healthcare systems developed by Wendt (2009), which is arguably the most influential of its kind. By using various quantitative and institutional indicators, Wendt identified three clusters of European countries with different health care systems. Cluster 1 consists of Austria, Belgium, France, Germany and Luxembourg. These countries all have high levels of total health expenditure and a high share of public health funding. This cluster does somehow fit the VoC logic in that most of these countries are CMEs, although France is sometimes classified as a state influenced market economy (Schmidt 2016). It becomes more interesting when we look at Cluster 2, which fares much less well than cluster 1 when one compares it to the VoC literature. This Cluster includes the archetypical LMEs UK and Ireland, the CMEs (or Nordic/Welfare capitalists) Denmark and Sweden and Italy, an MME according to most influential sources (see e.g. Hancké et al. 2007). According to Wendt (2009), all these countries are characterized by a medium level of total health expenditure, a share of public health funding and moderate private out-of-pocket funding. Another defining feature of Cluster 2 countries is that access to medical professionals, as well as doctors' salaries, are highly regulated. Finally, Cluster 3, which is also a bit of a mixed bag when using a VoC lens, with MMEs like Portugal and Spain and a CME (or Nordic/Welfare market economy) like Finland. These countries are characterized by a very low level of per capita health expenditure, relatively high private out-of-pocket payments, a high control of patients' access to medical doctors and, like cluster 2 countries, highly regulated salaries for medical professionals.

It could be argued that this discussion on health care typologies and whether a VoC lens is a useful addition to the discussion on institutional diversity in European health policy, is obscuring the fact that we have in fact witnessed a convergence of health systems on a single neo-liberal model (Minogiannis, 2018). In line with a broader IPE scholarship on the retreat of the state (e.g., Cerny 1994; Strange 1996), there is a body of research which point at the fact that, because of the three trends discussed above (marketisation, privatisation and globalisation), countries in Europe have witnessed an increased role for the market in the area of public health and, in turn, that a process of convergence has taken place. As discussed in more detail below, this is what many scholars working in the *critical* IPE/EPE tradition argue. This is not to say that, according to this logic, all European health systems have become identical. In fact, there are very few scholars that believe that a complete convergence of health care systems among EU countries is likely to happen in the near future, but it is argued that there is a general trend over time towards a more limited role for the state and public institutions (Minogiannis, 2018).

What does all of this mean for European integration in the field of health? As explained above, there is a consensus that institutional heritage of health care systems among EU countries has led to distinct differences in the way countries have historically organised public health and that this has for long impeded the delegation of regulatory authority to the EU-level (Scharpf 2002). However, as discussed above as well, this has changed in recent years and there has been a trend towards "uninvited" *Europeanization* in EU health policy (Greer 2006). This is in part the result of activities of EU institutions in areas outside health, both legislative and judicial, which have had unexpected consequences for health policy.

Ideational European Political Economy

Ideational (or constructivist) approaches have made important contributions to the disciplines of international relations (Finnemore and Sikkink 1998; Wendt 1999), European integration (Risse et al. 2001) and IPE (Blyth 2002). However, when compared to the other schools of thought discussed in this chapter, it is only relatively recently that scholars have stated to look at public health through an ideational lens. According to constructivists, health policies (or any other policies for that matter) are not (or not only) the result of pre-determined material interests of actors, but socially constructed and mediated through ideas and discourses. That is, ideas-based approaches focus on the kind of ideas that circulate among decision makers, where these ideas come from and the way they are framed, as well as what arguments are used for adopting certain ideas over others in the decision-making process (Jones et al 2017).

So, an important part of the ideational research agenda is studying the role of frames and framing. In the field of health policy, this means concretely that scholars have focussed on how different approaches to health policy are contested as a result of competing frames for understanding possible policy responses and the relevant policy instruments, but also who the legitimate actors are to define health problems and participate in action towards solutions (McInnes et al. 2012). In the words of Jones et al (2017: 71), "[f]rames construct rationales for particular policy responses because they symbolically attach to ways of understanding health (e.g. human rights, development) that may persuade specific policy actors." For instance, the way pandemics are framed, will lead to different responses and justifications for policy choices (McInnes and Lee, 2012). As discussed in Box 13.2 in more detail, if we look at the very different domestic responses in Europe to the Covid-19 pandemic we have clearly seen this logic of framing at work.

What is also interesting from an ideational/framing perspective is that, despite these stark differences in domestic responses to the pandemic in the EU, when it comes to discussions about the Covid-19 economic recovery plan at the EU level, the message conveyed by heads of state and President of the European Commission Von Der Leyen was that the crisis should be addressed by 'walking the road together' and to avoid 'leaving countries, people and regions behind' (Von der Leyen, 2020). The initial response was very different: in the first couple of months of the pandemic the divisive imagery of saints versus sinners, as also used during the Euro crisis (Matthijs and McNamara 2015), reappeared in Europe's public sphere, which in turn led to fears about another existential EU crisis. Ferrera et al (2021) convincingly show that this puzzling shift from "harsh antagonism to relative appeasement" was the result of the fact that certain EU leaders became convinced that a new existential crisis had to be avoided at all costs and that this could only be achieved in part by framing the economic recovery plan in solidaristic terms to make sure to keep the member states together. As such, leaders engaged in a deliberate strategy of "symbolic communication" and this 'communicative discourse' played a key role in building consensus around the adoption of the recovery plan. This is in line with what Hervey (2008: 104) has said about the role of ideas in EU health policy more generally. She states that within the multi-level environment of the EU, ideas "have constitutive effects" and that "social learning is a means of disseminating such ideas and, in so doing, of helping constitute or construct the interests of actors and, ultimately, effecting policy change."

The ideational literature has also looked at what happens before the framing process by asking where ideas that form the basis for competing frames and policy justifications come from. An important role is played by epistemic communities in this regard. For instance,

Williams and Rushton (2009) argue that the global biomedical epistemic community has been able to wield influence on health policy by means of persuasion and justification of particular (scientific) approaches and solutions over others, which also became apparent during the Covid-19 pandemic (Lavazza and Farina 2020). Ideas also come from other on-state actors, in particular corporate actors. Firms do not only possess the kind of material power discussed in the section on the Open European Economy Politics approach, but they also possess the ability to shape the core ideas and discourses underpinning health policies and regulatory frameworks in ways that support their interests. Examples include the tobacco industry's use of language concerning smoking as a personal choice and, in cases where countries proposed stringent tobacco control measures, "caution against the growth of the nanny state, associated loss of individual freedom of choice, and the threat of similar regulation being imposed on alcohol and fast-food products" (MacKenzie et al. 2018: 1004). The food industry often put emphasis on "balanced diets," which should include treats; and the alcohol industry on "risky behaviours." Across these industries, emphasizing the behavior of consumers and their personal choice, has proven effective in keeping regulatory debates away from calls for change to industry practice (Eckhardt and Lee 2019).

On the other hand, constructivist scholars have also suggested that, in certain contexts, less materially affluent and powerful social and employment actors can get a platform to shape health policy decisions through ideational power (Harmer, 2011). Zeitlin and Vanhercke (2018) for instance argue that this is what happened when the EU decided to integrate social objectives and policy co-ordination (including the accessibility of health care) into the EU post-GFC governance architecture. They argue that in the aftermath of the GFC, there has been "a partial but progressive 'socialization' of the 'European Semester' of policy co-ordination, in terms of increasing emphasis on social objectives in its priorities and key messages […]

intensified social monitoring and review of national reforms; and an enhanced decision-making role for EU social and employment actors" (p. 149). It must, however, be noted that Vanhercke and Verdun (2022) argue that after the introduction of NextGenerationEU – the €800 billion EU scheme to support member states hardest hit by the COVID-19 crisis – social actors were in fact side-lined.

Critical and Feminist European Political Economy

Of all the approaches discussed in this Chapter, Critical approaches have the longest history of incorporating health into the study of political economy (see e.g. Navarro 1975). In fact, the interface between actors and structures across the political and economic realm, was until relatively recently largely associated with neo-Marxist and other critical perspectives and thus falling outside mainstream analysis of health policy.

One of the central themes of critical and feminist approaches is the relationship between global economic structures and power asymmetries (between states; between state and private actors; and between gender groups) on the one hand and health inequalities on the other. The starting point of much of this work is the observation that stark differences exist between, - and within countries when it comes to basic indicators like life expectancy at birth, infant and maternal mortality rates, and incidence of disease. Research suggests that such health inequalities between countries, and across specific populations, are persistent and potentially widening. Although Europe fairs relatively well when it comes to health inequalities in comparison to most countries in the Global South and other Western economies such as the US (Mackenbach et al. 2018), systematic differences also exist in European countries between for instance people with a lower and higher socio-economic status (Mackenbach 2019). As Mackenbach (2019) observes, in the Netherlands men in the

highest income group live seven years longer and live many more years in good health than those in the lowest income group. As discussed in Box 13.1 below, The Covid-19 pandemic has brought these inequalities to the fore once again.

The extent to which these trends of health inequalities are associated with the nature of the global economy remains subject to debate. Neoliberal development theory suggests that economic growth from accelerated globalization in the 20th and 21st Century has benefited all countries in the aggregate, even if there is a time lag to allow for "trickle down effects" (e.g. Dollar and Kraay 2004). Economists working in this tradition also often point at the fact that during this period, the global life expectancy rose from about 25-30 years at the end of the 19th Century, to 47.7 in 1955 at that since then it has risen even more sharply to 67.2 in 2005 and 70.8 in 2015 and that such a rise has taken place in all groups of countries (Ayuso 2015). Although these figures are not disputed, those working in the tradition of critical and feminist political economy, argue that the restructuring of production and exchange and shifts in power relations within a neo-liberal globalized economic system have created "winners" and "losers" within and across countries and economic sectors (Phillips 2017) which, in turn, have created novel patterns of health, health inequalities and disease (Stephens et al. 2022).

The implications of neoliberalism on unequal access to health care and health outcomes, especially in the Global South, have received most attention (e.g. Nunes 2020; Rowden 2011). However, as the work by scholars such as Navarro (2000; 2007) and Labonte and Schrecker (2007) have shown, social and health inequalities created by neoliberalism and globalization are not just present in the Global South but also in the Global North, as the discussion on the Covid-19 in Boxes 13.1 and 13.2 also illustrates. Benatar et al. (2011: 646) argue that "the present dominance of perverse market forces on global health" has created a situation in

which “disparities in wealth and health have persisted and, in many places, widened.” The authors put much of the blame on international economic institutions such as the IMF, the World Bank, and the WTO, as they directly and indirectly promote neoliberal policies such as the privatisation of health services and reduced government expenditure on health care. The EU institutions are often also held responsible for reinforcing a “neoliberal rationality” in the field of health policy; both within the EU itself (Godziewski, 2020), as well as through its external (economic) relations such as the signing of trade agreements (Jarman and Koivusalo 2017). Finally, there is an increasing body of work, which argues that in our globalised neo-liberal economic system, global power asymmetries have become the main reason behind health inequities (see e.g. Chorev 2013; Kentikelenis and Rochford 2019). As Kentikelenis and Rochford (2019: 2) note, “there is no level playing field among equal actors, but an imbalanced decision-making apparatus where different actors command varying degrees of political, economic, symbolic, or epistemic power.”

Another important theme among critical scholars is the relationship between globalization and the rapid spread of infectious diseases such as HIV/AIDS, and more recently Covid-19, as well as the increase in the global incidence of non-communicable diseases (NCDs) since the late twentieth century. Although epidemics and pandemics are of course not a new phenomenon, it is well established that the current wave of globalization – which is *inter alia* associated with increased mobility of people; intensified trade in goods and services; and climate change – has led to a much more rapid cross-border spread of infectious diseases (Saker et al 2004). The spread of non-communicable diseases such as diabetes, hypertension, coronary heart disease and most types of cancer, which have become the main cause of death globally, are also linked to globalization (Stephens et al. 2022). Data shows that the so called “epidemiological transition” model, which suggests that when countries become more

developed, they will move from a higher incidence of communicable diseases to NCDs (Omran 1971), does not fully describe contemporary trends. That is, all countries across the globe have experienced an unprecedented rise in NCDs, regardless of their development trajectory and for many low-income countries, this has meant a "double burden" from both disease categories (Eckhardt and Lee 2019). As this rapid increase of NCDs cannot be explained by demographic trends such as ageing alone, scholars have started to look at the nature of global economic development as an explanatory factor. Although this is a relatively new research area, recent scholarship suggests that changes in the production and consumption of certain types of goods and services such as ultra-processed food and beverages, tobacco and alcohol products, as well as shifts in lifestyle or employment patterns, all issues associated with economic globalization, can offer a fuller explanation (Stephens et al. 2022).

The negative implications of the increase in migration of health care workers from the global south to the global north and medical tourism are also part of the *critical* research agenda. Although the migration of health care workers is not a new phenomenon and is not per definition bad, research has shown that it has increased in the last three decades and that the implications for lower income countries can be severe (Labonté et al. 2015; Stillwell et al 2004; Walton Roberts et al 2017). That is, there is a large group of countries which, according to the WHO, are having a "critical shortage" of health care workers because of "structural imbalances in resource allocation and global incentive structures" (Mackey and Liang 2012: 66). Although there is a lack of reliable recent data on destination countries, a report from the WHO published in 2014 (Siyam and Dal Poz 2014) suggests that most health care workers from global south countries migrate to Anglo-American OECD member countries (Australia, Canada, New Zealand, the UK, and the USA) although EU countries are also an important destination. In case of medical tourism, people exploit cost and regulatory differences

between countries for their personal well-being (Mosedale 2016). Such tourism has become a profitable niche market for some countries in the Global South and offers countries in the Global North with escalating waiting lists and costs a way to outsource health care and, as such, puts the onus on individuals to fund their own treatment (Smith 2012: 2). Although in some ways this can be seen as a positive development, critical scholars point out that medical tourism aggravates the negative effects of the neoliberal turn in health, given that medical tourism often increases inequalities in terms of access to health care, as well as its cost and quality in both the home markets and the destinations countries (Connell 2011; Smith 2012).

Directions for further research

As the above overview shows, health has in recent years become an important area of study for those interested in EPE/IPE. Having said that, compared to "classic" EPE/IPE issue areas such as trade and monetary and financial affairs, the EPE/IPE of health research agenda remains in its infancy. One of the shortcomings of some of the above cited works is that, although they surely touch upon relevant EPE/IPE themes, they are often not conducted by EPE/IPE scholars and as such do not always make full or explicit use of relevant EPE/IPE theories and have left important issues EPE/IPE students are interested in unexplored. As a result, there is much scope for further research in this important area of EPE/IPE.

Firstly, there is still relatively little research which has explored how the globalisation of production and investment affects health policy outcomes in the EU and beyond. Exploring this will help to better understand important issues such as (shifts in) preferences and the relative power of state and private actors in the area of health, as well as supply chain resilience and vaccine nationalism, issues which came to the fore during the Covid-19 pandemic. Scholars could draw on the burgeoning IEPE/PE research on global value chains

(GVCs) and global production networks (GPNs) to further develop this research agenda (Gerreffi 2005; Yeung and Coe 2015). This research has shown that the establishment of GVC/GPN and the different ways these are governed, as one of the key characteristics of the contemporary world economy, has major implications for policy preferences and political behaviour of key actors and, therefore, shape decision-making and institutional design at the domestic and global level. Although these insights have so far mainly been applied to the area of trade (Curran et al. 2019; Eckhardt and Poletti 2018; Gereffi et al. 2021), they seem very relevant for the EPE/IPE of health too.

Secondly, the Covid-19 pandemic has shown more than any event in the past how complex and multifaceted the EPE/IPE of health has become. Health decisions are complex because of their overlap with other policy areas but also because of the number of actors and institutions involved in decision making at different levels of governance. The rich research agenda on regime complexity could help students investigate the "rising density of institutions, policies, rules and strategies to address" (global) health issues (Alter 2022). So far there is surprising little research which has used a regime complexity lens to study health policy outcomes in general (but see Fidler, 2010) and in the EU context in particular. The key question is whether and how regime complexity impacts decision-making and political strategies, as well as empower some actors and interest groups (Alter and Meunier 2009).

Thirdly, there is ample scope for more comparative research in the tradition of the VoC literature. As indicated above, so far there has been very limited usage of the VoC approach to study health policy outcomes because of the rather static and strictly dualistic character of the approach. However, recent work in the comparative capitalism (CC) tradition has opened the door for a research agenda which includes a much wider set of capitalist models than put

forward by the original VoC approach (Nölke 2019) – including Dependent Market Economies (DMEs), Mixed Market Economies (MMEs), State Permeated/Influenced Market Economies (SMEs), and so forth – and this could be a fruitful framework to study certain aspects of the relationship between institutional differences and health policy outcomes in Europe and elsewhere. Having said this, even if one would take a wider lens and include varieties of capitalism beyond CMEs and LMEs in the analysis, it is questionable whether this would be sufficient to fully understand the variation in health care systems in Europe and its implications as described in this chapter.

Conclusion

Although political economy has been used to study the relationship between state and market actors within the health sector, mainly from a critical perspective, for a long time, extending such an analysis to the international or European level has been more limited for most of the 20th Century. Only since the turn of the Century have students interested in health policy started to apply insights from IPE and/or EPE to the study of health beyond the nation state in a systematic way. The reason for this shift is that, while historically national governments were the main actors when it came to the organisation and governing of health systems and health care, in the last two to three decades the role of the state in the field of health has changed considerably because of marketisation, privatisation and globalisation. As health policy transnationalized and non-state actors started to play a more prominent role in health provision, health policy increasingly became a field of interest for IPI/EPE scholars.

In this Chapter, I have given a broad overview of the state of art of EPE research on health policy, focussing on the four theoretical traditions used throughout this volume. As I discussed, Scholars working in the tradition of Open European Economy Politics work along

two lines of inquiry: one group of scholars focusses on the interests of EU member states and how they navigate the institutional setting in which policy decisions are taken in the EU, while others look at how private actors (try to) shape policy outcomes at the national and EU level. The second strand of literature I discussed, Growth Models European Political Economy, tries to understand the significant institutional differences which exist between the ways EU member states have organised health policy. According to this body of work, these different institutional configurations can only be understood by looking at variations in underlying philosophies, historical decisions, normative aspirations as well as development levels. Ideational European Political Economy focusses primarily on the type of ideas that circulate among decision makers involved in EU health policy making. Scholars using this approach study where such ideas come from, how they are framed and what arguments are used for adopting certain ideas rather than others in health policy formulation and implementation. Finally, critical and feminist EPE scholars study the relationship between, on the one hand, economic structures at the global and European level and, on the one hand, health inequalities. Their aim is to unveil how trends of health inequalities are associated with power asymmetries and/or the changing nature of the global economy.

As this Chapter has shown, EPE/IPE scholars have made great progress in understanding health policy outcomes and their implications. However, as I have shown as well, the EPE/IPE research agenda on health policy is still much less developed than EPE/IPE scholarship on more traditional issue areas like trade, monetary and financial policy. In other words, there is still much more work to be done on this important policy area and the Chapter has highlighted various avenues for further research building on the insights from the literature on GVCs/GPNs, regime complexity and Comparative Capitalism.

Case studies

Box 13.1 *Covid-19 and inequality*

Research has shown that often made claims by politicians and commentators throughout the Covid-19 pandemic that we are 'all in it together' and that the virus 'does not discriminate,' cannot be further from the truth. In their book the Unequal Pandemic, Bambra et al (2021) argue that the pandemic is unequal in at least three ways and that we can only understand this by looking at interactions between covid-19 and existing social, economic and health inequalities.

The pandemic kills unequally – research shows that OECD countries with high levels of income inequality have performed significantly worse when dealing with the COVID-19 outbreak in terms of infections and deaths than countries with a more equal income distribution (Wildman 2021). Within countries, covid-19 deaths are highest in the most deprived neighbourhoods. For instance, data for England shows that COVID-19 deaths are twice as high in the most deprived neighbourhoods as in the most affluent. There are also significant inequalities by ethnicity and race, with death rates among ethnic minorities in the UK much higher than expected, and mortality among African Americans in US cities far higher than for their White counterparts (Bambra et al 2021). Finally, although data on Covid-19 death in the Global South is notoriously unreliable because of a lack of testing and reporting, a recent Oxfam (2022) report suggests that the COVID-19 death toll has been four times higher (and 31% higher on a per capita basis) in lower-income countries than in rich ones and that one of the main reasons for this disparity is the unequal access to vaccines.

The pandemic is experienced unequally – throughout the pandemic, countries across the globe have used lockdowns to slow the spread of infections and, as for instance the study by Bonacini et al (2021) on the Italian case shows, these have proven generally successful from an immunological point of view. However, lockdowns have also led to a significant increase in

social isolation and confinement within the home and immediate neighbourhood for long periods of time. Bambra et al (2021) show that the social and economic experiences of lockdowns are unequal because lower-income workers are a) most likely to face job and income loss; b) live in higher-risk urban and overcrowded environments; and c) and are more likely to catch the virus because they often occupy key worker roles. It must also be noted that, although low-income groups in the global north have surely suffered more from lockdowns than higher earners, the social and economic burdens have been particularly severe for those in the Global South. This is again in part the result of the unequal access to vaccines, which makes lower income countries more vulnerable to subsequent Covid-19 waves for a longer period without vaccines, which in turn may tempt governments in the global south to keep on reimposing lockdown measures (Eyawo et al. 2021).

The pandemic impoverishes unequally – the economic implications of Covid-19 and the subsequent lockdowns and economic emergency measures have resulted in an unprecedented shock to the economy, triggering the largest global economic crisis in more than a century (World Bank 2022). The economic devastation has resulted in job losses, reduction in wages, dramatically increased levels of private and public debt in the world economy, as well as a sharp increase in levels of poverty and inequality and 'deaths of despair.' The social and geographical distribution of these economic impacts are unequal, with economically disadvantaged groups such as low-income workers, women and ethnic minorities bearing the brunt (Bambra et al 2021). Vulnerable groups in the global south have been particularly hard hit. Illustrative is data suggesting that more than half of households in LIMCs were not able to sustain basic consumption for more than three months in case of income losses, while the average business could cover fewer than 55 days of expenses with cash reserves (World Bank 2022).

Box 13.2 *The EU's Covid 19 policy response*

Initially, the response of EU Member States to the pandemic was unilateral and without much coordination at the EU level. That is, through March and April 2020, national governments adopted border closures and export bans on crucial medical supplies and equipment to protect their own populations and, by doing so, obstructed the freedom of movement, and exhibiting behaviour indicative of European disintegration. A key reason for this response is that there is huge variation between Member states in terms of their national communicable disease control capacities, infrastructure and resources. Another reason is that the EU did not have the ability to respond exhaustively and effectively at the outset of the Covid-19 pandemic, as this was curtailed by the health competences assigned to it in the Union's founding treaties. As a result, there was no institutional system in place to coordinate between national communicable disease actors and, in turn, there was little coherence in and overside over national public health laws, competent bodies and emergency preparedness plans. What is more, the EU did not have the necessary stockpiles to respond to requests for personal protective equipment (PPE) and other critical resources and was unable to stop the wave of export bans adopted by EU Member States seeking to retain what supplies they had (Brooks and Greyer 2020). However, over time the EU began to play a much more active role in the pandemic response, as the value of collective action seemed to become apparent to leaders of the member states. This resulted in a much more coordinated response and agreement on a common 'exit strategy' (European Commission 2020). As part of this joint strategy, Member states took a series of measures in the course of 2020 and 2021 such as the lifting of export bans, the organisation of collective procurements, the introduction of an EU Digital COVID Certificate and the development and approval of vaccines by the European Medicines Agency (Brooks and Greyer 2020; Cavaleri et al. 2021).

All of this is not to say that national pandemic response suddenly became identical. On the contrary: stark differences exist in the stringency of responses to Covid-19 among EU member states and, as Narlikar and Sottilotta (2021) show, governments have framed the pandemic in very different ways. The authors show that political leaders in some countries have mainly put emphasis on the economic rather than the human costs of the pandemic in their narratives, while there was also a distinction between leaders who argued that the disease would affect 'only' certain sub-groups of society severely and those that emphasised that society as a whole was at risk. Sweden and Greece represent the two most extreme examples in this regard, whereby in case of the former the "economic costs/only certain groups" narrative was dominant while in the latter the opposite was true.

Others have also pointed at the fact that different EU member states have been affected differently and that "the original inequalities leading to these unequal impacts were a result of prior political choices, and policymakers could choose whether to address the unequal impacts of the pandemic, or not." Governments in the EU (and elsewhere) responded differently to Covid-19, and those with higher rates of social inequality and less generous social security systems had a more unequal pandemic (Bambra et al (2021: XIV). Navarro (2021) links this to neoliberal policies such as austerity measures, which have led to cuts in expenditures in medical care and public health services, as well as privatization of health services, adopted by governments in countries like Italy, Spain, and the US. According to him these past policy choices have significantly weakened capacity of certain countries to effectively respond to Covid-19.

Box 13.3 *The case of the EU Patients' rights directive*

Discussions about EU patient mobility and the free provision of cross border healthcare services has been going on for decades (for a more in-depth discussion see Martinsen 2015; 2017). In fact, the right to access healthcare in another member state was adopted in the 1950s between the original EU Member States as one of the first Community regulations which granted migrant workers the right to have their social security rights, including healthcare, coordinated across borders. Yet, Member States maintained considerable control of patients seeking planned health treatment in another EU country for most of the 20th century. That is, the Member States maintained considerable discretionary scope to grant or refuse cross-border healthcare and de facto such rights were seldom granted by most member states. "However, the justifiability of territoriality was challenged by the line of CJEU judicial interpretations from the end of the 1990s onwards where the Court laid down that the principles of free movement of goods and services [also] applied to the field of healthcare. [So] jurisprudence was an important push for further health policy integration, challenging national control." How did the EU respond to this legal push for integration?

The European Commission responded to these rulings by putting forward a proposal for a patient rights directive in 2008. The Directive was aimed at guaranteeing patient mobility and the free provision of cross border healthcare in the EU. Discussions on the directive took place between 2008 and 2011 and led to strong disagreement between the Commission and the Member States, as well as among Member States themselves, and many rounds of negotiations. The different positions were informed in part by the degree to which CJEU case-law had been implemented in the respective member states. There were only two countries (Sweden and Belgium) openly supportive of the proposal from the onset. Other Council members such as the UK, the Netherlands, France, Germany, and Denmark, agreed with the basic idea behind the Directive but had some serious doubts about certain elements of the

proposal. Finally, a large group of Southern and Eastern European Member States opposed the dossier and found it a wronged intervention in national competences. The list of concerns of the latter group of countries was long and included issues such as cost containment of the proposal and how to deal with pensioners from Northern member states residing in Southern members.

The negotiations eventually led to a significant downgrading of key provisions of the original Commission proposal with considerable national control and territoriality reinserted. In fact, Martinsen (2017) suggests that the final text of the Directive in many ways disincentivizes patients from seeking healthcare in another member state, which is of course the opposite of what the Commission and some Member States had hoped to achieve.

Questions

Exam questions

- Which three political and economic forces have played a role in changing the role of states in the field of health since the beginning of the 21st Century?
- Critically discuss the two strands of scholarship on health policy associated with the Open European Economy Politics literature.
- How far is the Varieties of Capitalism literature useful as a framework to compare health care systems across Europe?
- "Health policy outcomes are not the result of pre-determined material interests of actors, but socially constructed and mediated through ideas and discourses." Critically discuss this claim.
- What is the relationship between globalization and the rapid spread of infectious diseases non-communicable diseases (NCDs) since the late twentieth century? Discuss with reference to Critical and Feminist European Political Economy.

Research questions

- Have we witnessed 'a return of the state' in EU health policy in the aftermath of the Covid-19 pandemic?
- How can we explain the rising complexity in institutions, policies, rules, and strategies to address EU health issues and what are the implications of such regime complexity?

Suggestions for further reading

- Bambra, C., Lynch, J., & Smith, K. E. (2021). *The unequal pandemic: COVID-19 and health inequalities*. Policy Press.
- Greer, S. L., King, E., Massard da Fonseca, E., & Peralta-Santos, A. (2021). *Coronavirus politics: The comparative politics and policy of COVID-19*, University of Michigan Press.
- Hervey, T. K., Young, C. A., & Bishop, L. E. (Eds.). (2017). *Research handbook on EU health law and policy*. Edward Elgar Publishing.
- Mackenbach, J. P. (2019). *Health inequalities: Persistence and change in modern welfare states*. Oxford University Press.
- Minogiannis, P. (2018). *European integration and health policy: The artful dance of economics and history*. Routledge.
- Rowden R. 2011. *The Deadly Ideas of Neoliberalism, How the IMF has undermined public health and the fight against AIDS.* London: Zed Books.
- Stephens, C., Hawkins, B. and Liverani, M. (eds) (2022) *Globalization and Global Health: Critical Issues and Policy*, 3edition, Open University Press

Web links

- The official website of the EU provides a wealth of information about many topics related to health, but this link provides a good starting point: https://european-union.europa.eu/priorities-and-actions/actions-topic/health_en
- The European Health Information Portal is a great resource for population health data, as well as broader information and expertise on EU health: https://www.healthinformationportal.eu/
- The European Centre for Disease Prevention and Control provides health surveillance data, as well as detailed information on national disease-specific prevention and control programmes and initiatives across Europe: https://www.ecdc.europa.eu/en

References

Alter, K. J. (2022). The promise and perils of theorizing international regime complexity in an evolving world. *The Review of International Organizations*, *17*(2), 375-396.

Alter, K. J., & Meunier, S. (2009). The politics of international regime complexity. *Perspectives on politics*, *7*(1), 13-24.

Azzopardi-Muscat, N., Sorensen, K., Aluttis, C., Pace, R., & Brand, H. (2016). Europeanisation of health systems: a qualitative study of domestic actors in a small state. *BMC Public Health*, *16*(1), 1-

Bambra, C., Lynch, J., & Smith, K. E. (2021). *The unequal pandemic: COVID-19 and health inequalities*. Policy Press.

Baute, S., & De Ruijter, A. (2021). EU health solidarity in times of crisis: Explaining public preferences towards EU risk pooling for medicines. *Journal of European Public Policy*, 1-23.

Benatar S, Gill S, Bakker I. 2011. Global Health and the Global Economic Crisis. *American Journal of Public Health*, 101(4): 646-653.

Blyth, M. (2002). *Great transformations: Economic ideas and institutional change in the twentieth century*. Cambridge University Press.

Bonacini, L., Gallo, G., & Patriarca, F. (2021). Identifying policy challenges of COVID-19 in hardly reliable data and judging the success of lockdown measures. *Journal of Population Economics*, *34*(1), 275-301.

Brooks, E., & Geyer, R. (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., de Ruijter, A., & Greer, S. L. (2020). COVID-19 and European Union health policy: From crisis to collective action. *Social policy in the European Union: state of play*, 33-52.

Bulmer, S. J., & Radaelli, C. M. (2004). *The Europeanisation of national policy?* (No. p0042). Queens University Belfast.

de Carvalho, G., Schmid, A., & Fischer, J. (2021). Classifications of health care systems: Do existing typologies reflect the particularities of the Global South?. *Global Social Policy*, *21*(2), 278-300.

Cavaleri, M., Enzmann, H., Straus, S., & Cooke, E. (2021). The European Medicines Agency's EU conditional marketing authorisations for COVID-19 vaccines. *The Lancet*, *397*(10272), 355-357.

Chorev N. Restructuring neoliberalism at the World Health Organization. *Rev Int Polit Econ*. 2013;20(4):627–66.

Clare, K., Maani Hessari, N., & Milner, J. (2022). Meat, money and messaging: how the environmental and health harms of red and processed meat consumption are framed by the meat industry. *Food Policy*.

Connell, J. (2011). A new inequality? Privatisation, urban bias, migration and medical tourism. Asia Pacific Viewpoint, 52(3), 260-271.

Curran, L., K. Nadvi and L. Campling (2019), 'The influence of tariff regimes on global production
networks (GPNs),' Journal of Economic Geography, 19 (4), 873–895.

Duina, F., & Kurzer, P. (2004). Smoke in your eyes: the struggle over tobacco control in the European Union. *Journal of European Public Policy*, *11*(1), 57-77.

Eckhardt, J., & Lee, K. (2019). The international political economy of health. In *The Palgrave Handbook of Contemporary International Political Economy* (pp. 667-682). Palgrave Macmillan, London.

Eckhardt, J. and A. Poletti (2018), 'Introduction: bringing institutions back in the study of global value chains', *Global Policy*, 9 (S2), 5-11.

European Commission (2020). Joint European Roadmap towards lifting Covid-19 containment measures, 2020/C 126/01 of 17 April 2020.

Eyawo, O., Viens, A. M., & Ugoji, U. C. (2021). Lockdowns and low-and middle-income countries: building a feasible, effective, and ethical COVID-19 response strategy. *Globalization and health*, *17*(1), 1-5.

Ferrera, M., Miró, J., & Ronchi, S. (2021). Walking the road together? EU polity maintenance during the COVID-19 crisis. *West European Politics*, *44*(5-6), 1329-1352.

Fidler, D. P. (2010). *The challenges of global health governance*, Council on Foreign Relations Working paper, available at: https://cdn.cfr.org/sites/default/files/pdf/2010/05/IIGG_WorkingPaper4_GlobalHealth.pdf

Földes, M. E. (2016). Health policy and health systems: a growing relevance for the EU in the context of the economic crisis. *Journal of European Integration*, *38*(3), 295-309.

Gereffi, G., H-C Lim J. and Lee (2021), 'Trade policies, firm strategies, and adaptive reconfigurations of global value chains,' *Journal of International Business Policy*, forthcoming.

Godziewski, C. (2020). Evidence and power in EU governance of health promotion: Discursive obstacles to a "Health in All Policies" approach. *JCMS: Journal of Common Market Studies*, *58*(5), 1307-1324.

Gómez, E. J. (2022). Enhancing our understanding of the commercial determinants of health: Theories, methods, and insights from political science. *Social Science & Medicine*, 114931.

Greer, S. L. (2006). Uninvited Europeanization: neofunctionalism and the EU in health policy. *Journal of European Public Policy*, *13*(1), 134-152.

Greer, S., & Jarman, H. (2012). Managing risks in EU health services policy: spot markets, legal certainty and bureaucratic resistance. *Journal of European Social Policy*, *22*(3), 259-272.

Greer, S. L., King, E. J., da Fonseca, E. M., & Peralta-Santos, A. (2020). The comparative politics of COVID-19: The need to understand government responses. *Global public health*, *15*(9), 1413-1416.

Greer, S., & de Ruijter, A. (2020). EU health law and policy in and after the COVID-19 crisis. *The European Journal of Public Health*, *30*(4), 623.

Hancké, B., Rhodes, M., & Thatcher, M. (Eds.). (2007). *Beyond varieties of capitalism: Conflict, contradictions, and complementarities in the European economy*. OUP Oxford.

Hawkins, B., & Holden, C. (2016). A corporate veto on health policy? Global constitutionalism and investor–state dispute settlement. *Journal of Health Politics, Policy and Law*, *41*(5), 969-995.

Hawkins, B., Holden, C., Eckhardt, J., & Lee, K. (2018). Reassessing policy paradigms: a comparison of the global tobacco and alcohol industries. *Global public health*, *13*(1), 1-19.

Hervey, T. K. (2008). The European Union's governance of health care and the welfare modernization agenda. *Regulation & Governance*, *2*(1), 103-120.

Hornung, J. and Bandelow, N.C. (2021). Short-Term Health Policy Responses to Crisis and Uncertainty. *Journal of Social Policy*, 1-20.

Ile, F. L., & Țigu, G. (2017). Medical tourism market trends-an exploratory research. In *Proceedings of the International Conference on Business Excellence* (Vol. 11, No. 1, pp. 1111-1121).

Jarman, H., & Koivusalo, M. (2017). Trade and health in the European Union. In *Research Handbook on EU Health Law and Policy*. Edward Elgar Publishing.

Jensen, C. (2011). Marketization via compensation: health care and the politics of the right in advanced industrialized nations. *British Journal of Political Science*, *41*(4), 907-926.

Kentikelenis, A., & Rochford, C. (2019). Power asymmetries in global governance for health: a conceptual framework for analyzing the political-economic determinants of health inequities. *Globalization and health*, *15*(1), 1-10.

Kingma, M. (2018). *Nurses on the move: Migration and the global health care economy*. Cornell University Press.

Krachler, N., & Greer, I. (2015). When does marketisation lead to privatisation? Profit-making in English health services after the 2012 Health and Social Care Act. *Social Science & Medicine*, *124*, 215-223.

Krachler, N., Greer, I., & Umney, C. (2021). Can public healthcare afford marketization? Market principles, mechanisms, and effects in five health systems. *Public Administration Review*.

Kurzer, P., & Cooper, A. (2016). The Dog That Didn't Bark: Explaining Change in Germany's Tobacco Control Policy at Home and in the EU. *German politics*, *25*(4), 541-560.

Labonté, R., Sanders, D., Mathole, T., Crush, J., Chikanda, A., Dambisya, Y., Runnels, V., Packer, C., MacKenzie, A., Murphy, G.T. and Bourgeault, I.L., 2015. Health worker migration from South Africa: causes, consequences and policy responses. *Human resources for health*, *13*(1), pp.1-16.

Lavazza, A., & Farina, M. (2020). The role of experts in the Covid-19 pandemic and the limits of their epistemic authority in democracy. *Frontiers in public health*, *8*, 356.

Lee, K., and Collin, J. (eds.) (2005). *Global change and health*, McGraw-Hill International.

Lee, K., Eckhardt, J., & Holden, C. (2016). Tobacco industry globalization and global health governance: towards an interdisciplinary research agenda. *Palgrave communications*, *2*(1), 1-12.

Jones, C. M., Clavier, C., & Potvin, L. (2017). Adapting public policy theory for public health research: A framework to understand the development of national policies on global health. *Social Science & Medicine*, *177*, 69-77.

MacKenzie, R., Mathers, A., Hawkins, B., Eckhardt, J., & Smith, J. (2018). The tobacco industry's challenges to standardised packaging: A comparative analysis of issue framing in public relations campaigns in four countries. *Health Policy*, *122*(9), 1001-1011.

Mackenbach, J. P. (2019). *Health inequalities: Persistence and change in modern welfare states*. Oxford University Press, USA.

Mackenbach, J. P., Valverde, J. R., Artnik, B., Bopp, M., Brønnum-Hansen, H., Deboosere, P., ... & Nusselder, W. J. (2018). Trends in health inequalities in 27 European countries. *Proceedings of the National Academy of Sciences*, *115*(25), 6440-6445.

Mackey, T. K., & Liang, B. A. (2012). Rebalancing brain drain: exploring resource reallocation to address health worker migration and promote global health. *Health policy*, *107*(1), 66-73.

Martinsen, D. S. (2015). *An ever more powerful court?: The political constraints of legal integration in the European Union*. OUP Oxford.

Martinsen, D. S. (2017). Governing EU health law and policy–on governance and legislative politics. In *Research Handbook on EU Health Law and Policy* (pp. 36-59). Edward Elgar Publishing.

Martinsen, D. S., & Vrangbæk, K. (2008). The Europeanization of health care governance: implementing the market imperatives of Europe. *Public Administration*, *86*(1), 169-184.

Matthijs, M., & McNamara, K. (2015). The euro crisis' theory effect: Northern saints, southern sinners, and the demise of the Eurobond. *Journal of European integration*, *37*(2), 229-245.

Marmot, M. (2013). *Health inequalities in the EU. Final report of a consortium*. European Commission Directorate-General for Health and Consumers.

McInnes, C., Kamradt-Scott, A., Lee, K., Reubi, D., Roemer-Mahler, A., Rushton, S., ... & Woodling, M. (2012). Framing global health: the governance challenge. *Global Public Health*, *7*(sup2), S83-S94.

McInnes, C., & Lee, K. (2012). *Global health and international relations*. Polity.

Minogiannis, P. (2018). *European integration and health policy: The artful dance of economics and history*. Routledge.

Mishra, V., Seyedzenouzi, G., Almohtadi, A., Chowdhury, T., Khashkhusha, A., Axiaq, A., Wong, W.Y.E. and Harky, A., 2021. Health inequalities during COVID-19 and their effects on morbidity and mortality. *Journal of healthcare leadership*, *13*, p.19.

Moolla, I., Hiilamo, H., & Kouvo, A. (2021). In search of healthcare system ideal types—Changeable classifications and dimensions. *Finnish journal of social research*, *14*, 7-26.

Mossialos, E., G. Permanand, R. Baeten, and T. Hervey. 2010. Health systems governance in Europe: the role of European Union law and policy. In Health systems governance in Europe,

eds. E. Mossialos, G. Permanand, r. Baeten, and T. Hervey, 1–83. Cambridge: Cambridge University Press.

Mosedale, J. (2016). Neoliberalism and the political economy of tourism: Projects, discourses and practices. In *Neoliberalism and the political economy of tourism* (pp. 13-32). Routledge.

Narlikar, A., & Sottilotta, C. E. (2021). Pandemic narratives and policy responses: west European governments and COVID-19. *Journal of European Public Policy*, *28*(8), 1238-1257.

Navarro, V. (1977). Medicine under capitalism. *Nursing Administration Quarterly*, *1*(4), 90-91.

Navarro, Vicente. 2000. *The Political Economy of Social Inequalities: Consequences for Health and Quality of Life, Volume 1*. Amityville, NY: Baywood Publishing.

Navarro, Vicente, ed. 2007. *Neoliberalism, Globalization and Inequalities. Consequences for Health and Quality of Life.* Amityville, NY: Baywood Publishing.

Nölke, A. (2019). Comparative capitalism. In *The Palgrave handbook of contemporary international political economy* (pp. 135-151). Palgrave Macmillan, London.

Nunes, J. (2020). The everyday political economy of health: community health workers and the response to the 2015 Zika outbreak in Brazil. *Review of international political economy*, *27*(1), 146-166.

Oxfam (2022), *Pandemic of greed: A wake-up call for vaccine equity at a grim milestone*, available at: https://www.oxfam.org/en/research/pandemic-greed

Peedell, C. (2011). Further privatisation is inevitable under the proposed NHS reforms. *BMJ*, *342*.

Phillips, N. (2017). Power and inequality in the global political economy. *International Affairs*, *93*(2), 429-444.

Rowden R. 2011. *The Deadly Ideas of Neoliberalism, How the IMF has undermined public health and the fight against AIDS.* London: Zed Books.

Sabat, I., Neuman-Böhme, S., Varghese, N. E., Barros, P. P., Brouwer, W., van Exel, J., ... & Stargardt, T. (2020). United but divided: Policy responses and people's perceptions in the EU during the COVID-19 outbreak. *Health Policy*, *124*(9), 909-918.

Scharpf, F.W. 2002. The European social model. JCMS: Journal of Common Market Studies 40, no. 4: 645–70.

Schmidt, V. A. (2016). Varieties of capitalism: A distinct French model. *Oxford handbook of French politics*, 606-635.

Siyam, A., Dal Poz, M.R., 2014. *Migration of health workers: WHO code of practice and the global economic crisis*. World Health Organization.

Smith, K. (2012). The problematization of medical tourism: a critique of neoliberalism. Developing world bioethics, 12(1), 1-8.

Stephens, C., Hawkins, B. and Liverani, M. (eds) (2022) *Globalization and Global Health: Critical Issues and Policy*, 3edition, Open University Press

Stilwell, B., Diallo, K., Zurn, P., Vujicic, M., Adams, O., & Dal Poz, M. (2004). Migration of health-care workers from developing countries: strategic approaches to its management. *Bulletin of the World health Organization*, *82*, 595-600.

Thomas, C. (1989). On the health of International Relations and the international relations of health. *Review of International Studies*, *15*(3), 273-280.

Vanhercke, B., & Verdun, A. (2022). The European semester as goldilocks: Macroeconomic policy coordination and the recovery and resilience facility. *JCMS: Journal of Common Market Studies*, 60(1), 204-223.

Von der Leyen, Ursula (2020). 'Speech by President Von der Leyen at the European Parliament Plenary on the EU Recovery Package', 27 May 2020.

Walton-Roberts, M., Runnels, V., Rajan, S.I., Sood, A., Nair, S., Thomas, P., Packer, C., MacKenzie, A., Tomblin Murphy, G., Labonté, R. and Bourgeault, I.L., 2017. Causes, consequences, and policy responses to the migration of health workers: key findings from India. *Human Resources for Health*, *15*(1), pp.1-18.

Wendt, C. (2009). Mapping European healthcare systems: a comparative analysis of financing, service provision and access to healthcare. *Journal of European Social Policy*, *19*(5), 432-445.

Wildman, J. (2021). COVID-19 and income inequality in OECD countries. *The European Journal of Health Economics*, *22*(3), 455-462.

Wolff, S., & Ladi, S. (2020). European Union responses to the Covid-19 pandemic: Adaptability in times of permanent emergency. *Journal of European Integration*, *42*(8), 1025-1040.

World Bank. (2022). World Development Report 2022: Finance for an Equitable Recovery.

Yeung, H. W. C., & Coe, N. (2015). Toward a dynamic theory of global production networks. *Economic geography*, *91*(1), 29-58.

Zeitlin, J., & Vanhercke, B. (2018). Socializing the European Semester: EU social and economic policy co-ordination in crisis and beyond. *Journal of European Public Policy*, *25*(2), 149-174.