Chapter 6
Covid-19 as a catalyst for a European Health Union: recent developments in health threats management

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Introduction: the momentum for a European Health Union

The enduring Covid-19 crisis has shed light on the thorny question of the role of the European Union (EU) in managing health threats. Micro-organisms do not know borders and with free movement of persons guaranteed by the EU treaties, one might well assume that these same treaties should be protecting freedom of movement from its inherent negative externalities (Greer 2006). Yet, health prerogatives (with minor exceptions related to epidemiological monitoring) remain to this day a simple coordinating competence in the EU. As the Covid-19 crisis unfolds, the question of a European Health Union is increasingly structuring the conversation around the future of European integration alongside other key issues such as the future of the EU’s macro-economic governance. Such questions have a tremendous resonance in the context of the Conference on the Future of Europe, which opens a new space for participative democracy to address the EU’s future and could lay down the basis of future treaty reforms. A key proposal shaping the debate is the ‘stronger European Health Union’ advocated by European Commission President Ursula von der Leyen in her first State of the Union speech (16 September 2020). Though this can be seen as a strong new narrative from the EU in this sensitive policy area, it is unclear what form a European Health Union may ultimately take.

There is evidence that a first step in building the European Health Union is to further the institutionalisation of the current EU health threats management system. Indeed, on 11 November 2020, the European Commission published a Communication on ‘reinforcing the EU’s resilience for cross-border health threats’, accompanied by three legislative proposals aiming to strengthen Europe’s health agencies and setting up a health task force, to be deployed quickly within the EU and in third countries. This is supported by the new EU4Health programme adopted on 24 March 2020 (European Union 2021b), the primary aim of which is to develop capacity across the EU, especially with regard to the development of surveillance, preparedness and the availability of medicinal products in Member States.

But the ambition of a fully fleshed European Health Union can hardly be satisfied by the development of its technical and scientific features (Greer and de Ruijter 2020; Brooks et al. 2020). Indeed, evoking a ‘European Health Union’ conveys the image of an integrated health policy in the EU, with binding effects on Member State health systems, a move not allowed under current Treaty provisions.
While the Commission’s proposal is no ‘big bang’ for the European Health Union, it is very much in line with the stealth development (Martinsen 2012; Vollaard and Martinsen 2017) of a common health policy in the EU — a development which crises tend to accelerate (Boin et al. 2013; Lamping and Steffen 2009; Greer and Mätzke 2012; Deruelle and Engeli 2021). This chapter focuses on health threats management, a core area of public health, i.e. the protection of the general population from health risks. Unlike healthcare, which focuses on the treatment of patients and has remained the preserve of Member States (Hervey and Vanhercke 2010), public health is a coordinating competence of the EU. Starting with the Maastricht Treaty, there has been an incremental development of a public health policy in the EU which includes capacity building with the creation of European public health agencies and policy instruments based on mutualisation such as the joint procurement of medical devices. Nevertheless, the historical tension between the desire of Member States to maintain their prerogatives over public health competences and the need to develop a coordinated and coherent response mechanism for (present and future) health crises has resulted in political blockages.

These dynamics, however, changed as the Covid-19 crisis unfolded. Academic publications (Brooks et al. 2020; Paces and Weimer 2020) have pointed out that the logic of ‘every man for himself’ which used to prevail in public health has given way to a sense of solidarity among the 27 Member States. In a policy area in which the EU does not have binding instruments and where coordination is – for now – the only way forward, solidarity is no trivial matter.

Solidarity is not merely the expression of the ‘class bases of the European welfare state’ (Baldwin 1990), but a founding principle guiding Member States on their path towards integration. Jones (2012) defines solidarity as a form of commonality, whether based on interests, sympathies, aspirations or a combination thereof. Crucially, solidarity-based relationships involve responsibilities and rights that define action which, in the EU, will differ ostensibly upon the area (Jones 2005). In the EU, public health policy is not about creating an acquis communautaire, but about coordinating national risk reduction measures. As such, solidarity promotes equality of opportunity and efficient allocation of resources (Myrdal 1956) in the face of common health threats, and thus incentivises cooperation and coordination between Member States.

Solidarity-based governance is thus a way forward in the coordination of health threats management, in the absence of a coercive legal basis. The central question of this chapter is therefore: has the Covid-19 crisis led to a paradigm shift towards a solidarity-based European Health Union?

Mounting evidence indeed points to a paradigm shift: in the face of crisis, Member States have acknowledged their interdependence and the need for solidarity and coordination. This shows that the EU is engaging in the path towards this ‘stronger European Health Union’. But lessons are still being learned regarding its ultimate shape. Coordination and solidarity have limits, as exemplified by the controversies surrounding joint vaccine procurement, as well as the Porto Social Summit where a large group of Member States demonstrated their hostility towards overlarge steps towards a health union.
The chapter is structured as follows: Section 1 describes recent institutional developments in the governance of this ‘stronger European Health Union’. Section 2 discusses the challenge to solidarity posed by solidarity-based instruments, such as vaccine procurement and the recent EU4Health programme. The third section concludes the chapter by examining the capacity of the European institutions and Member States to cultivate this paradigm shift in order to secure the development of a fully realised European Health Union.

1. The governance of health threats management in the EU: the Covid-19 crisis as a paradigm shift

The governance of health threats management in the EU bears important specificities. Health threats management in the EU is characterised by a sharp division between risk assessment and risk management. Risk assessment involves the identification of risks through evaluating the magnitude, mechanisms and seriousness of threats to public health, a task performed by the European Commission (DG SANTE). This function requires important scientific work which the Commission delegates to an independent agency: the European Centre for Disease Prevention and Control (ECDC) created in 2004. The ECDC gathers epidemiological information from European Economic Area (EEA) health agencies. EU institutions are thus expected to take on a fire alarm role, framing epidemiological threats as transnational health problems. The counterpart to this is risk management: treatments such as vaccination and restrictions such as containment remain the prerogative of national authorities. At EU level, Member States meet in the Health Security Committee (HSC), a group formalised in the aftermath of the 2009 H1N1 (‘swine flu’) crisis and made up of national health ministries’ representatives. The HSC is a forum meant to facilitate the coordination of national responses to health threats.

In effect, this governance system puts clear practical limits on the production of a coordinated response and relies on soft governance, which limits capacity for action. The objective of this system of disease control is, ultimately, limited to coordinating the regulation of health risks – the governmental interference to control potential adverse consequences to health (Hood et al. 2001: 3; Weimer and de Ruijter 2017; Greer and Jarman 2021). This objective is, however, not reached through a classic command-and-control approach to regulation (Baldwin et al. 2013; Koop and Lodge 2015; Drahos and Krygier 2017). Indeed, the control of communicable diseases in the EU does not set out conditions and restrictions of behaviour (Lowi 1972), nor is it based on the notion of a ‘regulatory state’ (Majone 1994; Peters 2016) in which regulation corrects market failures. The control of communicable diseases in the EU is, in effect, a form of risk regulation that is voluntary, cooperative (Coen and Thatcher 2007; Levi-Faur 2011) and, historically, in the hands of Member States.

This system is the result of more than 20 years of incremental institutional development throughout which Member States have demonstrated their reluctance vis-à-vis the development of common capacity at EU level. However, recent developments point to a paradigm shift towards greater coordination and solidarity.
1.1 The prudent development of health threats management in the EU

With the Maastricht treaty, the Union was granted coordinating competences in terms of risk management which paved the way for epidemic intelligence harmonisation (TFEU Art. 168). The European Commission started with a small project: in 1993 it provided funding to the ‘Charter Group’, a network of national public health institutions (Bartlett 1998). The *raison d’être* of this group was to proceed with an inventory of joint actions in epidemiological surveillance and training that were currently taking place in the European Union (Newton et al. 1999). This inventory shed light on important gaps in terms of surveillance (such as foodborne diseases which were not kept under active joint surveillance) and led, in September 1998, to the creation of the *Network for the Epidemiological Surveillance and Control of Communicable Diseases in the Community*, established by a Decision of the European Parliament and the Council of the European Union (European Union 1998).

In 1998, formal institutionalisation in the shape of a new EU agency was still one step too far. Charter Group members were reluctant to relinquish control over the different forms of scientific cooperation they had set up. This opinion was widespread within the scientific community: *The Lancet* featured an editorial titled ‘Not another European Institution’ (The Lancet 1998). Wary of Member States’ reaction, the Commission thus sided with the Council of Ministers which also favoured a network approach (Deruelle 2016).

Views evolved in the early 2000s due to the persistence of health crises inherited from the 1990s (such as Bovine spongiform encephalopathy (BSE), aka the ‘mad cow’ disease) as well as the increasingly important question of bioterrorism (European Commission 2003a). In the face of concerns in this field, in late 2001 officials in the Directorate-General for Health and Consumers (DG SANCO, the pre-2014 DG SANTE) initiated informal meetings of health ministry representatives in the Health Security Committee (Greer and Mätzke 2012). With this marked focus on health threats in the Council, the creation of an agency able to identify health threats became more attainable. As early as June 2001, the possibility of a ‘European Centre’ was mentioned in the European Council conclusions (European Commission 2003b). In September 2002, Health Commissioner Byrne called for an agency that ‘will bring together the expertise in Member States and will act as a reference and co-ordination point both in routine and in crisis situations’ (European Commission 2002).

A few months later, in February 2003, the SARS-CoV-1 outbreak shook governments across the EU, leading to the European Commission rapidly putting forward the proposal to set up the ECDC on 2 August 2003. While its impact on the European continent remained limited, the SARS-CoV-1 crisis brutally placed the lack of preparedness of the Member States in the spotlight and convinced many of the urgent need for better EU-level coordination beyond the networks existing at the time (European Commission 2003b).

On 21 April 2004, the founding regulation of the ECDC (European Union 2004) entered into force. The then DG SANCO played a pivotal role in engineering the proposal
(Deruelle 2016; Greer and Löblöva 2016). The ECDC was built on the Network for Epidemiological Surveillance, a network focused on detecting the emergence of health threats (such as the SARS crisis) and monitoring threats over time (for diseases such as AIDS). But the Commission was careful to explicitly prohibit the ECDC from advising Member States on risk management (Council of the EU 2004). Indeed, the fine line between assessment and management was a contentious topic for Member States, to the point that the very wording was subject to debate: for instance, as the term ‘guidelines’ was considered too coercive, the term ‘guidance’ was preferred. Moreover, all attempts to discuss risk management measures, such as vaccinations, were met with circumspection (Deruelle and Engeli 2021).

Things started to change with the 2009 outbreak of H1N1 influenza, a test for the newly established Centre to demonstrate its added value (Liverani and Coker 2012). In summer 2009, amid the pandemic, the Commission tasked the ECDC, together with the European Medicines Agency, to define a vaccination strategy (Greco et al. 2011). For the ECDC, this was a first venture into risk management. However, this was only possible due to the fact that Member States were, amid the crisis, meeting regularly in the HSC and had agreed on a limited level of coordination vis-à-vis vaccination strategies (Baekkeskov 2016). Lessons were drawn from the H1N1 pandemic: the ECDC actively disseminated new surveillance practices established in the early days of the crisis to key national institutions in October 2009 (ECDC 2010a, b, d; ECDC 2011). The role of the HSC was formalised in 2013 (European Union 2013), enabling it to decide quickly on the coordination of national responses without the endorsement of the Council of the European Union (Greco et al. 2011).

In the aftermath of the H1N1 crisis, the governance of health threats was thus further institutionalised. But this was a mere formalisation of the system already in place, rather than a substantial qualitative leap forward. Indeed, the H1N1 pandemic was not as severe as previously feared (Nicoll and McKee 2010) and the crisis did not lead to a paradigm shift in the management of health threats in the EU. Consequently, on the eve of the Covid-19 crisis, Member States exhibited staggeringly different levels of preparedness regarding personal protective equipment (PPE) and had uneven access to testing (Bayer 2020; Guarascio 2020).

1.2 Covid-19: solidarity, coordination and rising expertise

Since the beginning of the Covid-19 crisis, there has been a sizeable shift in Member State attitudes: more willing to coordinate (Pacces and Weimer 2020; Renda and Castro 2020), they have increasingly relied on coordinated action and expert input from the Commission and the ECDC. As highlighted by calls from the scientific community for a qualitative leap forward towards further integration in public health (Clemens and Brand 2020; Greer et al. 2020; Beaussier and Cabane 2020), the Covid-19 crisis has demonstrated Member States’ commonality in the face of this health threat.

This realisation did not, however, happen overnight. In the early days of January 2020, Member States scrambled to come to terms with the scope of the crisis. The ECDC –
like numerous other public health agencies – struggled to assess the Covid-19 threat, as little data was available (HSC 2020a). But as soon as the risk of person-to-person transmission was confirmed, the ECDC re-assessed the potential impact of Covid-19 as high (HSC 2020b). This served as a reality check for Member States who started, under the coordination of the Commission, to request ECDC advice on risk management measures such as lockdowns and the use of personal protective equipment (PPE), despite the Centre’s limited competences. The ECDC developed advice on management measures in February (ECDC 2020b) and published guidelines on non-pharmaceutical mitigation measures (ECDC 2020a). When the issue of PPE came to the fore at the end of January 2020 (HSC 2020b), the European Commission mandated the ECDC to prepare an assessment of PPE needs, an initiative welcomed by Member States (HSC 2020c) and highlighting the extent of the paradigm shift between the 2009 H1N1 crisis and the Covid-19 crisis.

On 9 March 2020, the Italian government imposed a national lockdown, following local lockdowns enforced since 21 February 2020. In a European Council videoconference on 10 March 2020, Member States undertook to further coordinate management measures. Containment was part of the advice given by the ECDC as soon as clusters of human-to-human transmission appeared – a phenomenon that most Member States were already experiencing at the time (ECDC 2020c). This led to a domino-like coordinated entry into the first lockdowns: Slovakia, the Czech Republic enforced lockdowns on 12 March; the day after, Denmark, Poland, Latvia, Lithuania and Cyprus followed suit, while Germany, Spain and France initiated these restrictions on 16 March (HSC 2020f). ECDC guidance for discharge and ending isolation (ECDC 2020d) formed the basis for the 15 April European Commission communication on the European roadmap to lifting coronavirus containment measures (European Commission 2020c). Italy – the first Member State to have instituted a lockdown – lifted some containment measures on 4 May 2020, while France, Belgium, the Netherlands Germany, Austria, the Czech Republic, Greece, Bulgaria, Estonia, Finland, Ireland and Romania eased containment measures on 11 May 2020 (HSC 2020g). This was to be seen as a sign of sustained coordination: via the European Commission, the ECDC addressed strong and explicit messages on containment measures to Member States.

As the pandemic unfolded, the ECDC became the rising star of this new solidarity-based governance. Its advice not only informed Member States on surveillance or PPE, but also on containment. The Centre’s contribution to the European Commission’s advice on management gradually increased, specifically on the question of opening borders (European Commission 2020d). From May 2020 onwards, the ECDC was directly involved in the Council of the EU’s Home Affairs working parties (HSC 2020e). The ECDC consistently advocated that closing borders had little impact on the management of Covid-19, due to its (already) global distribution and respiratory transmission (ECDC 2020e). This increased ECDC involvement led Member States to adopt Council Recommendations on a coordinated approach to limit the restriction of free movement

1. Containment involves tracking the dissemination of a disease within a community, and then using isolation and individual quarantines to keep people who have been infected by or exposed to the disease from spreading it. It may result in quarantines, the closure of schools, the cancellation of major events, etc. and ultimately lockdowns.

The goal of this coordinated approach was to maintain free movement within the EU under safe conditions, by identifying measures applicable to persons moving between Member States, depending on the level of risk of transmission. The ECDC role consisted of mapping the risk of Covid-19 transmission and, together with the Commission, proposing adequate responses. The same coordinated approach prevailed when the Commission proposed on 10 May 2021 that Member States ease current restrictions on non-essential travel into the EU (European Commission 2021a) and develop a Digital Covid Certificate (previously known as the Digital Green Certificate), an information system ensuring freedom of movement for persons who are not at risk of spreading the disease. As of 1 July 2021, Member States are able to issue such certificates.

Amid the crisis, the health threats management system thus took a resolute shift towards a solidarity-based approach, under the auspices of the Commission and the ECDC. The balance of power is now altered, likely with lasting effects. ECDC has proven to be the rising star of the governance system for health threats management in the EU. Since the beginning of the Covid-19 crisis, ECDC scientific input is no longer confined to risk assessment. The Centre is now able to advise Member States on coordinated responses to health threats by producing explicit guidelines. This shows first and foremost that a paradigm shift has occurred: any such contributions from the ECDC would have been considered inappropriate by Member States before Covid-19. In this domain of high-level formal constraints, the role of crises was thus decisive in inciting (Boin et al. 2013; Lamping and Steffen 2009) and legitimising (Rhinard 2019; Vanhercke et al. 2020) collective action among EU Member States.

The ECDC is now de facto involved in coordinating risk management and will likely soon be involved de jure. On 18 May 2020, France and Germany jointly proposed setting up an EU ‘Health Task Force’ within the ECDC (Ministère de l’Europe et des Affaires étrangères 2020). This was followed by a plea from Denmark, France, Germany, Spain, Belgium and Poland on 10 June 2020 to widen the ECDC’s mandate, allowing it to coordinate, together with national health authorities, prevention and reaction plans against future epidemics within a future EU health task force (Momtaz et al. 2020). On 28 May 2020, the European Commission presented its proposal for the next Health programme (European Commission 2020b) which mentioned a potentially stronger role for the ECDC in coordinating management. On 16 July 2020, this position gained consensus among Member States (Bundesgesundheitsministerium 2020). On 11 November 2020, the Commission announced a new legislative proposal in order to extend the ECDC’s mandate (European Commission 2020f). This includes granting the ECDC the capacity to recommend measures for controlling outbreaks, thus providing risk management advice. While this was already the case in practice during the crisis, this measure would formally redefine the ECDC’s role and reinforce the EU’s health threats management system.

But if the ECDC is a winner of this process, are there also losers? Existing literature has analysed the institutional consequences of a crisis as empowering agencies at the
expense of the Commission (Bickerton et al. 2015; Hodson 2015). The Covid-19 crisis presents a more blended story: the rise of the ECDC in the Covid-19 crisis seems to have actually benefited the Commission. The latter has not lost any voice and the two institutions are together stronger in fostering coordination and solidarity within the HSC. Member States have similarly not lost out: while they may have relinquished their sovereignty by accepting to play the game of coordination, they may at any moment decide to go their own ways.

Ultimately, the European Union is still limited to coordinating management, with no means of regulating Member States’ strategies to fight health threats. However, the governance system of health threats management in the EU is becoming a fully implemented system of coordination, taking full advantage of the legal basis in the Treaty and in which all institutions are cooperating much more than in previous crises. Nevertheless, while solidarity seems to have emerged as the new ‘name of the game’ in health threats management, the means to achieve a coordinated policy are still in their infancy.

2. Solidarity-based policy instruments and their limits

While the Covid-19 crisis has caused a paradigm shift in the extent to which Member States accept coordination on health threats, this shift remains limited, even when Member States show goodwill. This came to the fore following the development of vaccines against the Covid-19 virus at the end of 2020. Here again, the 2009 H1N1 crisis offers a useful comparison: the main instrument of the health management system is the voluntary joint procurement of medical devices. Developed in the aftermath of the H1N1 pandemic, this allows Member States to pool their purchases of medical equipment (European Union 2013). Yet, because the H1N1 crisis was not as severe as expected (Nicoll and McKee 2010), the joint procurement mechanism was neglected in the years between H1N1 and Covid-19. This – at least partially – explains why Member States exhibited different levels of preparedness regarding PPE (Bayer 2020; Guarascio 2020). While Member States, under the stewardship of the Commission, have increasingly used this instrument during the Covid-19 crisis, the mere fact that this instrument relies on solidarity highlights its limits.

2.1 The controversies around vaccine roll-out and the limits of solidarity-based instruments

Once they grasped the salience of the Covid-19 crisis, Member States activated the mechanism of joint procurement of medical equipment on 28 February 2020 for PPE and on 17 March 2020 for ventilators (European Commission 2020a). Following the activation of the Civil Protection Mechanism, which does not help in purchasing but only in pooling Member States resources, a team of Romanian and Norwegian doctors and nurses was dispatched to Italy on 7 April 2020. These were signs that the paradigm shift evoked earlier was taking on a more concrete dimension in the management of the crisis. By relying on an instrument of mutualisation (McEvoy and Ferri 2020), Member
States were acknowledging that equality and efficient allocation of resources were seminal values for a coordinated exit to the Covid-19 crisis.

Turning to vaccines, coordination started months before they came into existence. In a health minister video conference held on 7 May 2020, many Member States expressed strong support for mandating the HSC to draw up a Covid-19 vaccination plan for the EU and EEA. They similarly expressed their interest in the possible joint procurement of Covid-19 vaccines (HSC 2020d). The question of equitable access was key here, as smaller Member States did not have sufficient purchasing power. However, solidarity was not yet in full swing, with Germany, France, Italy and the Netherlands joining forces to reach a deal with AstraZeneca on the supply of up to 400 million doses of its vaccine candidate. Taking place outside the EU framework (Deutsch 2021a), the negotiations did not include some smaller Member States which would have benefited the most from joint procurement.

To avoid a race for vaccines among EU Member States, the Commission presented a Communication on an EU strategy for Covid-19 vaccines on 17 June 2020 (European Commission 2020e). This emphasised that a coordinated approach ensured safety, as well as timely and equitable access to vaccines. To conduct negotiations, the EU set up a team of experts from all Member States to negotiate with vaccine makers the advance purchase of Covid-19 shots, with a budget of 2 billion euros fixed by Member States (Reuters 2021). Overall, from August 2020 until January 2021 the Commission signed so-called ‘advance purchase agreements’ with six different companies, for a total of 2.3 billion doses. The first deal signed was with AstraZeneca in August for 400 million doses, largely converting the agreement initially sealed by Germany, France, Italy and the Netherlands (Sánchez and Zalan 2021). In the second half of the 2020, the EU’s joint procurement efforts were thus sustained.

Nevertheless, the timeliness of this coordinated approach was questioned in early 2021. While the joint procurement of vaccines prevented a race between Member States, the global race was only just beginning. Countries such as the United Kingdom and the United States aggressively purchased doses at higher prices (Deutsch 2021a). These governments were able to act quickly and reactively, a strategy hardly implementable in the EU, as Member States need to jointly agree the sum to invest in the purchase of vaccines. In an already complex situation, the issue of manufacturing bottlenecks added to the complexity of pinpointing the cause of the slow roll-out, with the question of AstraZeneca’s vaccines at its core. The company was initially pencilled to provide between 80 million and 100 million doses by the end of March 2021. However, in January 2021 the company reduced the total to 40 million, citing manufacturing issues (Hirsch and Deutsch 2021). This issue is now at the centre of a legal action launched by the European Commission on 26 March 2021 (France 24 2021) and the larger problem of procurement was eventually overcome through the EU’s gargantuan and historic purchase of 1.8 billion doses of the Pfizer vaccines in May 2021 (Deutsch 2021b). Nevertheless, the controversy has been instrumental in casting blame on the EU’s strategy throughout the first months of 2021 and has shed a sobering light on the limits of the solidarity-based, coordinated approach that had prevailed.
Yet, difficulties in securing doses on the market are not sufficient to explain the slow vaccine roll-out. Mounting evidence shows that this was at least partially due to countries being unprepared to roll out vaccines quickly. This was highlighted by the European Commission on 19 January 2021, in a Communication calling on Member States to speed up the roll-out of vaccines across the EU (European Commission 2021b). Moreover, ECDC figures as of 7 March 2021 showed that most Member States had not used all shots available to them (ECDC 2021). This is another testament to the limits of solidarity-based governance. Unlike shared competences where the Commission is able to closely monitor and constrain Member States in the implementation phase, on the question of vaccines it can only raise the alarm and call for action. As such, the joint purchase of vaccines was ultimately a double-edged sword for the credibility of the EU. The Union was, in the public eyes, bearing the responsibility for rolling out the vaccines. However, once stocks were constituted and distributed among Member States, national authorities were in control of the process.

The issues and controversies surrounding the vaccine roll-out in the EU highlighted the limits of solidarity-based governance. The joint procurement of vaccines was meant to be the herald of solidarity-based measures, but it backfired and ultimately undermined solidarity. As a result, the controversy surrounding the slow vaccine roll-out in Europe has often been presented as a problem linked to the coordinated approach taken by EU Member States. This is correct, to the extent that the current solidarity-based instruments only offer limited leverage to develop coordinated action. The EU was particularly constrained by the mandate it was given by Member States and ultimately suffered from the limits of its mere coordination role in rolling out vaccines at national level. Nevertheless, the EU is learning from these lessons, with several recent initiatives, discussed in the next section, pointing towards the strengthening of solidarity-based instruments with a view to making coordination between Member States more fluid and reactive in times of crisis.

2.2 Towards the strengthening of solidarity-based Instruments

As seen earlier regarding the joint procurement of vaccines, solidarity-based instruments require a great deal of coordination between Member States. Despite the clear paradigm shift toward solidarity discussed in the first section of this chapter, solidarity-based instruments require mechanisms and capacity-building to foster coordination and, ultimately, the European Health Union. Two recent developments need to be highlighted here: the development of an EU Health Emergency Preparedness and Response Authority (HERA) and the ambitious EU4Health programme, both of which set new priorities in terms of investments for the future Health Union.

On 11 November 2020, as the European Commission unveiled its legislative proposal for a new mandate for the ECDC, it also announced the creation of HERA, with a view to proposing in 2021 a properly mandated and resourced dedicated structure to start operations in 2023 (European Union 2021a). The goal of this new authority is to complete and diversify the policy instruments to fight health threats. Its role is to enable the EU and its Member States to rapidly deploy management measures in the event of
a health emergency. This includes the deployment of medicines and vaccines. HERA would assist in the development of new medicines and medical equipment by covering the whole value chain from conception to distribution and use. HERA’s operations will be complementary to the work of the ECDC, developing more operational capacity at EU level, something lacking in the ECDC in the pre-Covid era.

The development of a new agency raises the question of ‘turf’: agencies tend to protect their uniqueness and their prerogatives (Busuioc 2016). Yet, turf issues are not systematically detrimental to interagency cooperation in the EU’s public health policy (Deruelle 2021). This is particularly relevant as HERA is tasked with operations outside the ECDC remit. HERA will support the smooth functioning of the joint procurement mechanism by ensuring that sufficient production capacity is available when necessary, as well as making arrangements for stockpiling and distribution. It is thus likely to play a central role in the practical aspects of preparedness, alongside the ECDC.

This approach, based on the coordination of public and private capabilities to enable a rapid response when the need arises, was tested amid the controversies over vaccine procurement. On 17 February 2021, the Commission launched the HERA incubator, also known as the European bio-defence preparedness plan against Covid-19 variants. This initiative is a trial for the future HERA and brings together researchers, biotech companies, manufacturers and public authorities in the EU. Specifically, it brings €75 million in EU funding to specifically develop specialised tests for new variants; and it launched the VACCELERATE project, a Covid-19 clinical research network involving academic institutions from 16 EU Member States and five associated countries, including Switzerland and Israel, to exchange data.

In a similar vein, the EU4Health programme adopted on 24 March 2021 (European Union 2021b) ramps up capacity-building at EU level. Over the course of seven years, the programme will redistribute a total of €5.3 billion, a twelvefold increase compared to the previous health programme (€446 million). This is lower than the European Commission’s initial proposal of €9.4 billion, but higher than the €1.7 billion that Member States had agreed to spend in July 2020 – due to the proactive work of the European Parliament.

The programme focuses on health threats management, although antimicrobial resistance, non-communicable diseases and other public health topics are also mentioned, mostly carried over from the previous health programme. With regard to health threats management, the programme shows a strong commitment to capacity-building, and especially to the development of surveillance capacities in Member States, something advocated by the ECDC since the start of the crisis. As with HERA, the programme’s core aims are the strengthening of preparedness, the availability of medicinal products and the support of research and development. As such, some of the primary beneficiaries of the funds are European Reference Networks (ERNs), virtual networks of healthcare providers across Europe. ERNs can improve access to diagnosis and the provision of high-quality healthcare and can be focal points for medical training and research and the dissemination of information. The aim of the health programme is thus to contribute to the upscaling of networking through ERNs and other transnational networks.
Overall, the development of a European Health Union, a publicised aim of the EU4Health programme, is thus very much grounded in the development of solidarity-based policy instruments. But this strategy is not deaf to the criticism levelled against the joint procurement mechanism. The goal of both HERA and EU4Health is, in effect, to foster capacity-building with a view to avoiding the trade-off between coordination and efficiency, as experienced during the Covid-19 crisis.

**Conclusion: solidarity and the legitimisation of a European Health Union**

From nobody knowing about health threats management in the EU, we have come a long way in 2020 (Greer and Jarman 2021). The development of the health threat management system as well as, in the future, its instruments, demonstrates that the Covid-19 crisis has legitimised the development of a nascent European Health Union (Vanhercke et al. 2020). This is due to the paradigm shift triggered by the Covid-19 crisis: by embracing a solidarity-based approach, Member States and European Institutions have taken the EU’s health threat management policy ‘out of the closet’.

Indeed, relying on solidarity has been somewhat successful in coordinating Member States efforts to fight the pandemic and solidarity has been instrumental in putting in motion the joint procurement of vaccines, a crucial instrument to supply vaccines for smaller Member States.

The Covid-19 crisis shows that this sense of solidarity, based on equality of opportunity and efficient allocation of resources, is first and foremost crystallised by health threats. In this sense, the Covid-19 crisis further demonstrates that, regarding public health, collective action is rather difficult in non-crisis situations (Boin et al. 2013; Lamping and Steffen 2009; Greer and Mätzke 2012). But even in the face of sizeable health threats, solidarity is not necessarily a foregone conclusion. Indeed, while the crisis has opened the door to a ‘stronger European Health Union’, the sense of solidarity among Member States did not come about instantaneously. In times of crisis, coordination is time-consuming and may prevent Member States from being as reactive as when acting on their own (Rocco et al. 2020). Solidarity is a complex equilibrium to uphold. While the procrastination of January and February 2020 was eventually overcome, it gave way to new issues, as exemplified by the difficulties experienced by the European Commission in securing vaccine doses in a timely manner.

Overall, the Covid-19 crisis demonstrates the limits of a solidarity-based governance system subject to the goodwill of Member States and European Institutions. More specifically, solidarity-based governance and instruments do not reflect what the EU would be able to do, were it to be endowed with shared competences rather than coordinating ones. Indeed, if ‘solidarity’ is the active compound that holds the Union together, the EU might just as well be a simple forum in which Member States cooperate and help each other. The internal market and associated four freedoms are built on strictly enforced legal ties. Member States act in concert because a complex legal order binds them together, enshrining solidarity in legal texts rather than because of the attractiveness of collective action. And thus, to be fully realised, the European Health...
Union will necessarily include a change in the treaties to ‘upgrade’ public health to a domain of shared competences.

While such a development would have seemed inappropriate throughout the 2010s, it is now within the grasp of the Conference on the Future of Europe to pave the way for Treaty change. On 9 May 2021, the day the Conference was launched, a clear message was sent out: the time had come to rise to the occasion and proceed with a qualitative leap forward in the integration of health. Nevertheless, it remains uncertain whether the Conference will be able to successfully advocate such a leap. On the eve of the Porto Social Summit, 11 Member States again showed their reluctance to endow the European Commission with new powers specifically on healthcare and social protection (Herszenhorn 2021). The outcome thus remains, once again, shaky. And it remains to be seen whether the paradigm shift triggered by the Covid-19 crisis was sufficient to pave the way towards a fully realised European Health Union.

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All links were checked on 22 October 2021.