NEWSLETTER GLAWCAL

Issue 16, 2014

# Focus on: Healthcare Policy in the World

## INDEX

### Healthcare Policy in the World

# Healthcare Policy in the World

## AHS STUDY: INCREASE IN USAGE OF E-CIGARETTES IN UK

An ASH study estimated that the number of people who uses electronic cigarettes in the UK has tripled over the past two years to 2.1 million. ASH's findings are released on the end of consultation on e-cigarette advertising.

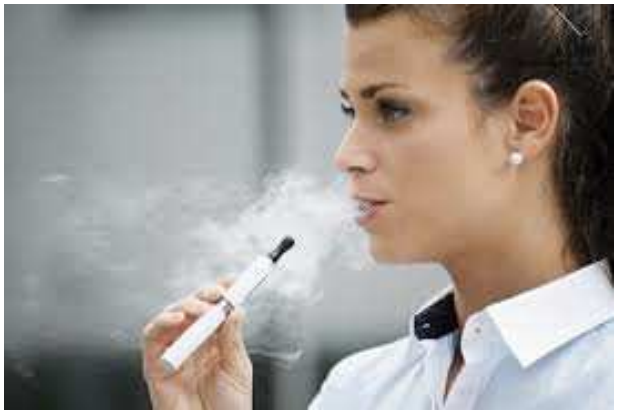
Despite the long term effects of e-cigarettes remaining unclear, just over half of current or ex-smokers have now tried electronic cigarettes, compared with 8% in 2010. From those 700,000 ex-smokers, 71% admitted to use the tobacco alternatives as a tool to quit smoking altogether.

Nearly two-thirds of users said they also smoked regular cigarettes, with the other third being ex-smokers, an increase in the proportion of former smokers compared to previous years. Just 1% of those asked who never smoked said they had tried electronic cigarettes.

Deborah Arnott, chief executive of Action on Smoking and Health (Ash) told that the increase in use of electronic cigarettes over the past four years declares that smokers are turning to these devices to help them stop smoking. Significantly, usage among non-smokers remains negligible.

A separate ongoing survey, the Smoking Toolkit Study, which covers England, has found that electronic cigarettes are overtaking the use of nicotine products such as patches and gum as an aid to quitting smoking.

According to this study, the proportion of smokers who have quit in the last year has increased and smoking rates in England are continuing to fall. The study leader Prof. Robert West said that electronic cigarettes may be helping to reduce smoking and there is no evidence that they are acting as a gateway into smoking. However, it is important to control the advertising of electronic cigarettes to make sure children and non-smokers are not being targeted.



# Healthcare Policy in the World

## ACT'S REQUIREMENT OF THE AFFORDABLE CARE

According to internal government documents, around 77,000 families and individuals have requested the exemptions from the individual mandate so far. But when compared to the 8 million who have signed up, the number of exemptions appears to suggest that Americans are complying with the mandate.

People who belong to certain religious groups, Native Americans, illegal immigrants and people falling under "hardship" categories may all request exemptions, including people who have experienced other hardships in obtaining health insurance. Not only Native Americans, undocumented immigrants, prisoners and those with religious objections are exempted from the individual mandate penalty, but there are also exemptions based on earning power and affordability. In fact, those who do not earn enough to file income tax returns are exempted.

Serco (the company which processes exemptions for all states but Connecticut) reports that there have been few people seeking hardship exemptions. As of April 20, just 2,700 of those applications were processed and have been set aside until the federal government said how to go ahead with them.

On Friday, Centers for Medicare and Medicaid Services officials said that the agency is working with those people to see if they can fit into a different exemption category. In addition, 20,000 applications have not yet been processed from people who say they can't afford insurance, Serco reported. CMS is testing a tool that will allow those people to calculate whether they are eligible for an income-based exemption.

While the exemptions are low now, the Obama administration estimates that some 12 million people will seek exemptions by 2016. Of the exemption requests, more than 32,000 came from Native Americans, who are exempted because their healthcare is funded through the federal Indian Health Service.

In addition, more than 11,000 religious exemptions were approved as of April 20, and organized efforts have been made in Amish and Mennonite communities that are already exempted from Social Security and Medicare.


*The Obama administration estimates that 12 million people will seek exemptions by 2016.*

# Healthcare Policy in the World

## BETTER CARE FUND DELAYED AFTER A CONFIDENTIAL WHITEHALL REVIEW. THE UK CABINET SUGGESTED MORE EFFORTS ON THE POLICY

The £3.8bn-a-year Better Care Fund, which aims to help people receive care in the own homes by bringing together health and social care services, was supposed to be launched last week but it was delayed after a confidential Whitehall review. During this review, it was concluded that the Better Care Fund would not work to reduce pressure on hospitals as anticipated, neither helping to balance the NHS budget, nor revolutionizing patient care. The Whitehall source reported that the Cabinet Office has called for more efforts on the policy.

According to the Cabinet Office review, plans to save money from local hospital budgets by moving care elsewhere lacked financial credibility. The Fund assumes that hospitals can quickly achieve a 15% reduction in emergency admissions and that these reductions will result in savings in the same year, at full cost. But reducing admissions takes time, and lowering the types of admissions targeted by the Better Care Fund costs money.

Better Care Fund, due to be introduced in April next year, was supposed to combine health and social care services in order to reduce the pressure on hospitals and help to keep people healthier in their own residences. Both these services have been funded by local authorities so far.

The Better Care Fund is partly funded by the Department of Health, which was expected to contribute with £1.9bn from the £40bn hospital budget from next April in the belief that it would release savings to compensate for the money transferred from the NHS. In fact, the delay in its launch is a disappointment for the supporters of the policy, Jeremy Hunt, the health secretary, and Eric Pickles, the local government secretary.

A team of officials from the Department of Health and NHS has been asked to give evidence of the expected result and credibility of the policy and to overcome the deep Cabinet Office skepticism.

# Healthcare Policy in the World

## BRAZILIAN HEALTHCARE SYSTEM: FROM THEORY TO PRACTICE

The Brazilian Constitution promises free public healthcare to every citizen, saying that "Health is a private right and a duty of the state". Public healthcare is provided to all Brazilian permanent residents and foreigners in Brazilian territory through the National Health Care System, known as Unified Health System - SUS.

Finland, for example, provides free healthcare to all its citizens, but the country is smaller and more homogeneous, while Brazil counts 200 million people. Universal healthcare is relatively cheap as well: the government spends just 9 percent of GDP on healthcare compared to 18 percent spent by USA.

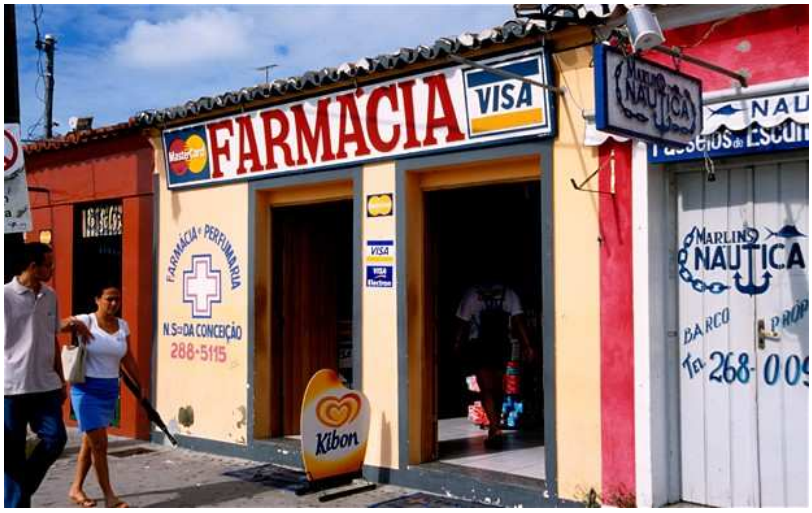
It is important to underline that the funding for the SUS system is split between the federal, state, and municipal governments.

This financial system entails a lack of hospital beds and long waiting times to see a doctor. It can take months to get an X-ray in Sao Paulo. A quarter of Brazilians are able to afford private doctors, paying with American-style insurance they get through work. However, a huge portion of the population is still poor, living in jungles or farms and relies on the publicly funded SUS.

*The financial system entails a lack of hospital beds and long waiting times to see a doctor.*

# Healthcare Policy in the World

By some measures, Brazil's income inequality is even worse than USA's. People from the south of the country tend to live better, healthier lives than people from the north. There are 11.4 million people who lives in favelas where the implementation of social services is lacking.




In Brazil, wealthy patients may complain about corruption, but at least they have specialists at their disposal. In Brazil, as in the United States, doctors usually come from wealthier areas and tend not to move. More than half of the country's neurologists, for example, live in the south, and just one percent in the north.

Brazilians called for more investment in healthcare in order to improve services and benefits for the lower and middle classes. Brazilian President Dilma Rousseff responded to the complaints by swearing to bolster healthcare. Over the past year, her government imported 13,000 doctors from abroad (especially from Cuba).

Some health experts have suggested that people from the United States may soon see a two-tiered healthcare system not unlike Brazil's, in which Medicaid patients wait weeks to see any physician available while richer patients use generous insurance plans to see the best doctors they can find. That proves how American health coverage is still far

*Brazials called for move investment in healthcare in order to improve services and benefits for the lower and middle classes.*

# Healthcare Policy in the World

## EU MINISTERS OF HEALTH TO DISCUSS HEALTHCARE FOR IMMIGRANTS

In 2008, the World Health Assembly adopted a resolution on migrant health, recognizing the need for migrant-sensitive health policies and systems, and equitable access to services. European Ministers of Health recognized the multiple challenges that governments and health systems face in addressing this issue, including the differences often found between migrants' health profile and that of the rest of the population, the need to ensure access to health services for this vulnerable group and the need for cross-sectoral and cross-border collaboration.

Greek Health Minister, Spyridon-Adonis Georgiadis, on April 28/29 hosted the Informal Meeting of the European Ministers of Health, at Zappeion Megaron in Athens. The Ministers had the opportunity to discuss a number of very important health issues for European Union citizens and the sustainability of health systems.

During the first session about migration and public health, Ministers concentrated on migration and its implications on public health and health services, focusing particularly on how to better address the health needs of the migrants and highlight the positive aspects of an enhanced cooperation of the EU Member States on a common public health

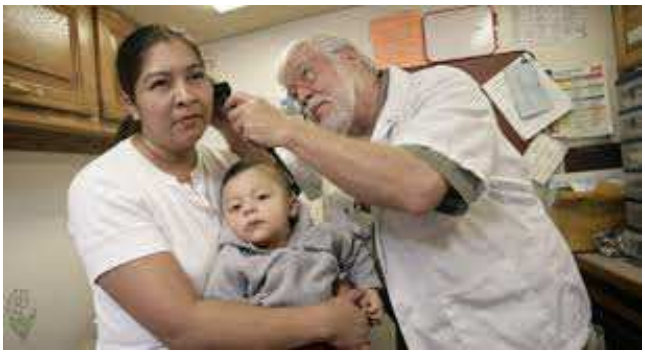
On the second day of the meeting, discussions focused on the impact of the economic crisis on health and healthcare systems. Ministers attending the meeting acknowledged that the new economic situation in Europe requires health systems to adapt and become more resilient.

European Ministers of Health have spoken of the need to carry out health screening on immigrants and refugees entering the EU. It remains to be decided whether screening would be the same for all immigrants or if the systems would be different depending on where they come from.

Ministers agreed to set up a working group under the EU Health Security Committee to explore developing voluntary guidelines for screening and vaccination. WHO will participate in the group, and its International Health Regulations (IHR) are an important tool.

EU Commissioner for Health Tonio Borg, added that a new EU fund worth 3.0 billion Euros ($4.2 billion) had been created to help member states manage immigration and asylum duties, including healthcare.

In the EU overall, there is no common law but undocumented migrants are entitled to emergency health treatment, and recognized refugees have to be treated like EU nationals, Borg said. Ensuring that people have equitable access to health care and that economic crises do not disproportionally affect vulnerable groups is a key



# Healthcare Policy in the World

## FDA: ABOUT 40% OF DRUGS USED IN US ARE PRODUCED OUTSIDE THE COUNTRY

About 40% of all over-the-counter and generic drugs used in the United States are produced in India. Companies have been using India for production largely because they have been able to do it cheaply. But it is becoming apparent that one of the reasons for those low costs may be because the results are under the standard level.

In response to this and other factors, the Food and Drug Administration Safety and Innovation Act was passed in July of 2012. Part of the law involved some changes to generic drug user fees. Companies looking for approval now need to pay some extra money to allow better inspection of production facilities.

Last year, inspectors from the FDA looked at 160 drug plants there. Drugs were sometimes adulterated or contaminated. Facilities were often filthy or infested with bugs. Ensuring quality has never been easy in the gigantic Indian pharmaceutical industry. The sector, with over 20,000 registered pharmaceutical companies, remains inadequately regulated. And this has been highlighted repeatedly in the past few years.

In the beginning of April, the U.S. Food and Drug Administration banned imports from Canadian drug maker Apotex Inc's manufacturing plant in India for not complying with quality standards, the latest in a series of sanctions against medicines produced in

The ban on Apotex's factory comes after manufacturing plants of top Indian drug makers like Ranbaxy Laboratories Ltd, Wockhardt Ltd. and Sun Pharmaceutical Industries Ltd. were banned from exporting to the United States due to quality concerns.

If pharmaceutical companies move out of India, they will likely decide to go to other countries that can also offer cheap services. One of those is most likely China. As in India, the FDA is working with the Chinese government and plans to increase staff—from the current eight U.S. officers to 27—to conduct timely inspections of more Chinese plants and other tasks.

*The Apotex logo*

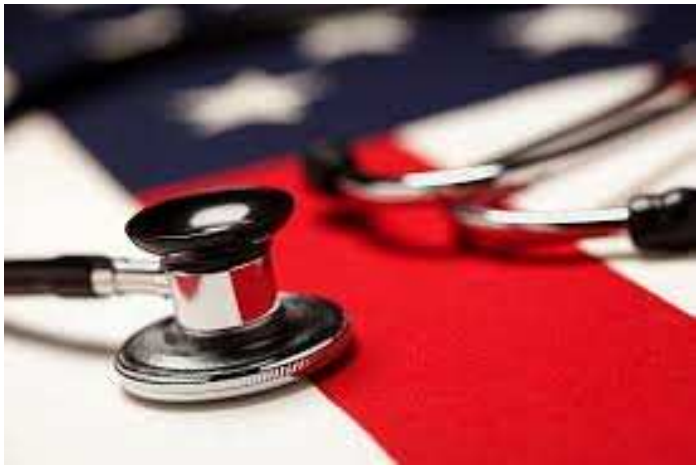
# Healthcare Policy in the World

## HEALTHCARE DISPARITIES BETWEEN NORTHERN AND SOUTHERN AMERICAN STATES

As the debate over the effects of President Barack Obama's healthcare law continues, a new study by the Commonwealth Fund finds that there are significant disparities between states that have access to quality health care and states that do not.

The Commonwealth Fund assesses states on 42 indicators of health care access, quality, costs, and outcomes over the 2007–2012 period.

The mixed performance of states' health systems over the five years preceding the implementation of the Affordable Care Act's major reforms shows that states and the nation are still a long way from becoming places where everyone has access to high-quality, affordable care and an equal opportunity for a long and healthy life.



*According to a Commonwealth Fund's study, Minnesota has the nation's best-performing healthcare system.*

According to a Commonwealth Fund's study, Minnesota has the nation's best-performing healthcare system, while Mississippi ranks last, following Louisiana, Oklahoma and Arkansas that are at the bottom of the list.

Other top-performing states are Massachusetts, New Hampshire, Vermont, and Hawaii. Their consistently high performance may be the result of their willingness and wherewithal to address health system change with focused initiatives spanning the public and private sectors.

Disparities registered through the country may partly reflect differences in state policies and funding of health care programs such as Medicaid. Medicaid expansion could be a way to fill the gap between the North and the South of the country.

Better access to care is associated with better primary and preventive care services and improved health outcomes. Thus geographic disparities in performance will widen and health care inequities within states worsen, if such health systems' reforms and innovations are not evenly spread across states.

# Healthcare Policy in the World

## US AND SPAIN: A DIFFERENT POINT OF VIEW ON HEALTHCARE POLICY

Comparing the United States and Spain's healthcare systems, it is clear that the respective policies are taking different positions. While the U.S. is trying to make healthcare coverage more affordable for citizens, Spain has adopted strict financial measures in order to cut the health expenditure. Both policies submit citizens to negative long-term consequences.

The American health care reform law (Affordable Care Act- ACA), better known as Obamacare, was enacted in March 2010. This law allows consumers an easier access to health coverage and protects them from companies' abusive insurance practices. Obamacare is far from the idea of a "National Health System" as those which exist in several European countries.

Despite that, the ACA has represented a huge legislative change in the U.S. because it aspires to increase the number of people covered by an insurance plan.

It is important to underline that about 50 million people in the U.S. are uninsured, even though the government spends almost 20% of its GDP on health, which is more than twice the GDP on health expenditure in any European country. That is why conservatives believe that ACA system is economically unsustainable.

*Considering the European situation, health systems used to be one of the main issues of national policies.*

Even if the Obamacare plan requires people to buy health insurance or pay a penalty, Republicans argue that insured patients will be stuck in an extremely expensive system, due to the fact that healthy and young people won't massively sign up.

Considering the European situation, health systems used to be one of the main issues of national policies. However, because of the financial crisis and austerity measures set up in many countries, budgets for health services have been decreased. For instance, Spanish administration heavily reduced the budget for health and social services and introduced a new law shifting health coverage from universal to employment-based in April 2012.

These facts entail that numerous illegal immigrants will have access only to emergency, maternity and pediatric care. This situation would not be new for American citizens, but these changes affect an important matter of Spain's social stability and have been imposed abruptly, without knowing the long-term consequences.

# Healthcare Policy in the World

## USA: HIGH PRICES PREVENT PATIENTS FROM ACCESS TO PRESCRIPTION DRUGS

The pharmaceutical industry is concerned that cost-sharing within most health insurance exchange plans could limit consumers' access to necessary medications, says a new report from the Breakaway Health prepared for the Pharmaceutical Research and Manufacturers of America.

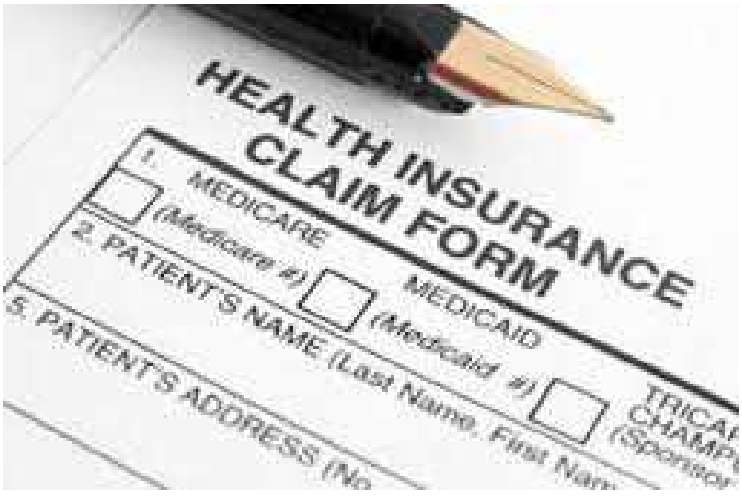
The worry comes from the fact that most employer-sponsored plans require consumers to pay 22 percent of prescription costs, but similar exchange plans require consumers to pay more than twice that amount, said John Castellani, who heads Pharmaceutical Research and Manufacturers of America (PhRMA), the drug


> *"In this situation, less and less people will be able to afford their medicines".*

For example, specialty drug copays an average $80 for employer-sponsored plans, yet consumers will pay $159 for silver plans and $157 for bronze plans for the same medications.

High prices in some areas can discourage people from enrolling in coverage or, once enrolled, high cost sharing requirements for deductibles and co-pays could discourage people from accessing care when they need it. In this situation, less and less people will be able to afford their medicines.

Insurers say that the problem is that drugs are too expensive. Data show that drug prices are rising and are one of the causes of healthcare cost increasement, as Clare Krusing, a spokeswoman for America's Health Insurance Plans, said. Any discussion of prescription drug coverage must also include a focus on the direct link between rising prescription drug prices and consumer cost-sharing.



# Healthcare Policy in the World

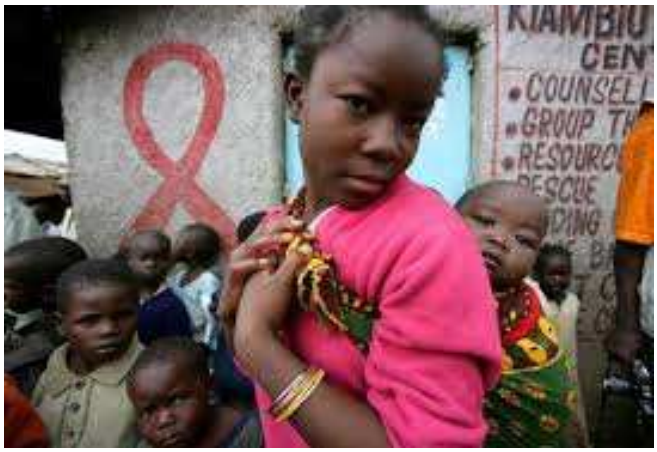
## KENYA STRUGGLES AGAINST HIV: IMPROVING MATERNAL AND CHILD HEALTH

Even though, Kenya is one of the most developed economies in East and Central Africa, the country needs to improve the issue of maternal and child health, in order to achieve the Millennium Development Goals by 2015.

In 2012, more than 100 000 children died before their fifth birthday, largely due to preventable causes. In the same year, 13 000 new HIV infections occurred among children and 62% of children living with HIV did not have access to life-saving antiretroviral drugs.

In order to improve maternal and child health outcomes in the country, the First Lady of Kenya, Margaret Kenyatta launched the 'Beyond Zero Campaign' on the 24th of January in Kenya's capital Nairobi. The new initiative also aims to accelerate the implementation of the national plan towards the elimination of new HIV infections among children.

*Kenya continues to struggle with treatment access and lack of resources.*



The 'Beyond Zero Campaign' is part of the initiatives outlined in the Strategic Framework for the engagement of the First Lady in HIV control and promotion of maternal, newborn and child health in Kenya that was unveiled on World AIDS Day 2013. The framework aims to galvanize high-level leadership in ending new HIV infections among children and reducing HIV related deaths among women and children in Kenya.

The strategic framework focuses on five key areas: accelerating HIV programmes; influencing investment in high impact activities to promote maternal and child health and HIV control; mobilizing men as clients, partners and agents of change; involving communities to address barriers to accessing HIV, maternal and child health services and providing leadership, accountability and recognition to accelerate the attainment of HIV, maternal and child health targets.

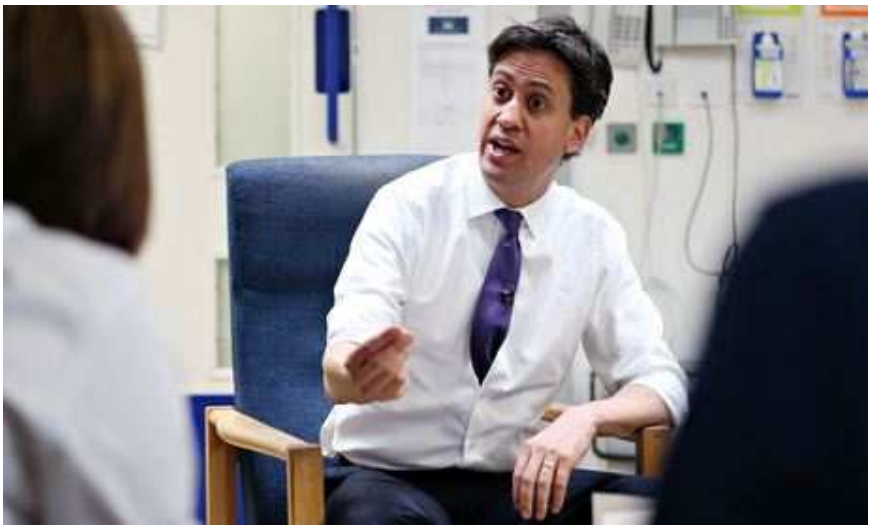
Kenya continues to struggle with treatment access and lack of resources. In order to address the gaps in access, Kenya's Ministry of Health will invest approximately $400 million this year in programs focused on reducing HIV transmission and maternal and child mortality, recruiting and training skilled health care workers, and providing health facilities with

# Healthcare Policy in the World

## ED MILIBAND (LABOUR PARTY) PROMISED GPs APPOINTMENTS WITHIN 48 HOURS

Labour leader Ed Miliband has vowed that patients will be able to see their general practitioners (GPs) within 48 hours. Every National Health Service (NHS) patient has the right to have a same day consultation with their local GP surgery, get an appointment if its urgent and be guaranteed an appointment within 48 hours.

He promised to plough an extra £100million into GP surgeries to end the "scandal" of NHS waiting times. Mr Miliband wants the NHS to be at the heart of Labour's campaigning: the commitment of the Labour government will be to have clear standards for access to GPs because so many people are struggling to see their GPs. An extra £100million in GP surgeries could pay for an additional 3 million appointments a year, Mr Miliband said, speaking in Manchester on



*Labour leader Ed Miliband speaks*

There is a growing crisis in waiting times to see a GP across the country, and it is clear that this will become a key issue at the next election. GPs want to provide better access to their patients, but are being prevented from cutting waiting times because of the funding black hole in general practice. Some studies have suggested a 5% increase in patients seeing their preferred GP could reduce emergency admissions by as many as 159,000 a year, saving £375m.

The Labour leader accused David Cameron of taking on new powers to close down health services, presiding over an increase in patients waiting four hours or more in A&E (accident and emergency departments) and shutting a quarter of NHS walk-in centers. In his Manchester speech, Miliband said Cameron has broken the bond of trust with the electorate over the NHS.

# gLAWcal activities

## Conferences and Workshops

- As part of the Research Project on "**Liberalism In Between Europe And China" - LIBEAC - Assessing the Socio-Cultural and Politico-Legal Dimensions of the Differences in Terms of Interpretation and Enforcement of Economic, Social and Environmental Rights in Europe and China**", 7th Framework Programme of the European Commission, the following events have been organized:

- Key Note Speech of Professor Daniel Bell (Professor at Department of Philosophy and Director of the Center for International and Comparative Political Theory at Tsinghua University) on "**Political Meritocracy: China and the Limits of Democracy**" divided in three sessions: Part I: "*On the Selection of Good Leaders in a Political Meritocracy*", Part II: "*What's Wrong with Political Meritocracy*", Part III: "*Models of Democratic Meritocracy*" held at Peking University, School of Government, Center for European Studies on 21st July 2014. Introduction and comments from Prof. Paolo Farah (University Institute of European Studies, IUSE, Turin, Italy). The event is organized by gLAWcal – Global Law Initiatives for Sustainable Development (United Kingdom) in collaboration with the following beneficiaries and partner institutions of the European Union Research Executive Agency IRSES Project "Liberalism in Between Europe And China" (LIBEAC) coordinated by Aix-Marseille University (CEPERC): University Institute of European Studies (IUSE) in Turin, Italy and the University of Piemonte Orientale, Novara, Italy Peking University, School of Government, Center for European Studies (China), Tsinghua University, Department of Philosophy (China). Work-package 2 and 4.

  **Leaflet:** http://glawcal.org.uk/files/Events/Daniel-Bell-leaflet-21-july-2014-FINAL.pdf

  **Extract of the Video**: https://www.youtube.com/watch?v=tyzjbaNGnJE

- Sara Marchetta, Vice-President European Chamber of Commerce in China and Partner Chiomenti Law Firm, Beijing Branch, "**Contract Law of the People's Republic of China**" held at Peking University, School of Government, Center for European Studies on 25th July 2014. Introduction and comments from Prof. Paolo Davide Farah (University Institute of European Studies, IUSE, Turin, Italy). The event is organized by gLAWcal – Global Law Initiatives for Sustainable Development (United Kingdom) in collaboration with the following beneficiaries and partner institutions of the European Union Research Executive Agency IRSES Project "Liberalism in Between Europe And China" (LIBEAC) coordinated by Aix-Marseille University (CEPERC): University Institute of European Studies (IUSE) in Turin, Italy and the University of Piemonte Orientale, Novara, Italy, Peking University, School of Government, Center for European Studies (China). Work-package 2 and 4.

  **Leaflet:** http://glawcal.org.uk/files/2014-07-25-Marchetta-chamber-of-comerce.pdf

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- Paolo Farah (Istituto Universitario di Studi Europei – IUSE), "**Intellectual Property Rights, Human Rights and Intangible Cultural Heritage**", held at Peking University, School of Government, Center for European Studies on 28th July 2014. The event is organized by gLAWcal – Global Law Initiatives for Sustainable Development (United Kingdom) in collaboration with the following beneficiaries and partner institutions of the European Union Research Executive Agency IRSES Project "Liberalism in Between Europe And China" (LIBEAC) coordinated by Aix-Marseille University (CEPERC): University Institute of European Studies (IUSE) in Turin, Italy and the University of Piemonte Orientale, Novara, Italy Peking University, School of Government, Center for European Studies (China). Work-package 2 & 4.

  **Leaflet:** http://glawcal.org.uk/files/2014-07-28-Farah-IPR-human-rightsIntangible_Cultural_Heritage.pdf

  **Extract of the Video**: https://www.youtube.com/watch?v=rv22Inltrv8

- Benoit Misonne, Team Leader, Intellectual Property: A Key to Sustainable Competitiveness (IP Key - An EU project implemented and co-financed by OHIM in partnership with the EPO), "**Protection of Copyrights in the Digital Era**" held at held at Peking University, School of Government, Center for European Studies on 29th July 2014. Introduction and comments from Prof. Paolo Davide Farah (University Institute of European Studies, IUSE, Turin, Italy). The event is organized by gLAWcal – Global Law Initiatives for Sustainable Development (United Kingdom) in collaboration with the following beneficiaries and partner institutions of the European Union Research Executive Agency IRSES Project "Liberalism in Between Europe And China" (LIBEAC) coordinated by Aix-Marseille University (CEPERC): University Institute of European Studies (IUSE) in Turin, Italy and the University of Piemonte Orientale, Novara, Italy, Peking University, School of Government, Center for European Studies (China). Work-package 2 & 4.

  **Leaflet:** http://glawcal.org.uk/files/2014-07-29-Benoit-Misonne-Copyright-Protection.pdf

  **Extract of the Video**: https://www.youtube.com/watch?v=IwD6hv92iYc

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## GLAWCAL

## GLOBAL LAW INITIATIVES FOR SUSTAINABLE DEVELOPMENT

### *WHO ARE WE*

gLAWcal is an independent non-profit research organization (think tank) that aims at providing a new focus on issues related to economic law, globalization and development, namely the relationship between international economy and trade, with special attention to a number of non-trade-related values and concerns.

Through research and policy analysis, gLAWcal sheds a new light on issues such as good governance, human rights, right to water, rights to food, social, economic and cultural rights, labour rights, access to knowledge, public health, social welfare, consumer interests and animal welfare, climate change, energy, environmental protection and sustainable development, product safety, food safety and security.

***All these values are directly affected by the global expansion of world trade and should be upheld to balance the excesses of globalization.***

**Owner and Editor:** gLAWcal - Global Law Initiatives for Sustainable Development

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