Spring 2016

HIV/AIDS and the European Union

Victor Hammarin
James Madison University

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HIV/AIDS and the European Union

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An Honors Program Project Presented to
the Faculty of the Undergraduate
College of Arts and Letters
James Madison University

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In Partial Fulfillment of the Requirements
for Degree of Bachelor of Arts

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by Victor Philip Hammarin
May 2016

Accepted by the faculty of the Department of Political Science, James Madison University, in partial fulfillment of the requirements for the Honors Program.

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Dedication


To my dear grandma Eva, you grew up in a Europe of war. Now you live in a country of freedom and future. I love you so much, and am thankful to those that have changed Sweden and Europe, the wonderful place you call home.

To Dad, Mom, and Grandma: thank you for everything. For putting me through college, for being my home, and for showing me love. I could do nothing less in return than make the time and investment you have put into me as worthwhile as possible. I love you guys.
Abstract

Acquired Immunodeficiency Syndrome (AIDS) is an ailment like no other. Despite huge improvements in treatments for the Human Immunodeficiency Virus (HIV), which causes AIDS, those living with the disease continue to suffer from treatment inequality and discrimination. This is especially true in the European Union (EU), which is a supranational entity that works to improve prosperity, equality, and wellbeing among member-states. Despite extensive EU efforts to improve the standard of living across the inter-governmental body, treatment inequality for those living with HIV/AIDS in the EU continues to be a major issue. This study hypothesized that a strong EU initiative, which would establish a European Healthcare System with firm treatment guidelines, would reduce inequality and work to improve the lives of those living with HIV/AIDS in the EU. This study was divided into several parts, which analyzed the procedural characteristics of the British, German, and Italian healthcare systems, as well as that of the existing healthcare policies and initiatives in the EU. Each of the preceding cases were EU countries that have significantly different treatment experiences for HIV/AIDS patients compared to the EU average. Additional case studies were also conducted to analyze the legal and social frameworks affecting this disease in each case. Results of this investigation indicated that a common EU-healthcare policy might ultimately be effective in improving treatment equality across the continent. However, it was also shown that current financial troubles affecting member-states, coupled with waning public support for the EU, would create divides in the European community, and a supranational healthcare policy would likely be counter-productive to improving patient’s lives.
Introduction

Europe has united to become one of the greatest examples of peace and prosperity on the planet. Much of this continent’s history is riddled with conflict, inequality, and periods of authoritarianism; yet, the Europe that we see today is a leading example of how peace between the greatest of rivals can be achieved. In the 1930s the idea of any sort of friendship existing between nations like France and Germany seemed ludicrous. Less than a century later, these two countries are not only firm partners, but share open borders and a common currency. Such great improvements in European cooperation and stability have flourished in many areas, most notably in terms of the economy, but this has not been true for certain other functions of government.

European integration has been extremely successful at creating a strong, unified, and efficient system of supranational governance that has harmonized regional differences and helped to make the European Union (EU) one the most prosperous areas in the world in terms of combined GDP (Gross Domestic Product). European integration has come substantially far, but policy areas such as healthcare have seen comparatively little integration, resulting in varying standards and quality of care, which is something not at all consistent with the idea of a modern, equal, and fair Europe. Treatment experiences for HIV/AIDS and other chronic diseases are quite different across nations, and a common European Union (EU) healthcare policy should help to improve overall healthcare efficiency as well as treatment across the continent, in the same way that a common EU policy has developed an effective multinational European approach to other policy issues.

One of the better examples of a strong coordinated, and multi-national European policy is that of the Schengen agreement. This treaty sets up clearly defined rules and procedures for open borders and freedom of movement across the continent. Whenever situations with respect to
border issues arise in the European Union, the Schengen agreement can be referenced as the ground law. The same cannot be said for other policy areas, particularly healthcare. Despite all of the improvements we have seen throughout the past century; in today’s Europe, healthcare is still very inconsistent across countries. Even though cooperation among European nations is arguably greater now than it has ever been; costs, treatment effectiveness, healthcare procedures, and access to basic care vary greatly across the EU.

After having looked at a number of European healthcare systems, three particularly strong cases come to mind. The first is the United Kingdom, a nation with a typical system of universal health coverage that is at the forefront of European politics. Italy is another important case to examine, because while this nation has a similar universal healthcare system to that of the United Kingdom, it faces unique geographic, economic, and political challenges not experienced by most other EU member-states. Germany is another prominent case that is of particular interest due to the fact that it does not have a classic system of universal healthcare, but instead has a complex system of public and private insurance providers that define its health services. The healthcare system in every European nation is unique, yet every one of these healthcare systems contains aspects found in other countries.

Performing an in-depth examination of the healthcare system in each individual nation in the European Union would allow for a comparison that would hopefully point to a member-state that excels at healthcare compared to other countries, and whose healthcare model could be exported to the rest of the EU. However, measuring healthcare practices and efficiency must also include cultural and economic variables, which play a huge role in defining how a healthcare system actually works in practice. It is also true that the governments, policies, and thus healthcare systems tend to overlap among different European nations. For instance, nations like
Sweden and Denmark may each have their own unique systems of healthcare, yet elements of one will be found in the other. This is also the case for healthcare systems that are generally thought of as being procedurally different, such as those of the United Kingdom and Germany. Performing a qualitative study of the healthcare systems, as well as all of the related explanatory variables in each member-state of the European Union would be impractical considering the time such a study would take and the relative similarities among EU member-states. Therefore, examining three of the largest, most prominent, and developed healthcare systems on the continent will allow for a time and resource efficient qualitative study to be conducted. From the results of those cases, it is my belief that an optimal system of healthcare may be found. Optimal in this sense means cost and treatment effective, as well as being “exportable,” or having the capacity to be integrated across member-states of the European Union.
Literature Review

Using HIV/AIDS to study different healthcare systems in Europe requires several important elements of background research. The first is an examination of differences among individual healthcare systems in Europe and around the world, followed by a look at what sort of research has been conducted with respect to why such variations exist among these nations. The second is to look at studies conducted on treatment experiences for HIV/AIDS in Europe and the world, which will allow me to get a sense of what type of research has been done in terms of cultural and nationalistic factors affecting treatment. Lastly, theories of European integration should be analyzed to get a sense of what steps the European Union as a whole may take in the future with respect to healthcare.

Comparison of Healthcare Systems

Europe with Respect to the World

Healthcare policy is not standard across European nations or elsewhere. Even for countries that are members of the European Union, the differences between healthcare policies are vast. Experts Kieke Okma and Theodore Marmor point out in a 2013 cross-sectional study that differences in global healthcare systems are immense. Even among first world countries “there is a lack of generally agreed [medical] vocabulary” (Okma and Marmor, 487, 2013). These authors also point out that such differences lead to “misleading terms,” which in part defines the large differences in healthcare systems that we see (Okma and Marmor, 487, 2013). The bulk of Okma and Marmor’s research compared the American, Canadian, and European healthcare systems. One of the chief differences that were pointed out is that Europeans consider terms like “primary care” things that keep “patients out of the hospital,” while in nations like Canada “primary care connotes community involvement” (Okma and Marmor, 488, 2013). Such
differences imply a large variance in healthcare services. Okma and Marmor’s comments on the Canadian healthcare system, as well as that of other nations, imply that home-based healthcare services, and early detection of disease are generally the first healthcare initiatives of European countries.

Other researchers have created more concrete models, which they believe global healthcare systems fall into. Authors Ashish Chandra, William Willis, and Katherine Miller analyzed several particularly relevant categories in a publication exploring differences among global healthcare initiatives. The first mentioned is the “engineering model,” which “treats physicians as applied scientists” (Chandra et al, 37, 2010). This approach seems most relevant to the United States, given the tendency of American healthcare to involve extensive in-patient treatment versus preventative care. The “collegial model places physicians and patients on an equal basis,” and is most characteristic of European healthcare systems (Chandra et al, 37, 2010). Chandra, Willis, and Miller mention other models that apply to less developed nations; however, these models refer to physicians as “priestly” members of society, and are less characteristic of Western medicine (37, 2010). Okma and Marmor describe European healthcare as generally being different than that of other nations in terms of focusing on addressing medical issues preemptively. Willis, Miller, and Chandra, whose collegial model of patient/physician equality seems particularly characteristic of Western European nations, support this.

Healthcare in the European Union

With this research in mind, a cross-country comparison of European healthcare systems provides us with a strong starting point for this research. Looking back through time, public health in the European Union has generally improved in the post-World War II years up to the present. Many different variables such as an increase in income, the absence of war, and the
availability of new technologies are just some of the things that can explain this. Even though aggregate European healthcare has become some of the best in the world, there still exist many differences among individual European nations, as well as a lack of a standard European Union healthcare policy. This has led to pronounced differences in the efficiency of healthcare systems across the continent.

In 2010 professors Laura Asandului, Monica Roman, and Puiu Fatulescu evaluated the efficiency of public healthcare in Europe, using Data Envelopment Analysis, a “method which identifies an efficiency frontier on which only the efficient Decision Making Units are placed, by using linear programming techniques” (Asandului et al, 2010). Their study included “life expectancy at birth, health adjusted life expectancy, and infant mortality” as “output variables,” as well as “number of doctors, number of hospital beds, and public health expenditures as percentage of GDP [Gross Domestic Product]” as “input variables” (Asandului et al, 2010). Their results indicate that healthcare efficiency in Europe seems to be relatively independent of the respective input variables of this study. One such indication from their conclusion was that “the number of physicians ranges from 19.2 physicians per 10.000 inhabitants in Romania to 60.4 physicians per 10.000 inhabitants in Greece,” yet the former nation ranked sufficiently higher in overall efficiency when compared to the latter (Asandului et al, 2010). Another study conducted in 2011 by professors Sharon Hadad, Yossi Hadad, and Tzahit Simon-Tuval employed a similar method of research to that of Asandului and her colleagues, but instead looked at a number of OECD (Organization for Economic Co-Operation and Development) countries, rather than exclusively looking at nations in Europe. These researchers examined healthcare efficiency, or lack thereof, as being the result of “inputs considered to be within the discretionary control of the healthcare system,” as well as the lifestyle habits and behaviors of
individuals (Hadad et al, 2011). Using a similar type of Data Envelopment Analysis as to what was done by Asandului, Hadad and her team created two distinct models for their research, with the first studying only inputs of the healthcare system. Results from this model show consistent findings with those of Asandului, although it is noteworthy that German healthcare efficiency ranked significantly lower than many other OECD countries in this model. Nonetheless this model indicated that in terms of healthcare inputs, all OECD countries are fairly efficient. Many nations in Hadad’s study earned an efficiency score higher than 80 percent, with the lowest scores tending to range from 60 percent to 70 percent.

Hadad’s second model was structured the same way as the first, and ranked healthcare efficiency in those same OECD countries based only on lifestyle choices. The results of this second model were more interesting than that of the first, and countries’ efficiency scores in this model were all over the place. Some of the highest scores were in eastern European nations (Poland, the Czech Republic, and Slovakia), while western European countries (including Italy, Denmark, and Iceland) ranked much lower. Hadad’s model gave the Czech Republic, the top performer in this model, an efficiency score of 95 percent. On the other hand Greece, which ranked lowest out of all OECD countries studied in this model, earned a score of 46 percent. With respect to determining European healthcare efficiency, the second model created by Hadad had the most interesting and relevant results of the two. Although Hadad’s institutional model, along with the one used by Asandului had results that were intriguing, both of these models showed that most European countries tended to cluster around the same area of the scale. Hadad’s lifestyle factors model showed much greater variation among European countries, and indicates that individual choices are a critical factor for determining healthcare efficiency in Europe.
Having looked upon some of the research done in terms of determining the strength of healthcare systems in Europe, the next step is to look at research done with respect to healthcare funding in these nations and the healthcare choices available to residents in those countries. Researcher Wen-Yi Chen published an article in 2013, which studied patterns of healthcare spending in OECD countries from 1960 up to 2009 (Chen, 2013). Chen’s research revealed that European countries studied have tended to strongly support their healthcare systems through public spending, however Chen’s results also indicate that there were some signs of variation from this strong pattern of public spending around the 1970s. While public healthcare spending may have dropped in that period, Chen’s conclusions demonstrate that for most of the nations studied, the percentage of healthcare funding that was public in 2009 shows little deviation from what those figures were in 1960. While Chen’s work indicates that European governments are generally willing to invest large sums of money into their healthcare systems, it leaves the researcher curious as to how decisions regarding that financing are made, while it also begs the question of any inefficiency in European healthcare being the result of a poor national health or funding policy.

In 2014 Mio Fredriksson, Paula Blomqvist, and Ulrika Winblad researched how the Swedish government administers public health funds, as well as how it encourages good health practices. Sweden was one of the countries considered relatively efficient in Hadad’s study, and this is a nation where health outcomes have historically been quite good in comparison to other countries in the region. Fredriksson’s study shows that local governments and city councils have traditionally made healthcare policy decisions in Sweden, based on the funding and directions given to them by the central government (2014). Fredriksson’s conclusions then indicated that
central high-ranking Swedish politicians in the national parliament have begun to take more control over how public healthcare funds are managed in the country.

Researchers Valerie Moran and Armin Fidler’s 2009 study detailed the differences in health expenditures among a number of European countries. Moran and Fidler divided European nations into three categories based on income, and did a case study on health outcomes for each of these groups. Their results indicate, as can be expected, that high-income European countries have better access to emerging treatments and more comprehensive healthcare. Moran and Fidler then say that these high-income European countries “should provide technical assistance” and otherwise help lower income countries to access better health technologies (Moran and Fidler, 141, 2009). Among the high-income countries that these researchers mention are Sweden, Italy, and the United Kingdom. Each of these nations has a well-developed healthcare system by international standards, yet there are significant differences among the three. Professors George France and Francesco Taroni conducted a case study of Italian healthcare in 2005, which revealed that “the pace of change in the [Italian] healthcare system has accelerated” (France and Taroni, 169, 2005). The change that Taroni and France mention is not necessarily good change, as their case study reveals that there are many regional differences in healthcare within Italy, meaning that quality of care is somewhat inconsistent throughout the country. France and Taroni refer to this as a “decentralization process,” and imply that if this continues at the current rate, Italy could face a major healthcare crisis (France and Taroni, 182, 2005). Looking back to Hadad’s study, we can see evidence of this in the efficiency rankings created by her and her team. Italy earned a score of 82 percent in terms of the efficiency of the healthcare structure (Hadad et al, 2011). Shifting gears slightly, Frediksson’s article on the Swedish healthcare system implies that Sweden has a significantly better healthcare structure than Italy, which
results in a greater level of healthcare system efficiency. Thinking once again to Hadad’s study, one can see that Sweden had one of the most efficient healthcare systems in Europe (Hadad et al, 2011). Looking at the United Kingdom, a system similar to the Swedish one can be seen, yet with its own share of structural issues that are reminiscent of the Italian system.

According to a 2014 British nursing publication, the United Kingdom’s National Health Service (NHS) has become fragmented, and is beginning to show regional differences like what we see in Italy (Reed, 23, 2014). The article refers to “devolution” in British healthcare policy, which according to Reed, means that the central government is becoming less involved in healthcare issues around the country (24, 2014). Reed even points out that “policy variations” have become so great that fundamental aspects of the healthcare system such as prescription drug coverage are very inconsistent in Northern Ireland, Scotland, Wales, and England (24, 2014). Nonetheless, the United Kingdom remains one of the better countries in Europe in terms of healthcare outcomes and policies, even though the NHS seems to have had better days.

Considering these arguments, it seems that a common European Union healthcare policy would help governments coordinate and harmonize healthcare services across the continent, which would ultimately help patients. This is especially true in this day and age, where there are few practical borders left in Europe. Such open borders mean that trans-national travel in today’s world requires other cross-national initiatives.

Authors like Reed and Fredriksson argue that structural differences occur for separate reasons. To Fredriksson, Swedish healthcare efficiency is stronger than that of nations like Italy, because there is a greater coordination between the central government and local governing institutions. Reed argues that when it comes to healthcare, devolution of decision-making power from the center to local governments creates differences in healthcare efficiency, and are overall
detrimental to national health. Consequently, we can also see the arguments of Taroni (with respect to Italy) aligning with the points that Reed makes.

HIV/AIDS in Europe and the World

A Global Pandemic

Having looked at previous research that has been done on the structure of global healthcare systems, a comprehensive review of HIV/AIDS studies in Europe and the world is needed. One particular textbook that deals exclusively with HIV/AIDS explains that for two important reasons, treatment for this virus is significantly different than that of other chronic diseases. The first, as doctors Christian Hoffmann and Jürgen Rockstroh point out, is that HIV is a chronic condition which requires lifelong therapy, which means that medical expenses will be extremely significant in the long run, regardless of the prognosis or treatment results (2012). The second reason is that successful treatment of the virus requires the use of at least three anti-retroviral medications (Hoffmann and Rockstroh, 2012). If any fewer anti-retroviral agents were to be used, the virus would develop resistance to these medications, rendering them ineffective (Hoffmann and Rockstroh, 2012). Many of these drugs are protected by patents, which make them extremely expensive to consumers.

HIV/AIDS has shown a global decline in recent years, which has become especially true of the developed world. Nonetheless, AIDS deaths continue to occur all over the world, and there are large treatment disparities among nations, especially in the European Union. According to a report by researcher Hazel Barret, HIV/AIDS deaths have fallen by 25 to 49 percent in a number of sub-Saharan African countries where AIDS is the leading cause of death (50, 2014). That same report also indicates that in European Countries like Germany AIDS deaths have declined by close to 45 percent, while nations like France, the United Kingdom, and Italy have seen
relatively little change in their annual number of AIDS deaths (Barret, 50, 2014). AIDS deaths around the world have largely stabilized in the past decade, and we are now looking at a downward trend of these deaths across the world. Despite this, that decline has not been seen the same way in the European Union, with some nations in this organization having disproportionately high number of AIDS deaths and HIV infection rates with respect to other nations in the European community.

**HIV/AIDS in the European Union**

Studies conducted in the past reveal that one of the other issues at the forefront of HIV/AIDS treatment is the problem of treatment resistance. This occurs when the virus is able to replicate, despite the presence of multiple anti-retroviral agents (Hoffman and Rockstroh, 2012). Although the chances of this occurring are fairly low when medications are taken as prescribed, Hoffman and Rockstroh reveal that missing even a few anti-retroviral doses can cause the virus to become immune to a certain type of anti-retroviral (2012). The real issue arises when a treatment-resistant strain of the virus is passed on to another person, requiring new and more expensive medications to combat it. Research by a large team of European scientists revealed that, on average, 10 percent of new HIV/AIDS diagnoses on the continent are treatment resistant strains (Frentz et al, 7, 2014). Frentz and his team go on to explain that much of this resistance does not involve Protease Inhibitors, a newer type of medication used to treat the virus, yet he also points out that such findings “underscore the importance of baseline drug-resistance testing prior to the beginning of treatment” (Frentz et al, 8, 2014). The implication from this study is that while researchers seem to have found a type of medication with a relatively low rate of resistance, patients must be screened for viral mutations, and must also strictly adhere to their treatments for them to be effective.
HIV/AIDS treatments, as well as patient’s adherence to medications, differ significantly across the world. Previous research in this field suggests that one of the main reasons for this is differing attitudes and perceptions of the disease. Researcher Ingrid Katz and her team conducted a study in 2013 to determine what effect HIV/AIDS stigma has on treatment adherence. The results of her study show that cultural factors play a very large role in whether or not patients adhere to their medicine (Katz et al, 2013). “Social rejection” was listed by Katz and her team as one of the greatest reasons for this lack of treatment adherence, though they also point out that side-effects from the medicine, the use of drugs and alcohol, as well as anger at the HIV diagnosis play a large role in patients not taking their medicine (Katz et al, 8, 2013). In order to ensure patients live healthy lives despite their HIV infection, as well as to prevent anti-retroviral resistance, Katz and her team make a list of suggestions on combating HIV/AIDS stigma. They point out that “interventions to reduce stigma should target multiple levels of influence” including “intrapersonal, interpersonal” and “structural [referring to society in general]” (Katz et al, 1, 2013). Such steps seem to be imperative for any healthcare system to address the issues associated with treating HIV/AIDS.

Theories of European Integration

Origins of the Union

The end of World War II brought substantial reform to Europe, and one of the greatest results of this has been the co-operation of European nations. Historically, European nations have valued symbols such as their national currencies as key to their identity, yet many have exchanged that for a supranational system that has given some nations less power over their currency. The theories of European integration examine under what conditions integration may
take place (as well as what eventual integration may look like), and can be broadly applied across much of European government structure, function, and public policy.

The European Union as we know it today did not appear overnight. The end of World War II saw a need for European cooperation, as well as an end to nationalistic rivalries on the continent. From the 1950s onwards, new international legislation has brought European nations closer than ever, and in this time period one can also see the inclusion of new member-states to the now 28 nation-bloc. The origins of the European Union are in the European Coal and Steel Community (ECSC), which was initially a cooperative industrial policy created by a few European countries after the war. The Treaty of Rome in 1957 then established the European Economic Community (EEC), which turned the ECSC into something of a customs union with a common market. Moving further along in the 20th century, the Maastricht Treaty was agreed upon in 1992, which created the European Monetary Union (EMU). The later treaties of Amsterdam and Nice created common rights for all Europeans, and focused on stronger political integration and supranationalism. In 2007 the Treaty of Lisbon amended the voting procedures of the European Union, which ultimately governs how new legislation comes into affect in this political bloc today. Ultimately the treaty of Lisbon may have the greatest effect on the possibility of a common European healthcare policy; however, this is of course true of the Treaty of Rome as well, which is the ‘original treaty of the European Union’, so to speak.

In a 2001 publication, professors Jessica Adolino and Charles Blake studied the history of European integration with respect to public policy. They mentioned that the Treaty of Maastricht, which was passed in 1991, “formally created” the European Union, and established common European “economics, foreign and security policy,” as well as “justice and domestic affairs” (Blake and Adolino, 94, 2001). Blake and Adolino go on to describe the European
system of decision making as “bureaucratic,” with the European Commission being the most important government institution of the European Union in terms of integration (94, 2001). Many theories have emerged as to why Europe has come together the way that it has, as well as what course of action future integration may take. Blake and Adolino mention several of the treaties, notably Maastricht and Amsterdam, as being extremely important steps towards European unity. These same authors point out that these treaties are largely at the root of the creation of a common monetary policy (also referred to as the EMU or Eurozone), which is the policy area where we have seen some of the greatest European integration. Given the current governance structure of the European Union, any common policies that would emerge in the future would likely emerge from a treaty in the way that the Eurozone did. With that said, the many theories of integration offer a powerful insight as to how, and if, such common policies are a possibility.

**Functionalist Theories**

In a 2000 publication, author Ben Rosamond looked at the most well known of the integration theories, and analyzed the argument behind each of them. Functionalism and Federalism are two older theories of integration, which Rosamond starts off his publication by evaluating. Federalism refers to a concrete division of power between a central government and smaller, regional governing bodies (Rosamond, 2000). The United States is often referred to as one of the better examples of a federalist system in practice. Functionalism plays into the federalist theory (as the former of these two recognizes interests that different states share), and seeks to create a federal policy to address that (Rosamond, 2000). Rosamond describes these theories as being less relevant to modern European integration, yet they remain important because one of the most prominent theories of integration is based off of these two.
Neo-Functionalism is a theory of integration largely supported by Ernst Haas. Rosamond refers to the goal of Neo-Functionalism as being the idea “that an international society of states can acquire the procedural characteristics of a domestic political system” (Rosamond, 56, 2000). Rosamond further explains this crucial part of Functionalism, which is referred to as Spillover. Rosamond describes this as a process by which “deepening of integration in one economic sector would create pressures for further economic integration within and beyond that sector, and greater authoritative capacity at the European level” (Rosamond, 60, 2000). According to the idea of Spillover, as originally put forth by Ernst Haas, European integration in one area such as the European Monetary Union should create an incentive for other sectors of European governments to integrate, and resort to a supranational system of political administration gradually emerging.

Haas mentions that this theory refers to integration as “referring exclusively to a process that links a given concrete international system with a dimly discernible future concrete system (sic)” (Haas, 29, 1968). Unlike Functionalism, Haas’s theory is less in support of a federalist type of government, yet assumes that European integration would occur relatively swiftly (1968). In terms of public policy, we have seen some elements of integration follow a path of action similar to what Haas mentions. Blake and Adolino point out that in terms of fiscal policy, countries like Germany were relatively quick to align themselves with supranational guidelines established by the treaty of Maastricht (2001). These authors also show that such swift change and integration seems to be the exception rather then the rule (Blake and Adolino, 2001). Blake and Adolino reveal that in terms of healthcare policy, reform and structural changes to individual healthcare systems were executed independently by European nation states (2001). In their overview of 1990s German healthcare reform, these same authors mention that German public
healthcare spending was cut as the deadline for fiscal restrictions imposed by the treaty of Maastricht approached (Blake and Adolino, 2001). European healthcare systems looked quite different from each other at this point in time, and the lack of integration in a policy area such as this one may be attributable to the financial changes nations were required to undergo to comply with the Maastricht treaty. Although we can point to specific examples where Neo-Functionalism seems to have worked, examples such as this one do not make it seem like the best overall explanation for European integration.

**Cooperation as an Alternative to Supranationalism**

Going back to Rosamond’s analysis of European integration, the next theory he mentions is Inter-governmentalism. Rosamond explains that European states play a “two-level game,” meaning that whatever terms one country negotiates with another country, must also be ratified by both nation’s domestic populations (Rosamond, 135, 2000). The theory of Inter-governmentalism therefore seems to advocate for minimal integration, and instead emphasizes regional cooperation, believing that whatever integration does take place will occur slowly (Rosamond, 2000). Thinking back to what we know about European healthcare policy, this theory seems like a decent descriptor of how far integration in this field has come. Substantive integration is not well supported by this theory, and therefore Inter-governmentalism involves very little in terms of supranational institutions. Rosamond mentions a split in the Inter-governmental school of thought, and emphasizes the existence of a newer twist on this theory called “Liberal Inter-governmentalism” (Rosamond, 136, 2000). This newer look on Inter-governmentalism, pioneered by professor Andrew Moravcsik, is one of the more complicated theories of integration, yet has some of the best descriptors of the factors driving integration. Moravcsik begins his analysis by addressing the other theories we have discussed as “classical
theories of integration,” and mentioning that his theory is “narrowly focused yet more broadly generalizable,” believing that its potential for application is greater than that of the other theories (Moravcsik, 19, 1998). Moravcsik, using primarily the EMU as an example, believes that concrete integration is favored by European states when there is potential to become financially wealthier and stronger from it (Moravcsik, 1998). Going off on the European Monetary Union example, Moravcsik argues that the reason we see such strong integration in this area of European politics, is because creating a supranational body was desirable to citizens and governments since the gains to European nations would be immense, yet integration would take place at more or less the same pace as in Inter-governmentalism (Moravcsik, 1998). If we were to apply Moravcsik’s theory of Liberal Inter-governmentalism to European healthcare policy, supranational integration would likely only be possible if there were clear economic gains to both national governments and their populations.

Ideational Theories of European Integration

In addition to the conventional theories of European integration, there are ideational ones that should be addressed as well. In a 2014 article professor Tommaso Pavone analyzed these theories, and provided a strong overview of them. In short, Pavone critiques the work of European ideational theorist Craig Parsons. Pavone explains that Parsons seems to believe Europeans came together as result of “eurofederalists (sic)” desiring a stronger sense of community and being met with less opposition while doing so (Pavone, 2, 2014; Parsons, 1-34, 2014). Parsons’ theory looks at Liberal Inter-governmentalism and Neo-Functionalism as lacking substantive reasons for European integration (Pavone, 2, 2014; Parsons, 1-34, 2014). Pavone is quick to point out that Parsons “incorrectly equates” elements of other integration theories with
his own visions of them (Pavone, 2, 2014). In comparison to the more well known theories of 
European integration, the ideational ones seem to get the least recognition and credibility.

At the end of his work, Rosamond synthesizes each of the integration theories, with the ideational ones, and reflects on which he believes will have the most relevance moving forward. He concludes that while each theory makes its own relevant contributions to potential future European integration, “theoretical endeavors on European integration are likely to develop most fully as sub-sets of other concerns,” meaning that new areas of integration will likely prompt the emergence of new theories, or new twists on these existing ideas (Rosamond, 197, 2000).

Another thought that arises after considering European integration theory is the question of what these ideas will mean for the integration of new policies in the European Union. According to a 2014 study on common European policies, it seems that the implementation of current policies differs significantly throughout countries in the European Union (Voermans, 2014). Differences in public policy are in line with certain theories, such as Inter-governmentalism, but create questions for theories like Neo-Functionalism in terms of how strong European integration can truly become. As Voermans implies, while the European Union does have “treaty based compliance tools,” it seems that other methods of enforcement may be required to fulfill the necessary conditions of a theory like Neo-Functionalism (Voermans, 355, 2014). Looking forward to future European integration, such ideas will likely form an important part of any new theories of integration that may emerge.
Methodology

The substance of this research will primarily consist of qualitative studies. First, an in-depth look will be taken at the healthcare systems of various European Union member-states, as well as of the EU as a whole. In addition to closely studying these healthcare systems, this research will also consist of a quantitative comparison of the strengths and weaknesses of each of these healthcare systems. It will then be possible to draw conclusions concerning where the best overall healthcare strengths exist in Europe. With that in mind, cross-sectional healthcare information will play an important role in the later discussion and conclusion sections.

Second, an in-depth look will be taken at the quality and consistency of HIV/AIDS treatment and prognoses in Europe. The countries on the continent with the most and least effective treatments results for this virus will be analyzed, as will the case of HIV/AIDS across the European Union as a whole. As with the earlier case study, social and cultural factors affecting HIV/AIDS treatment will be studied to see if those findings are applicable to other healthcare systems in Europe, and that of the European Union. Data for these case studies will come from a number of reputable, international, and scholarly sources. Primarily, these sources will come from groups such as the World Health Organization, United Nations, and of course the European Union itself. Additional sources and information published by individual nations will also be examined. Furthermore, scholarly sources along with differing statistics and perspectives on healthcare and HIV/AIDS in Europe will be closely examined. In addition to modern data, a look at historical figures will be taken as well to determine if any evidence supports major trends of overall healthcare or HIV/AIDS treatment improvement, or lack thereof, in some countries versus others.
The primary strengths of this approach are that it will allow for a close analysis of healthcare systems in Europe, as well as HIV/AIDS treatments. Focusing extensively on these cases will allow for a stronger study than a simple cross-country comparison would. Furthermore, this approach will theoretically allow for underlying reasons of success (or failure) in European countries to become visible. The downside of such an approach is that it will look at one specific region of the world, and share little information about any other part of the globe. This means that results will be less relevant for non-European nations, as well as for countries on the continent that are not members of the European Union.
Healthcare in Europe

After examining the intricacies behind the theories of European integration, looking at a nation that has shown itself to be on the periphery of European integration gives my research an interesting perspective from which it can move forward. A subsequent look at European states with stronger leanings towards the policies of the European Union should provide an interesting contrast, and expand upon the questions left open by the previous chapter. Finally, a study of the aggregate healthcare policies of the European Union will bring about a final important reference point with respect to European healthcare and HIV/AIDS, allowing me to examine what seems to work well for each of these entities and what does not.

Great Britain

The United Kingdom is one of the oldest members of the European Union, yet it is a country that values its sovereignty in a way that is different from the other major powers of that body. Great Britain is not a member of the Schengen agreement, nor is it a part of the European Monetary Union (EMU), and its government has generally been against giving up power to a supranational authority. One of the key aspects of the British model of government, also known as the Westminster system, is that any and all actions of parliament can be undone. While the British parliament can choose to devolve its powers of government, those actions are not irrevocable. For this reason the United Kingdom has been reluctant to join European movements that involve pooling their sovereignty at the supranational level. The prime example of this would be the British refusal to partake in the EMU, and to instead continue using the British pound. British acceptance of the Euro as its currency would involve the Bank of England, which is a quasi-governmental organization, giving up its power to make monetary policy to another
entity, and not having the ability to go back on the decision without causing huge financial issues.

Britain, much like other European countries as I will soon show, has a universal system of healthcare. The system is referred to as the NHS (National Health Service), which is a fundamental aspect of the modern British nation. To take something like the NHS away from the British would strip the country of an important part of its national identity. The same can be said about the British pound, as replacing it with the Euro as a national currency would undoubtedly hurt the British cultural image. One key difference between these two policy areas is that the European Monetary Union has involved some of the greatest integration among member-states that the continent has seen to this day, but was not a requirement for membership to the European Union. Unlike the well-integrated EMU, there is today virtually no policy of the EU that effectively regulates healthcare across member-states; however, should such a policy come into existence, it would most likely come in the form of a court decision or treaty that member-states would not have the option to opt out of. For instance, if the European Court of Justice (ECJ) took on a case concerning healthcare inequality or discrimination among EU member-states, the resulting verdict could call for more stringent transnational healthcare rules that would inch the European Union closer to a common healthcare policy. Likewise, if another major treaty targeting something such as European citizenship where to come about, a clause in such an agreement could call for stricter policies and procedures on healthcare throughout the EU. However, such a treaty would likely have to be ratified by each and every member-state in order to enter into force, and would certainly be a tough sell if put to a national referendum.

Keeping all of that in mind, an in-depth look at the British healthcare system is needed. Traditionally healthcare in the United Kingdom has been some of the best in Europe, especially
with respect to chronic diseases such as HIV/AIDS. The British non-profit HIV/AIDS support network AVERT describes the disease’s current situation in Britain as a massive healthcare issue for the country (2012). AVERT explains that while overall infection rates have remained somewhat steady over the past decade, a new surge of infections is evident, particularly among young white males. These statistics come to light despite numerous advances in HIV/AIDS treatments, greater awareness of the virus and how it is transmitted, and a greater number of treatment choices.

For someone infected with the HIV virus in Britain, assuming that they do not seek treatment in another country, every part of their treatment experience would ultimately involve the NHS. This means that everything from the initial diagnosis, any prescribing of treatment medications, and follow-up visits would all likely be handled through the British state-run system of universal healthcare. The official National Healthcare Service website mentions that the NHS “was born out of a long-held ideal that good healthcare should be available to all, regardless of wealth,” and describes itself as one of the world’s largest employers (National Health Service, 2015). Further information from the NHS indicates that all of its revenue comes from taxes, and that since its inception in 1948, funding for the NHS has increased by more than 1200 percent adjusting for inflation (National Health Service, 2015). In an article analyzing the history of the NHS, the British Journal of Healthcare Management revealed that the “financial burden” it initially caused was overwhelming, and led to a shortage of qualified medical staff in the United Kingdom (Jones, 78, 2015). The author mentions that in recent times the NHS has undergone many changes, including new methods of funding, and devolution of some authority to local governments in England, Scotland, Wales, and Northern Ireland. Nonetheless, the article establishes that the British central government remains at the heart of the NHS (Jones, 2015).
The article concerning the history of the NHS concludes with the statement, “it has often been said that the NHS is a victim of its own success because it created a belief that everyone could (and should) be cured of whatever illness befell them. But it can also be said that it is a victim of its own failure—a failure to deliver on the promises of ‘a free universal health service’ made before its inception” (Jones, 79, 2015). This author is not the only one with such feelings about the NHS, as many feel that the NHS is inadequate to effectively perform everything required of it.

Nonetheless the National Health Service promises to provide full treatment to all in Great Britain, so for someone with HIV/AIDS, the government will cover treatment costs. In addition to HIV/AIDS patients requiring frequent intensive care, the virus is extremely costly to treat, which creates questions regarding the effectiveness of the NHS in tackling the virus in all of United Kingdom. Cost is one of the primary concerns, and according to information provided by the NHS on one of their health management websites, “it is estimated that without radical changes to the way the system works, as demand rises, and costs rise too, the NHS will become unsustainable, with huge financial pressures and debts. If we make no changes we face a £30 billion funding gap for the NHS nationally by 2020” (National Health Service, 2015). Such a funding gap would create massive problems for those living with HIV/AIDS in the United Kingdom due to the high treatment costs associated with the virus. Most HIV/AIDS treatment regimens, referring to the combination of pills that must be taken to effectively treat the virus, range in price from twenty-thousand to thirty-thousand dollars a year per patient (Horn, 2012). The virus also requires constant treatment in order to prolong a reasonably healthy life, and any interruption of treatment can cause future medications to become ineffective against HIV.

Annual costs for HIV patients, when scheduled appointments and blood testing are accounted
for, can be in the hundreds of thousands of dollars. This creates a huge problem for the NHS, not to mention those living with the virus in Britain. Should the National Health Service be unable to cover treatment expenses, Britain could face an epidemic of HIV treatment failures.

Modern challenges facing the NHS include addressing the needs of an elderly generation that continues to grow, an increasing number of immigrants, and the need for more advanced treatments. Despite all of the additional government funding that has been channeled to the NHS, the system today is described as being on the brink of collapse by many. British Prime Minister David Cameron can be seen in many instances taking extensive criticism for the current state of the NHS; however, the British parliament has yet to imply that it is considering any sort of revolutionary reform to the current state of the system. One elderly patient at the NHS described how she has supported the system throughout her life and believes in equal access to healthcare, but has seen first-hand the many shortcomings of the system. NHS patient Jenni Murray describes a healthcare system where those critically injured are often quickly attended to, but those arriving for regular visits, such as HIV/AIDS patients receiving scheduled treatments, may be forced to wait for hours (2015). Murray goes on to describe how the resources and employees of the NHS have become critically stretched and refers to nurses regularly working shifts in excess of 14 hours (2015). Nonetheless, Murray ends her article saying “I will continue to support the principle of the NHS. I certainly won’t be arguing in favour of paying £5 to been seen in casualty, as some have suggested. Free at the point of need is what we are so proud to maintain (sic)” (2015). Criticisms of the NHS aside, it has proven to be a system of healthcare that provides to all. Keeping the cost of expensive treatments like those required for HIV/AIDS in mind, it seems fair to argue that the National Health Service has both financially and physically saved many patients from a darker alternative. One British doctor named Max
Pemberton, who has worked with HIV patients in London for many years, describes living with the disease in the UK as being preferable to having diabetes (Pemberton, 2014). Dr. Pemberton mentions that HIV treatment has improved to such a level, that “HIV/Aids wards and specialist units [in the UK] have closed simply because there is no longer the volume of patients to fill them (sic)” (2014). Pemberton attributes this to the fact that HIV/AIDS can be effectively treated by taking a few pills once a day, which makes it a far cry from the death sentence that this disease was in the 1980s. However, Pemberton makes no mention of finances or the cost of treatment in his article, which can be attributed to the universal healthcare structure of the NHS. Had the National Health Service not been around to cover the huge treatment costs associated with the virus, it is unlikely that Pemberton would have ever written this article. In a scenario where the NHS is no longer able to cover the costs of anti-HIV medicines, the situation for those living with HIV in the United Kingdom would likely turn dire. Looking forward (regardless of positive and negative views of the NHS), the question of how the system can handle an increasing amount of the medicinal and financial problems it faces remains to be answered.

Figure 1 (pg. 90) shows current population predictions for the United Kingdom.

Figure 2 (pg. 90) shows diagnoses and deaths from HIV/AIDS in the United Kingdom in recent years.

Germany

German history generally does not positively embrace any system where a single person or entity has any type of supreme power. This is a notion that is at the core of the German constitution and flows into all aspects of German government and public policy. In the United Kingdom we saw a fusion of powers, meaning that all power is vested in a single entity (the British Parliament), and that any devolution of power from that entity can always be undone. A
division of powers instead characterizes the German system, with a greater emphasis on balanced
decision making. This notion is seen in the German healthcare system, which displays many
differences from what we saw with the National Health Service in Britain. One 2015 publication
from the London School of Economics and Political Science provides a substantive overview of
the many different healthcare systems in Europe. The authors of this publication describe
healthcare in Germany as consisting of a national health insurance system, in which there are a
number of different providers, but individuals are legally required to participate in one or more
of them (Mossialos et al, 2015). Much like the Affordable Care Act in the United States, the
system is extremely complex and consists of multiple insurance providers including employers
and the government. In addition to being required by law, healthcare coverage is guaranteed to
all in Germany, but is not administered by a single private or government entity. Instead, the
many aspects of healthcare are broken down into options and services provided by regional
governments and some private entities (Mossialos et al, 2015). Separation of responsibility and
authority regarding healthcare reflects one key aspect of powers being separated in Germany.
The immediate consequence is that individuals are guaranteed more freedom and a better choice
of treatment options than what they may face under systems such as the NHS in the United
Kingdom; however, this also means that treatment experiences will show variation across
Germany.

Everyone is required to have health insurance in Germany. However, the conditions and
regulations governing which plan one must choose are complex. According to the international
organization that seeks to provide information to those looking to live abroad, InterNations, one
must obtain public health insurance in Germany, unless one of two conditions are met: your
“gross income has exceeded the yearly limit of 53,500€ for the past three years,” or “you have
not participated in any EU member-state’s public health insurance plan for at least three years out of the last five years (sic)” (InterNations, 2015). In the event that either of these conditions applies to an individual, that person must obtain private health insurance. In short, “signing up with a public health insurance company is relatively easy, you don’t need a health check [referred to as a physical in the United States], and preexisting conditions never form an obstacle” (InterNations, 2015). However, public insurance in Germany will limit the options that a patient has in terms of which doctor they want to see, or which hospital they want to undergo treatment at. Private insurance, although more expensive, offers a number of benefits such as “hospital treatment by one of the chief physicians” (InterNations, 2015). Regardless of what sort of health insurance plan an HIV-positive individual living in Germany takes, they will have access to quality treatment. However, a patient with private insurance may get a better level of care, better medications, and more personalized treatment. This creates a situation where the healthcare experiences of those who are comparatively wealthy will likely be more pleasant and efficient, while those with lower incomes will likely be subject to long wait times and less personalized care. More simply, HIV/AIDS treatment in Germany is somewhat analogous to the choice of buying a car: both a Toyota and a BMW will get you from point A to point B, but the BMW will make for a smoother ride. In this example a Toyota is the equivalent of public health insurance and the BMW is the counterpart to private health insurance, but one must remember that private health insurance in Germany is often not a matter of choice. Therefore, costs and treatment experiences differ in this country, but not in a way that guarantees better treatment to any income group.

Official statistics released by the World Bank indicate that Germany has a slightly higher rate of HIV/AIDS infection than other Western European nations such as the United Kingdom
Curiously, another set of statistics released by the CIA (Central Intelligence Agency) show that in a given year the United Kingdom sees roughly 600 deaths from HIV/AIDS, while Germany experiences around 400 (CIA World Factbook, 2015). Although the numbers may seem marginal, these statistics raise the question as to why a country with a greater rate of HIV/AIDS infections has a lower annual death rate from the virus. Tejas Chhaya and Andrew Nguyen are two American medical students, who as part of their studies interned for a month at a hospital in Germany. They describe the German medical system as being characteristic of greater patient satisfaction and attention from medical staff than what they were used to seeing in the United States (Nguyen and Chhaya, 2013). These two students further mention that healthcare in Germany is more tightly controlled by government oversight. In Germany, reimbursement was simpler and much more reliable, allowing physicians and the clinics to accurately and efficiently account for their income and expenses. A higher proportion of health care expenditures in Germany were also spent on preventative care, as seen in the higher proportion of primary care physicians in the workforce (Nguyen and Chhaya, 2013).

For those patients living with HIV/AIDS, preventative care is a crucial part to getting a good prognosis, and a better quality of life. The German healthcare system is more characteristic of a closer relationship between patients and caregivers than what we saw in the British system. Nonetheless, the German model seems not to allow for the same exact type of universal health coverage that was seen in Britain, raising the question of how a very low-income person in Germany can afford basic healthcare services.

The answer is simple: government regulation. According to a report by American National Public Radio (NPR), healthcare costs in Germany are based very closely on one’s income (Greenhalgh, 2008). Those who earn more money will have to pay a greater chunk of their income towards health insurance, while those who earn less will pay less (Greenhalgh,
2008). The author of this NPR piece also goes on to describe that the German government regulates health insurance to ensure that prices are fair and affordable, and that the state-run national insurance provider ensures that all have equal access to healthcare (Greenhalgh, 2008). Although such a statement is far from conclusive, greater interaction between patients and caregivers can provide an explanation for a lower HIV/AIDS mortality rate, despite a higher morbidity rate than other similar nations.

As far as public healthcare funding in Germany goes, despite the greater number of healthcare workers and access to healthcare than we see in other countries, the German government spends comparatively less tax revenue on its health system. Figures provided by the World Bank in 2014 show that in Germany, roughly 75 percent of healthcare expenditures come from public spending (2014). Those same statistics indicate that this number was about 83 percent in the United Kingdom during that same year (World Bank, 2014). Although these figures only show a rough eight percent difference between the United Kingdom and Germany, such a number amounts to billions of dollars. Development indicators from the World Bank also show that in the year 2014, Germans on average (in terms of American dollars) spent roughly 5,000 per capita on health costs, while that amount was about 3,600 in the United Kingdom (World Bank, 2014). It would be incorrect to say that healthcare in Germany is superior to that in the United Kingdom; however, the evidence thus far presented shows that patient experiences as well as factors such as hospital wait times are comparatively better in Germany, though at an average per capita cost of about 1,400 dollars more than in the United Kingdom. So what happens to those people who cannot afford those extra healthcare costs? In both the United Kingdom and Germany a low-income citizen would receive substantial assistance from the state, which should allow for at least basic health coverage. For someone living with HIV/AIDS in
either of these countries, personal health expenses would likely amount to more than 5,000 dollars, considering the expensive treatments required for this disease. Theoretically healthcare services should be the same across the European Union, yet the differences that we see between Germany and the United Kingdom are some of the smaller ones within this inter-governmental body. Nonetheless, in terms of sustainability and access to treatment Germany comes out on top.

Now take a large member-state with a system that is similar to both of the previous two, yet is currently facing a unique migrant and financial crisis. How does a country with radically different circumstances and issues presented before it provide health services to its people?

**Italy**

No doubt about it, Italy is a unique place in Europe. Everything from the food to the culture is extremely different from what someone would expect to see somewhere like the United Kingdom. Italian history is arguably some of the richest in Europe; Italy’s importance from the renaissance, to the rise of Mussolini, to the present refugee crisis facing Europe cannot be overlooked. Throughout its history, this is a country that has transitioned away from and eventually returned to democracy multiple times, yet this is also a nation with a fairly unusual system of modern government. Everything from political scandals to frequent collapses of the government plague the Italian nation today; yet, the country is still one of the wealthiest and most influential in the world. As can therefore be expected, this is a nation with a modern healthcare system, but also one that is faced with unique challenges.

Much like what was seen in the United Kingdom, Italy provides a universal system of healthcare coverage to its citizens. Further information from the London School of Economics and Political Science shows that healthcare in Italy is financed by the government and covers all individuals, including “legal foreign residents” in the country (Mossialos et al, 73, 2015). When
looking at healthcare in Italy, it is especially important to keep non-citizens in mind, considering that for a number of factors Italy is home to many migrants (many of whom are undocumented), who will often have extensive medical needs. Although private healthcare options do exist in Italy, they are not part of the national healthcare system, which limits their access to many people in the country (Mossialos et al, 2015). Statistics from the World Bank show that in 2014 public spending accounted for 78 percent of all healthcare expenses in the country (2014). This is particularly interesting when thinking of other nations like Germany, which in theory do not have a state-run system of healthcare, yet do have an almost equal amount of public spending going towards healthcare as what is seen in Italy. In terms of HIV/AIDS, very few statistics are available regarding the disease in this country; however in 2013, the CIA World Factbook put Italy as having roughly a .28 percent HIV/AIDS prevalence rate among the adult population (2013). Despite the lack of further statistics regarding the virus in this nation, information from healthcare patients in Italy show what those infected with HIV/AIDS must deal with.

One Italian patient named Susanna describes the system as being “far from perfect,” but also being characteristic of a democracy that provides healthcare to all its people (Steeves, 2015). Susanna further describes the Italian healthcare system as consisting of very long wait times, as well as being riddled with scandals, many of which involve hospitals operating under unsanitary conditions (Steeves, 2015). Another Italian individual mentions that healthcare quality varies significantly in Italy depending on what part of the country you are in. Italian healthcare in the Alps region is supposedly much better than the care one can expect to experience south of Rome (Steeves, 2015). One of the likely explanations for this is that in recent years the Italian government has devolved a lot of power to regional authorities, which has contributed to large differences in healthcare quality across the country.
One study conducted in 2013 did a quantitative analysis of healthcare quality and differences across Italy, hypothesizing that in regions of the country where health care costs are generally reimbursed to individuals and hospitals by the government at a fixed rate, quality of care will be higher (Cavalieri et al, 2013). The researchers in this study describe that healthcare in Italy has seen a lot of regional devolution in recent years, meaning that many health standards as well as payment methods are determined by regional governments, and are thus subject to variation (Cavalieri et al, 2013). After performing a statistical analysis, the researchers in this study found that their hypothesis was confirmed by the data, and that there is evidence to suggest that regions of Italy with greater government financial influence on the healthcare system led to a greater quality of care (Cavalieri et al, 2013). Another study conducted in 2012 showed that the European financial crisis has sped up devolution of healthcare power to regional entities across Italy, which has resulted in cost-cutting initiatives across several Italian regions (Giulio de Belvis et al, 2012). One of the most significant of these is a “reduction in investments for preventive medicine,” which can have catastrophic effects for many patients (Giulio de Belvis et al, 2012).

In terms of HIV/AIDS treatment, preventative care is a crucial aspect to a good prognosis. If efforts are not made to preventatively treat the spread of the HIV virus, it will not only continue to spread among the population, but will also likely develop into AIDS at an accelerated rate. Further information published by Italian physician Francesco Traina reveals that “Italy has the highest number of physicians subject to criminal proceedings related to malpractice” in Europe (1, 2008). Traina mentions that many of these cases occur in locations where hospitals are understaffed and underfunded (2008). Needless to say, the implications of medical malpractice can be detrimental not only to the prognoses of HIV/AIDS patients, but also to the healthcare system as a whole. Traina’s article was published in 2008, which was just as the financial crisis
was occurring and healthcare devolution was beginning. Given the current state of income disparity in this country, it is unlikely that the rate of medical malpractice has declined. Unlike in the cases of Germany and the United Kingdom, there is little evidence and resources available to document the statuses of HIV/AIDS treatment and healthcare quality across Italy. Furthermore, the fact that healthcare devolution is continuing in Italy means that regional governments will have far more control over the budgets and procedures regarding healthcare occurring in these regions. Given the income divide in Italy, this is a huge problem.

**Figure 5** (pg. 93) shows the distribution of income across Italian states.

As Figure 5 shows, healthcare in the Northern parts of Italy generally face a better financial situation than their counterparts in the South. Assuming the devolution of healthcare authority continues, this will mean that inequality will persist and expand in Italy, and could possibly lead to a healthcare crisis should quality of care cause individuals in the South to seek treatment in the North. This of course raises the question as to why healthcare in Italy, which is still technically considered to be a universal system of care, has been subject to such extensive regional devolution. One potential answer is the impact of political scandals in the nation, and the national government seeking to ease the difficulties that it faces. The European Monetary crisis, the migrant issue, as well as weak GDP growth have all put extreme pressure on the Italian state in recent years. This makes it not altogether surprising that the national government would choose to devolve healthcare authority, which it has less pressure to address than say the economic situation, to regional entities. The migrant crisis can also help to explain why differences in healthcare quality vary so greatly across this country. The geographic location of Italy creates a situation where the northern part of the country becomes home to significantly less migrants than the southern part of the nation. Given the distribution of population, and thus need
for healthcare services, devolution of healthcare authority in Italy is a good solution for relieving pressure off of the national government; however, there is no denying that such devolution has caused the Italian model of healthcare to become inconsistent and less characteristic of a truly universal system, as well as provide unequal levels of healthcare quality across the country.

*The European Union*

From Nice to Amsterdam, then down to Lisbon and back up to Maastricht; Europe is arguably closer today than it has ever been in the past. While European history is full of stories of empires conquering the continent; the Europe of today is held together by a free coalition of democracies brought together by a desire for peace and prosperity. For better or worse, one must acknowledge that the European Union has become far more influential and successful than what the European Coal and Steel Community in the 1950s could have envisioned. As we have discussed, some realms of policy making have seen an extreme level of integration across this inter-governmental body, while others have seen relatively none.

In terms of healthcare the official policy of the European Union is to leave it to “national governments to organize healthcare and ensure that is provided”; however, the European Union does acknowledge the need to tackle cross-border healthcare issues (*The European Union*, 2015). Out of all of the EU legislation that exists, a considerably small amount of it deals with healthcare across the supranational body. Article 168 of the “Treaty of the Functioning of the European Union” explains that member-states should cooperate with one another in implementing cross-border healthcare; however, there are no explicit policies in the legislation that dictate specific cross-border healthcare procedures that must be undergone (*The European Union*, 123, 2010). While the article does set up some basic aspects for cross-border healthcare initiatives to occur, it gives little information as to a timeframe when such programs should
begin, nor what sort of involvement the EU government in Brussels will have aside from encouraging these developments. More simply put, the official statement that the European Union has made regarding healthcare policy in general is “the EU does not define health policies, nor the organisation and provision of health services and medical care (sic)” (The European Union, 2010). Instead, its action serves to complement national policies and to support cooperation between member countries in the field of public health (The European Union, 2010).

The issue with Article 168 is that it ignores the obstacles that exist in terms of encouraging cross-border healthcare initiatives. One scholarly article demonstrated that in most European countries public spending on healthcare increased dramatically prior to the 1970s, which was followed by many nations cutting their public health expenditures (Mossialos et al, 2002). Their study shows that one of the greatest challenges to a trans-European healthcare policy is harmonizing public spending across the EU. The authors demonstrate that in recent times, public healthcare funding has increased by over eight percent in some EU countries, while simultaneously decreasing at a rate of almost four percent in other member-states (Mossialos et al, 2002). Article 168 leaves most healthcare decision making power at the national government level, and creates a framework that gives little guidance or incentive for any member-state to lead a movement towards a rigidly defined system of supranational care.

Considering the analysis of the UK, Germany, and Italy conducted, it can be said that one great issue in Europe is the lack of a standard level of healthcare across the EU, which is evident by the German healthcare system ranking ahead of that of the UK and Italy, respectively. Looking forward, there are plans to make healthcare in the EU more consistent and accessible across borders, but these actions come across as being more theoretical than practical. In March of 2011 the European Parliament issued a directive intending to harmonize healthcare across the
union, yet this directive did relatively little in terms of changing actual policies. Although the right of all European citizens to healthcare in other member-states is established by the policy, it is explicitly noted that “member-states retain responsibility for providing safe, high quality, efficient and quantitatively adequate healthcare to citizens,” which establishes that healthcare authority is essentially an exclusive power of national governments (European Parliament, 1, 2011). The directive also goes on to mention previous rulings of the European Court of Justice (ECJ), and establishes that patients do have a right to be reimbursed for healthcare costs incurred in another member-state (European Parliament, 2011). Information for citizens regarding these rulings are provided by the European Commission, which states “patients will be allowed to receive treatment in another EU country and be reimbursed without prior authorization for hospital care however, under certain circumstances, a Member-state may decide to introduce a system in which patients require an administrative prior authorization before seeking care abroad” (European Commission, 2008). Nonetheless, it is also made explicitly clear that “the patient will have to pay the costs to the healthcare provider abroad up front, but will have those costs afterwards reimbursed up to the level of reimbursement for the same or similar treatment in their national health system” (European Commission, 2008). The problem with such a policy is that it essentially leaves finances in limbo, and puts patients at the mercy of the healthcare system in any given member-state.

If patients have to pay up front for healthcare in a member-state other than their own, what happens when they are financially unable to do so? Furthermore, if a patient from a state that is a member of the European Monetary Union pays for treatment in a member-state that does not use the Euro as its currency, what should happen in terms of reimbursement when either country’s currency fluctuates? Unanswered questions such as these show us some of the
problems of supranational integration. In terms of current and future possible policies, the European Union is certainly not perceived the same by all of its citizens. For a number of reasons, many Europeans have an apathetic or less than favorable view of the European Union. Figure 3 (pg. 91) shows favorability and perception of the European Union in member-states as of 2015.

The evidence so far studied suggests substantial differences in healthcare across the EU. If one takes another look at Figure 3, the question can be asked: would a more effective policy on healthcare improve favorability of the EU? Just based on Figure 3 and the expenses it would take to implement any such policy, the short answer would probably be no. However, if a common policy would ultimately create a better framework across the continent that improved on inefficient healthcare systems, the answer might be different.

In most countries of the EU, public spending plays a major role in healthcare financing. Trust and confidence in the government varies significantly across member-states of the EU, which plays an important role with respect to how a supranational healthcare policy might be perceived. In 2014 the World Values Survey Association studied what percentage of the given population in a country have feelings of confidence about their government, and ended up with a range of different results in EU member-states. An average of 36 percent of citizens surveyed in European Union countries expressed confidence in their national government, with Slovenia ranking lowest at only eight percent (World Values Survey, 2014). The World Values Survey then indicated that Sweden and Finland were the highest-ranking member-states, with both nations showing 64 percent of survey respondents expressing confidence in their governments (2014).
Connecting that back into healthcare, one can also see a great variation in out-of-pocket healthcare expenditures across the European Union. According to figures published by the World Bank in 2014, an average of 20 percent of healthcare costs were paid directly by European citizens (World Bank, 2014). At 49 percent Cyprus had the highest average number of out-of-pocket healthcare costs, while the Netherlands had the lowest at 5 percent (World Bank, 2014).

For someone living in the Netherlands, healthcare expenses in a country like Cyprus would seem astronomical. Under the current system, a Dutch person receiving healthcare in Cyprus is likely to be faced with a very steep medical bill that they would have to pay upfront in order to receive treatment. However, it is important to note that a Dutch person seeking healthcare in Cyprus would possibly have a wider range of options, and a potentially greater number of treatments to choose from compared to what they have back home. Curiously, those statistics published by the World Values Survey show a 47 percent government approval rating in Cyprus, while that figure was only 35 percent in Holland (2014). There are many factors beyond healthcare that influence confidence in government, yet financial well-being is one of the most critical of these. If citizens in nations such as Slovenia and Holland generally feel less confident about the policies of their government, it is possible that they would be more open to accepting a supranational European Union policy in a field like healthcare.

In terms of the treatment of HIV/AIDS, the current state of universal healthcare systems in countries like the United Kingdom and Italy may soon pose a very serious threat to those living with the virus. In 2003, the World Health Organization (WHO) determined that HIV/AIDS cases in Western and Central Europe had “doubled to almost 170,000” cases since 1995 (World Health Organization, 47, 2003). Today those numbers are substantially higher, with early 2015 estimates from the WHO indicating that these figures in Western and Central Europe
have risen to roughly 900,000 infected individuals (World Health Organization, 2015). Further information from the non-profit HIV/AIDS support group AVERT indicates that although the rate of HIV infection in Western European countries remains high, the number of AIDS deaths has generally decreased (2014). While this is good news in terms of treatment effectiveness, the future situation does not look as positive across the European Union. Should universal healthcare systems, such as the British NHS, reach some sort of a breaking point there is a very high probability that HIV patients will bear the brunt of such failure. The high treatment costs associated with the virus (and the intensity of care generally needed coupled with the lower income status of many infected individuals) could spell disaster should any of these systems collapse.

Despite all of the speculation, universal systems in nations like Britain and Italy continue to function and provide the services necessary. Given the current relative political and economic wellbeing in Britain, the odds of the NHS being unable to provide coverage to those that rely on it is fairly slim. However, in a place like Italy the same cannot be the said. The Italian state is already under significant pressure from the present migrant and monetary crises; should these issues further deteriorate, or if another crisis emerges, the healthcare system could face a massive funding shortage. With the lack of a common European policy to guarantee effective treatment in the event that this would occur, such a scenario could have a devastating effect on a nation like Italy, or the many other EU states that are dealing with similar problems.

The European Union has made efforts to address the need for greater access to treatment for patients living with chronic conditions, and has outlined some of the issues that the inter-governmental body faces with respect to HIV/AIDS. The European Centre for Disease Prevention and Control (ECDC) released a special report in 2012, which indicated that roughly
“more than 85% of those diagnosed with HIV [in European Union member-states] and known to need ART [referring to HIV treatment] receive it” (ECDC, 4, 2012). The report emphasizes that while this a great improvement over previous years, many problems with respect to treating the disease continue to exist. The report mentions that “members of vulnerable and marginalised populations in EU/EFTA countries find it more difficult to access HIV treatment, care and support than members of the general population. In EU/EFTA countries, this was reported to be the case by civil society respondents in almost all countries [88%] and by government respondents in almost two thirds [64%] (sic)” (ECDC, 4, 2012). The report goes on to mention that while the lack of access to treatment certain groups face “does not appear to be particularly due to laws, regulations or policies,” there is still a situation where “antiretroviral therapy is reported to be available to undocumented migrants in less than half of the EU/EFTA countries” (ECDC, 4-5, 2012). As is indicated by the publication, the European Union is interested in improving access to healthcare across member-states; however, this report and others like it do little to suggest new powerful initiatives.

Considering that laws and regulations seem to have little to do with preventing certain groups across the European Union from accessing healthcare, an agreement among member-states is not likely to have an improving effect on the situation. There are of course many other variables that contribute to why certain people are unable to get the care that they need, such as treatment stigma, fear of deportation, and an inability to navigate the healthcare system. All of these factors are extremely relevant with respect to HIV/AIDS, especially considering the cultural effects that this virus has had on societies. There is no doubt that healthcare quality, cost, and reliability vary significantly across the European Union; however, national governments and the European Union need to address more than just the healthcare aspects of policy, especially
with regard to the treatment of something like the HIV virus, should they hope for the situation to improve across the continent.
HIV/AIDS Treatments and their Cultural Influences

Stereotypes and prejudices are found in all aspects of life, and the healthcare field is certainly no exception to that. Perhaps the most classic example of healthcare stigma is a fear to touch someone with leprosy, for fear of contracting the disease. However, modern healthcare stigma is much more apparent and abundant than many think, even for ailments as simple as a common cold. Imagine having dinner with a friend, who arrives coughing and sneezing. More likely than not you would refrain from touching them, and would be very careful about not sharing food with that person. However, in reality your friend may not be contagious, and could instead be suffering from chronic allergies. It seems like a silly example, but such a situation illustrates on a very small scale what healthcare stigma is like. Even when we may have no chance whatsoever of becoming sick ourselves, we tend to avoid and develop misconceptions about people who are displaying a variety of symptoms. Perhaps more so than any other disease, HIV/AIDS has been subject to a wide range of stigmas and prejudices.

Understanding HIV/AIDS Stigma & Its Importance

When addressing the issue of prejudices and misconceptions concerning the HIV virus, it is important to make one important distinction. Both rich and poor countries face similar stigma issues with respect to this disease, though the conditions and consequences vary depending on factors unique to the developed and developing worlds. In a wealthy region like Western Europe as well as in a poor one like Sub-Saharan Africa, a person with HIV/AIDS can face rejection by society. In the third-world such rejection could motivate an infected individual to commit a terrible crime such as rape, given the belief among some cultural groups that having sex with a virgin can cure HIV/AIDS. The developed world is much better informed regarding the disease and how it is spread; yet, this has only had a small effect on mitigating the stigma of this disease.
The resulting stigma in a region like Western Europe can scare a person away from seeking treatment for the disease, which results in the virus spreading further. In terms of stigma the situation in Western Europe is not nearly as problematic as it is in sub-Saharan Africa; however, stigma remains a crucial and under-investigated part of the HIV/AIDS problem in Europe, and it is something that the European Union must address if it seeks to develop a policy to effectively regulate healthcare and manage this disease.

According to the HIV/AIDS support organization AVERT, the primary reason for stigma with respect to HIV existing in the developed world comes as a result of “very little” information being “known about how HIV is transmitted, which made people scared of those infected due to fear of contagion” when the virus first came to light in the 1980s (AVERT, 2015). Individuals from this organization go on to explain the importance of recognizing such stigma, as well as the effect that it continues to have today, even after much more knowledge about HIV/AIDS has become available. Experts at AVERT mention that stigma can cause a patient to receive poor health treatment, experience depression, and face discrimination (AVERT, 2015). Although the stigmas that exist in the European Union are largely different from and may seem less harmful than those that are prevalent in the developing world, the most basic type of stigma can have a tremendously negative effect. Some of the most common misconceptions in the European Union include the belief that HIV can be passed by casual contact, that an HIV/AIDS diagnosis is synonymous with a death sentence, and that HIV infection only occurs in certain social or ethnic groups. Unlike with other diseases, false beliefs about how the HIV virus is spread are much more common among educated individuals than misconceptions about other diseases.

One of the main reasons for this is the fallacy that correlation equals causation. HIV/AIDS tends to occur in higher numbers among the poor, homosexuals, and drug users.
However, there are established reasons for this, and it is not true that the HIV virus only occurs in these populations. Lack of adequate healthcare knowledge and access to condoms has helped explain why the virus tends to occur more frequently among non-affluent populations. HIV must enter the bloodstream in order to reproduce. The lining of the rectum is extremely fragile, subject to bleeding and tearing, and not intended to be subject to intense friction. Hence a tendency to participate in anal sex provides one of many explanations as to why the disease occurs more frequently in homosexuals. Lastly, many drug users tend to inject narcotics directly into their bloodstream. The sharing of needles between individuals in a non-sterile environment therefore provides an explanation as to why HIV/AIDS is common among illegal drug users. All of these correlations are constantly mistaken as being the cause of, and sole way to be infected by, the HIV virus. In actuality, the virus is capable of spreading to any and all individuals; however, it all ties in to blood on blood contact and probability. The chance of an injection drug user coming into contact with an infected needle is much greater than the probability of a nurse being accidentally stuck by a misplaced needle while on duty; yet, both of these situations can cause the virus to spread from person to person. In places like the European Union it is commonplace to think that healthcare systems are well regulated, and that the right thing is always done in hospitals. Yet, as the earlier case study of the Italian healthcare system in particular proved, no country is immune from accidents or health system scandals. Such reasoning helps to explain why HIV/AIDS stigma is so prevalent in the developed world, despite the fact that information about how the disease is spread is readily available to the public.

Stigma has become such a large obstacle to the treatment of HIV/AIDS that the United Nations Programme on HIV/AIDS (UNAIDS) has devoted entire publications to the issue with respect to tackling the spread of the disease. Throughout the European Union, as well as any
other country on the globe, UNAIDS makes it clear that “reducing HIV-related stigma and discrimination is critical in ensuring proportionate and equitable access to services to those most affected” by the disease (UNAIDS, 5, 2014). Further information from UNAIDS details methods that can be implemented to challenge such stigma, as well as some of the challenges associated with them. One method in particular recommended by UNAIDS seems like it would be the most effective at addressing the stigma issue. According to experts from the United Nations, collecting evidence on HIV/AIDS stigma at the community level, and taking legal action against those who indulge in it, may be an effective way to target HIV/AIDS discrimination in Western Europe (UNAIDS, 8, 2014). The obvious issue with this suggestion is the cost and intensity that the realization of such a project would require, not to mention the difficulties of implementing something like that at the supranational level. To understand the best way to deal with such an issue, taking a closer look at where stigma and discrimination are most prevalent in Europe is important.

In an August 2015 study, professor Heleen French and several colleagues addressed the issue of whether HIV/AIDS stigma tends to be worse in either rural or urban populations, as well as what type of treatment such stigma entails (French et al, 2015). French and her colleagues, who studied rural and urban African populations, determined that levels of stigma experienced were primarily the same in both of these settings (French et al, 2015). However, these researchers also discovered that the bulk of HIV/AIDS stigma is related to issues of disclosure (French et al, 2015). In many African countries, it was difficult for many people to keep their HIV status confidential due to societal and legal factors in those countries.

Another article took a simultaneous look at the HIV/AIDS stigma in both the developed and the developing world, and conducted an analysis of whether or not efforts to combat stigma
have been effective. The authors took a look at twenty-two different investigations conducted on HIV/AIDS stigma, and analyzed the results and effectiveness of those investigations (Brown et al, 2003). In the results of their study, these authors point extensively to the difficulties associated with directly testing stigma in general (Brown et al, 2003). The authors found that majority of anti-stigma initiatives “did report some positive results,” but that some “also found negative and mixed results” (Brown et al, 65, 2003). One of the issues with this study is that it makes little distinction between HIV/AIDS stigma in the first-world versus the third-world, and is not able to outline a single approach to combat stigma that has a high degree of success in either of the two. Furthermore, the authors point out that many of the anti-stigma efforts studied showed “evidence of superficial changes in attitudes based on improved knowledge, but little change in deep-seated fears” (Brown et al, 65, 2003). The implication of which, is that measuring deep seated beliefs on such sensitive issues in any country will prove to be extremely challenging given the inefficient polling methods available to researchers. Nonetheless, another important takeaway from this article is the researcher’s findings that in most studies of anti-stigma efforts examined, “information together with skill building is more effective in raising knowledge levels and reducing some stigmatizing attitudes among the general population, as compared with information alone” (Brown et al, 65, 2003). If we now apply this data exclusively to the European Union, where extensive privacy and non-HIV status disclosure laws already exist, one would think that HIV/AIDS stigma in the EU might be less problematic than elsewhere.

When we then look back and consider that healthcare systems such as that of Germany function significantly better than that of Italy or the United Kingdom, with the former often experiencing fewer healthcare issues and controversies than the latter two, it is not surprising that
such HIV stigma and discrimination in the EU continues to exist. The People Living With HIV Stigma Index (Stigma Index), a United Nations affiliated organization, conducted extensive studies in both Germany and the United Kingdom with respect to how stigma affects HIV/AIDS interacting with their respective healthcare systems. In the United Kingdom it was found that “some participants [of the study] reported that they were reluctant to attend hospital appointments, either because of risk of being disclosed or obligation to disclose [referring to HIV status]” (Sharp and Hudson, 48, 2010). The report conducted by the Stigma Index in the United Kingdom consisted of many qualitative studies, while a subsequent study by the same organization conducted across Germany examined the stigma situation more quantitatively.

While it can be challenging to compare and contrast a qualitative study with a quantitative one, the Stigma Index analysis of the United Kingdom looked at several respondents (out of a random sample of HIV-positive individuals), indicating that they faced some sort of stigma or discrimination from the healthcare system (Sharp and Hudson, 2010). The quantitative study conducted in Germany revealed that “only 37% of the interviewees [referring to HIV positive individuals questioned] are sure that medical documents about their HIV-infection are handled completely confidentially, 49% are not sure and 13% find it obvious that confidential handling is not ensured” (Vierneisel, 6, 2013). The general theme when comparing these two studies is that HIV stigma seems like it would be comparatively milder in Germany than in the United Kingdom, which a relatively stronger German healthcare system could help to explain. However, a deeper analysis shows us something different, while these two previously mentioned studies show us key indicators as to where and how HIV stigma has a detrimental effect across the European Union.


**HIV Stigma in Germany, Italy, and the United Kingdom**

Looking at stigma on a country-by-country basis is an area of HIV/AIDS research that receives little attention. Therefore, it is difficult to acquire and validate statistics on the subject. The Stigma Index is at the forefront of measuring where stigma exists, and how much of it is prevalent; however, few other figures can be found regarding HIV/AIDS stigma. Additional statistics do exist, and while some come from reputable sources, these figures are generated via polling methods that are not ideal. For this reason, the primary material in this section originates from The Stigma Index, with additional sources being included when appropriate.

Before conducting research on HIV/AIDS stigma, it was my plan to divide a case study on the issue into three parts, giving equal weight to Germany, Italy, and the United Kingdom. Not long into my research, I discovered that there was an abundance of HIV/AIDS groups in the United Kingdom, including many that seek to directly support affected individuals by targeting stigma. This was less of the case in Germany, and for Italy it was extremely difficult to find HIV/AIDS studies and support networks. Given the evidence available, it therefore seemed most appropriate to study the information that exists for the Italian case first, and then compare and contrast that with the other two countries.

Very few studies of HIV/AIDS in Italy have been published, however, there is one in particular that gives insight into rates of infection across the country. One group of Italian researchers studied the rate and prevalence of both the HIV virus and AIDS in Italy, and came up with an interesting finding (Castelnouvo et al, 2003). What is of particular relevance about this study is that it conducted an analysis of HIV/AIDS immediately following the massive improvements of treatment for the disease that emerged in the year 1996. This researcher’s study points out that in the period from 1993 to 1996 the prevalence of AIDS (the final stage of HIV-
infection) in Italy, per 1000 individuals, was 9.24 for females, and 20.45 for males (Castelnouvo et al, 2003). In the period from 1996 to 2000 the number of female AIDS cases per 1000 individuals with AIDS decreased by about 16 percent (Castelnouvo et al, 2003). However, in the case of male Italian AIDS patients, the number of individuals diagnosed with this final-stage of HIV disease from 1996 to 2000 rose by almost 28 percent (Castelnouvo et al, 2003). These researchers attribute the rise of male HIV infections in Italy, at a time when most of the developing world instead saw a decline, as potentially being due to “the fact that women are routinely offered HIV testing during pregnancy and may thus become aware of their HIV status during the asymptomatic phase” (Castelnouvo et al, 668, 2003). However, one of the issues with this argument is that it assumes the greater majority of women undergo pregnancy testing, which cannot be corroborated without additional research.

That aside, the authors also make little distinction between HIV and AIDS diagnoses in their results; their conclusions may explain a decline in rates of HIV-infection, but leaves the reader wondering how the prevalence of AIDS among men can increase so rapidly in such a short time period. Another study of HIV/AIDS infection rates throughout Western Europe shows that in comparison to other European nations Italy has a relatively low rate of HIV infection, but a very high comparative rate of AIDS deaths and diagnoses (Harners and Dawnes, 2004). The authors believe that one of the reasons for this has been intravenous drug use, which is “very high (greater than 25%), and might be increasing in some regions or cities in several countries including Italy” (Harners and Dawnes, 87-8, 2004). These authors also point out that a large number of migrants from Africa, where HIV/AIDS is very prevalent, might also explain why Italy is so disproportionately affected in comparison to other European nations (Harners and Dawenes, 87-8, 2004). However, as we will soon see, there is a lack of adequate support,
initiatives, and statistics on HIV/AIDS in Italy. Addressing a deadly disease, at a time when healthcare devolution and government scandals are rampant might be another reason as to why HIV/AIDS is such a problem in Italy.

One of the few HIV/AIDS nationwide support networks in Italy is La Lega Per La Lotta Contro L’Aids (Italian League for the Fight Against AIDS), an organization that primarily seeks to conduct research on the disease in Italy. Information from this group is available almost exclusively in Italian, thereby potentially excluding migrants and citizens of other EU states. Most materials from this support network indicate that their focus is on research, while also addressing HIV prevention. Aside from this group and their few affiliates, there is a lack of nationwide HIV/AIDS support networks in Italy. This, coupled with the fact that it is difficult to find HIV statistics in this country, gives little hope for Italy ranking higher than the United Kingdom or Germany in terms of HIV/AIDS treatment effectiveness. The Stigma Index has no information whatsoever on what the issue is like in Italy, yet considering the large number of poorly educated refugees that this nation takes in, it seems fair to presume that HIV stigma in this country may especially target the non-native Italian community. There is some evidence that this may be the case. Research published in 2015 by La Lega Per La Lotta Contro L’Aids and the University of Bologna indicated that roughly 61 percent of those living in Italy with HIV/AIDS that were surveyed keep their HIV positive status a guarded secret (Cerioli et al, 2015). This study also revealed “more than half of respondents with HIV reported unfair or different treatment because of their serological [referring to having a positive HIV test] status” (Cerioli et al, 2015). One of the issues with this study is that it was presented as an “anonymous on-line questionnaire” to a group that was “82% male” (Cerioli et al, 2015). Considering the nature and substance of the Italian healthcare system, the actual situation is likely to be significantly worse
than what this study suggests. This is in large part due to healthcare devolution occurring extensively in the nation, which is also affected by a system that is below the standards of that of many of its neighbors. When turning to Germany and the United Kingdom, one can see that living with HIV/AIDS in Italy is comparatively worse than in Germany or the UK.

As is the case with HIV/AIDS support groups and awareness in the United Kingdom, an abundance of studies and statistics with respect to the subject are available for Germany. In addition to what is provided by the Stigma Index, certain government entities and universities have extensively studied the disease and its treatment in the UK. One of these studies conducted regarding HIV/AIDS stigma in the United Kingdom addressed specifically what patients thought regarding their own HIV-status. The study found that roughly 63 percent of those living with HIV suffered from low self-esteem, and while that number was almost “exactly the same for men and women,” it was much higher among homosexual and immigrant populations (Sharp and Patterson, 2014). Tying this back into the Italian case, where the number of undocumented migrants in particular is very high, one can only assume that feelings of low self-esteem among those living with the disease in Italy are far more prevalent. Self-esteem is a key indicator of mental health, and one of the key factors that play into how HIV/AIDS stigma affects treatment and the experience of the patient. Less information is available regarding HIV/AIDS stigma in Germany than what can be found in the UK, though there is an abundance of data and statistics for this topic in Germany in comparison to Italy. One of the key elements of HIV stigma that has been thoroughly examined in both the United Kingdom and Germany is stigma in the workplace. This is a particularly interesting area to explore, given that the workplace is one of the most relevant places for HIV stigma to play into the healthcare system. The average person spends a huge portion of their time at the workplace, and must interact extensively with people who may
not be close friends. Stigma occurring in the workplace is likely to be some of the most
detrimental, because of the need to interact with the same individuals on a daily basis. Such
negative feelings, especially in the absence of mental health or caring relatives, can lead to low
self-esteem, and a reluctance for patients to start or continue seeking treatment. Stigma in the
workplace is even more relevant in Germany versus the UK or Italy, considering that health
insurance in Germany may be provided through the workplace in certain cases.

Throughout its various reports, the Stigma Indexed analyzed HIV/AIDS discrimination in
the workplace in both the United Kingdom and Germany. Many HIV positive individuals were
interviewed in the United Kingdom, and though no overarching statistics were provided for this
country, the general result was that HIV discrimination was not as huge of an issue in the
workplace as in other countries (Sharp and Hudson, 2014). One of the main reasons for this, as
described by one individual, is that "the law changed [so] they can’t ask about your medical
history prior to the interview [referring to employment]” (Sharp and Hudson, 2014). Anti-
discrimination laws are comparatively strict in the United Kingdom, and the presence of these
laws provides some explanation as to why HIV discrimination is not a major problem in the
workplace. In Germany it was reported that 26 percent of individuals surveyed, because of their
HIV status, experienced discrimination in the workplace (Vierneisel, 2015). It was also made
clear by the report on Germany that “from those who lost their jobs in the year before the
interview [referring to employment] and base this on their HIV-infection, more cite HIV-related
discrimination as the basis for their dismissal rather than HIV-related poor health status”
(Vierneisel, 6, 2015). The Stigma Index continues to have no information regarding HIV
discrimination in Italy, but from the lack of support groups and lack of nationwide attention
given to the issue, the situation in Italy ranks as being worse than in the United Kingdom or Germany.

When comparing the functional and procedural characteristics of the national healthcare systems, Germany came out as the firm leader ahead of the United Kingdom and Italy. However, the evidence also shows that Germany is lacking in terms of efforts to eradicate HIV/AIDS discrimination. The German system performs outstandingly in terms of actually treating and managing HIV; however, cultural and societal factors in Germany continue to be an obstacle to the successful treatment of HIV/AIDS. On the other hand, we see that Great Britain does comparatively better in terms of targeting and combating discrimination, yet the National Health Service is inferior to the German health care system in terms of actual treatment. Italy then ranks at the bottom, having neither a strong healthcare system, nor positive societal factors that help those living with HIV/AIDS.

*Applying What Works Across the European Union*

In terms of creating a common EU policy, exporting what has successfully worked in one country to other nations is one possible way that healthcare across the European Union can be improved. However, there are barriers and obstacles to exporting any such policy. In an ideal situation, the German healthcare system would exist alongside the laws and cultural dynamics of the United Kingdom, which should work together to create an optimal environment for those affected by HIV/AIDS and other diseases.

One of the chief issues with exporting either the British approach to HIV discrimination, or the German method of actually providing treatment, is the cultural barrier. In a country like the United Kingdom, the healthcare system that is currently in place is a key part of national identity. When looking at the British example it is true that the National Health Service is
lacking in key areas, but replacing that system with something different would likely conjure up a great amount of British dissent, and could be perceived as an attack on the British identity. This is true as well in other European nations, and is compounded by the fact that the EU is not extremely popular to many European citizens. According to the Pew Research Center, roughly 52 percent of Europeans view the European Union favorably (2014). It is also made clear by Pew Research that positive perceptions of the EU have generally improved over the past couple of years (2014). However, one of the main reasons for this appears to be the effect that the European Union has had on the economy. According to additional data from the Pew Research Center, only 26 percent of survey respondents disagreed with the statement that “[European] integration has favored the economy” (1, 2014). Economic benefits have been one of the strongest drivers of European integration, which creates an issue for developing a joint healthcare model. Implementing a supranational healthcare system in the European Union would be very costly and would likely complicate ongoing treatments across the continent. Looking back to the European Monetary Union, which is perhaps the best integrated of all current and historic EU initiatives, the economic benefits were very clear. Considering that this is not the case for healthcare, strong opposition against any such common policy would be guaranteed to occur.

Another large issue of hypothetically exporting the German healthcare model to the rest of the EU is actual implementation. When one takes a look back at the Italian healthcare system, universal care riddled with problems can be seen. Considering the vast array of scandals and complications that plague the Italian healthcare system, it is a quite a stretch to believe that implementing a totally new healthcare system there would be effective. In the case of Italy, transitioning to different HIV/AIDS treatment system than what is currently in place is likely to
create a number of treatment interruptions, as well as complicate the method by which Italians are used to receiving both basic services as well as things as complex as HIV treatment.

When taking a look at the United Kingdom, one can see a system that is marginally better than what exists in Italy. It is true that the National Health Service (NHS) is in need of some sort of overhaul, and that changing it to something on par with the German system would be optimal. However, in the case of Great Britain cultural obstacles to integration become a key issue. As has been noted, the British view their healthcare system as a part of their identity. Furthermore, the British mindset towards the European Union is some of the most negative in the EU. Much of this has to do with the British cultural identity and the reluctance of Britain to adapt certain aspects of supranationalism. However, the situation is unique in Britain in the sense that Prime Minister David Cameron has announced that he will hold a referendum in the near future concerning British membership in the European Union. One source revealed that “support for a British exit [from the EU] rose to 39 percent, the highest level since 2012, up from 27 percent in June. That more than halves the ‘in’ lead to 13 percentage points from 34 points in June” (Faulconbridge, 2015). Support among the British public for exiting the European Union is unlikely to create a situation where a common healthcare policy is looked upon favorably in Britain.

Figure 4 (pg. 92) shows popular opposition to the EU in Britain.

The next question to then examine is whether or not cultural aspects can be exported across the European Union. The evidence thus far examined shows that applying the German healthcare model across Europe will be nothing short of a difficult, up-hill battle. With that being said, one can also see that the cultural factors surrounding HIV/AIDS are significantly better in the United Kingdom than they are in Italy or Germany. Creating a common EU healthcare policy
may not be an optimal first step in improving the lives of people with HIV/AIDS, nor those suffering from other chronic conditions across the European Union. However, trying to change the cultural mindset across Europe may be one of the better steps to take in the short-term, versus introducing sweeping changes.

Approval of the European Union and its policies by citizens of member-states is correlated with whether or not member-states feel well off, particularly in terms of the economy. Approval for the EU made a very publicized fall following the 2008 financial and Greek debt crises, though it is generally reported that most European citizens do not wish for their country to exit the EU. This closely ties in to the issue of creating a common EU healthcare policy, given that such a policy would likely have a high cost and lack initial efficiency, and would likely create sentiment against the European Union. One Gallup poll conducted in early 2015 demonstrated that roughly 29 percent of European citizens felt that the EU has made their country better off (Sonnenschein and Kluch, 2015). On the other hand, roughly 33 percent of citizens felt that their country was worse off as a result of EU membership, while the remaining 37 percent either had no opinion on the issue, or felt that the EU had not made things better or worse for their country (Sonnenschein and Kluch, 2015). One of the interesting things about this particular poll is that it was conducted in March of 2015, before the Syrian refugee crisis reached the level of publicity that it did later that year. The current refugee crisis has left the European Union tackling yet another major issue, on top of the ongoing debt crisis, which has pitted certain member-states against each other. The result has been a fall in the approval rating of the European Union. Another poll conducted in November of 2015 by the organization Survation showed that “53 percent” of Britons wanted to leave the European Union (RT, 2015). This is a sharp fall from the 60 percent of survey respondents who indicated in a 2014 Gallup poll that
Britain should not leave the EU (Sonnenschein and Kluch, 2015). It is important to examine the United Kingdom in particular with respect to approval of the European Union and the possibility of exporting a cultural mindset for two reasons. The first is that evidence has shown that British laws and accommodations have made living with chronic diseases like HIV/AIDS, in terms of social conditions, comparatively better in Britain than in Germany or Italy. The second reason surrounds the fact that Britain is one of the most notable member-states to opt out of EU movements when possible, and has a comparatively high rate of citizens who do not value British membership in the European Union.

Given the migrant and debt crises that the EU is now simultaneously combating, coupled with falling support for the European Union by citizens, it seems unlikely that a common healthcare policy is anything we will see in the near future. For cultural and financial reasons, it would be very difficult to export elements of the German healthcare model to the rest of the union, even if this is a model that better helps citizens affected with diseases like HIV/AIDS. However, a cultural healthcare policy that creates stronger anti-discrimination laws and access to treatment laws for those suffering with diseases like HIV/AIDS, like what we see in the United Kingdom, would be easier to implement, and more likely to succeed. Convergence of effective policies, such as the German healthcare system with the British legal framework governing the health-care industry, might create the ideal environment for HIV/AIDS treatments across the EU to improve. With that being said, it is unlikely that any such change can successfully be accomplished at a time when the EU is facing two major crises and waning support.
Conclusions

Overview of Initial Findings

This study has focused on the quality and level of HIV/AIDS care and treatment throughout the European Union; however, the strongest findings were in the conclusions that I could draw for each case studied. For the United Kingdom, Germany, and Italy I analyzed healthcare systems and HIV/AIDS treatment. When looking towards the entire European Union, and considering what sort of supranational healthcare policy might be beneficial, I identified numerous obstacles that stand in the way of such a policy becoming effective. Furthermore, I highlighted a number of the procedural and cultural differences among EU member-states, which affect healthcare, and other areas of European integration.

Summary of Findings in the United Kingdom

In Great Britain I saw a strong healthcare system, which is driven by a notion that everyone should have equal and fair access to healthcare. Nonetheless, the British National Health Service (NHS) faces severe funding problems, which as my research showed, will create an inevitable issue for patients living with HIV/AIDS and other chronic illnesses. At the moment, treatment of HIV/AIDS is not problematic, in fact some sources I cited in this study show that it is in a better state now than it has ever been. However, one must also recognize that the British healthcare system is facing a decline. The NHS will at some point either need to be completely overhauled, or receive huge increases in funding, because the current system is becoming unsustainable given the current population and healthcare issues facing the United Kingdom.

In terms of living with HIV/AIDS, taking financial and procedural healthcare information aside, living with the disease in the United Kingdom is comparatively better than in Germany or
Italy. The primary reason for this is the strong legal framework that has been established in Britain, which provides extensive protection for individuals against discrimination and a denial of treatment services. Unlike in the other two countries, extensive and effective initiatives exist in Britain to free workplaces from discrimination, and promote social programs to improve the quality of life for infected individuals. Perhaps as a direct consequence of that legislation, and the gradual change in social attitudes that it has produced overtime, the United Kingdom is home to an extensive number of support networks that provides support to those living with HIV/AIDS. This means that both the legal and social frameworks in this nation are optimal, especially in comparison to the Italian and German cases, and are ideal for helping those with the disease in Britain carry on with their lives.

When looking towards the European Union, and the idea of a supranational healthcare policy, British opposition to such a prospect cannot be ignored. Public opinion in the United Kingdom tends to lean against stronger cooperation with the EU. Despite favorability for the European Union gradually increasing in the United Kingdom over the past few years, the current European migrant crisis has largely caused that trend to reverse itself. With British sovereignty from mainland Europe being a key part of what it means to be British, as well as the persistence of financial and migrant issues in Europe, my conclusions do not support a scenario where the United Kingdom will adopt any major type of supranational policy, particularly not in a field such as healthcare, which is not at the forefront of many British citizen’s minds.

**Summary of Findings in Germany**

Germany came out at the very top in terms of procedural healthcare characteristics. Quality of care in this country is very high, and the German healthcare system is comparatively more efficient than that of Italy or the United Kingdom. Curiously, unlike the other two cases,
Germany technically does not have a universal system of healthcare. Nonetheless, public, private, and government-backed health insurance schemes allow everyone to gain access to treatment in this country. Healthcare costs were slightly higher in Germany compared to the other cases; however, treatment outlooks for HIV/AIDS patients moving forward in this nation are financially and procedurally more optimistic than in Italy or the United Kingdom. When looking at the practical characteristics of the German healthcare system, the lives and treatments of HIV/AIDS patients showed little difference than those suffering from other chronic illnesses.

When it comes to laws and the societal factors that govern life with HIV/AIDS in Germany, results showed that this country ranked below the United Kingdom, but ahead of Italy. There are anti-discrimination laws in force in Germany; however, they do not offer the same effectiveness and degree of protection that those laws offer in the UK. It was also noted that HIV/AIDS discrimination in the workplace remains a problem in Germany, and that the country has one of the higher rates of HIV infections in the European Union. This was particularly relevant for the German case, since some HIV/AIDS patients have access to treatment through insurance programs sponsored by their employer. Results here also suggested that stronger German legal and social measures to combat the HIV/AIDS stigma, as well as to promote treatment of the disease, would help to further bring German HIV/AIDS further to the forefront of “what works” in the European Union.

Germany is one of the least-hesitant nations in the EU to welcome supranational change. This contrasts from what was seen with the UK, for instance with the British feeling strong connections to their currency and healthcare system and being less receptive to change. Germany is often at the forefront of movements in the European Union, and has usually been one of the largest drivers of change across the continent. Nonetheless, the European migrant crisis has
changed the attitudes of many voters in Germany, with anti-European political parties such as the *Alternative Für Deutschland* (Alternative for Germany) gaining popularity. Should a common healthcare policy emerge in the European Union, it is unclear if Germany will lead the way; however, as was the case in Britain, nationalistic and anti-European movements are an issue standing in the way of this nation partaking in new cross-border healthcare initiatives.

**Summary of Findings in Italy**

Italy ranked at the bottom of this study in procedural healthcare characteristics, and in terms of efforts to combat HIV/AIDS and help those living with the disease. Although Italy does have a universal system of healthcare, I have shown that the quality of care varies greatly within the country. Treatment experiences for HIV/AIDS patients are likely to be of much better quality in the northern, wealthier parts of the country, versus the more economically challenged south. Devolution of medical authority to regional governments has exacerbated this divide in treatment quality, and the presence of healthcare scandals in the country continue to drive a wedge in effective treatments offered to patients.

While anti-discrimination laws exist in Italy, their effectiveness can be described in many instances as uneven. Both Germany and the United Kingdom had comparatively more effective laws and measures to prevent discrimination against HIV/AIDS patients than what was seen in Italy. Another alarming result that this study revealed in the Italian case is that in addition to very few national statistics about HIV/AIDS prevalence being available, there also exists a glaring lack of support groups and organizations looking to help those with HIV/AIDS.

Having ranked below Germany and the United Kingdom in each of the investigations conducted in my study, HIV/AIDS patients in Italy would hypothetically stand to gain more from an effective supranational healthcare policy than their German or British counterparts.
would. However, the Italian government’s decision to extensively devolve healthcare authority does not paint an optimistic picture for Italy adopting an EU supranational healthcare system or more effective framework for stronger healthcare initiatives. The effects of the European migrant and monetary crises are much more pronounced in Italy than they are in Germany or the United Kingdom, which creates additional difficulties to any sort of healthcare reform in this nation emerging in the near future. Furthermore, waning support for the European Union as well as apathy towards healthcare reform in the face of the two ongoing European crises in Italy will also create additional obstacles to such reform.

*Anti-Discrimination Measures in the European Union*

Based on the results of this study, procedural healthcare reform in the European Union does not seem like the most beneficial outcome for HIV/AIDS patients given the difficulties involved with implementing such change at the national level, along with the likelihood that national support for such an initiative would be very weak. Nonetheless, results from the case studies of the United Kingdom in particular point to another solution, which may in turn help to generate better care for HIV/AIDS patients in the EU without actual healthcare reform. As mentioned, anti-discrimination law in the United Kingdom is some of the most effective in the EU, and has led to HIV/AIDS patients in Britain enjoying comparatively better daily lives than their counterparts in other European nations. The European Union has also implemented supranational anti-discrimination laws, though they lack optimal effectiveness, but would be much easier to amend and reform than cross-national healthcare policy.

EU anti-discrimination law, stemming largely in power from the Treaty of Amsterdam, “enhances the importance of human rights within the EU legal order, even providing for the possible suspension of a state where there is ‘a serious and persistent breach’ of human rights”
In the Treaty of Amsterdam, the European Union also acknowledges ongoing racism, particularly towards “resident migrants,” and states that it is the duty of the European Union to work against this (1997). Nonetheless, the text in this law is vague, and the EU has never gone as far as suspending a member-state. The Council of the European Union approved a directive in the year 2000, which supplemented the anti-discrimination terms mentioned in the Treaty of Amsterdam. This directive (also known as 2000/78/EC) is vague in its text, but mentions specific instances where EU power under the Treaty of Amsterdam can come into effect. 2000/78/EC mentions the need to improve “the principle of equal treatment between persons irrespective of racial or ethnic origin,” and re-enforces that this directive “already provides protection against such discrimination in the field of employment and occupation” (The European Union, 2000). Nonetheless, in 2008 a proposed directive on discrimination was developed that would enhance this multi-national organization’s ability to impose fines on states that do not work against discrimination (The European Union, 2008). Aside from the ability to impose fines on member-states, this proposed 2008 directive is more specific in its definition of what is illegal, and defines discrimination “based on religion or belief, disability, age or sexual orientation” as being “prohibited by both the public and private sector” (The European Union, 2008). The proposed directive goes on to include “social security and health care; social advantages; education; access to and supply of goods and services which are available to the public, including housing” as areas in which discrimination are strictly prohibited (The European Union, 2008). However, the Treaty of Amsterdam only set up a very basic framework that consolidated provisions laid out in earlier treaties of the European Union.

Therefore, it is from Amsterdam that some of the most relevant laws and procedures of the EU concerning discrimination can be seen. The Treaty of Amsterdam lays out only basic
provisions that define discrimination as illegal, and weakly emphasizes how the practice should be combatted. Council directive 2000/78/EC on the other hand, builds up some of the provisions that define discrimination and talks extensively about the need for “social protection” and taking care of “the needs of disabled people at the workplace” (The European Union, 2000). It is important to note that HIV/AIDS patients qualify as people who are considered to have a disability. Nonetheless, beyond loosely clarifying that disabled persons are protected from discrimination by EU law, 2000/78/EC does not define practical measures by which such actions can be prevented. The 2008 proposed directive would create provisions that should help the EU take a much more active role in addressing discrimination by increasing member-state initiatives against the practice. This proposed directive is extensive, and references provisions set up by the United Nations in terms of recognizing and targeting discrimination (The European Union, 2008). However, given that this directive is only a proposal, it does not have the force of law.

Nonetheless, I have seen that HIV/AIDS discrimination continues to occur at different rates among member-states in the EU despite these measures. Even though the European Union theoretically has some power to punish nation-states that do not take more active roles against discrimination, it has instead implemented other alternatives to combat discrimination. The European Commission has worked to introduce “anti-discrimination training activities” in addition to “supporting intermediary actors such as NGO’s [Non-Governmental Organizations]” (The European Union, 2008). Results of my study imply that in a country like Italy, such measures would likely be ineffective in combatting HIV/AIDS stigma given the lack of NGO’s helping patients suffering with this disease, as well as the vagueness and difficulties involved with implementing blanket anti-discrimination programs. Nonetheless, this policy of the
European Union remains one that would be much simpler to amend, and make stronger on a supranational basis than something as grand as procedural healthcare policy.

Keeping the complexities of EU law in mind, it is important to include a quick note on where legal authority for anti-discrimination policy in the European truly stems. The European Union has what are considered “primary laws,” which are the various EU treaties that have been ratified (The European Union, 2016). These primary laws are then supported by what the EU refers to as “secondary laws,” which are directives and other measures designed to give the intergovernmental body more power to complete the duties granted to it under primary law (The European Union, 2016). When talking about anti-discrimination measures in the European Union, the Treaty of Amsterdam is the primary law that concerns this issue. However, the Treaty of Amsterdam is essentially a revision of many earlier treaties (which can also be considered primary law), meaning that much of what the Treaty of Amsterdam states comes from earlier legislation. The 2008 proposed directive, on the other hand, is an example of a proposed secondary law, which would lend support to what the European Union can do under primary law.

*The 2008 Proposed Directive on Anti-Discrimination*

The European Commission’s 2008 proposed directive on anti-discrimination policy, also known as CNS 2008/0140, would enable the EU to take a stricter stance towards discrimination (The European Union, 2008). Considering that this directive is only a proposal, it does not have the power of EU secondary law. However, the content of this proposed directive reflects a realization of the EU that discrimination continues to be a problem within Europe, and that more needs to be done to address this issue. Although there continues to be a lack of direct enforcement of anti-discrimination policies at the supranational level by the European Commission, this entity is able to sue member-states in the ECJ for policy violations. Should this
directive eventually become a piece of EU secondary law, it is possible that we will see more
cases concerning discrimination come before the ECJ. Nonetheless, one particular case stands
out and sets something of a legal precedent for anti-discrimination law in the European Union.

In 2008 a case concerning discrimination regarding time off from employment was
brought before the European Court of Justice. The initial case, referred to as the Coleman Case,
was based in the United Kingdom, and later brought to the attention of the ECJ (Equality and
Human Rights Commission, 2015). In short, the plaintiff (named Sharon Coleman) had a son
“with a rare condition affecting his breathing,” which required her to take extensive time to care
for her son (Equality and Human Rights Commission, 2015). She was denied time off from
work, despite her coworkers being given time-off when they had requested it, and brought the
case to the ECJ (Equality and Human Rights Commission, 2015). Based on directive
2000/78/EC, such discrimination should have been prevented by the United Kingdom.
According to the Equality and Human Rights Commission, the court ruled in Coleman’s favor,
and issued a ruling stating that the United Kingdom had to amend its anti-discrimination laws to
adhere to those of the 2000 European directive, and Treaty of Amsterdam (2015). The year that
this case reached the ECJ is the same as when that new 2008 directive was brought up by the
Council of the European Union. Should the EU eventually adopt CNS 2008/0140, it would
undoubtedly work with the Coleman case to provide a stronger point of EU secondary law.

The impact of this case cannot be overlooked. The implication is that when national laws
contradict (or are not up to par with) laws of the EU, then the European Commission via the ECJ
can take action to assert the supremacy of its law. As the Equality and Human Rights
Commission explains regarding the Coleman case, “ms (sic) Coleman's victory before the
European Court of Justice has ensured that the UK's disability discrimination law provides
protection on the grounds of someone's association (including caring responsibilities) with a disabled person” (2015). Despite the value of this ruling, anti-discrimination legislation in the European Union remains weak. Technically speaking, the European Commission did nothing to enforce the 2000 directive in the Coleman case. The only reason that the decision against the United Kingdom was brought in front of the ECJ was because Sharon Coleman, not the European Commission, took the law of the UK to trial.

Looking forward, enforcement practices concerning anti-discrimination laws by the European Union may benefit tremendously from being stepped up in two ways. The first is for the European Commission to take a more active role in ensuring that its directive is being followed. There are few other cases in the European Court of Justice that touch on discrimination issues, and it is often individual citizens who are plaintiffs in ECJ cases. If the European Commission takes a more active role, even via the ECJ, in enforcing its laws, then anti-discrimination practices (particularly in countries like Italy) may improve. Additionally, enforcement practices may be stepped up by giving the European Commission power to directly punish member-states for violations, rather than going through the ECJ. Such a provision would cut down on the bureaucratic aspects that the EU must deal with when enforcing regulations, and would give member-states a greater incentive to adhere to the existing anti-discrimination laws of the European Union.

*The Problem with Supranational Healthcare Policy*

Looking back to the theories of European integration that were discussed in the literature review, the idea of inter-governmentalism seems to fit my findings the best. The theory of inter-governmentalism says that European states will work together on tackling certain issues, but that sovereignty will be maintained by the nation-state. Given what was observed in the three cases I
studied, particularly in Italy, this seems like the most fitting out of the integration ideas studied. However, that is not to say that the theories of integration discussed earlier in my study are the only methods by which European integration in the healthcare field may form.

In response to the many “newer” factors that are influencing European integration, or lack thereof, a new idea of Constraining Dissensus has developed. Authors Liesbet Hooghe and Gary Marks argue that European integration, as well as its future, revolves around the key idea of identity (2008). In addition, these authors go on to explain that “most mainstream parties are more Euro-supportive than voters” and that these parties have attempted to “depoliticize” issues of integration (Hooghe and Marks, 21, 2008). Keeping once again in mind the notion of a “two-level game” that is characteristic of European politics, this argument of Constraining Dissensus provides one of the better summaries for why integration in the healthcare field is not in Europe’s best interest, as well as how it may harm rather than help HIV/AIDS patients. If we look at the Italian case in particular, results from my study have painted a picture of a system that is barely able to get by. In addition to all of the funding issues discussed earlier, the level of inequality that is characteristic of healthcare in this nation is probably the most important factor that distinguishes it from its more effective German and British counterparts. Imagine now if procedural healthcare reform were to take place in Europe. If we look back to the argument of Constraining Dissensus, it is quite likely that we would see the mainstream political parties advocating for such a policy, particularly in a nation like Germany. However, the failure of these parties to de-politicize the issue, as authors Hooghe and Marks mentioned, will become a large obstacle in the successful implementation of such a policy.

To best explain this, let us imagine a hypothetical scenario where European leaders have come together in agreement that the German healthcare system in the best in the European
Union, and that the practices and methods of this system should be implemented across the intergovernmental body. In a nation like Italy (keeping the inequality that this system is characteristic of in mind) such reform would likely be disastrous from day one. Setting aside all of the blatant issues of implementation such as funding, integration with existing healthcare practices, and changes in treatment procedures, popular opposition to such reform would be extremely pronounced. Considering again my findings in the Italian case, it is quite unlikely that any such reform would go over smoothly in Italy. The ultimate result would likely be a straining of the national budget, continued inequality in healthcare treatment across the country, and a need for other European countries, such as Germany, to provide financial support. Before even bringing up the issue of Constraining Dissensus, one can quickly understand that such a scenario will not help any HIV/AIDS patients.

Once such a situation unravels, public support against a universal European healthcare initiative will be almost guaranteed to decline. Mainstream parties would continue making their efforts, as Hooghe and Marks mention, to de-politicize the issue (2008). However, in the face of such high costs and poor effectiveness in implementation, as we would likely see in the Italian case and as the argument of Constraining Dissensus mentions, such efforts would be futile. The ultimate result would instead likely be an even larger decline in support for the European Union, more power going to the far right, and most importantly poorer treatment for HIV/AIDS patients than what is presently seen.

However, that same view of Constraining Dissensus does shed light on a different aspect of this question. As author Philippe Schmitter mentions, “no serious threat to the integrity of EU institutions has emerged and decision-making has proceeded more-or-less unimpeded” (215, 2009). This portion of the argument refers to institutions already in place, such as the European
Monetary Union, which gives some hope to the prospect of supranational healthcare policy. Once in effect, such a policy may begin to become effective in the long run. However, the fact of the matter is that there are too many compounding factors and obstacles in the short-run for such a policy of healthcare integration to be successful. Furthermore, my study analyzed HIV/AIDS and healthcare characteristics in only three European countries. In reality, there are many more nations with unique aspects defining their healthcare policies, such as Greece, Spain, and Portugal, which may result in even larger obstacles emerging for a policy of healthcare integration.

**Discussion of Results**

*Is a European Union Cross-Border Healthcare Policy Practical?*

The ultimate results of my study suggest that a supranational European healthcare policy would not be able to be effectively implemented. As my research has shown, there are a number of variables and current events that stand in the way of a cross-border healthcare policy, which I will discuss in detail. However, let us first isolate the healthcare question, and look specifically at this issue before considering those other variables.

**Looking at Healthcare**

Currently, there is effectively no legislation concerning cross-national healthcare in the EU. The legislation that does exist only guarantees treatment to EU nationals in other member-states, but leaves terms concerning treatment quality and cost vague. The existing framework is extremely bare-bone, and could stand to benefit from new legislation. As mentioned earlier, the notion of primary and secondary law in the European Union is quite important. One of the greatest issues concerning a cross-border healthcare policy is that there is effectively no primary law that can lead to any such policy. For that reason, any sort of directive (or other form of
secondary law) would have no legal basis to improve the issue. The obvious implication is that cross-border healthcare reform would require a new piece of EU primary law to come about. When looking back at EU primary law, particularly what is stated in the Treaty of Amsterdam, the intentions of the European Union become somewhat difficult to follow. The EU frequently mentions human rights, and implies the need to care for every person within EU borders. However, treaties such as Amsterdam establish very little effective law concerning healthcare, which is an issue of upmost importance when thinking towards human rights. More specifically, when looking at the Treaty of the Functioning of the European Union, there is only one article (number 168) that seems relevant to cross-border healthcare. Article 168 says, “a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities,” and mentions that it is the duty of the EU to promote cooperation concerning this issue among member-states (The European Union, 2012). However, Article 168 says relatively little about how cooperation among member-states in this area can be fostered, as well as what sort of enforcement power the EU has. Another directive, approved in 2011 (also referred to as 2011/24/EU), mentioned some more stringent rules concerning the provisions established in Article 168 (The European Union, 2011).

Chapter 2 discussed the limited role that EU policies play in the realm of cross-border healthcare. My findings indicated that there is little effective EU guidance in terms of how cross-border healthcare should be governed or dispatched; the Union simply stipulates a few financial provisions. Furthermore, my research showed that these financial provisions were bureaucratic and prone to problems of operationalization; they do not necessarily make it easy for an EU citizen to get reimbursed for healthcare services acquired outside of their home country. Recall my earlier example of a Dutch HIV/AIDS patient receiving care in Cyprus. Out-of-pocket
healthcare expenditures are much higher in Cyprus than in the Netherlands (which could potentially be correlated with better treatment quality in Cyprus), but would leave that Dutch patient in a difficult situation in terms of being reimbursed for health costs. This all dates back to the primary law (which is essentially the Treaty of Amsterdam), as well as the later 2011 directive addressing the issue. That directive, 2011/24/EU, states that EU member-states have an “obligation to reimburse costs of cross-border healthcare,” but that this reimbursement should be “limited to healthcare to which the insured person is entitled” (The European Union, 2011). A later report from the European Commission discusses some practical difficulties with the implementation of 2011/24/EU. The report mentions that several member-states, as of 2015, still have not enacted reforms based on the directive, and that there continues to be ongoing litigation with respect to this issue (The European Commission, 2015). However, the greatest difficulty found by the European Commission concerning this directive seems to be that “the number of citizens who are aware of their general rights to [healthcare] reimbursement is extremely low” (European Commission, 13, 2015). Raising public awareness about this directive and patient rights in addition to putting more pressure on member-states to adopt reforms based on EU legislation may help to improve the cross-border healthcare situation. However, other issues remain. Directive 2011/24/EU does little to change the status quo established by the primary law. Medical procedures in one member-state may call for an HIV/AIDS patient to see a doctor more frequently, or to take a different set of medications than they normally would in their home country. The result of this could be the patient not being able to be fully reimbursed by their home country upon returning, due to the fact that the treatment they received in the other member-state was not consistent with the home country’s guidelines. This does little to improve cross-border healthcare, and even without stronger primary law, this directive has limited
influence. However, something to point out here is that while there exists some EU primary law concerning discrimination, there exists comparatively less with respect to healthcare. Therefore, it is interesting to note that the 2008 proposed directive on anti-discrimination practices has not been approved, while a 2011 directive concerning healthcare was adopted.

Stronger European Union primary law concerning healthcare across the EU is the method by which we may see better cross-border healthcare practices. This would mean that a new treaty would be required, but the effects that it would have on HIV/AIDS patients, as well as other individuals suffering from chronic illnesses living with the EU could be immense. If a strong primary law guaranteeing treatment equality across the EU is established, then HIV/AIDS treatment across the continent should become much more harmonized. As my research indicated, there are countries in the EU (like Germany) where healthcare systems function comparatively better than elsewhere in the Union. This is especially true if the 2008 proposed directive, or another strong anti-discrimination legislation, becomes adopted as well. In an ideal scenario, the creation of strong EU primary law governing cross-border healthcare practices would ultimately help those living with HIV/AIDS. However, as I mentioned, there are many other variables at play. Implementation and the difficulty of creating and approving new primary law are the first things that come to mind. However, there are other compounding factors in addition to this (although they might initially seem less relevant), which may be some of the most pressing in terms of the future of cross-border care, and HIV/AIDS treatment in the European Union.

Considering Other Variables

At the present moment it would be extremely difficult for cross-border legislation on something as substantial as procedural healthcare reform (or any other form of primary law for that matter) to be approved by member-state governments, but my results indicated a number of
reasons for this: waning EU-support, the European economic crisis, and the European migrant crisis. The latter of these three have a strong influence on the first; however, each of these issues define what is happening in the modern European Union, which affects far more than just healthcare policy.

The European monetary crisis has been extensively studied, and nearly every commentator has added his or her viewpoint on what will happen next. The crisis began in 2008 and hit Southern Europe the hardest, but nonetheless the situation has gradually begun to improve since then. This crisis is still very much ongoing, particularly with respect to Greece, but the European Union has thus far managed to maintain support and manage the fallout. Nonetheless, this is a crisis that has heavily preoccupied the governments of countries participating in the European Monetary Union (EMU), which constitute the bulk of EU member-states, and can be seen as a potential cause for the rise of Euroscepticism and the European far right. At a time when the future of the strongest example of supranational power in Europe (the EMU) is in jeopardy, it is not altogether surprising that EU politicians have refrained from greater integration in other areas. One of the classic notions that define politics of the European Union is that of a “two-level game”. Politicians might seek to improve things such as cross-border healthcare for HIV/AIDS patients, which is something one can see in the existing healthcare and anti-discrimination policies of the EU. However, if advocating for such a position will cause them to lose votes at home they have little incentive to do so. The same is true with respect to the more recent, and arguably far more serious, European migrant crisis and the effect that it has on the future of HIV/AIDS and healthcare in the European Union.

The European migrant crisis has affected each member-state of the European Union, and has damaged EU approval ratings across the continent. Much like the financial crisis, once the
migrant crisis began, no end could be seen. Millions of refugees have been pouring into Europe from Africa and the Middle East, having initially arrived in countries bordering these regions, such as Italy. The European Union’s inability to create an effective policy to regulate the flow of migrants, as well as to effectively distribute refugees across member-states, has caused much internal division in the EU. As a result, support for the European Union has shown a sharp decrease, and many European voters have flocked to far right political parties. In seemingly every member-state of the EU, there is a right-wing political party that wants their country to leave the European Union, and is strongly against accepting migrants. The popularity of these parties has increased in recent years, which adds pressure to that “two-level game” that European politicians must play. The need for European governments to focus their attention on addressing the migrant issue takes the attention of national governments away from topics like HIV/AIDS morbidity and healthcare inequality.

Furthermore, the failure of the European Union to effectively address the migrant crisis leaves some with doubts as to how effective this international organization really is. The migrant crisis has shown policymakers just how divided different European nations are about core issues, such as how many immigrants to allow in, and what benefits to give them. The weakness that the EU has demonstrated with respect to the migrant crisis implies that something that requires much deeper integration, such as procedural healthcare reform, would run into the same conflicts of interest that potential solutions to the migrant and financial crises have. With that said, one must also acknowledge that both of these crises are on-going crises, and it may be that new, effective, and supranational solutions to these dilemmas lie just ahead on the horizon. In short, it cannot be said that a supranational European healthcare program will fail, simply because the EU has so far been unable to develop effective solutions to these crises. However, the present situation does
suggest that if Europe is to take action on procedural healthcare reform, the time is certainly not now.

More so than these two crises, and also as a result of them, poor public support for the European Union continues to be one of the largest obstacles to a common EU healthcare policy being developed. Many Europeans are apathetic about the EU, and tend to focus more on national politics. However, it seems that nowadays with the emergence of far right and Eurosceptic political parties in Europe, European citizens may become less apathetic and more opposed to the EU. The notion of a “two-level game” is perhaps the most critical aspect to take into account when analyzing any sort of EU policy or initiative. There is simply no incentive for a politician to be voted out of office in their home country at the price of advocating for an unpopular supranational policy. One of the best examples of this is the relatively recent emergence of a far-left political party in Greece, which can largely be attributed to their predecessor giving more concessions to the European Union than what many Greeks would have wanted. With public support for the European Union being the way it is right now, it seems unlikely that any sort of pan-European initiative, which does not deal with the two previously mentioned crises, will emerge anytime soon. It can also be argued that falling support for the EU has been compounded by recent events such as the 2015 killings in Paris and 2016 attacks in Brussels. These attacks, and other instances of violence in Europe, have helped to kick-up islamophobia and anti-immigrant sentiments. The European Union’s decision to continue letting migrants in can be the cause of great political upheaval, and will likely benefit the Eurosceptic far right in coming elections. As mentioned earlier, another potential solution to improving healthcare and the quality of life of HIV/AIDS patients is to develop and implement a stronger European policy that targets discrimination. Such a legislative change will undoubtedly be easier
to implement than reworking entire healthcare systems; however, with popular support being largely pitted against the EU, this is a policy reform that may need to wait as well. At the present moment, it may be that the European Union is about to face another impending crisis: the success of far right parties to influence their governments to move away from supranationalism. At a time when Euroscepticism is as strong as it has become, it may be wise for the EU to avoid implementing a policy change or directive that could make European citizens feel that their national governments are subservient to the European Union; and thus draw more voters to favor nationalistic solutions instead of European cooperation.

*Is a Strong Anti-Discrimination Policy the eventual way Forward?*

If present anti-European sentiments are set aside, attacking the issue of discrimination in Europe may be the best step forward for practical and effective supranational healthcare reform, and would benefit HIV/AIDS patients in particular. Increasing anti-discrimination measures across the European Union in theory should be far simpler and more feasible to conduct than large healthcare reform. While the 2008 directive would not give the European Union the strongest of tools to address the discrimination issue, it would effectively build upon previous European legislation. The Treaty of Amsterdam is somewhat weak in terms of discrimination, and gave the EU effectively little practical power to step in when there is a case of discrimination, which is something the 2008 directive would do a decent job of correcting. Nonetheless, that directive (which is currently only a proposal) would give the European Union comparatively little power to address discrimination than what it otherwise potentially could. If the EU were given the authority to levy fines or other similar punitive measures against national governments that do not effectively enforce anti-discrimination policy, the result for HIV/AIDS patients would be substantial. As was seen in the British case, laws and regulations played an
important role in helping HIV/AIDS patients seek treatment for their disease, as well as feel safe
within their community. In Italy I saw the complete opposite, where a lack of effective
enforcement of anti-discrimination procedures has created an extremely difficult living situation
for HIV/AIDS patients in that country when coupled with the current process of healthcare
devolution that Italy is presently undergoing. Another finding to make note of is that wherever I
saw strong and effective anti-discrimination legislation, I also tended to see a larger presence of
support organizations for groups such as HIV/AIDS patients. In Italy, I saw poor anti-
discrimination measures and a very weak support network, while I saw the absolute opposite in
Britain. Additionally the German case fell between Italy and the United Kingdom in terms of
both anti-discrimination measures and support groups. This is simply an observed correlation,
however, it is an area that requires more investigation in the future, should a stronger
supranational anti-discrimination policy attempt to be created.

One aspect that suggests reforming anti-discrimination policy would be more effective
than proposing procedural healthcare is ease of implementation. Adjusting to a new legal
framework, ratifying treaties, and effectively managing that “two-level game” is by no means
easy; however, it is much simpler than what the alternative would call for. Aside from all of the
major issues concerned with implementing supranational healthcare reform that I have discussed,
inequality across the European Union is possibly the biggest obstacle to such reform. There is no
doubt that different policies and procedures, even those that are supposed to be uniform, tend to
show a lot of variation among European countries. The best example of this is probably that of
the European Monetary Union (EMU). The EMU called for a universal currency to be adopted in
the EU, along with stringent guidelines concerning public debt and fiscal policy. However,
implementation of these provisions was anything but uniform across the EU. Portugal, Italy,
Greece, and Spain took a very different attitude to public debt and spending than what was the case in countries such as Finland and Germany. The result, also due in part to several other factors, was the ensuing European monetary crisis.

One must remember that there is always variance between how something looks in theory, and how it works in practice. The EMU, while by no means a failure, did not consider many cultural and situational factors. Supranational cross border healthcare policy would likely be more difficult to effectively implement than the EMU was, and given the country-specific characteristics and variances that I have seen as a result of the European monetary crisis, it would be naïve to assume that procedural healthcare reform would not become a victim of these same pitfalls. If a stronger cross-border anti-discrimination policy can provide an effective mechanism by which HIV/AIDS patients can enjoy a better life in Europe, then the relative ease by which such a policy could be implemented should be taken into consideration. Creating and enforcing new anti-discrimination measures would evolve extensive legislative action, and would have to be implemented with respect to that “two-level game”. Nonetheless, the relative ease and potential effectiveness of this in comparison to the alternative cannot be ignored.

Another aspect that makes this type of legislative reform seem like the more practical solution is that despite the growing wave of Euroscepticism discussed, this type of reform would be much less substantial than the procedural healthcare reform, and would likely not garner as much opposition from the European far right as the former alternative would. However, that is not to say that such supranational legal reform by the European Union will not be met with resistance, or that it should be pursed before the two current crises that the EU is facing are resolved. Given the present situation in Europe as discussed earlier, stronger anti-discrimination
legislation seems like the most effective way to achieve practical change in terms of healthcare for HIV/AIDS patients.

Looking Forward

The initial hypothesis for my study was that strong public spending and a common European healthcare policy may lead to greater equality in European healthcare, as well as improve the lives of those living with chronic conditions such as HIV/AIDS patients. In short, the results of my study showed evidence against that hypothesis. From the evidence studied in the United Kingdom, Germany, and Italy all findings suggest that these are all very different healthcare systems, that reforming them would be extremely difficult, and that such change would probably do more harm than good. In summary, my study did produce evidence suggesting that a stronger European anti-discrimination law would be more feasible and effective than healthcare reform, especially with respect to HIV/AIDS patients. My study also indicated that one of the biggest obstacles to any sort of supranational European policy, whether that be healthcare or otherwise, is waning support for the EU.

The primary consideration that my study offers for future research is that a closer look at anti-discrimination laws and practices in the European Union is needed. Furthermore, extensive research into the rise of the far right in Europe is necessary as well. Keeping in mind the two crises that the European Union is currently undergoing, it may be that citizens turn in greater numbers to these parties due to their alternative strategies on tackling those crises. The importance of this with respect to the future of the European Union, as well as any future European supranational policy, must be acknowledged. Should the far right continue to rise and win elections, it may be that the European Union will face yet another crisis of member-states opting to exit the organization.
There are of course many variables that play into whether or not changes in healthcare practices and a better life for HIV/AIDS patients in Europe will emerge in the EU. Nonetheless, the influence of the far right in European politics is the most important finding that of my study that should be emphasized. For the short term, it seems that any sort of major supranational policy in Europe would not be feasible. However, that is not to say that in the coming years this will change. In addition to examining the role and feasibility of implementing a stronger EU anti-discrimination policy, timeframe is a very important variable for further research to consider. It may be that Europe is ultimately destined for more and more supranational reform, and that the emergence of the far right is just a bump on the road for European integration. If things in Europe improve over the next decade, support for the EU rises, and the need for European healthcare overhaul emerges, then the question of supranational healthcare should again be examined. It may be that in the coming years, Europe will once again be ready and willing to undergo an extensive and carefully planned supranational reform, just like it did with the European Monetary Union after the fall of communism in Europe, and that we might once again see the expansion of the EU.
Appendix

Figure 1

Population & Population Projections for the United Kingdom

Source: http://www.migrationwatchuk.org/briefing-paper/243

Figure 2

UK HIV Diagnoses, AIDS Diagnoses, and AIDS Deaths by Year
(1981 to 2012)

Figure 3

Percent Who View the EU as "Something Positive"

- More than 50%
- 40%-50%
- 30%-40%
- Less than 30%

Source:
http://www.worldatlas.com/webimage/countrys/europe/euoutl.gif
Figure 5

Source: Eurostat, 13-03-2012
http://italy.mapfacts.co/italymapof/ItalyBlankMap.png
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