EU solidarity in fighting COVID-19: State of play, obstacles, citizens' attitudes, and ways forward

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An initiative to create centralised control of medical countermeasures at the EU level would solve many coordination issues in times of crisis. However, a unified European response faces a number of legal and political obstacles. This column uses a survey conducted before the COVID-19 outbreak to understand EU citizens' attitudes towards a joint solidarity programme. It suggests considerable support already exists for an effective policy framework centralising the procurement, stockpiling, and allocation of medicines.

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Solidarity in health is multifaceted. It refers to the public enforcement of necessary collective action (e.g. quarantines, mandatory medical examinations, and vaccinations) and to systems of insurance and redistribution, ensuring universal access to medical care and public health.[1] This is a shared EU principle (Council of the European Union 2006), but the organisation of the solidarity is a national responsibility.[2] In areas where redistribution and entitlements are at play, the EU is legally prohibited from legislating.[3] Furthermore, member states have been adamant in drawing strict boundaries between national health law and EU internal market law.[4] Hence, the capacity to organise a true *European* solidarity response to infectious diseases is limited.

Export bans of urgent medical supplies

With the increasing shortages of countermeasures to COVID-19, some member states have instituted bans on the exports of crucial medical supplies. In response, the European Commission (2020a) has published a communication that such goods need to be "channelled to those who need them most". Generally, an export ban is prohibited under Article 35 of the Treaty on the Functioning of the EU (TFEU), unless this national ban can be legitimised by reason of public health. If member states want to restrict exports for solid public health reasons, they have the authority to do so as long as it is proportionate and non-discriminatory (Art. 36 TFEU). Interestingly, the Commission offers a new reading of this proportionality principle:

[The measurers need to be] appropriate, necessary and proportionate to achieve such [health] objective, by ensuring an adequate supply to the persons who need the most while preventing any occurrence or aggravation of shortages of goods, considered as essential – such as individual protective equipment, medical devices or medicinal products – **throughout the EU**.

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This interpretation of proportionality implies a novel rebalancing of health concerns and market objectives. Where previously this balancing would presume that health is a responsibility of member states and might need protection from internal market principles, now the reading is that health solidarity is an EU objective that can trump member state prerogatives.[5]

Nevertheless, it is questionable that an infringement procedure for enforcement of internal market law along the line proposed by the Commission will be enough to ensure the distribution of urgently needed medicines for the whole EU. Therefore, the EU needs to have actual control of the supply chain of medicinal countermeasures, which is where solidarity is now most at stake.

EU control of the medical countermeasure supply chain

Despite the central role for member state solidarity, some legal bases justify a broader solidarity role for the EU in health emergencies. The first is in Article 222 TFEU (solidarity). The second is in Article 168 TFEU (public health), which outlines:

> Union action, which shall ***complement*** national policies, shall be directed towards improving public health, […]. Such action shall cover the fight against major health scourges, by […], and ***monitoring, early warning of and combating serious cross-border threats to health***. […]

Article 168 TFEU was amended in this sense after consecutive health crises (e.g. Bird flu, SARS). At the time, an attempt was made to create EU stockpiles of medical countermeasures, such as pre-purchase agreements for vaccines, antivirals, and medical supplies. However, no agreement could be reached between the member states. During the Swine flu epidemic, the distribution problems and costs of medical countermeasures were significant (European Medicines Agency 2011, Turner 2016). Therefore, the EU established an ad hoc, voluntary public procurement system whereby member states lacking access to the vaccine could still obtain it, and a stockpile was created using excess capacity of vaccines in member states. Following this, and despite early opposition from member states, the ad hoc voluntary system became generalised by Decision 1082/2013 (Art. 5) for health emergencies.[6] The Joint Procurement Agreement (JPA) implementing Article 5 entered into force in June 2014.[7]

Although significant steps have been made on this basis – 15 member states joined in a pre-purchase agreement for pandemic vaccines and new initiatives are unfolding – the system does not make it possible to centrally allocate medicines using central EU executive (emergency) powers.[8] Decisions regarding urgency and need are organised in a fully contractual manner, which means that they must be taken inter-governmentally.

The role for the EU on the basis of Article 222 TFEU is not very different. This Article mandates that in disasters, member states provide mutual assistance and act in cooperation. However, such cooperation is voluntary.[9] The EU Civil Protection Mechanism established on the basis of this Article also depends on the willingness of member states to join forces. In 2019 the Civil Protection Mechanism was strengthened by 'rescEU', in an attempt to centralise EU capacities.[10] Article 12 of this Decision provides for the EU to use its internal funds or pre-committed national funds, and EU co-financed member states' capacities at the disposal of EU efforts, to respond to a major emergency. Importantly, this mechanism also creates the possibility for joint procurement, operating in parallel to the JPA under the health infrastructure.[11] Here, the Commission can assume a more central role because the Decision allows for central EU implementing decisions towards distribution and allocation. Nevertheless, the actual capacity of rescEU still largely depends on the willingness of member states to contribute, and it is doubtful that for medical countermeasures EU internal funding will be comparable to what can be organised at the national level or through the JPA in the EU health context.

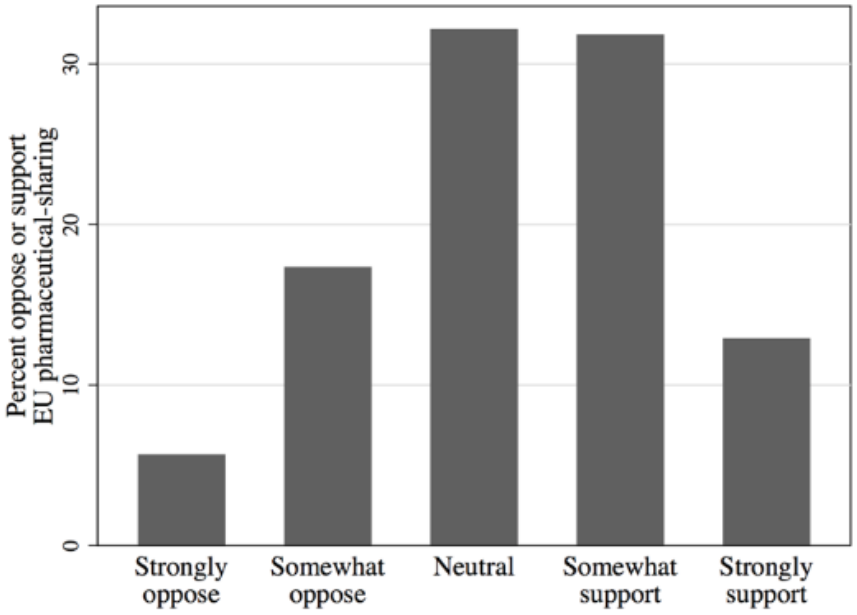
The tension between these two voluntary approaches is clear: one favours forward-looking governments to decide to pool forces while being relatively inflexible amidst distributional challenges; the other is able to cope with distributional challenges, but its activation follows rather than anticipates an outbreak. Merging the two systems is politically controversial, since EU citizens may differ in how they think about joint solidarity.

EU citizens preferences

Public support for improving existing arrangements is therefore essential. To shed light on public support for the EU's role in the purchase of medical countermeasures, we conducted an original survey as a pilot for a larger project on attitudes towards EU fiscal and medical policies. This pilot used a representative sample of 400 Dutch respondents in November 2019, just *prior* to the COVID-19 outbreak. This yielded a sample of 2,400 judged packages. The design was a 'conjoint experiment' exploring support for different variants of EU risk-pooling in the purchases and accessibility of pharmaceutical medicines relevant to major outbreaks.

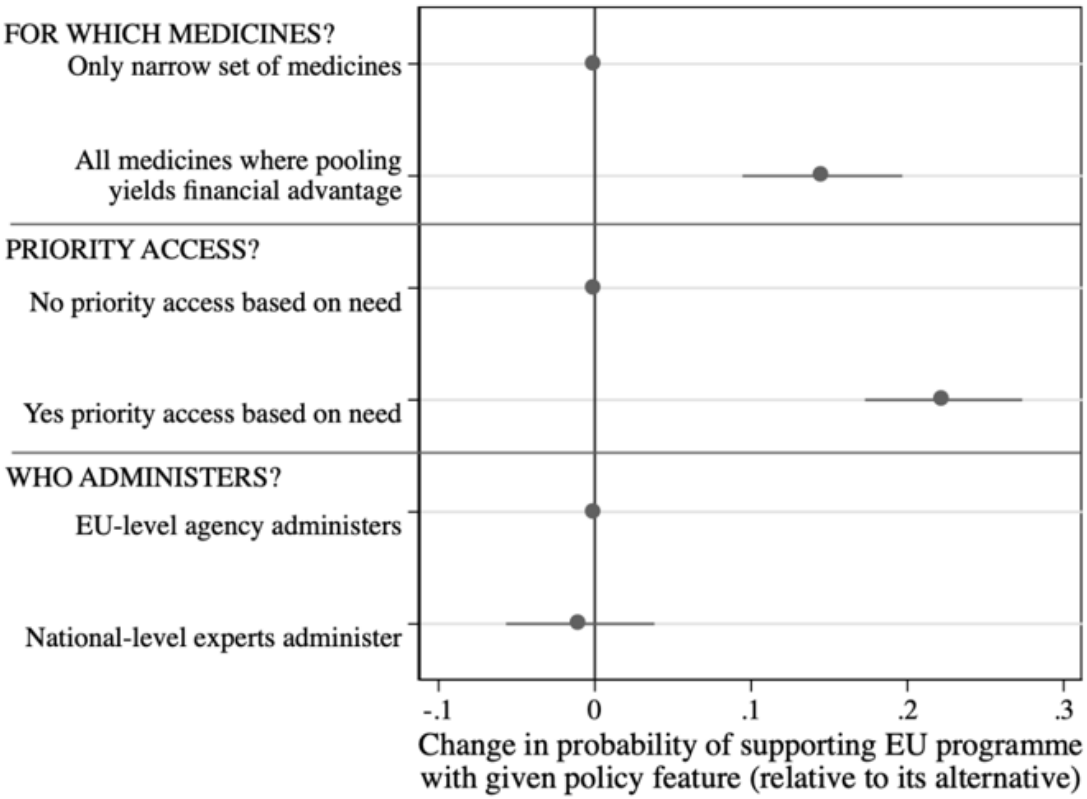
The results, while based on a limited sample in one country and a particular pre-crisis moment, reveal important information about public support for EU competences. First, as Figure 1 summarises, overall support for EU-level pharmaceutical facilities is substantial: 44% of the sample were somewhat or strongly supportive, while 'only' 23% were opposed (32% were indifferent). These patterns are stable across basic demographic sub-groups (younger versus older, more versus less educated, men versus women).

Figure 1 Support for EU sharing of medicine procurement



Second, Figure 2 summarises preferences about variants of the policy. Respondents were essentially indifferent as to whether EU-level or national experts and agencies administer such programmes. On the other hand, they were 15% more likely to support EU procurement policies covering all products for which public procurement is beneficial rather than a more limited range. Finally, they were also 23% more likely to choose those EU procurement policies that give priority access of medicines to countries where a contagion can be traced, rather than to countries based on actual contributions (the baseline).

Figure 2 Predicted support for policy features of EU medicine procurement sharing



Ways forward

The organisation of health solidarity traditionally set limits on market integration. However, the current crisis is demonstrating the limitations of the internal market. Ensuring medical countermeasures go to the places where they are needed most is in everybody's interest. The EU's role in the procurement of a pandemic medicine and other medical products can be scuttled if member states, amidst COVID-19, undermine supply chains. The process within the medical procurement and rescEU remains voluntary and intergovernmental, and may be encumbered by actual export bans. EU solidarity is undermined by hoarding and limitations on supply.

The EU must develop a truly centralised capacity for the procurement of medical countermeasures, to avoid the inefficiencies of the current intergovernmental and voluntary process. Central procurement is now needed for protective devices and will be needed for the COVID-19 vaccine once it becomes available. It will also be needed for *future* infectious diseases. Funding can come from the EU budget or a separate contribution by member states.

With a common stockpile managed at the EU level, inefficient excess demand and excess supply across countries would no longer exist. Because the stockpile would be common and larger than any potential national stockpile, there would be much greater firepower to target outbreaks of infectious diseases as soon as they emerge. Decisions where to target the firepower should be taken at the central level. This would avoid scenarios where some countries engage in self-defeating deviations from the cooperative solution by securing as much of the medicine supply as possible at the expense of other countries.

Our research strongly suggests that citizens are ready for a more central role for the EU. Even among Dutch survey respondents, who are among the most sceptical about expansion of the EU budget, a majority were prepared to pool medicine procurement and share risks at the EU level. EU *citizens* seem more willing than their leaders to accept solidarity arrangements to cope with emergencies.

Editors' note: The views expressed in this column are those of the authors, and do not necessarily represent those of the institutions with which they are affiliated.

References

De Ruijter, A (2019), *EU Health Law & Policy: The Expansion of EU Power in Public Health and Health Care*, Oxford University Press.

European Commission (2019), "Framework Contracts for Pandemic Influenza Vaccines", MEMO28/03/2019,

European Commission (2020a), "Coordinated economic response to the COVID-19 Outbreak", COM(2020) 112 final, Brussels.

European Commission (2020c), "Health Security Committee Summary 11th meeting on Outbreak of Coronavirus disease (COVID-19)".

European Medicines Agency (2011), "Pandemic Report and Lessons Learned. Outcome of the European Medicines Agency's Activities during the 2009 (H1N1) Flu Pandemic".

Council of the European Union (2006), "Council Conclusions on Common Values and Principles in European Union Health Systems", (2006/C 146/01) (O.J. 146/1).

Majone, G (1993), "The European Community between Social Policy and Social Regulation", *Journal of Common Market Studies* 31(2):153-170.

Majone, G (1999), "The Regulatory State and Its Legitimacy Problems", *West European Politics* 22:1-24.

Turner, M (2016), "Vaccine Procurement during an Influenza Pandemic and the Role of Advance Purchase Agreements: Lessons from 2009-H1N1", *Global Public Health* 11(3):322-335.

Endnotes

1 Universal access to (public) health care and medicines entails equal access to a predetermined basket of care.

2 For sure, the EU has developed a capacity in the surveillance and early warning of public health threats. The EU also legislates on health and safety; but the latter 'regulatory role' does not interfere with the forms of (redistributive) solidarity mentioned in the text (cf. Majone, 1993, 1999).

3 See these prohibitions in Article 168 (5) TFEU on public health, and for access to health care Article 168 (7) TFEU.

4 Case C-376/98 Germany v Parliament and Council (Tobacco Advertising) [2000] ECR I-8419.

5 To manage such tension, the Commission created a taskforce, including a role for the Member States, to assess export limitations.

6 For a case study on the regulatory changes as a result of Influenza A H1N1, see De Ruijter (2019).

7 This agreement applies to joint procurement of medicines (antivirals, treatments or vaccines), medical devices (infusion pumps, needles) and 'other services and goods' needed to mitigate or treat cross-border threats to health, such as laboratory tests, diagnostic tools, decontamination products, masks or personal protective equipment.

8 Belgium, Croatia, Cyprus, Estonia, France, Germany, Greece, Ireland, Luxembourg, Malta, the Netherlands, Portugal, Slovakia, Slovenia and Spain have signed framework contracts for the joint procurement of pandemic influenza vaccines with pharmaceutical company Seqirus (March 2019). Member States are also preparing joint procurement procedures for Personal Protective Equipment, see European Commission (2019, 2020b).

9 Council Decision of 24 June 2014 on the Arrangements for the Implementation by the Union of the Solidarity Clause (2014/415/EU) OJ L 192/53.

10 Decision (EU) 2019/420 of the European Parliament and of the Council of 13 March 2019 amending Decision No 1313/2013/EU on a Union Civil Protection Mechanism (OJ L 77I , 20.3.2019, p. 1–15).

11 Par 20. ibid.

Topics: Covid-19 EU policies Europe's nations and regions Health economics Politics and economics

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