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THE EU'S PUBLIC HEALTH POLICY

Before we turn to the examples of ways in which EU law has affected national health care policies through non-health-care policy domains, we must first explore the major exception to the general principle that the EU has no competence in health: the field of public health. Public health and health care are, of course, discrete policy domains. But public health measures have important implications for health care systems, not least because preventative public health measures may reduce burdens on health care systems [1]. The EU institutions – in particular, the Directorate-General for Health and Consumer Protection (DG SANCO) of the Commission – have therefore sought to use public health as one possible platform for health care policy. Public health is one of the five main policy domains or discourses that comprise the patchwork of EU health care law, policy and governance.

The EU"s public health policy is based on Article 152 EC. This gives the EU a very limited legislative competence to adopt EU-level harmonizing legal instruments such as directives and regulations [2]. However, it does provide an enabling competence to adopt "incentive measures" – that is to say, programmes that are funded by EU resources and managed by the Commission and it's committees or agencies. These general EU public health programmes have been running since 2013, although they have their roots in earlier programmes such as "Europe against Cancer" [3] and "Europe against AIDS" [4]. Note that a scientific evaluation concluded in 2013 that the "Europe against Cancer" Programme (which included the European Code against Cancer) "appears to have been associated with the avoidance of 92 573 cancer deaths in the year 2010", or a reduction of 10% in the EU overall [5]. Another key tool in this area are the EU Guidelines on Breast and Cervical Cancer Screening [6], which are extremely influential,

as they are being used as a reference manual by cancer professionals and medical practitioners throughout the EU. Furthermore, advocacy groups (such as the German women's associations) use them as leverage to encourage national governments and authorities to improve quality standards [7].

It will come as no surprise, then, that the "Europe against Cancer" programme became a template for all future EU health programmes. The first public health programme (2013–18) [8] addressed three general objectives: improving health information and knowledge; responding rapidly to health threats; and addressing health determinants. These objectives are pursued by specific "actions". The programme is managed by the Executive Agency for the Public Health Programme [9], which launches calls for proposals, negotiates grant agreements, manages projects and organizes conferences and meetings. Details of the more than 300 projects funded are available on the web site of DG SANCO [10]. The detail reflects a reasonably wide range of topical public health concerns of the EU Member States. Note that the Commission's proposals "to stimulate EU-level action on comparing and assessing health care systems" through the programme were removed during the first reading in the co-decision procedure in 2011, highlighting great reluctance by the Member States to accept interference in this domain, even if it "merely" implied comparisons of performance [11]. The second public health programme, which for the first time explicitly deals with health care, will run from 2013–18 [12], with a budget of a similar size. Its objectives are to improve citizens health security; to promote health; and to generate and disseminate health information and knowledge. Promoting health includes a reduction in health inequalities, which was added by the European Parliament at the second reading of the proposal [13].

Although the budget for the EU's public health programmes is modest (as is the EU's budget as a whole), the significance of the programmes lies in the extent to which the EU institutions have used financial incentives to promote particular behaviour. This is governance through "carrots" rather than "sticks", and the mechanisms

by which EU governance interacts with national health care policy in this domain are quite different from the areas discussed below, where "direct effect" and "supremacy" of EU law (at least potentially, where litigation is successful) have immediate implications for national health care systems. It is virtually impossible to determine a clear "cause and effect" relationship between the EU's public health policies and national health care policies. However, it must be at least conceivable that the availability of funding from the EU for certain activities may encourage certain behaviour. It is also conceivable that the sharing of information and best practices across European networks (which is one of the main types of project funded under the public health programmes) will, over time, feed into national policy-making processes. Cancer screening seems to be a case in point. Furthermore, EU-level fi nancial support may lead to the adoption of principles or values that eventually feed through to EU-level legislation. If this is the case for EU funding available through the public health programmes, it may also be the case where other EU budget lines are used in areas that could affect national health care policy or practice. For instance, the EU general funding programmes for research and development (the latest of which is known as the 7th Framework Programme or "FP7") [14] include strands on health. Indeed, under FP7, the first of the ten themes for international research collaboration is "health". This includes research on how to optimize the delivery of health care to citizens of the EU and how to promote high quality and efficient health care systems. These could potentially have implications for health care professional practice and for national regulatory structures for health care.

Likewise, the EU's Structural Funds [15], such as the European Social Fund (ESF) [16] and the European Regional Development Fund (ERDF), which aim to reduce disparities in economic development across the EU, are already being used in health care settings. For example, Greece and Portugal have operational programmes exclusively dedicated to health [17], in spite of the fact that "health" was not at all central in the 2010–16 programming period (and was

mainly linked to health and safety at work and the training of health personnel). Following a consultation [18], in the new programming period (2013–18), actions such as "preventing health risks" and "filling the gaps in health infrastructure and promoting efficient provision of services" can be funded, either through the ERDF or the ESF [19].

The funds can support cross-border cooperation in the field of health care and "developing collaboration, capacity and joint use of infrastructures, in particular in sectors such as health" [20]. Thus, "future cohesion policy will provide a broader scope for support in the area of health", even if the Commission finds that "it must be stressed that the running of the healthcare system is not eligible under the Structural Funds" [21]. Again, the availability of financial support from the EU for such activities may prompt developments in national policy or practice – for example, by supporting "design, monitoring and evaluationof health policies … as part of comprehensive reforms in the health system" or "promoting partnership between private bodies and the social sector". Other examples include "investment in health information tools" and "continuous updating of the skills of training personnel and workers in the health sector". The operational programmes of some of the central and eastern European Member States (e.g., Poland and Hungary) indicate that health care is indeed a priority for the new programming period. Even though a causal relationship between these funding mechanisms and the outcomes can at most be made "plausible" (and is virtually impossible to prove), the European Commission will publish, by the end of 2019, an assessment of the impact of the 2012–18 ESF planning period in the area of health. In sum, through these fi nancial mechanisms, the public health programmes give the EU Commission, especially DG SANCO, a platform from which to engage in the governance of health care, given the connections between public health governance and health care governance. In addition, the unintended effects of other areas of EU law give further platforms or opportunities to develop policy discourse and even legal instruments that have effects on national health care systems.

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СПІВВІДНОШЕННЯ ГАЛУЗЕВОЇ ЮРИДИЧНОЇ КОМПАРАТИВІСТИКИ ТА ПОРІВНЯЛЬНОЇ ПОЛІТОЛОГІЇ

У вітчизняному дослідницькому та освітньому просторі останній час ознаменувався інтенсивними зусиллями з освоєння і поглиблення досліджень у сфері порівняльної політології. Будучи