

Does the EU have sufficient healthcare competences to cope with COVID-19?

Federico Ottavio Reho

During the last decade or so, the European Union has been spared little in the way of dramatic crises: the biggest financial meltdown since the Great Depression, the largest refugees' inflow since the massive population transfers that concluded WWII, and now the deadliest epidemic in over a century. In conjunction with each of them, a reasonable case could be made, and has been made, that the best solution was a 'federal' EU state responsible for, respectively, fiscal and economic policy, migration policy, and now health policy.

Former Belgian Prime Minister and longstanding MEP Guy Verhofstadt, for example, [proposed](#), among other things, the creation of a new European Health Agency fully empowered to take emergency measures such as issuing mandatory common confinement rules, pooling medicines and hospital equipment, or temporarily closing borders. Similarly, a group of 'prominent Europeans', including former prime ministers, commissioners, and high-ranking officials, [denounced](#) 'the current EU as an incomplete Res Publica, (...) with little competences and powers to face the pandemics.' It is urgently necessary, they argued, to 'make public health and the fight against epidemics a shared competence of the EU, subject to the ordinary legislative procedure, and provide the Commission with extraordinary powers to coordinate the response to the epidemics, as a federal government should do.'

In the year that will hopefully still see the opening of a planned Conference on the Future of Europe, though probably with a delay and under the unforeseen shadow of the coronavirus, those and other similar proposals deserve serious consideration.

Here are some very preliminary thoughts on the problem of the EU's competences in relation to healthcare and the management of epidemics.

The EU is rather active in important aspects of health policy

To begin with, we should recall that the last few decades have, in fact, seen a steady [expansion](#) in the number and scope of EU competences and secondary legislation relating to health. As in many other fields, this was initially primarily driven by the side-effects of the Single Market's four freedoms, such as the need to guarantee the social security rights of workers who exercised their freedom of movement. Besides, under art. 114(3) TFEU, all measures of harmonisation adopted for the sake of the Single Market must pursue a high level of health protection, something that affects EU legislation across the board and, with it, health protection levels across the Union.

Relevant secondary legislation has long been adopted, for example, on such health-related issues as the [production](#) and [advertising](#) of tobacco and the [protection](#) of patients' rights to medical treatment and reimbursements across the Union. Other importantly affected fields include food safety, health and safety at work, pharmacies, and pharmaceutical companies. In fact, Union legislation is by now so concerned with the details of citizens' health that the development of a wholly new 'EU lifestyle policy' on the likes of alcohol, tobacco consumption, and unhealthy diets has been [noticed](#). This has profoundly changed European citizens' daily approach to their health and influenced the scope and shape of national health policies. The process went so far as to justify concerns about a

‘competence creep’ at work in health policy, with EU intervention encroaching into healthcare matters which might be considered reserved to the national level.

The risk of this happening with little democratic legitimacy has been compounded by the formulation of, at times exceedingly detailed, country-specific recommendations regarding healthcare in the context of the European Semester since 2012. The most invasive (and contested) of the EU’s demands concerning the organisation of healthcare were obviously addressed to ‘programme countries’ such as Greece during the eurozone crisis. But most member states have been the object of the Commission’s attention in this quarter. The EU’s presence here has more recently been confirmed by the inclusion of [principle 16](#) within the European Pillar of Social Rights, according to which ‘everyone has the right to timely access to affordable, preventive and curative health care of good quality’.

The EU’s role in fighting pandemics can be reinforced under the current treaties

Admittedly, what most lament these days is the EU’s seeming lack of adequate competences to fight cross-border pandemics like COVID-19, more than a general lack of competences in healthcare. In fact, in the history of European integration, new treaty provisions more directly assigning EU competencies on healthcare beyond the Single Market were gradually introduced, most notably in what is now [art. 168 TFEU](#).

The most relevant stipulations for our current situation are that ‘Union action, which shall complement national policies, (...) shall cover the fight against the major health scourges, by (...) monitoring, early warning of and combating serious cross-border threats to health’ (Art. 168(1)), and that the ‘Europe-an Parliament and the Council, acting in accordance with the ordinary legislative procedure (...), may also adopt incentive measures designed to (...) combat the major cross-border health scourges, measures concerning monitoring, early warning of and combating serious cross-border threats to health, (...) excluding any harmonisation of the laws and regulations of the Member States’ (168(1)). The treaty also empowers the Council to adopt recommendations for those purposes on a proposal from the Commission (Art. 168(6)).

COVID-19 seems precisely the sort of ‘cross-border health scourge’ which these provisions were meant to help the EU manage.

Although some EU agencies and mechanisms have been [created](#) in implementation of this article to coordinate an EU-wide response, we have arguably not explored and realised its full potential for EU action yet. Doing so might help us get ready for the next cross-border epidemics without necessarily jumping to the conclusion that additional centralisation of health policy within the EU is a necessity. The Conference on the Future of Europe is the appropriate forum to seriously reflect upon this.

Of course, this potential will surely look meagre to those who, by health policy, only mean the power to directly define, organise and deliver health services and medical care, as well as to allocate the necessary resources to them. Member states are indeed solely responsible for this under EU law (art. 168(7) TFEU), although, as observed, the consequences of the Single Market and the innovations of the European Semester are de facto steadily eroding their responsibility.

However, this protection of subsidiarity requiring EU action to respect the responsibilities of Member States seems entirely justified, including from the perspective of a sound federalism. The effective organisation and provision of healthcare is heavily dependent upon local circumstances, and the preferences of communities on how to best achieve this are very diverse. Even the national level is usually much too remote from local realities to be adequate, let alone the European level.

No ‘federal’ EU institution can take ultimate responsibility for managing health emergencies

Even with unchanged health competences, there are compelling reasons mandating the close coordination of national reactions to a pandemic like COVID-19, and even to epidemics of lesser magnitude. First, uncoordinated national responses can cause much disruption to such core areas of European integration as the Single Market and the Schengen Area. Second, the extreme ease of travelling within the EU facilitates the cross-border spread of epidemics and their rapid spiralling out of control. In this regard, the timely restriction of mobility and the temporary reintroduction of some border checks might prove necessary to confine epidemics to the countries where they first spread, in the interest of the Union as a whole. This is no scandal: after all, as we have all witnessed, major restrictions on mobility might also have to be put in place within individual member states.

What is imperative is that the common interest of the Union in those deliberations is acknowledged and safeguarded. The introduction and lifting of such measures by some or all member states cannot come as a disorganised fait accompli to European institutions and other member states, but rather after close consultation and coordination with partners, enabling them to safeguard theirs and the EU's most vital interests. Clearer procedures must, therefore, be put in place identifying all national and EU stakeholders to be involved in such 'policy loops' at both the technical and the political level, in order to activate them timely in case of epidemics and to come to rapid common deliberations.

The exact coordinating role and powers of the Commission, the Council, and possibly other technical agencies in case of 'cross-border health scourges' must be strengthened and clearly spelled out, possibly in the form of Council recommendations. Careful thought must also be given to the most effective legislative infrastructure of 'incentive measures' that can be put in place by the Parliament and Council to maintain and support them. As mentioned, all of this seems possible under art. 168 TFEU. It is pointless to look further for more fanciful and unrealistic innovations until we have explored and exhausted its potential.

Under the current treaties, it is difficult to imagine the creation of any federal agency or institution with executive powers to manage a continental pandemic overriding national authorities, as suggested by [some](#). This might sound appealing from the vantage point of efficiency during emergencies, but there are many inefficiencies that federal orders are ready and even eager to tolerate for the sake of preserving decentralisation and local control over important policies.

In fact, the powers of centralised management that some would like to ascribe to a new European Health Agency are often not even given to the central governments of established federal states, except when they wield, as many of them are doing under the current circumstances, emergency powers. However, the EU acquiring the power to over-ride member states in cases of (health) emergencies means an unspoken Copernican revolution in European politics and a fundamental transformation of the EU's constitutional nature. The EU would, de facto if not de jure, be attributed ultimate executive authority over the health and safety of all European citizens.

This means the advent of 'European sovereignty' in an altogether different way from that advocated by

even President Emmanuel Macron. No longer the sound notion that only by joining forces at the European level the individual nations of our continent can truly defend their sovereignty and matter in the global arena; but the rather different notion that ultimate sovereignty lies with the Union and, when exercised, trumps and crashes any residual national sovereignty. In its ultimate constitutional implications, this is not the European Res Publica, but rather the European Leviathan.

Only the European Council has the legitimacy to be the ultimate executive authority during epidemics

Armed with the experience of the last ten years, when not even the existential threat of the euro crisis was sufficient for member states to create a fully consolidated European sovereignty, we should perhaps come to recognise that, for the time being, this is an unhelpful pipe dream diverting attention and energies from what can realistically be achieved.

Stronger coordination will have to happen by creating a permanent and effective network of national health authorities, both scientific and political, working and deciding together in preparation of and during major epidemics. The mandate and budget of the European Centre for Disease Prevention and Control (ECDC), created in 2004 in the aftermath of the SARS outbreak, might be adjusted for this independent agency to play a more important role in such a scheme.

Ultimate executive authority for directing member states' responses to pandemics on behalf of the EU can only be wielded by the European Council, closely supported by the Council of the European Union and the Commission. As the highest political authorities in their countries and, collectively, the highest political authority in the EU, only heads of state and government can credibly take responsibility for hammering out coordinated crisis responses and making sure basic European interests are protected. Most importantly, only they can truly guarantee that their collective deliberations will be faithfully incorporated into domestic decisions on crisis management and legitimated according to national democratic procedures. There is an obvious precedent for this mode of EU crisis management: the 'executive intergovernmentalism' tested during the EMU crisis.

Like the COVID-19 crisis, the EMU crisis confronted the Union with cross-border disruptions and spill-overs from national policies, such as budgetary and fiscal policies, over which, under the treaties, member states retained ultimate responsibility. As

today in the case of healthcare and the fight against 'health-scourges', transferring responsibility for such policies to the EU was problematic, as it would have completely transformed the constitutional nature of the Union and its member states. The solution found was for the European Council to discuss and agree on common responses even in areas that did not, strictly speaking, fall within EU competences, but nonetheless required joint action. Adopting and legitimising the agreed measures was then left primarily to national governments.

Executive intergovernmentalism as a *form of governance* elicited justified [criticism](#). During the EMU crisis, it was used to partially centralise fiscal and budgetary competences beyond what was foreseen by the treaties and in ways that partly emasculated national legislatures and were subject to relatively little scrutiny at the EU level. However, I believe most of these concerns are eased if we only accept executive intergovernmentalism as a *temporary mode of crisis management*. This is simply about close, but transitory, emergency coordination at the highest applicable level, to be immediately phased out as soon as the cross-border health emergency is under control, and the risk of adverse effects on EU policies has been averted.

For those who have eyes to see it, the beauty of the EU lies precisely in its 'in-between' nature: it being neither a fully consolidated federal state where unity trumps everything, nor an international organisation where diversity reigns supreme. In health as in most other domains, the duty of true Europhiles can only be to protect and reinforce the Union's own unique brand of 'Unity in Diversity'.

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