Tackling the COVID-19 pandemic: Are the EU's current competences used to their full potential?

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Dit artikel is onderdeel van de debatpagina Coronacrisis: solidariteit in de Europese Unie? Bekijk ook de andere bijdragen.

The COVID-19 pandemic has sparked the debate on strengthening European-level cooperation and solidarity in tackling the disease. The debate has focused on several questions: Given the common threat to public health, is conferral of more competences upon the EU (1) desirable and (2) feasible? As for desirability: Can the EU better achieve the public health goals than Member States can and is there an added value in increasing EU competences? As for feasibility: Can a competence increase be carried out in practice - given the cross-country differences in the organizational and managerial features of national healthcare systems? Healthcare systems are influenced by the underlying normative aspirations, historic legacies, and level of economic development of the given country. They are characterized by a high degree of government intervention and absorb a significant share of public funds, so no wonder this sector is politically sensitive. So concretely, if more powers are to be conferred upon the EU, what exactly should these powers consist of, bearing in mind the principles of subsidiarity and proportionality?

That being said, I suggest refocusing the debate. Rather than arguing whether and how a competence shift could be carried out, I would ask the following: Are the currently existing EU competences used to their full potential to fight the pandemic?

To reflect on this, I will put forward two lines of argument:

1. Existing EU competences in public health are still under-used and there is room for more and better use of the current legal basis for EU action. Although the legal basis stipulated in Article 168 TFEU on public health is narrowly constructed, the EU does have the competence to enhance efforts to support the healthcare workforce and strengthen national healthcare systems' response to the pandemic. Acquiring and distributing medicines, vaccines and protective equipment for healthcare workforce are examples where enhancement of cross-border coordination and solidarity is needed, and the EU has taken similar action in the past. Let us recall the 2009 H1N1 pandemic, when the reluctance of some Member States to share their stockpiled vaccines and antivirals with other countries, have prompted the adoption of a European mechanism for joint procurement of medical countermeasures, vaccines and antivirals to fight future pandemics1. To date, this Joint Procurement Agreement has been signed by 36 countries including all EU Member States.

2. The narrow wording of Article 168 TFEU has not stopped the EU in the past from taking regulatory action in public health. Other, non-health articles of the EU Treaties have been repeatedly used as a legal basis and indeed, the history of EU action in health shows that whenever there is political will, there is a way. Let us recall the use of the internal market clause of the Treaties to enact the directives on tobacco control and on patients' rights in cross-border healthcare. Notably, the latter created the European Reference Networks, which has been used by the European Commission to launch the COVID-19 Clinical Management Support System2 to help the work of clinicians in hospitals. As we could repeatedly witness, the limits drawn to EU competences in the public health article of the Treaties have been circumvented – with the endorsement of the national governments'

representatives in the Council of the EU – whenever the Member States recognized the added value of EU regulatory action. Or, let us recall the creation of the Europe Against Cancer program3 in the 1980s, the very first Europe-wide public health program to which national political will and the commitment of French President Mitterand were instrumental. This program had been launched on the basis of a non-health Treaty article, before the Maastricht Treaty formally incorporated a legal basis for Community action in public health, and it subsequently paved the way for the adoption of binding EU law on tobacco control.

The COVID-19 pandemic has exposed a number of vulnerabilities of healthcare systems in Europe. Individual countries' responses to the pandemic also illustrates that health is about political choices. The question is to what extent the individual Member States are willing to recognize the added value of cooperation and solidarity with other countries. National governments have stringently safeguarded their powers to define public health policy and have drawn limits to EU action in this field. I do not see much political appetite to formally re-draw these limits. I do, however, see the benefits of exploring the possibilities to make more efficient use of the EU's existing public health competences. Unfortunately, COVID-19 will keep haunting us for a while and it is unlikely to be the last pandemic. Despite its devastating effects, it provides an opportunity to learn to better use European-level cooperation and solidarity to improve preparedness for future outbreaks.

Dr Mária Éva Földes is lecturer in EU Law, International and European Law Program & Research group Changing Role of Europe at The Hague University of Applied Sciences

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1. https://ec.europa.eu/health/preparedness_response/joint_procurement_en

2. https://ec.europa.eu/health/ern/covid-19_en

3. http://aei.pitt.edu/5009/1/5009.pdf

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