



WHICH HEALTH CRISIS? PREPAREDNESS, SECURITISATION AND THE NEGLECT OF COMMERCIAL DETERMINANTS OF HEALTH IN THE EU

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1. Introduction

Successive crises have become a defining feature of European integration, testing not only the Union's capacity to respond but also the legal and political consequences of those responses. Even where crises do not formally transform EU competences, they may alter relationships between institutions, create new governance frameworks and redirect policy priorities. EU health policy provides a particularly revealing case of such change: Covid-19 left the division of competences largely intact while reshaping the balance between emergency preparedness and response, on the one hand, and the long-term prevention of health risks, on the other.

Taking the EU's response to Covid-19 as its starting point, this article examines how the pandemic reshaped the exercise of EU health powers and the balance between emergency preparedness and long-term prevention. It advances three connected arguments. First, the Union's immediate response to Covid-19 left the formal distribution of competences intact but changed how existing powers were exercised, resulting in particular in strengthened executive authority.¹ Second, these changes did not disappear once the immediate emergency receded but were partly consolidated in the European Health Union (EHU). The EHU established a stronger framework for health emergency preparedness and response, while remaining modest in scope: it increased the Union's operational capacity without transferring greater responsibility for health and healthcare from the Member States to the Union.² Third, this new preparedness framework embodies a growing paradigm of health securitisation at EU level. Preparedness is politically attractive because it can be presented simultaneously as health protection, security and investment in European industrial capacity. Regulation addressing the commercial determinants of health, by contrast, has lost political priority, particularly where it would impose costs on specific industries and thereby come into tension with the EU's competitiveness agenda.

The third argument requires further explanation. The EHU has increased the Union's capacity to act through coordination, funding and procurement while

* Leiden University, The Netherlands. An earlier version of this article was presented at the EmergEU workshop 'The EU's Response to Internal Crises and Emergencies: Transforming Competences, Institutional Balance, and Policy Directions?', held at Maastricht University on 30–31 March 2026. I am grateful to the organisers and participants, and in particular to Guido Bellenghi, Matteo Bonelli and Ellen Vos, for their generous comments and suggestions. All errors remain my own.

¹ See Vincent Delhomme and Tamara Hervey, 'The European Union's Response to the Covid-19 Crisis and (the Legitimacy of) the Union's Legal Order' (2022) 41 Yearbook of European Law 48.

² See Vincent Delhomme and Carina van Os, 'Building the European Health Union (2019–2024): Successes, Limits and Future Perspectives' (2025) 16 European Journal of Risk Regulation 942.

privileging an emergency-oriented mode of intervention. The result is a growing asymmetry between preparedness and prevention. This is not an argument that Covid-19 was wrongly treated as an emergency or that chronic non-communicable diseases (NCDs), such as cancer, should be governed through permanent exceptional powers. The question is why the Union can mobilise far-reaching capacity in response to one temporal form of harm while repeatedly failing to sustain, through ordinary democratic processes, preventive regulation in response to another.

The analysis proceeds in four parts. The first revisits the immediate response to Covid-19, showing how the Union exercised its existing powers flexibly and reinforced executive authority without formally altering the distribution of competences. Similar flexibility was apparent in the Union's fiscal and budgetary framework, most notably in the adoption of the NextGenerationEU (NGEU) recovery plan, although that development in economic and fiscal policy falls outside the scope of this article.³ The second examines the European Health Union as a form of capacity-building without competence transformation, with particular attention to HERA's institutional design and operational role. The third identifies the securitisation of post-pandemic health governance, including the growing alignment of preparedness with security and industrial policy. The fourth tests the claim that the commercial determinants of health have been neglected against the uneven record of action, delay and inaction in food, pesticides, tobacco and alcohol policy.

2. The Covid-19 Response: Flexibility Within the Boundaries of Competence

2.1 A differentiated response structured by the distribution of competences

For most of the health response to Covid-19, the Union was not in the driver's seat: it could not impose lockdowns, manage hospital capacity or devise national vaccination strategies. These limits reflected the distribution of competences rather than an absence of EU action. Within the boundaries established by the Treaties, the Union made extensive and, in several respects, innovative use of the powers and instruments available to it. Responding to the pandemic required action across three dimensions: (i) limiting transmission through monitoring and public health measures, including social distancing and closures; (ii) organising healthcare systems, particularly intensive-care capacity; and (iii) procuring medical countermeasures, including treatments and vaccines. These dimensions mapped onto the Union's mixed and fragmented health competence. Although the Treaties formally confer only limited supporting powers in the field of human health,⁴ that description does not capture the full legal framework. The TFEU combines direct

³ Bruno De Witte, 'The European Union's COVID-19 Recovery Plan: The Legal Engineering of an Economic Policy Shift' (2021) 58 Common Market Law Review 635; Paul Dermine, *Le plan de relance 'Next Generation EU' de l'Union européenne: Analyse constitutionnelle d'une initiative historique* (Larcier 2023); Päivi Leino-Sandberg, 'The Secret Life of the EU Treaties: NGEU and the Politics of the EU's "Living Constitution"' [2026] European Law Open.

⁴ Arts. 6(a) and 168(5) TFEU.

and indirect health-related powers of different natures,⁵ which have developed incrementally over time.⁶

The first dimension concerned ‘public health’: the management of health risks and prevention of disease,⁷ as distinct from the provision of healthcare.⁸ Under Article 168(5) TFEU, the Union may support and coordinate national action against serious cross-border health threats and adopt incentive measures or recommendations,⁹ but it may not harmonise national laws. Before Covid-19, these powers had taken legal and institutional form principally through Decision 1082/2013/EU,¹⁰ which provided for epidemiological surveillance through the European Centre for Disease Prevention and Control (ECDC),¹¹ monitoring, early warning and response planning, as well as joint procurement of medical countermeasures such as personal protective equipment and laboratory equipment. These mechanisms became central during the pandemic.

The second dimension concerned healthcare systems, where the Union’s role is narrower still. The organisation and delivery of health services and medical care remain Member State responsibilities,¹² while Union action is limited to the coordination of social security systems¹³ and cross-border healthcare.¹⁴ The Commission nevertheless used its coordinating role to facilitate cooperation between healthcare facilities, including cross-border patient transfers, at a time when several national systems were under severe pressure.¹⁵ It did not seek to prescribe the internal organisation of national healthcare systems or hospitals, which remained outside its competence.

The third dimension concerned medicinal products and medical devices. Here, the Union possesses stronger powers permitting the adoption of harmonisation measures setting high standards of quality and safety, which operate

⁵ Most notably, the EU has been granted a shared competence to address ‘common safety concerns in public health matters’, Arts 4(2)(k) and 168(4) TFEU.

⁶ See T. Hervey and B. Vanhercke, ‘Health Care and the EU: The Law and Policy Patchwork’, in E. Mossialos et al. (eds.), *Health Systems Governance in Europe* (Cambridge University Press 2010); Delhomme and van Os (n 2).

⁷ Scott L Greer, ‘The Three Faces of European Union Health Policy: Policy, Markets, and Austerity’ (2014) 33 *Policy and Society* 13, 13; Tamara K Hervey and Jean V McHale, ‘What is European Union health law?’ in Tamara K Hervey and Jean V McHale, *European Union Health Law: Themes and Implications* (Cambridge University Press 2015) 69.

⁸ On the difference between ‘public health’ and ‘health-care’, see Anniek de Ruijter, *EU Health Law & Policy: The Expansion of EU Power in Public Health and Health Care* (Oxford University Press 2019) 62–63.

⁹ Art 168(5)–(6) TFEU.

¹⁰ Decision No 1082/2013/EU of the European Parliament and of the Council of 22 October 2013 on serious cross-border threats to health and repealing Decision No 2119/98/EC, OJ L293/1.

¹¹ See Regulation (EC) No 851/2004 of the European Parliament and of the Council of 21 April 2004 establishing a European Centre for disease prevention and control, OJ L142/1.

¹² Article 168(7).

¹³ Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems, OJ L166/1.

¹⁴ Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients’ rights in cross-border healthcare, OJ L88/45.

¹⁵ See European Commission, ‘Communication from the Commission – Guidelines on EU Emergency Assistance on Cross-Border Cooperation in Healthcare related to the COVID-19 crisis’ [2020] OJ C111I/1.

alongside its internal market competence.¹⁶ Medicines, vaccines, tests and medical equipment are therefore regulated by EU law throughout their life cycle. The European Medicines Agency (EMA) played a pivotal role in the assessment of Covid-19 treatments and vaccines,¹⁷ helping to ensure that these are safe for human use. The Union's role also extended beyond product regulation to the centralised procurement of vaccines. Acting on behalf of the Member States, the Commission used the Emergency Support Instrument, based on Article 122(1) TFEU, to conclude advance purchase agreements with vaccine producers.¹⁸ By aggregating demand and sharing the financial risks associated with vaccine development and production, EU action provided clear added value while leaving vaccination policies and implementation to the Member States. This experience foreshadowed the model subsequently institutionalised through HERA: greater EU operational capacity through procurement without a corresponding transfer of responsibility for healthcare.

On the health side, the differentiated EU response therefore largely reflected the pre-existing distribution of competences. Within that framework, however, the Union mobilised the legal and institutional instruments at its disposal on an unprecedented scale. The broader response displayed two further features: considerable flexibility in the application of internal market law and a more general reinforcement of executive authority.

2.2 *A flexible internal market and a strengthened executive*

At the height of the pandemic, the Member States adopted poorly coordinated border controls and export restrictions severely disrupting the free movement of goods, persons and services.¹⁹ The Commission sought to preserve movement for essential goods and workers, discourage disproportionate internal border restrictions and coordinate their gradual removal.²⁰ The EU Digital Covid Certificate eventually created a common legal framework for movement and constituted an important example of the Union's capacity to develop a common solution to fragmented national responses.²¹ Much of the earlier response, however, relied on guidelines and

¹⁶ See Article 168(4) TFEU, in conjunction with Article 114 TFEU.

¹⁷ Regulation (EC) No 726/2004 of the European Parliament and of the Council of 31 March 2004 laying down Community procedures for the authorisation and supervision of medicinal products for human and veterinary use and establishing a European Medicines Agency [2004] OJ L36/1.

¹⁸ Council Regulation (EU) 2016/369 of 15 March 2016 on the provision of emergency support within the Union [2016] OJ L70/1. See Erich Schanze, 'Best Efforts in the Taxonomy of Obligation – The Case of the EU Vaccine Contracts' (2021) 22 German Law Journal 1133 <<https://doi.org/10.1017/glj.2021.50>>.

¹⁹ For an overview of the measures adopted, see S. Montaldo, 'The COVID-19 Emergency and the Reintroduction of Internal Border Controls in the Schengen Area: Never Let a Serious Crisis Go to Waste', 5 European Papers (2020) p. 521; B. Pirker, 'Rethinking Solidarity in View of the Wanting Internal and External EU Law Framework concerning Trade Measures in the Context of the COVID-19 Crisis', 5 European Papers (2020) p. 573.

²⁰ See e.g. European Commission, 'Communication from the Commission Guidelines concerning the exercise of the free movement of workers during COVID-19 outbreak', OJ 2020 C102I/12; European Commission, 'Covid-19 Guidelines for border management measures to protect health and ensure the availability of goods and essential services', OJ 2020 C 86I/1.

²¹ The main instrument was Regulation (EU) 2021/953 of the European Parliament and of the Council of 14 June 2021 on a framework for the issuance, verification and acceptance of interoperable COVID-

recommendations rather than the enforcement of EU law on free movement. This approach enabled the Commission to steer national action rapidly under conditions of considerable uncertainty, while preserving cooperation between the Member States. It was not beyond criticism. The legality and proportionality of border controls and travel restrictions remained contested,²² while both the World Health Organisation (WHO) and the ECDC cautioned against indiscriminate border closures and questioned their overall effectiveness.²³ Member States nevertheless continued to adopt such measures, with limited Commission scrutiny and no formal infringement proceedings. The Commission thus prioritised coordination over confrontational enforcement, accepting a degree of deference to national measures that would have been unusual under ordinary internal market conditions, a phenomenon referred to by Kreuder-Sonnen and White as ‘domestic exceptionalism’.²⁴

The adaptability of EU law was even more visible in the economic response. The Union also activated emergency frameworks and relaxed the ordinary application of internal market obligations, including public procurement, competition and state aid rules, enabling Member States to respond to the pandemic’s social and economic effects.²⁵ This flexibility did not rest on a general emergency competence. Some possibilities were expressly provided for in existing law. The Commission relied for instance on Article 107(2)(b) TFEU, under which aid compensating damage caused by exceptional occurrences is compatible with the internal market.²⁶ More significantly, it used its enforcement discretion to adapt the application of existing rules at an unprecedented scale, notably through the

19 vaccination, test and recovery certificates (EU Digital COVID Certificate) to facilitate free movement during the COVID-19 pandemic, OJ 2021 L 211/1.

²² Iris Goldner Lang, “‘Laws of Fear’ in the EU: The Precautionary Principle and Public Health Restrictions to Free Movement of Persons in the Time of COVID-19” (2021) *European Journal of Risk Regulation* 1; Daniel Thym and Jonas Bornemann, ‘Schengen and Free Movement Law During the First Phase of the Covid-19 Pandemic: Of Symbolism, Law and Politics’ (2021) 2020 5 *European Papers - A Journal on Law and Integration* 1143.

²³ WHO, ‘Policy and technical considerations for implementing a risk-based approach to international travel in the context of COVID-19’, <<https://www.who.int/news-room/articles-detail/policy-and-technical-considerations-for-implementing-a-risk-based-approach-to-international-travel-in-the-context-of-covid-19>> accessed 1 October 2026; ECDC, ‘Considerations for travel-related measures to reduce spread of COVID-19 in the EU/EEA’ (2020), <<https://www.ecdc.europa.eu/en/publications-data/considerations-travel-related-measures-reduce-spread-covid-19-eueea>> accessed 01/10/2026.

²⁴ Christian Kreuder-Sonnen and Jonathan White, ‘Europe and the Transnational Politics of Emergency’ (2022) 29 *Journal of European Public Policy* 953.

²⁵ See e.g. European Commission, ‘Communication from the Commission - Guidance from the European Commission on using the public procurement framework in the emergency situation related to the COVID-19 crisis’ [2020] OJ C1081/1.

²⁶ See the relevant decisions in European Commission, ‘Authorisation for State aid pursuant to Articles 107 and 108 of the Treaty on the Functioning of the European Union — Cases where the Commission raises no objections’, OJ C125/1. For a discussion of the application of Article 107(2)(b) TFEU to Covid-19 measures, see Phedon Nicolaides, ‘Application of Article 107(2)(b) TFEU to Covid-19 Measures: State Aid to Make Good the Damage Caused by an Exceptional Occurrence’ (2020) 11 *Journal of European Competition Law & Practice* 238.

Temporary Framework under Article 107(3)(b) TFEU for aid remedying a serious disturbance in a Member State's economy.²⁷

The significance of this response lies in the combination of flexibility and legal continuity. The response did not displace the normal application of EU law. Its exceptions, derogations and discretionary spaces were instead mobilised expansively to facilitate public intervention while preserving a common legal framework. The internal market proved capable of accommodating measures that would have been difficult to contemplate under ordinary circumstances, without requiring any formal alteration of the distribution of competences. The crisis therefore changed less what the Union was legally empowered to do than the intensity and manner in which its existing powers were exercised.

The constitutional significance of the response lies perhaps more in how these choices were made. As in earlier crises, executive authority was reinforced. The Commission assumed a central coordinating role and exercised extensive enforcement discretion, while the Council and European Council provided political direction. This concentration of authority was, to a significant extent, a functional response to the urgency of the situation and the need to coordinate action across 27 Member States. Parliament retained its legislative role where measures were adopted through the ordinary legislative procedure, including in relation to the EU Digital Covid Certificate, but had no comparable role in the adoption of the core emergency instruments under Article 122 TFEU, which were adopted by the Council on a proposal from the Commission without Parliament's participation.²⁸ Further, much of the response was non-legislative and relied on Commission communications, Council recommendations and other forms of soft law.²⁹ These instruments allowed the Union to react more rapidly than ordinary legislation would have permitted. Their extensive use nevertheless raises questions because measures capable of shaping national choices were adopted through processes offering more limited participation to Parliament and other stakeholders.³⁰

These practices correspond in part to what Jonathan White describes as a politics of last resort: action presented as necessary to confront an urgent threat limits political alternatives and displaces some contestation from ordinary democratic forums.³¹ The pandemic response did not occur outside EU law, it

²⁷ Communication from the Commission Temporary Framework for State aid measures to support the economy in the current COVID-19 outbreak, OJ C91I/1. See also, in the field of antitrust: European Commission, 'Communication from the Commission - Temporary Framework for assessing antitrust issues related to business cooperation in response to situations of urgency stemming from the current COVID-19 outbreak', OJ C116I/7.

²⁸ See Delhomme and Hervey (n 1).

²⁹ Mariolina Elia Antonio and Oana Ștefan, 'The Elusive Legitimacy of EU Soft Law: An Analysis of Consultation and Participation in the Process of Adopting COVID-19 Soft Law in the EU' (2021) 12 *European Journal of Risk Regulation* 159.

³⁰ Oana Ștefan, 'COVID-19 Soft Law: Voluminous, Effective, Legitimate? A Research Agenda' (2020) 2020 5 *European Papers - A Journal on Law and Integration* 663; Barbara Boschetti and Maria Daniela Poli, 'A Comparative Study on Soft Law: Lessons from the COVID-19 Pandemic' (2021) 23 *Cambridge Yearbook of European Legal Studies* 20. See also Sacha Garben, 'Competence Creep Revisited' (2019) 57 *JCMS: Journal of Common Market Studies* 205, 210–211.

³¹ Jonathan White, *Politics of Last Resort: Governing by Emergency in the European Union* (Oxford University Press 2019), 64–85.

operated largely through flexibilities already embedded in the Treaties and legislation. Yet legal continuity coexisted with a political mode centred on necessity, speed and executive discretion. As White observes, the comparatively limited codification and constitutionalisation of transnational legal structures makes them more malleable, allowing executives to ‘bend the law, or work creatively within it’.³² The response therefore demonstrated both the adaptability of the EU legal order and the constitutional tensions accompanying that adaptability. The Union was able to coordinate national action, preserve essential movement and facilitate far-reaching public intervention despite the limited and fragmented competences on which it relied. At the same time, the conditions that made this possible placed pressure on two distinct, and sometimes competing, understandings of EU legitimacy: one rooted in constitutional procedures and political participation, the other in technocratic expertise. Constitutionalist legitimacy was strained as consequential choices migrated towards executive coordination, while claims to technocratic legitimacy were weakened by conditions of uncertainty in which scientific expertise could not be separated from political judgement.

The legacy of Covid-19 does not, however, lie simply in the emergency measures adopted during the pandemic, most of which were temporary. It lies also in the governing functions and methods that the crisis brought to the fore: executive coordination, surveillance, procurement and intervention in the production and availability of essential goods. As the next section shows, these functions were subsequently incorporated into the European Health Union (EHU) and given a more durable institutional form, most visibly through HERA. The pandemic thus provided both the practical experience and the political justification for a standing preparedness architecture that increased the Union’s operational capacity without formally expanding its health competences.

3. The European Health Union: Continuity and Change

3.1 Formal continuity and financial limits

The preceding section showed that the Covid-19 crisis changed how the Union exercised its existing powers without altering their formal distribution. The EHU represents the subsequent institutional consolidation of that development. The rhetoric surrounding its creation suggested that the pandemic might mark a turning point in EU health governance. Yet a closer examination of the reforms adopted since 2020 reveals a more nuanced reality. They did not substantially redefine or expand the Union’s formal health mandate, but they did increase its capacity to respond to future health emergencies. At the highest levels of EU policy making, the first reference to a European Health Union appeared in Ursula von der Leyen’s 2020 State of the Union address.³³ In the economic, monetary and energy fields, the ‘unionisation’ of a policy area has acquired both descriptive and prescriptive

³² Kreuder-Sonnen and White (n 24) 955–956.

³³ European Commission, ‘State of the Union Address by President von der Leyen at the European Parliament Plenary’, 16 September 2020.

significance. It suggests that EU action has reached a certain level of maturity and coherence, while simultaneously setting the direction for further integration. The language of a European Health Union performed a similar function: it brought previously fragmented fields of EU action under a common political label and created expectations of a more substantial EU role in health.

The emergence of the EHU nevertheless left the Union's formal position as a health actor largely unaltered. Despite early calls by President von der Leyen to discuss 'the question of health competences',³⁴ Member States showed little appetite to open the Pandora's box of Treaty change. Nor was there a major constitutional reinterpretation of existing powers comparable to that surrounding NGEU.³⁵ The EHU is therefore neither a health federation nor an empty political slogan. It is a political and institutional framework that combines pre-existing initiatives with new forms of capacity-building,³⁶ without fundamentally changing the allocation of responsibility between the Union and the Member States. The absence of competence transformation is not necessarily a defect. The existing division of tasks remains broadly satisfactory: the Union focuses on public health, cross-border coordination and product regulation, while Member States retain primary responsibility for organising and delivering healthcare and managing health crises on their territory. The more significant weakness lies elsewhere, particularly in the limited fiscal solidarity and financial transfers available to address persistent differences in the resources of national healthcare systems.

Comparative federal analysis illustrates how little the Union does to redress fiscal disparities between its richest and poorest regions.³⁷ Economic theory generally favours pooling financial risks at the highest level of a federation while leaving the delivery of healthcare services to sub-federal authorities.³⁸ The EU largely follows the latter principle but makes only limited provision for the former. The EHU nevertheless produced a substantial increase in EU health funding. The initial 2021–2027 EU4Health budget of 5.3 billion euros represented a major expansion compared with the approximately 450 million euros allocated to the 2014–2020 programme.³⁹ This should be considered alongside health-related investments in the national recovery and resilience plans adopted under NGEU.⁴⁰ The subsequent trajectory of EU4Health funding is nonetheless revealing. Following the revision of the 2021–2027 multiannual financial framework, 1 billion euros was

³⁴ Ibid.

³⁵ Leino-Sandberg (n 3).

³⁶ For an analysis of the EHU's developments during Ursula von der Leyen's first mandate, see Delhomme and van Os (n 2). On the EHU, see also Martin McKee and Anniek de Ruijter, 'The Path to a European Health Union' (2024) 36 *The Lancet Regional Health – Europe*.

³⁷ Scott L Greer, 'Health, Federalism and the European Union: Lessons from Comparative Federalism about the European Union' (2021) 16 *Health Economics, Policy and Law* 90.

³⁸ Ibid 98.

³⁹ Regulation (EU) No 282/2014 of the European Parliament and of the Council of 11 March 2014 on the establishment of a third Programme for the Union's action in the field of health (2014–2020) and repealing Decision No 1350/2007/EC, OJ 2014 L 86/1; Regulation (EU) 2021/522 establishing a Programme for the Union's action in the field of health [2021] OJ L 107/1.

⁴⁰ Velina Lilyanova, 'Health-related measures in the national recovery and resilience plans' (European Parliamentary Research Service 2023).

redeployed from the programme, reducing its overall budget to approximately 4.4 billion euros.⁴¹ Even at its peak, EU4Health represented only a small part of the Union's overall financial commitments: the 2021–2027 long-term budget and NGEU together amount to more than €2 trillion.⁴² EU health funding also remains modest compared with national healthcare expenditure. Although the figures are not directly comparable, Germany alone spent approximately €492 billion on healthcare in 2023.⁴³ Financially, the Union therefore remains a relatively minor health actor. Its greater significance lies in how it coordinates and deploys the resources and regulatory capacities available to it.

3.2 *HERA and the institutionalisation of preparedness*

These elements of continuity do not mean that the post-pandemic reforms were inconsequential – far from it. The Union modified its legal and institutional apparatus to address shortcomings exposed during Covid-19, strengthen preparedness and bring greater coherence to future emergency responses. The most visible of these changes was the creation in 2021 of a new Commission service, the Health Emergency Preparedness and Response Authority (HERA).⁴⁴ HERA is principally concerned with ensuring the availability of medical countermeasures in the event of a health crisis. Its activities extend across the chain from health threat monitoring and assessment, research and development, to production, procurement, stockpiling and distribution.⁴⁵

The choice to establish HERA inside the Commission rather than as an independent agency is institutionally significant. Its designation as an ‘Authority’ may suggest a degree of autonomy that it does not possess. Unlike a decentralised agency, HERA does not have a separate legal personality or management board. Its placement within the Commission facilitates rapid coordination with other policy fields, provides access to existing financial and regulatory instruments and enables political direction during a crisis. At the same time, it raises questions concerning transparency and accountability. The Commission’s 2025 review acknowledged the continuing debate over HERA’s governance and its relationship with other EU bodies, while ultimately retaining the current institutional model.⁴⁶

⁴¹ European Commission, ‘EU4Health Programme 2021–2027 – A Vision for a Healthier European Union’ <https://health.ec.europa.eu/funding/eu4health-programme-2021-2027-vision-healthier-european-union_en>, accessed 1 October 2026.

⁴² European Commission, ‘The 2021-2027 EU budget – What’s new?’, <https://commission.europa.eu/strategy-and-policy/eu-budget/long-term-eu-budget/2021-2027/whats-new_en#revision-of-the-eu-budget-2021-2027> accessed 1 October 2026.

⁴³ Eurostat, ‘10% of the EU’s GDP went to healthcare in 2023’, <<https://ec.europa.eu/eurostat/web/products-eurostat-news/w/ddn-20251117-2>>, accessed 1 October 2026.

⁴⁴ Commission Decision of 16 September 2021 establishing the Health Emergency Preparedness and Response Authority [2021] OJ C 393I/3.

⁴⁵ HERA Decision, Article 2. See also Olivier J Wouters and others, ‘The Launch of the EU Health Emergency Preparedness and Response Authority (HERA): Improving Global Pandemic Preparedness?’ (2023) 133 Health Policy 104844.

⁴⁶ European Commission, ‘Review of the Implementation of the Operations of the Health Emergency Preparedness and Response Authority (HERA)’, COM(2025) 147 final.

HERA's importance extends beyond improved coordination. Its functions allow the Union to influence technological and market developments by determining which products, research priorities and production capacities receive public support. Centralised procurement makes this transformation especially visible. Joint purchasing and advance purchase agreements allow the Union to aggregate demand and negotiate with suppliers on behalf of participating Member States. Without altering the formal distribution of competences, procurement gives the Union significant operational and market-shaping power over prices, investment, production and the future availability of medical products. The experience of centralised vaccine procurement during Covid-19 was thereby incorporated into a more permanent institutional structure. The Union has therefore become a more substantial health actor even though responsibility for the organisation, management and delivery of healthcare remains with the Member States under Article 168(7) TFEU.

The creation of HERA was complemented by a new general framework on serious cross-border threats to health. Regulation (EU) 2022/2371 replaced Decision 1082/2013/EU and strengthened preparedness planning, surveillance, reporting and coordination between the Commission, Member States, EU bodies and the WHO.⁴⁷ It also empowers the Commission, after considering the relevant expert opinions, to formally recognise a public-health emergency at Union level.⁴⁸ Such recognition makes specific emergency measures available. Relatedly, under the Emergency Framework Regulation, the Council may, on a proposal from the Commission, activate measures intended to ensure the supply of crisis-relevant medical countermeasures.⁴⁹ The framework also reinforces joint procurement, including the possibility for participating states to agree to exclusivity where this strengthens the Union's negotiating position.⁵⁰ The mandates of the EMA and ECDC were also reinforced. The EMA acquired a greater role in monitoring and mitigating shortages of medicinal products and medical devices, both in preparation for and during health emergencies.⁵¹ The ECDC's reinforced mandate similarly expanded its capacity to provide scientific expertise and recommendations concerning serious cross-border threats.⁵²

These reforms also perpetuate, in a long-term fashion, the executive orientation of the pandemic response. Parliament participated in establishing the legislative framework, but many consequential downstream decisions – identifying priority threats, recognising an emergency, activating response measures, allocating

⁴⁷ Regulation (EU) 2022/2371 on serious cross-border threats to health [2022] OJ L 314/26.

⁴⁸ Ibid, Article 23.

⁴⁹ Council Regulation (EU) 2022/2372 of 24 October 2022 on a framework of measures for ensuring the supply of crisis-relevant medical countermeasures in the event of a public health emergency at Union level [2022] OJ L 314/64, Article 3(1).

⁵⁰ Ibid, Article 12 and Recitals 18-19.

⁵¹ Regulation (EU) 2022/123 of the European Parliament and of the Council of 25 January 2022 on a reinforced role for the European Medicines Agency in crisis preparedness and management for medicinal products and medical devices, OJ 2022 L 20/1.

⁵² Regulation (EU) 2022/2370 of the European Parliament and of the Council of 23 November 2022, OJ 2022 L 314/1.

support and organising procurement – are entrusted primarily to the Commission, the Council and specialised bodies.

Taken together, these reforms are significant. The legacy of Covid-19 lies not principally in the survival of the exceptional measures adopted during the pandemic. Nor were coordination, surveillance and joint procurement entirely new: several of these instruments predated the crisis. The change lies in their expansion and institutionalisation within a standing preparedness architecture. HERA and the wider EHU converted functions tested or developed during Covid-19 into more durable executive, administrative and market-shaping capacities. This strengthened the Union's ability to prepare for identifiable cross-border threats while leaving both the formal allocation of health responsibilities and its limited redistributive capacity largely intact. These capacities are not politically or economically neutral. By focusing on the production and supply of medical countermeasures, the new architecture aligns health preparedness with wider security and industrial-policy objectives. The following section examines this securitising turn and the particular model of health intervention that it privileges.

4. The European Health Union: The turn to health security

4.1 The growing health-security nexus

The European Health Union is thus neither an empty label nor a health federation. It is a selective form of integration, centred on surveillance, preparedness and joint procurement, that increases executive coordination and the Union's capacity to organise markets while leaving the formal division of health responsibilities largely intact. The strengthening of the EU's emergency-response apparatus forms part of a broader transformation of EU governance towards greater securitisation. The securitisation of health refers to the political and institutional process through which particular health risks, especially infectious diseases and cross-border outbreaks, come to be understood and governed as security threats.⁵³ The resulting health-security nexus brings public health into the domain of 'high politics'.⁵⁴ In practice, it integrates public health into wider security and crisis-management frameworks. Health governance consequently centres on risk assessment, surveillance, early-warning systems, preparedness planning and rapid-response structures intended to prevent or contain threats to populations, economic stability or the functioning of the state. It also brings public health authorities into closer cooperation with institutions responsible for civil protection, security and crisis management.

⁵³ Oscar Fernández, 'The European Union's Securitisation of Global Health: Was COVID-19 a *Zeitenwende*?' (2024) 33 *European Security* 449; Hylke Dijkstra and Anniek de Ruijter, 'The Health-Security Nexus and the European Union: Toward a Research Agenda' (2017) 8 *European Journal of Risk Regulation* 613. More generally, see Barry Buzan, Ole Wæver and Jaap de Wilde, *Security: A New Framework for Analysis* (Lynne Rienner 1998).

⁵⁴ Jeremy Youde, 'High Politics, Low Politics, and Global Health' (2016) 1 *Journal of Global Security Studies* 157.

This orientation was developing before Covid-19, particularly in response to pandemics, bioterrorism and chemical, biological, radiological and nuclear threats.⁵⁵ The pandemic nevertheless accelerated and consolidated it. Covid-19 was frequently framed as an individual and collective ‘war’,⁵⁶ while security-based arguments were central to the Commission’s justification of HERA before institutional and public audiences.⁵⁷ The significance of securitisation therefore lies not only in language. It is reflected in the creation of permanent structures, the allocation of resources and the definition of the threats around which EU health capacity is organised. Securitisation consequently affects not only which risks receive political attention, but also the institutional form through which health policy is made. It privileges forms of intervention – surveillance, planning, procurement and rapid mobilisation – that are best delivered through executive and administrative structures.

The subsequent direction of EU policy confirms this development. The 2025 Preparedness Union Strategy adopts an ‘all-hazards’ approach covering pandemics alongside natural disasters, cyberattacks and geopolitical threats.⁵⁸ It calls for preparedness to be integrated ‘by design’ across EU policies and promotes whole-of-government and whole-of-society approaches involving civilian and military actors. The Union prevention, preparedness and response plan for health crises, adopted later that year, translates this orientation into an operational toolbox structured around the different phases of the health-crisis cycle.⁵⁹ Health preparedness is consequently becoming part of a wider architecture concerned with safeguarding the Union’s security, resilience and essential functions. A similar development is visible in the 2022 EU Global Health Strategy,⁶⁰ which gives considerably greater prominence to security than earlier EU approaches to global health.⁶¹

The industrial dimension of this development is particularly explicit in the 2025 Medical Countermeasures Strategy, which connects the development, production, procurement and stockpiling of medical countermeasures with security of supply, strategic autonomy and the competitiveness of the European health and

⁵⁵ Dijkstra and Ruijter (n 53).

⁵⁶ Stephane J Baele and Elise Rousseau, ‘At War or Saving Lives? On the Securitizing Semantic Repertoires of Covid-19’ (2023) 37 *International Relations* 201.

⁵⁷ Charlotte Godziewski and Simon Rushton, ‘HERA-Lding More Integration in Health? Examining the Discursive Legitimation of the European Commission’s New Health Emergency Preparedness and Response Authority’ (2024) 49 *Journal of Health Politics, Policy and Law* 831.

⁵⁸ European Commission and High Representative of the Union for Foreign Affairs and Security Policy, Joint Communication to the European Parliament, the European Council, the Council, the European Economic and Social Committee and the Committee of the Regions, ‘European Preparedness Union Strategy’, JOIN(2025) 130 final.

⁵⁹ European Commission, Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, Introducing the Union prevention, preparedness and response plan for health crises COM(2025) 745 final.

⁶⁰ European Commission, Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, ‘EU Global Health Strategy – Better Health for All in a Changing World’, COM (2022) 675 final.

⁶¹ Fernández (n 53).

biotechnology sectors.⁶² Preparedness thereby becomes simultaneously a health policy, a security strategy, and a form of industrial policy. This alignment obviously serves industrial interests. The language of competitiveness, innovation and strategic autonomy pervades the Strategy, while it creates market opportunities for pharmaceutical, biotechnology and medical-technology companies. This convergence of public and commercial interests, while it should be noted, does not necessarily mean industry capture. Industrial capacity is being mobilised here in pursuit of a compelling public-health objective.

Securitisation offers evident advantages. It can raise political attention and justify investment before a threat materialises. Its difficulty lies in its blind spots. Security-oriented governance tends to privilege sudden, cross-border and disruptive threats for which surveillance, stockpiling and rapid intervention offer identifiable solutions. In doing so, it may marginalise the long-term prevention of non-communicable diseases, which requires sustained intervention over time and more direct confrontation with commercial interests.⁶³

4.2 *Crisis, emergency and political convenience*

The problem is therefore one of selectivity and institutional opportunity cost: both attention and governing capacity become concentrated around threats amenable to surveillance and rapid intervention. Threats become politically urgent not solely because of the quantity of harm they cause, but also because of how that harm is temporally organised and narrated. An important distinction must here be made between the twin concepts of crisis and emergency.⁶⁴ An emergency is an acute situation requiring rapid and sometimes extraordinary intervention. A crisis is a broader moment of judgement in which political actors identify a serious threat and determine what must change. Crises are not simply objective descriptions of harmful events, they are socially constructed events: they involve a political choice about which forms of harm demand collective action. In the health field, for instance, cancer is not an emergency, but it surely constitutes a crisis.⁶⁵

In the Union's preparedness and health-security framework, however, crisis and emergency tend to be conflated, with the result that only certain kinds of crisis are addressed. The Union prevention, preparedness and response plan for health *crises* illustrates this orientation. Despite its broader title, the plan is operationally organised around fast-burning threats capable of escalating through successive stages of a crisis-management cycle. Its illustrative scenarios include an outbreak of

⁶² European Commission, Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, 'Preparing the EU for the next health crisis: a Medical Countermeasures Strategy' COM(2025) 529 final.

⁶³ Kent Buse, Sonja Tanaka and Sarah Hawkes, 'Healthy People and Healthy Profits? Elaborating a Conceptual Framework for Governing the Commercial Determinants of Non-Communicable Diseases and Identifying Options for Reducing Risk Exposure' (2017) 13 *Globalization and Health* 34; Luke N Allen, Arian Hatefi and Andrea B Feigl, 'Corporate Profits versus Spending on Non-Communicable Disease Prevention: An Unhealthy Balance' (2019) 7 *The Lancet Global Health* e1482.

⁶⁴ Guido Bellenghi, 'Neither Normalcy nor Crisis: The Quest for a Definition of Emergency under EU Constitutional Law' [2026] *European Journal of Risk Regulation* 20.

⁶⁵ Charles M Balch and others, 'The Global Cancer Crisis: A Review of Growing Burden, Deepening Inequality and Initiatives for Prevention and Early Detection' (2026) 20 *ecancermedicalscience* 2071.

zoonotic influenza, an explosion at a chemical production facility, an extreme weather event, the use of an unknown toxin during an armed conflict and a cyber incident affecting healthcare.⁶⁶ A novel pathogen fits this model particularly well: it is visible and mobile, produces rapidly changing indicators and offers the prospect of an eventual return to normality. Non-communicable diseases, by contrast, accumulate through ordinary economic and social practices. Their causes are dispersed across individual, environmental and commercial determinants,⁶⁷ while their prevention requires regulatory commitments maintained over electoral cycles.

This temporal difference does not mean that political attention should be allocated mechanically according to mortality figures, or that Covid-19 did not justify an emergency response. It does, however, make it difficult to regard the resulting asymmetry as a neutral allocation of attention. Worldwide, the health concerns most readily securitised do not closely correspond to the principal sources of mortality and morbidity.⁶⁸ The health burden of non-communicable diseases in the EU is considerable. OECD modelling estimates that cancer, cardiovascular diseases, chronic obstructive pulmonary disease and diabetes account for 46 per cent of premature deaths in the EU.⁶⁹ In 2021, approximately 1.1 million deaths in the Union, nearly 21 per cent of all deaths, were attributable to the combined effects of smoking, excessive alcohol consumption and high body-mass index.⁷⁰ These harms are not simply the aggregate result of individual choices. They are shaped by economic forces. The concept of the commercial determinants of health, defined as the ‘strategies and approaches used by the private sector to promote products and choices that are detrimental to health’,⁷¹ is therefore particularly relevant here. Political urgency is not proportionate to cumulative disease burden and tends to privilege threats possessing particular temporal and causal characteristics.

The emphasis on emergency preparedness reflects not only these characteristics but also political convenience. Regulating the commercial drivers of non-communicable diseases often entails direct confrontation with powerful economic sectors. Measures regulating tobacco, alcohol, ultra-processed food or pesticides directly affect established markets and generate distributive conflicts concerning employment, trade and competitiveness.

These conflicts follow a familiar political-economy pattern.⁷² The costs of preventive regulation are concentrated upon identifiable industries, while its public-health benefits are dispersed across the population and frequently materialise only

⁶⁶ European Commission, ‘Introducing the Union prevention, preparedness and response plan for health crises’, p. 11.

⁶⁷ David V McQueen (ed), *Global Handbook on Noncommunicable Diseases and Health Promotion* (Springer New York 2013).

⁶⁸ Youde (n 54).

⁶⁹ OECD, ‘The Benefits of Addressing Non-Communicable Diseases in the EU’ (OECD Publishing 2026).

⁷⁰ OECD and European Commission, *Health at a Glance: Europe 2024: State of Health in the EU Cycle* (OECD Publishing 2024).

⁷¹ Ilona Kickbusch, Luke Allen and Christian Franz, ‘The Commercial Determinants of Health’ (2016) 4 *The Lancet Global Health* e895. See also Anna B Gilmore and others, ‘Defining and Conceptualising the Commercial Determinants of Health’ (2023) 401 *The Lancet* 1194.

⁷² James Q Wilson (ed), *The Politics of Regulation* (Basic Books 1980).

over time. Those bearing the immediate costs therefore have strong incentives to organise against regulation, whereas its future beneficiaries are numerous and less easily mobilised. The WHO has documented how the tobacco, alcohol, ultra-processed food and fossil-fuel industries exploit this imbalance by lobbying decision-makers, shaping scientific evidence and public discourse, promoting self-regulation and presenting regulation as a threat to employment, consumer choice or economic growth.⁷³ Pandemic preparedness has a different political economy. It need not place public authorities in the same direct conflict with producers and can more readily be framed as an industrial strategy benefiting investment and innovation. The following section tests whether this asymmetry is reflected in the uneven record of action, delay and inaction in food, pesticides, tobacco and alcohol policy.

5. The neglect of the commercial determinants of health

The asymmetry identified in the previous section has had concrete consequences. The period following Covid-19 has not been favourable to health promotion and the prevention of NCDs. The economic consequences of the pandemic, the war in Ukraine and mounting geopolitical tensions shifted political attention towards security and immediate economic pressures. This change is particularly visible in the fate of the Union's two flagship health-related initiatives adopted in 2020 and 2021: the Farm to Fork Strategy and the Europe's Beating Cancer Plan.⁷⁴ Both recognised that a meaningful prevention strategy requires changes to the environments in which health risks arise and that commercial determinants of health must be addressed. Their implementation has, however, been markedly insufficient.

5.1 Food, nutrition and pesticides: the great retreat

The Farm to Fork Strategy promised a transformation of the European food system, towards one that 'provides and promotes safe, nutritious and healthy food of low environmental impact for all current and future EU citizens in a manner that [...] is robust and resilient, economically dynamic, just and fair, and socially acceptable and inclusive'.⁷⁵ Although it was never as transformative as its presentation suggested,⁷⁶ it marked a significant increase in ambition. Its proposed measures extended across the food chain, from production to consumption. In doing so, the Strategy recognised, at least in part, that unhealthy diets cannot be addressed through individual responsibility alone, but require regulatory action directed at businesses and the products they place on the market.

⁷³ WHO Regional Office for Europe, *Commercial Determinants of Noncommunicable Diseases in the WHO European Region* (2024).

⁷⁴ European Commission, 'A Farm to Fork Strategy for a fair, healthy and environmentally-friendly food system' COM (2020) 381 final; Communication from the Commission to the European Parliament and the Council, 'Europe's Beating Cancer Plan', COM (2021) 44 final.

⁷⁵ SAPEA (Science Advice for Policy by European Academies), 'A sustainable food system for the European Union' (2020), p. 68.

⁷⁶ Vincent Delhomme, 'Rethinking Consumer Empowerment: New Directions for Sustainable Food Law in an Era of EU Discontent' (2024) 15 *European Journal of Risk Regulation* 232.

Despite the good intentions behind it, the Farm to Fork Strategy has so far failed to deliver on much of this ambition. Most of the promised initiatives have yet to be translated into proposals by the Commission, while some of those formally presented have been significantly watered down. Key initiatives concerning unhealthy diets have faced sustained resistance from agricultural and food-industry actors.⁷⁷ The Commission did not present the proposal for harmonised front-of-pack nutrition labelling expected in 2022, despite the fragmentation of national schemes and the clear case for EU-level harmonisation.⁷⁸ It has likewise delivered only a fraction of its promised animal-welfare package, principally through a proposal concerning the transport of animals.⁷⁹ The proposed Sustainable Use Regulation (SUR) on pesticides followed a similar trajectory. Presented in 2022, it sought to establish binding targets for reducing the use and risks of chemical pesticides. It encountered strong opposition from agricultural organisations and the pesticide industry, as well as resistance within the Parliament and the Council. The Parliament rejected the proposal in November 2023, and the Commission formally withdrew it in May 2024.⁸⁰ Concerns about food security and the economic position of farmers progressively displaced the environmental and public-health objectives on which the proposal had been based.

The change of direction is also apparent in the Commission's 2025 'Vision for Agriculture and Food'. Where the Farm to Fork Strategy had promised a 'fair, healthy and environmentally-friendly' food system, the Vision places greater emphasis on making the agricultural sector 'attractive' and 'competitive'.⁸¹ Sustainability has not completely disappeared from the Union's agenda, but it is no longer thought of as requiring the same transformation of the food system. The emphasis has shifted towards the economic viability of European agriculture and the capacity of farmers to compete on world markets. The Farm to Fork programme has therefore not been formally repudiated, but its transformative ambition has been all but abandoned.⁸²

This shift forms part of the broader elevation of competitiveness and regulatory simplification under the second von der Leyen Commission. The competitiveness agenda makes the reduction of regulatory burdens a central

⁷⁷ Regarding front-of-pack nutrition labelling, see e.g. Morgane Fialon, Lydiane Nabec and Chantal Julia, 'Legitimacy of Front-of-Pack Nutrition Labels: Controversy Over the Deployment of the Nutri-Score in Italy' (2022) 11 *International Journal of Health Policy and Management* 2574.

⁷⁸ Nikhil Gokani and Amandine Garde, 'Front-of-pack Nutrition Labelling: Time for the EU to Adopt a Harmonized Scheme' (2023) 33 *European Journal of Public Health* 751.

⁷⁹ European Commission, Proposal for a Regulation of the European Parliament and of the Council on the protection of animals during transport and related operations, amending Council Regulation (EC) No 1255/97 and repealing Council Regulation (EC) No 1/2005 COM (2023) 770 final.

⁸⁰ European Parliament, 'Sustainable Use of Pesticides – Revision of the EU Rules', *Legislative Train Schedule*, <<https://www.europarl.europa.eu/legislative-train/theme-a-european-green-deal/file-sustainable-use-of-pesticides-%E2%80%93-revision-of-the-eu-rules>>, accessed 1 October 2026.

⁸¹ European Commission, Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions, 'A Vision for Agriculture and Food: Shaping together an attractive farming and agri-food sector for future generations' COM(2025) 75 final 22.

⁸² Hanna Schebesta, 'How to Save the Farm to Fork Strategy: A Two-Phased Approach' (2023) 18 *European Food and Feed Law Review* 231.

objective,⁸³ including through legislative proposals intended to simplify the food and feed safety framework and reduce the burdens it imposes on businesses.⁸⁴ Recent analysis has connivingly argued that these and other omnibus initiatives, despite being presented as ‘simplification’, operate as deregulatory instruments that weaken the precautionary principle in Article 191(2) TFEU and the environmental integration principle in Article 11 TFEU.⁸⁵

5.2 *The uneven implementation of Europe’s Beating Cancer Plan*

Europe’s Beating Cancer Plan also gave prevention a prominent place. It committed the Union to pursuing a tobacco-free generation, reducing harmful alcohol consumption and limiting exposure to environmental carcinogens. The Plan announced the revision of EU tobacco-control legislation, including measures addressing new products. It also envisaged action to reduce young people’s exposure to alcohol advertising and promotion and to improve consumer information on alcohol, including through health warnings and ingredient information.

The implementation record is nevertheless mixed. The Commission’s 2025 review reports that more than 90 per cent of the Plan’s actions have been completed or are ongoing.⁸⁶ That aggregate figure obscures important differences between the forms of intervention concerned. Considerable progress has been made on cancer screening, vaccination and research, as well as on data infrastructure and networks of cancer centres. These developments represent substantial achievements. These developments largely concern healthcare, medical intervention and research, rather than action addressing the environmental and behavioural risks of cancer – the form of prevention most likely to confront commercial interests. Progress has been much slower where action would directly constrain the marketing and sale of harmful products. One important exception is the revised EU air-quality legislation, which demonstrates that binding preventive regulation remains possible.⁸⁷ Otherwise, the review of the tobacco-control framework has not yet resulted in new legislation,⁸⁸ while there has been no progress on alcohol and no sign that any legislative proposal is under consideration. Unhealthy diets, another important cancer risk factor, fall

⁸³ European Commission, ‘A Competitiveness Compass for the EU’, COM(2025) 30 final.

⁸⁴ Proposal for a Directive as regards the simplification and strengthening of food and feed safety requirements, COM(2025) 1021 final; Proposal for a Regulation of the European Parliament and of the Council as regards the simplification and strengthening of food and feed safety requirements, COM(2025) 1030 final.

⁸⁵ Ifigeneia Tsakalogianni, “Simplification” as Regulatory Retreat? The Omnibus Packages and the Erosion of the Foundations of EU Environmental Law’ [2026] European Journal of Risk Regulation 1.

⁸⁶ European Commission, Review of Europe’s Beating Cancer Plan, SWD (2025) 39 final.

⁸⁷ Directive (EU) 2024/2881 of the European Parliament and of the Council of 23 October 2024 on ambient air quality and cleaner air for Europe (recast) OJ L, 2024/2881.

⁸⁸ A proposal for the revision and repeal of the Tobacco Taxation Directive (2011/64) was made in 2025, Proposal for a Council Directive on the structure and rates of excise duty applied to manufactured tobacco and tobacco related products (recast), (COM)2025 580 final. The call for evidence for the revision of the Tobacco Products Directive (2014/40) and the Tobacco Advertising Directive (2003/33) has closed on 14 August 2026, paving the way for a possible legislative proposal in 2027, <https://ec.europa.eu/info/law/better-regulation/have-your-say/initiatives/17612-Tobacco-products-and-tobacco-advertising-revision-of-EU-rules_en>, accessed 1 October 2026.

within the failures of the Farm to Fork Strategy discussed above. Research on the implementation of the Cancer Plan attributes part of this record to imbalances in access and influence, insufficient transparency and a continued belief in voluntary industry self-regulation,⁸⁹ despite the latter's clear record of ineffectiveness.⁹⁰

5.3 *A selective retreat*

To be clear, nothing proves or even suggests that the rise of preparedness directly caused the stagnation of regulation addressing the commercial determinants of health. Industry resistance to tobacco, alcohol, food and environmental measures long predates Covid-19, and the difficulties encountered by individual proposals have their own legal and political explanations. Nor has all prevention been placed on the back burner. Pandemic preparedness is itself a form of prevention.

The crises that followed the pandemic nevertheless changed the environment for action on preventive public health. Food and energy security, inflation and geopolitical tensions increased the salience of the immediate economic costs of regulation. The competitiveness and simplification agendas subsequently gave those concerns a more durable institutional expression. Measures imposing visible costs on European producers must now overcome an even stronger presumption in favour of limiting regulatory burdens. By contrast, health measures that support EU industrial policy and strategic autonomy, while creating opportunities for companies, are much more likely to attract political support, as the development of the preparedness framework demonstrates.

This development also forms part of what Vauchez and White describe as a crisis of long-termism in the EU: durable policy commitments, which EU institutions were once particularly well placed to sustain, are increasingly displaced by recurrent emergencies and changing executive priorities.⁹¹ EU politics in recent years has been heavily reactive in style. Prevention is especially vulnerable to this temporal logic. Its benefits become visible only gradually, while compliance costs and organised opposition arise as soon as regulation is proposed. A succession of emergencies does not simply add new items to the political agenda. It changes how institutional attention is allocated and makes commitments extending beyond the immediate crisis more difficult to sustain.

⁸⁹ Amandine Garde and others, 'Lobbying, Transparency and Trust: Power Imbalances and the Failure to Implement Europe's Beating Cancer Plan' (2025) 51 *The Lancet Regional Health – Europe* 101238; Ollie Bartlett, 'Lobbying Regulation in the EU: A Case Study of the Alcohol Industry' [2026] *European Journal of Risk Regulation* 1.

⁹⁰ Oliver Bartlett and Amandine Garde, 'Time to Seize the (Red) Bull by the Horns: The EU's Failure to Protect Children from Alcohol and Unhealthy Food Marketing' (2013) 38 *European Law Review* 498; Amandine Garde, 'Harmful Commercial Marketing and Children's Rights: For a Better Use of EU Powers' (2020) 11 *European Journal of Risk Regulation* 841.

⁹¹ Antoine Vauchez and Jonathan White, 'The Crisis of Long-Termism: Time and Independence in the European Union' (2026) 49 *West European Politics* 1383.

6. Conclusion: which health crisis?

The central question raised by this article is what the Union recognises as a health crisis. Covid-19 was an emergency requiring rapid and far-reaching action. The EU responded largely within the existing distribution of competences, but the crisis altered how those competences were exercised and left behind a permanent preparedness architecture. The European Health Union has reinforced the Union's capacity to coordinate and organise its response around identifiable cross-border threats. In doing so, however, it has institutionalised a particular understanding of crisis: one centred on sudden disruption and the need to restore normality. The displacement identified in this article is also institutional. Priority has shifted towards threats amenable to executive coordination and decision, and away from harms whose prevention requires legislative intervention in how markets operate.

This understanding risks displacing other health crises whose urgency is less visible but whose effects are no less serious. Non-communicable diseases develop slowly, but the harms caused by tobacco, alcohol and unhealthy food are neither remote nor hypothetical. Addressing them requires more than preparedness. It requires the Union to confront the commercial interests involved in producing and promoting harmful products. This is politically more difficult than mobilising against an external threat, precisely because it questions activities embedded in the ordinary functioning of the internal market.⁹² Yet, neither political difficulties nor geopolitical tensions provide a justification for weakening the Union's commitment to protecting the health of Europeans. The Treaty integration clauses impose binding constitutional obligations,⁹³ reinforced in the health field by Article 35 of the Charter.⁹⁴ They are not merely aspirations that apply only when compatible with prevailing economic priorities.

The choice is not between preparedness and prevention. The Union needs both. But preparedness must not become the sole model through which health risks gather political and institutional attention. A European Health Union worthy of the name must be capable of responding to the next acute emergency while sustaining action against harms that accumulate over time. The answer to the question 'which health crisis?' cannot be limited to crises that threaten the operation of markets and create opportunities for European industry. It must also include those crises whose resolution requires commercial interests to be confronted and markets to be transformed.

⁹² See Vincent Delhomme, *Regulating Unhealthy Lifestyles in the European Union: The Dilemmas of an Internal Market for Tobacco, Alcohol and Foods* (Cambridge University Press 2026).

⁹³ Articles 9 and 168(1) TFEU.

⁹⁴ Oliver Bartlett and Anja Naumann, 'Reinterpreting the Health in All Policies Obligation in Article 168 TFEU: The First Step towards Making Enforcement a Realistic Prospect' (2021) 16 *Health Economics, Policy and Law* 8.