

Digital determinants of health



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LETTER FROM THE PRESIDENT



The European Parliament's report on the health workforce crisis must be translated into genuine policy action

The Council of the European Union sent a clear message when it [adopted](#) its Conclusions on the Future of the European Health Union in June 2024: Europe's health workforce is one of the defining challenges facing our health systems. European doctors have long agreed that our chronic health workforce crisis cannot be solved by countries working alone but requires coordinated action.

Despite this, there is a growing mismatch between the Council's strategic vision and the European Commission's political priorities. The Commission's current agenda largely reframes health around competitiveness, pharmaceutical resilience and preparedness. Indeed, these are all essential ambitions, but they cannot be achieved without the people who deliver care.

On 17 September, the European Parliament plenary explicitly called on the Commission to urgently develop a comprehensive and long-term European healthcare workforce strategy to increase the healthcare workforce by at least one million professionals by 2034.

We commend the Parliament's public health committee and the many committed MEPs who have advanced this important work. We now hope that the political mandate provided by the European Parliament will be followed by impactful policy decisions.

We urge the Commission to respond to the Parliament's clear and urgent call by presenting an ambitious, comprehensive EU health workforce strategy to provide the long-term direction and coordinated action that Europe's patients and health workforce so desperately needs.

Dr Ole Johan Bakke, *CPME President*

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Europe faces a defining moment for the future of digital health

The current digital health policy agenda faces many challenges.

It is trying to match the speed of technological innovation with perceived competitiveness risks and geopolitical pressures, but misses opportunities to reflect on doctors' experiences.

When policy meets real-life healthcare, many questions remain unanswered and we have to find capacity to engage in implementing EU legislation with national processes.

In my practice as a GP in Nice, in the south of France, we are witnessing the ongoing digital revolution in healthcare in real time. New digital tools are changing our clinical workflows. For example, many doctors are using ambient AI to help make patient summaries.

When a patient arrives in the practice, they sign a form allowing us to process their information. For a trustworthy relationship between patient and doctor, we both need to be confident in how that data is used. That is why digital health is one of CPME's highest priorities.

Dr Jacqueline Rossant-Lumbroso
CPME Vice-President



In her State of the Union speech, European Commission President Ursula von der Leyen called for AI to empower doctors, not replace them.

The real question is what the EU must do to make that pledge a reality.

In the same speech, she identified health as a priority sector for the development of European industrial AI, using health data as a strategic asset to boost the EU's competitiveness.

Achieving both ambitions will need careful consideration of trade-offs. The competitiveness agenda is advancing rapidly and the safeguards to protect patient safety and ensure rigorous professional standards are comparatively undefined.

AI systems provide new regulatory challenges. For example, generative AI is adaptive, and the same prompt may not deliver the same result twice. This requires appropriate safeguards and tailored rules such as human oversight, transparency and an explanation of the role AI played in making the clinical decision. In addition, we must consider training data quality and bias examination, accuracy, robustness and cybersecurity, and the protection of fundamental rights.

Initially, the EU's AI Act was hoped to provide a trustworthy legal environment to access and share personal data. However, fast-track procedures to amend it, such as the EU Digital Omnibus on AI, undermine trust and create uncertainty.



Ursula von der Leyen addressing MEPs on 16 September, © European Parliament

We now see attempts to remove medical devices and in vitro diagnostic medical devices from the requirements for high-risk AI systems set out in the AI Act.

We still see no evidence of if, how and when safety requirements would be upheld in absence of the application of the AI Act high-risk chapter, for example on transparency rules or deployers obligations.

CPME continues to call to prioritise health and patient safety in the balance of interests and create a safe regulatory framework by maintaining the Medical Devices Regulation in the scope of application of the AI Act's requirements for high-risk devices.



Weakening of GDPR risks confidentiality and patient data

CPME is also following the ongoing EU Digital Omnibus on Data, which will amend rules under the General Data Protection Regulation (GDPR). The changes proposed go far beyond a technical modification of the GDPR, amounting to deregulation with an impact on patient safety and patients' rights.

We are concerned that a presumed legitimate interest gives access to personal data to train AI. There is also a lack of safeguards for access to doctors' equipment.

CPME warns that the proposed amendments may allow:

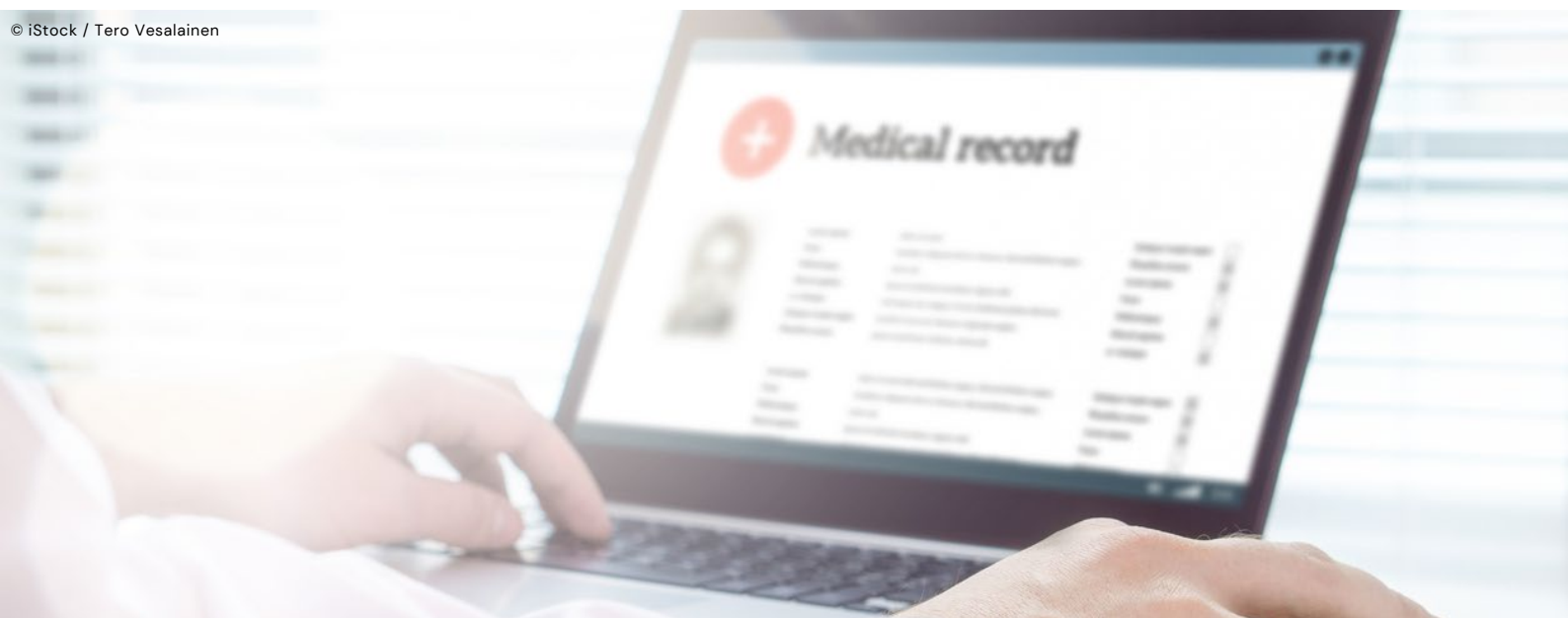
- Easier profiling of patients, especially vulnerable people, by digital platforms, to infer sensitive data, such as the health status, without sufficient justification.

- Unethical and illegal reuse of personal data, such as expanding options to track users' devices and enabling the illegal sale of health data.
- Circumvent data access rules established in EU law, for example the permitted and prohibited defined in the European Health Data Space (EHDS).

Robust protections for personal data, in particular for health data, must remain in place to ensure ethics and privacy in the roll out of digital healthcare.

The weakening of personal data protection impacts trust in digital health, medical research and AI.

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The EHDS has immense potential but it's implementation must not disrupt clinical workflows.

The EHDS has the potential to improve the use of health data for patients, and reuse for researchers and policy-makers.

The successful implementation will be contingent on clear and coherent technical solutions to ensure safety, user friendliness, seamless exchange of electronic health record (EHR) and respect of privacy and medical confidentiality.

CPME is engaging in the [i2X project](#), which aims to demonstrate the value of the EHR exchange format and test it in clinical setups.

Cooperation between national authorities, European institutions and national medical associations is vital to ensure trustworthy solutions without additional costs to the healthcare professional.

Experience has shown that outcomes improve where those who implement digital health in patient care are at the table when decisions are made. This prevents dissatisfaction and safety risks from poorly designed technologies.

To future-proof the digital transition, we need an interactive dialogue. European doctors remain committed partners.

We continue this dialogue by making digital health a central theme of this edition. We invite you to read the report on the digital determinants poor of health from our spring General Assembly and an interview with MEP Michael McNamara, who served as rapporteur on the digital omnibus on AI.

The Digital Determinants of Poor Health



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The digital revolution has transformed our society, and poses new public health problems, which require new debates and solutions.

At CPME's Spring General Assembly in Dublin, the Irish Medical Organisation held a conference addressing social consequences of the rapidly evolving digital landscape.

The conference highlighted new regulatory needs, such as content and age restrictions.

"Is social media addictive? Of course it is! There is not something that people are using on average for 5 hours a day that hasn't some element of dependency upon them."

This opening by Prof. Dr Matthew Sadler set the scene for potential the health impacts for the billions of people on Instagram, TikTok, Snapchat, YouTube and other social media platforms.

The negative psychological consequences of social media are not limited to addiction. For example, he reported that TikTok, used by 53% of teenagers, has been shown to decrease empathy and reflective abilities, shorten attention spans, and even lower IQ.

“Algorithms expose children to harmful content such as depictions of self-harm, eating disorders, misogyny, and sexualisation, within minutes.”

According to Prof. Dr Sadlier, girls will quickly be exposed to materials imposing unattainable beauty standards, while boys instead are inclined to see “manosphere content” with algorithms favoring political extremism.

“Platforms know about the psychological effects of their products; however, commercial interests often prevail.”

For instance, Prof. Dr Sadlier cited current lawsuits against Meta, which briefly removed a beauty filter, improving the self-esteem of young users. Despite this, the filters got reinstated after leadership noticed a decrease in engagement and revenue.

Harms can go even further than psychological effects. Social media has growing numbers of cases of grooming, sexual exploitations and extortions occurring against children.

Prof. Dr Sadlier pointed out that a few major companies own most social media platforms, none of which are European, and wield considerable political control. He stated “so long as politicians use social media as their main way of communication to the public, the companies have a grip on the political class like no other corporations since the sorts of the Dutch or the British East India company of the 17th century”.



Prof. Dr Matthew Sadlier (President of the Irish Medical Organisation)

Age restrictions on social media could protect children

Prof. Dr Sadlier called for social media bans, not only for children, but for a collective move away from social media for people of all ages.

He cited the approach in Australia as a positive example, following their mostly successful social media ban for children under 16. He noted that while some people find loopholes, many thousands of children are no longer using social media.

He drew the parallel to alcohol, which is illegal for young people, and while some people will drink anyway, that does not mean it should be unregulated for everybody. Sadlier also called for an EU state-run internet provider for strategic independence.



Ruth Breslin (Director of The Sexual Exploitation Research and Policy Institute)

Pornography addiction needs multipronged approach

One online sector – pornography, might require to be addressed specifically, according to Ruth Breslin, director of The Sexual Exploitation Research and Policy Institute.

Conveying the scale, Breslin revealed that 86% of male students and 24% of female students aged 16–18 reported being regular pornography consumers in Ireland. And exactly what these users are seeing is worth noting.

She explained that the most watched pornography videos regularly feature incest, teen actors dressed-up to appear child-like, degrading violence and strangulation. “In the last 20 years, what was formerly niche content has gone into the mainstream through online pornography websites”.

Further, minors curious about sex routinely turn to pornography to learn, and what they see is usually deeply shocking. Breslin, who engages and speaks to minors about this topic, recalled girls anxiously asking “am I going to have to agree for that being done to me?”.

By repeated exposures, increasingly extreme content tends to become normalised. This increases the risk of real-world violence, Breslin explained, with men more often perpetrating violence against women.

Strangulation shows up in popular culture, memes and in online jargon. According to Ruth Breslin, young people do not understand the associated dangers, including seizures, strokes and brain damage.

She also cited reports of mainstream platform teen content triggering searches for child pornography, and more than half of young English women have been strangled without prior consent, with the trend having resulted in multiple instances of brain damage.

Age restrictions and content moderation on pornography platforms may reduce real world violence

Breslin advocates for content moderation on pornography sites, banning specific harmful practices such as strangulation and dressing up like children. This restriction was recently successfully implemented in the UK.

Effective age control mechanisms and improved education provided both by parents and teachers may also be viable solutions.

Another escalating issue – online gambling was presented by Tony O'Reilly, a former gambler and now an accredited gambling counselor.

O'Reilly provided his personal gambling story revealing how his gambling journey started by winning a £1 bet with a 45 times return rate.

His addiction escalated and culminated in a suicide attempt and massive debt, fueled by theft, rationalised as borrowing.

O'Reilly noted "technology has made gambling worse. It is now available 24 hours a day, user-friendly. No need for a physical casino. It has removed age and transport barriers."

Despite theoretical age restrictions, minors can circumvent the system using fake IDs, or by account-transfers allowing verified accounts to cash out.

He noted a 2023 study estimating that one out of 30 Irish people suffer from problematic gambling, spending on average €1000 monthly, which is a tenfold increase compared to 2019.

This rise follows aggressive advertising campaigns, sometimes targeting specifically vulnerable individuals.



Tony O'Reilly tells his personal gambling story to CPME delegates

Gambling websites use visual stimuli and other psychological tactics to keep gamblers on the site: "In Ireland if you spend a lot, the companies give you free bets and bonuses.

"To become a VIP customer, you have to be the biggest loser. You may lose tens of thousands of euros. They give you benefits, so you lose money to them, not their competitor. If you win too much, they will restrict your account" says O'Reilly.

O'Reilly also highlighted that influencer marketing is also used, with the rapper Drake famously earning €100 million annually for gambling promotion, plus 15% from all money lost by fans registering with his code.

The General Assembly continued to discuss digital health, including the EU's [Digital Omnibus](#) (see the editorial on page 4), and by adopting a [policy](#) on gambling (see page 12).

European Doctors call for urgent EU action on gambling and gaming harms

CPME urges policymakers to take immediate and coordinated action to address the growing public health crisis posed by gambling and gaming.

In a newly adopted [policy](#), the medical community warns that the rapid expansion of online platforms, combined with aggressive marketing and addictive design features, is driving harmful behaviours across Europe, particularly among young people.

Gambling, now widely accessible both online and offline, is increasingly recognised as a major public health issue. It is associated with serious consequences including financial hardship, mental illness, family breakdown, and increased risk of suicide.

While often perceived as an individual issue, doctors stress that its impacts extend to families, communities, and future generations.

CPME President Dr Ole Johan Bakke said “Gambling and gaming are no longer isolated entertainment activities. They are powerful commercial forces shaping bad health outcomes.

“Without decisive policy intervention, harm will continue to grow, especially among vulnerable populations.”



CPME Treasurer Prof. Dr Ray Walley added “Advertising, marketing, promotion and sponsorship of gambling and gaming must be ended.

We also need a harmonised and mandatory EU-wide age verification solution. This would protect especially youth and the most vulnerable who are routinely exposed to gambling product advertising, industry messaging and sponsorship.

It is time to position gambling and gaming as commercial determinants of health where profit-driven strategies contribute to significant health harms.”

Interview with MEP Michael McNamara

MEP McNamara is a vice-chair of Parliament's Committee on Civil Liberties, Justice and Home Affairs. He has taken a prominent role in EU digital policy, including acting as rapporteur on the digital omnibus on AI



In your view, should addictive algorithms be considered a public health concern, in particular for minors?

The protection of minors online is a growing concern, globally. Meta recently agreed to pay \$18 billion to settle US lawsuits over children's social media addiction.

In the EU, we have some tools to address harms to minors online, including the Digital Services Act (DSA). The upcoming Digital Fairness Act (DFA) should also address addictive design.

President von der Leyen outlined new EU-wide online safety measures and age restrictions for minors during her State of the Union address to the Parliament in September. Some Member States have already moved ahead with their own bans.

Key questions will be whether a full ban is the right approach, as perhaps the onus should be on Big Tech to design safe services for children, and what an appropriate age threshold should be.

Social media is also a technology through which young people can experience the world and express themselves, and bans could potentially be circumvented with VPNs, so any solution need to be proportionate and also enforceable.

What are your reflections on the recently negotiated Digital Omnibus on AI, in particular for healthcare?

I was glad, in the final AI Omnibus text, that it did not go as far as fully removing AI-embedded medical devices from the AI Act's Annex 1A and moving it to 1B. I met with several organisations from medical doctors, consumer rights and the digital rights groups and I shared their concerns.

However, this battle is not over. The Commission's proposed revision of the Medical Devices Regulation, in which there is a proposal to remove medical devices and in vitro diagnostic devices from the AI Act's scope, means this issue is still ongoing.

The AI Act is a horizontal instrument precisely so that risk, not sector, determines the level of protection. Carving out medical devices, one of the highest-stakes applications of AI there is, would undermine that horizontal architecture at exactly the moment it's meant to start proving itself.

And it would do so in a sector that is already extensively regulated, where the argument that AI Act obligations are somehow superfluous simply doesn't hold up.

Medical devices need more scrutiny when AI is involved, not less.

Furthermore, the argument that it would involve duplicative or parallel certification processes doesn't hold up in circumstances where the AI Omnibus, which passed this summer, simplifies the procedures for conformity assessment by allowing a single application and a unified assessment process.



Frankly, I have some sympathy for those who worked hard to deliver workable, coordinated rules through the AI Act only to see that work potentially undercut before it has even had the chance to be properly implemented through various Omnibuses.

Legal certainty should be a cornerstone. It's hard not to see this as the product of intense industry lobbying, particularly from Germany's medtech sector, bearing fruit.

I fear that in this new era of 'simplification' and cutting red tape, this Parliament may not find the majority to reject it. If anything, there appears to be less opposition to the changes proposed to the regulation of AI embedded in medical devices (and awareness of its impact) than there was to the Annex shift proposed in the Parliament's position on the AI Omnibus.

The mood in this house has shifted, and that shift is exactly what industry is now banking on.

What do you see as the biggest opportunities and challenges in the Digital Omnibus on Data?

The Digital Omnibus is an opportunity to reshape Europe's digital rule book so that it is simple enough for businesses to comply with and innovate under, while remaining strong enough to ensure people's fundamental rights remain protected, including in healthcare.

However, the Commission did not carry out a full impact assessment and stakeholder consultation for the Digital Omnibus, as was also the case for the AI Act Omnibus. This undermines confidence in the proposal, particularly due to the Digital Omnibus proposals impacting fundamental rights, including changes to the definition of personal data under the General Data Protection Regulation (GDPR).

The Parliament has requested a targeted impact assessment focusing on fundamental rights to be carried out by the European Parliamentary Research Service (EPRS), expected in the coming months.

The Commission has proposed a new definition of personal data introducing a "relative" approach to identifiability, where the data might be personal for one entity but non-personal for another.

This could have the potential to take large amounts of data out of scope of the GDPR's protections, undermining trust in data sharing, including in the health sector and the sharing of clinical data.

The Commission also proposed other fundamental changes such as harmonising rules for pseudonymisation and processing personal data for the development and operation of AI.

Some negotiators support the deletion of these proposals, so we have to wait to see what a compromise position might look like.

I might expect consensus on clear simplification measures, such as common rules and templates for Data Protection Impact Assessments (DPIAs), albeit with a stronger role for the European Data Protection Board instead of the Commission.

There should also be broad agreement on maintaining the rights of data subjects when requesting information.

There are differing positions between political groups on cookies and browser-level consent management, but there should be the political will to find a consensus.

Other important proposals for healthcare include the definition of scientific research, which the Commission expands to include research supporting technological development. This is also contested between political groups.

The Digital Omnibus should be an opportunity to simplify the digital rulebook, but these proposals make substantial changes and appear to be an example of deregulation rather than simplification.



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Are you concerned with the broad scope of training AI with health data?

Health data can be incredibly valuable for research, diagnosis and the development of better treatments. The question is whether we have the right safeguards around its use.

The Commission's Digital Omnibus proposal could potentially take some personal data out of scope of the GDPR and also allow for personal data to be processed for the development and operation of AI under legitimate interest.

The Commission's proposal would also allow for the processing of special categories of personal data, such as health data, for the development and operation of AI, subject to some safeguards.

We need to develop European AI, including in health, but this must not come at the expense of fundamental rights.

These issues will be subject to strong debate as negotiations on the Digital Omnibus continue.

Michael McNamara is an independent Irish MEP representing the Ireland South constituency and a member of the Renew Europe group. As a vice-chair of Parliament's Committee on Civil Liberties, Justice and Home Affairs, he has taken a prominent role in EU digital policy. He served as a co-rapporteur on the Digital Omnibus on AI and is Renew Europe's shadow rapporteur on the separate Digital Omnibus on data.

A stronger Europe starts with access to medicines



Stine Bosse MEP

Vice-Chair of the European Parliament's public health committee

Danish Moderates Party and Renew Europe



European Parliament

Many patients living with a paediatric cancer or rare disease do not actually have access to any approved treatment today.

For many, including children with life-threatening conditions, a clinical trial may be the only way to access any treatment at all before it is too late.

This is why I firmly believe that we, as policymakers, owe it to our citizens to build framework for clinical research that delivers for every patient, no matter where in our Union they happen to reside.

This is ultimately about both saving lives and about supporting the uniquely innovative life sciences ecosystem that have built here in Europe.

That is why I believe we need to rethink the way we talk about access to medicines in Europe.

Access does not only start at availability in a hospital or pharmacy.

It starts where we fund and do the research, run the trials and manufactures the medicines of tomorrow – in and for Europe.

We will not have access to what we do not invent and what we do not manufacture.

And this matters even more in an increasingly hostile global economic and political environment.



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If research and manufacturing keep leaving Europe, as they do today, we risk losing more than jobs and investment. We risk losing patient access, both in the form of new trials and timely drug launches.

I believe the best thing the EU can do for patients is to make Europe the place where companies want to invest, where researchers want to run trials, and where patients reap the benefits of that through our public health systems.

Now, if we want to give patients continued access to innovative treatments in the shadow of policies like Most Favoured Nation, we need to think more European.

With the European Biotech Act, that I am negotiating in the European Parliament, we have a unique opportunity to build a genuine Single Market for clinical trials. A real Trial Union, instead of a collection of countries doing things their own way just because that's the way we've always done it.

We must make it much easier to run one trial across several countries; Europe must offer rules that are as predictable as those in the large single markets of the United States and China, and patients should be able to participate across borders.

For patients with rare diseases, this is especially important. A small country may simply not have enough patients to make a clinical trial viable on its own. But if we can connect patients, researchers and healthcare systems across Europe, we can create the scale that makes these trials possible.

That is why I believe some decisions, with the buy-in of our Member States, should move to the European level.



Europeanising clinical trials can help us serve patients better while also strengthening Europe's ability to compete with the US and China.

I refuse to believe that the clinical ethics standards in Ireland and Denmark are so different that the two countries cannot come together and make a once-only decision that will apply on national, regional, and hospital levels. I think they can, and I think we can save many lives if they do – especially in areas like orphan medicines and paediatrics.

Health is a right for every European, regardless of where they live. But it is also a matter of our security.

Imagine a crisis where Europe needs millions of doses of a vaccine, but the production capacity is on the other side of the world. Or where an armed conflict, like the war in Ukraine, skyrockets demand for antimicrobials. These are health security problems. They are Europe's biodefence.

We would never accept being completely dependent on other countries for our defence capabilities. Why should we accept it for the medicines and technologies that keep our citizens alive?

Europe must retain the capacity to produce critical antimicrobial APIs and vaccines. NATO allies have committed to spending 5% of GDP on defence and security by 2035, and part of that is meant for resilience and preparedness. I believe part of that investment should help us maintain the capacity to produce critical medicines here in Europe.

This ambition must of course be reflected in the EU budget. I have consistently fought for a strong EU4Health programme. And in the next long-term EU budget, I am fighting to ensure that health receives a strong and larger budget within the €409 billion European Competitiveness Fund.

The rocky road to modernise EU tobacco laws



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Markus Kujawa
Senior EU Policy Adviser

The EU tobacco control legislation is outdated, and the European Commission officially agrees.

It is currently in the process of revising the three key pieces of EU tobacco law. However, the road to complete the revisions is not a smooth one.

The European Union has an objective of achieving a tobacco-free generation by 2040. At the same time, WHO estimates that the European region is on course to maintain its status as having the world's highest tobacco use prevalence by 2030.

Something must be done as tobacco products still kill 1.1 million people in the WHO European Region each year and nearly 700,000 in the EU.

The EU rules on tobacco control have contributed to a significant decline in smoking and tobacco-related deaths across the Union.

The ongoing revisions have a great opportunity to strengthen regulatory measures to reduce the affordability, access, consumption, and appeal of tobacco and nicotine products and smoking devices.

Last year, the European Commission already presented a proposal to update the Tobacco Taxation Directive (TTD), previously revised in 2011.

Earlier this year, it kicked off the process to modernise the Tobacco Products Directive (TPD), previously revised in 2014, and the Tobacco Advertising Directive (TAD), previously revised in 2003.

The update is easier said than done. The revision process of the tobacco tax laws has already showed it.

The Commission's proposal to increase the minimum tax rates and extend the scope of the directive to new products, such as nicotine pouches, does not please all the EU member states. This makes the revision complicated as tax legislation requires unanimous agreement.

This also means that in the end the directive will be weaker than the Commission's proposal, if it is adopted.

The revision of the two other directives requires a majority vote, but it does not make the process necessarily much easier.

The previous revision of the TPD was extraordinarily complicated and became the most heavily lobbied dossier in EU history.

The process was stalled by unprecedented tobacco industry interference, high-level political scandals, including the resignation of a health commissioner, and the complex task of regulating new product categories.



The range of new tobacco and nicotine products is ever evolving

There are growing challenges linked the rapid emergence of new products, particularly among young people, who are nowadays exposed to a wide variety of flavours and colourful packaging.

Several European countries have therefore introduced their own bans or severe restrictions on flavours. The UK went even further as it prohibited tobacco sales to anyone born after 2008. Also, marketing practices have changed, especially digitally, as products are increasingly being promoted through digital channels, especially social media, and often by influencers.

Therefore, the Commission aims to develop policy options for example to strengthen the rules on labelling and packaging, including plain packaging, but also on digital marketing and advertising. The aim is also to introduce more flexibility to address rapid product developments in the future.



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The ongoing EU work is overshadowed by orchestrated tobacco industry interference.

According to the recent European Commission's analysis, more than a quarter of public feedback to their TTD consultation were linked to organised lobbying as the consultation saw thousands of extremely similar responses.

The trend continued with the consultation on TPD and TAD as more than 82,000 responses were submitted to the call for evidence within one month, mostly by EU citizens, or more likely by AI-driven bots.

However, European policy-makers must prioritise public health when making policies and limit interactions to the strict minimum with representatives of the interests of the tobacco industry and organisations promoting so called "harm reduction" products.

Policy-makers must be free to make evidence-based and ethical decisions for the benefit of public health.

At the same, the EU institutions must adhere strictly to international commitments, like the legally binding WHO Framework Convention on Tobacco Control, to protect policies from commercial interests of the tobacco industry.

Finally, we have to remember that regulation alone is not sufficient.

The directives provide essential and unified rules, but they must also be implemented and enforced in practice, in all the EU Member States.

In practice, this means a combination of monitoring systems, mandatory national regulations, and local market inspections.

The role of the civil society organisations remains fundamental in advocating for stronger public health protections, ensuring transparency, and counteracting massive corporate lobbying.

A better tomorrow begins with protecting our children today

Dr Klaus Reinhardt, President of the German Medical Association (GMA), highlights the urgent need for EU action on tobacco and nicotine-containing products and social media.

"A better tomorrow" and "Delivering a Smoke-Free Future." Who would not want that?

These are the slogans of two of the world's largest tobacco companies: British American Tobacco and Philip Morris. Both advertise a future without smoke. On their websites, we see gleaming, elegant devices. Not a trace of smoke.

So, when it comes to abolishing smoking: Have these companies given up cigarette production? Of course not. And their decision not to has paid off for them.

Because alongside the classic cigarette, a new market has emerged. E-cigarettes, heated tobacco products, and other nicotine products like pouches are gaining in importance. And the two are connected.



Dr Reinhardt presented this speech at the German Medical Association's MED.SUMMER event in Brussels on 1 September 2026

The Dutch EU Commissioner Wopke Hoekstra once described new nicotine products as "the tobacco industry's revenge." He made an important point: We mustn't only focus on the heavy smoker who might want to reduce their individual health risks by switching to a different product.

Some of the most popular flavours are strawberry, raspberry, and cherry ice. So, who are these products supposed to appeal to? Do we really need flavours if the only goal is to offer a nicotine-addicted adult an alternative to cigarettes?

We still know too little about the long-term health consequences of inhaling aerosols and the chemicals used in their production.



Tobacco prevention has long been hailed as a success story. For a long time, rightly so.

Today, we must acknowledge that this success story is in jeopardy.

The European Union has set itself a clear goal. With the Beating Cancer Plan, the Commission aims to achieve a "tobacco-free generation" by 2040. Less than five percent of the population should then still be consuming tobacco or nicotine products.

At the end of March, I had the opportunity to speak with Health Commissioner Várhelyi about the planned measures concerning tobacco products and tobacco advertising. I am pleased that the Commissioner, like the scientific community and the medical profession, is not convinced by the alleged "harm reduction" of novel tobacco and nicotine products.

The Commission has since initiated concrete steps. These include proposals for higher taxes on novel nicotine products and the planned modernisation of European tobacco legislation.

The direction is right. But there is still a long way to go before this becomes binding law. And there are plenty of obstacles.

The public consultation on revising tobacco law received more than 82,000 responses. An analysis revealed that more than 90% contained at least one substantial objection to the proposed regulatory approach.

At first glance, this sounds like overwhelming public resistance, but we need to take a closer look.

Journalists from the Netherlands analysed responses from their country and concluded that 9 out of 10 responses were generated by Philip Morris's AI. Therefore, skepticism is warranted.



Dr Reinhardt addresses guests at the German Medical Association's MED.SUMMER event in Brussels on 1 September 2026, © Mélanie Wenger

Fake public pressure and populism are not new tools of the tobacco industry. Their goal is always the same: to delay or prevent political decisions. This summer, the German Commissioner for Addiction and Drug Issues, Prof. Dr Hendrik Streeck, even experienced outright "stalking" by representatives of the tobacco industry at political receptions.

We encourage policy-makers: do not let yourselves be deterred from the goal of enabling a tobacco- and nicotine-free future for our youth. For this, we need:

- an EU-wide ban on all flavorings and cooling agents in e-cigarettes, as well as all additives that make nicotine consumption attractive;
- an EU-wide ban on single-use electronic devices;
- standardised packaging for all tobacco and nicotine products with factual and deterrent warnings;
- stricter rules for influencer content and brand advertising;
- and more harmonised taxation of all tobacco and nicotine-containing products.

And above all, we need all of this now.

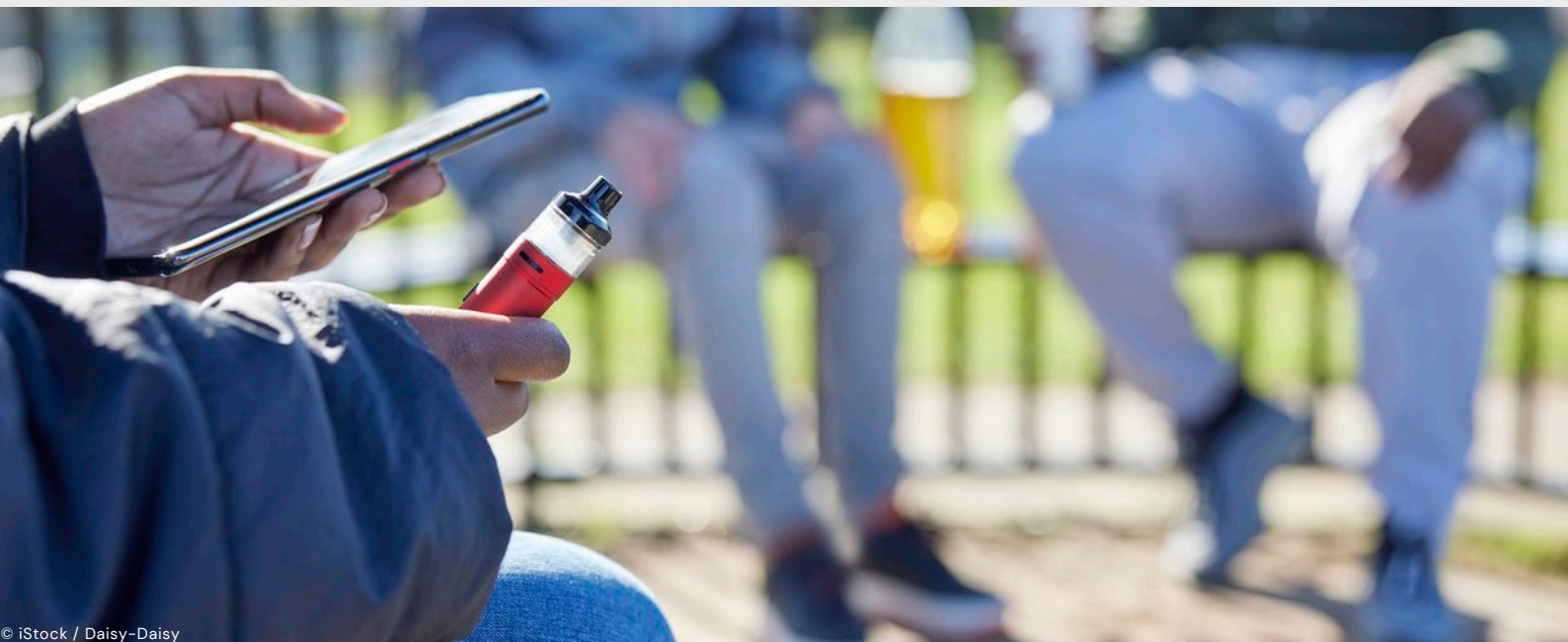
There is also a second threat of addiction that is now quite literally in the hands of our children: the internet.

Here, too, the question arises: How do we protect children and young people from products that compete for their attention.

In July, Commission President Ursula von der Leyen, together with psychiatrist Prof. Dr Jörg Fegert and her French colleague Dr Maria Melchior, presented proposals for better protecting children and young people on digital platforms.

The recommendations are clear:

- an EU-wide age limit for access to social media for children under 13;
- reliable and privacy-friendly age verification;
- and digital services that are designed to be safe from the outset – "safe by design" and "safe by default."



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The concept is intended to inform the preparation of the Digital Fairness Act, which the Commission plans to present later this year. Even children themselves are now demanding greater protection from addictive design elements and overwhelmingly support forms of age verification.

Professor Fegert and Dr Melchior pose the crucial question: we should not discuss when and under what conditions we allow our children access digital platforms. Rather, we should be debating when and how do we allow digital platforms access to our children?

This is a shift in perspective. And this is precisely the shift in perspective we need.

It's not about prohibiting children from using new means of communication and forms of expression. It's about reversing the logic:

Only when providers demonstrate that their platforms effectively protect children can we discuss granting them further freedoms.

We are still a long way from that today.

Therefore, my request to legislators and all other stakeholders: Work together to ensure that our children can grow up to be autonomous users of digital platforms – and not their dependent consumers.

Whether it's about nicotine or digital policy: children should not be a business model by which our society measures its profits.

Let's therefore work together to ensure that "A better tomorrow" is more than just an advertising slogan. A better tomorrow begins with protecting our children today.

Medicine shortages and the shared challenge of continuity of care



Jorge Batista
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When a prescribed medicine is unavailable, the consequences extend from the pharmacy counter to the doctor's consultation room.

Whilst patients need reassurance and a safe way to continue their treatment, pharmacists and doctors work together to find a workable solution, often while managing already demanding workloads.

Medicine shortages are therefore a shared challenge for the professions and the patients they serve.

The [PGEU Medicine Shortages Report 2025](#) (published in March 2026) illustrates the scale of that challenge, spanning across Europe.

Drawing on responses from member organisations in 27 EU and EFTA countries, this report found that 96% of responding countries reported shortages.

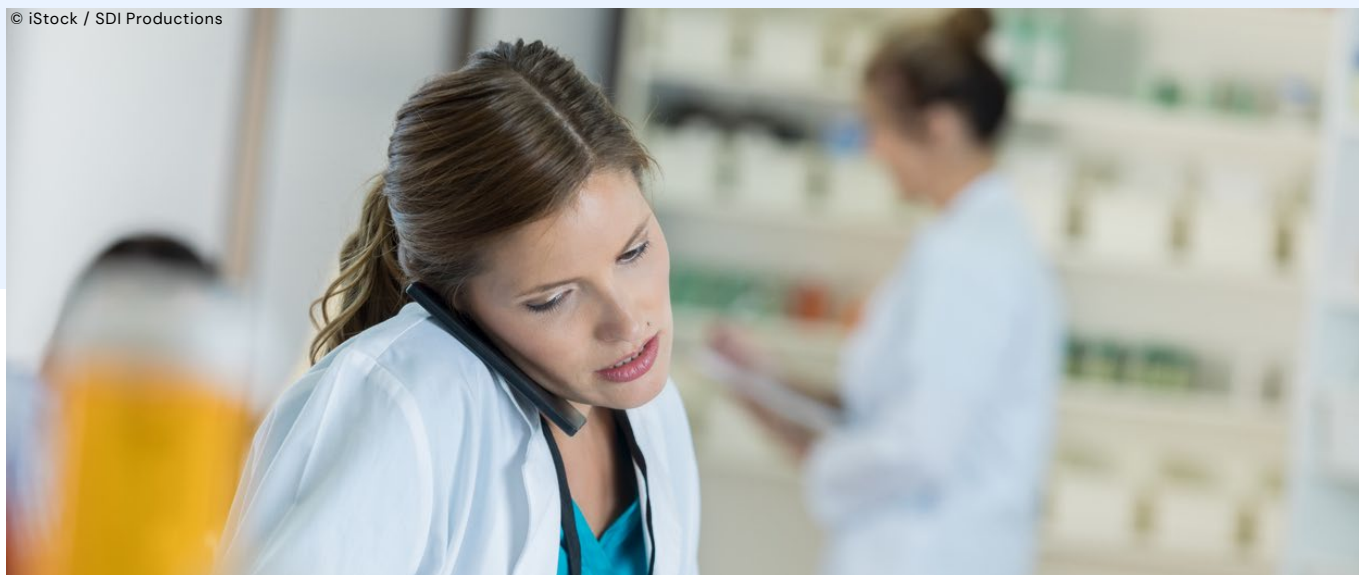
In 70% of these, the situation was unchanged compared with the previous year. This stagnation at high levels offers little reassurance to patients and the healthcare system.

Medicine shortages are no longer episodic disruptions but an embedded and persistent feature of the pharmaceutical supply chain.

The clinical consequences are substantial to patients.

Treatment interruptions were reported in 89% of responding countries, while 44% reported medication errors following changes in the prescribed medicine.

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Shortages extend across therapeutic areas, including cardiovascular medicines, antibiotics, cancer treatments and insulins.

Finding an alternative requires careful clinical assessment, particularly when suitable strengths or pharmaceutical formulations are unavailable. Often, compounding a medicine for a specific patient is the only suitable alternative to avoiding treatment interruptions and maintaining clinical care.

The latest data shows that community pharmacists spend 12 hours each week managing shortages, more than twice the time recorded in 2021.

This work includes finding alternatives, contacting prescribers, counselling patients and completing administrative procedures.

Reduced patient trust was the most frequently reported impact on pharmacies, identified in 85% of responding countries.

The effort needed to maintain treatment is substantial, even when patients ultimately receive their medicine.

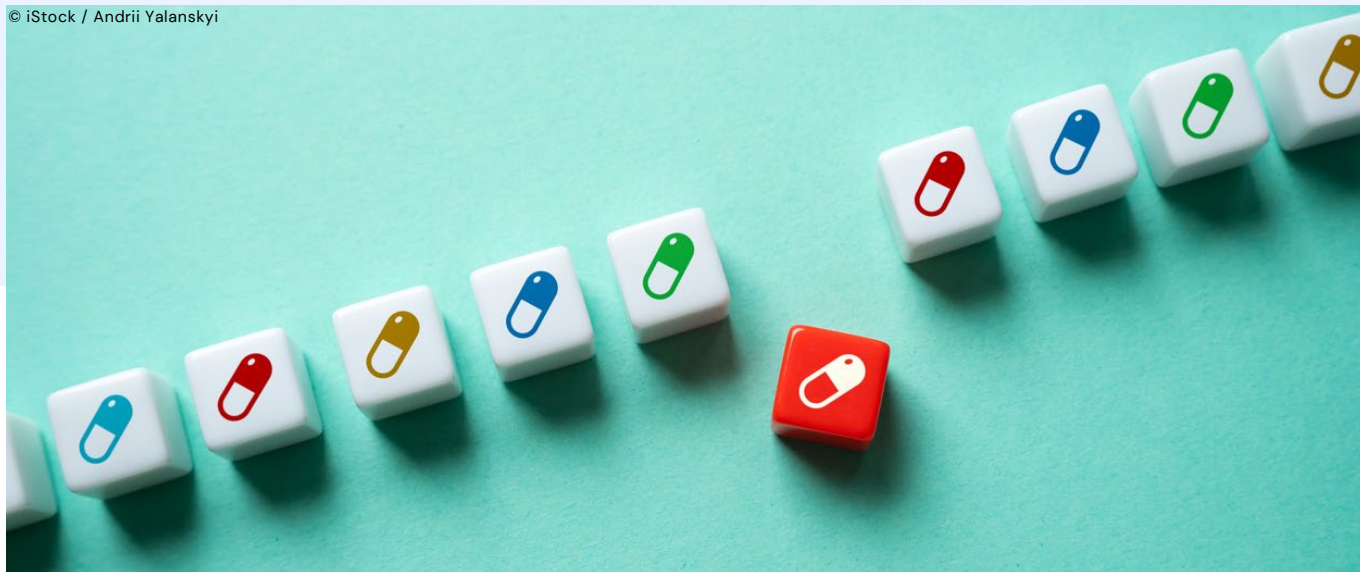
The observed trend is clear: pharmacies are acting as operational shock absorbers within fragile supply chains.

For doctors and pharmacists, close coordination is an essential part of an effective response.

Clear communication about availability and treatment changes can help patients understand what medicines changed, the reasons behind it, and how to take the new medicines.

The PGEU report calls for communication tools that support this cooperation. It also highlights existing limited legal flexibility, as only 15% of responding countries allow therapeutic substitution by pharmacists, often within protocols agreed with prescribers.

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PGEU advocates for broader substitution frameworks under defined protocols organised together with doctors, pharmacists and patients, to enable timely and safe responses to shortages.

Prevention of medicine shortages requires action beyond individual practices and pharmacies.

PGEU calls for stronger European coordination, more diversified manufacturing, and pricing and procurement policies that sustain reliable supply.

Early warning systems should be interoperable, with digitally integrated reporting that includes information from community pharmacists. Their daily experience dealing with the unavailability of medicines should help authorities identify emerging problems and respond sooner.

The response must also protect patients from additional costs caused by shortage-driven substitutions and recognise the time pharmacists devote to managing disruptions.

These measures would support both access to treatment and the sustainability of care.

Pharmacists believe that curbing medicine shortages is a shared priority, ensuring that a treatment decision can be translated into treatment received.

Cooperation between doctors and pharmacists is therefore indispensable when supplies fail and patients feel insecure.

Policy-makers must consequently match that commitment with measures that prevent shortages and give healthcare professionals the required tools to maintain continuity of care.

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