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EU Response to Fighting the Coronavirus – Coordination, Support, Action – Heeding its Citizens’ Calls?

ANJA NAUMANN

I. Introduction

After the SARS-CoV-2 virus hit Europe in March 2020 and EU Member States started to introduce national measures to address the virus and the illness COVID-19 causes,¹ calls became louder for the EU and its institutions to start taking distinct EU-level action to address the pandemic. EU citizens expressed their views on inter alia European Action taken in response to the pandemic² in an official survey conducted on behalf of the EU Parliament (Parliament Survey).³

Notably with regard to this volume’s focus on democratic relationships, decision-making structures, and respective changes prompted by COVID-19, surveyed citizens expressed that ‘the EU should have more competences to deal with crises such as the Coronavirus pandemic.’⁴ The citizens’ calls for broader EU competences aligned with similar ones from newspapers, who called out the EU’s response as too slow and condemned Member States’ individual approaches as ‘selfish,’ fighting the crisis against, rather than with each other.⁵ It was frequently

¹ For an overview of some of the bigger Member States see S Price, ‘COVID-19 in the EU Member States’ (*Health Europa*, 10 August 2020) www.health.europa.eu/covid-19-in-the-eu-member-states/102019/.

² European Parliament and Kantar, ‘Uncertainty/ EU/Hope – Public Opinion in Times of COVID-19 – Public Opinion Survey’ (2020) 22 et seq www.europarl.europa.eu/at-your-service/files/be-heard/eurobarometer/2020/public_opinion_in_the_eu_in_time_of_coronavirus_crisis/report/en-covid19-survey-report.pdf.

³ European Parliament and Kantar (n 2). The results were published in June 2020. The information was gathered from 23 April to 1 May 2020 from 21,804 respondents in 21 EU Member States.

⁴ 23% strongly agreed and 46% ‘tended to agree’ *ibid* 8, 30 et seq.

⁵ See eg P Müller et al, ‘The EU Struggles for Relevance in the Fight against Coronavirus – DER SPIEGEL – International’ *Der Spiegel* (23 March 2020) www.spiegel.de/international/europe/corona-the-eu-struggles-for-relevance-in-the-fight-against-coronavirus-a-83052f57-ed42-4a69-85fd-61e6795a4d20; J Rankin, ‘Coronavirus Could Be Final Straw for EU, European Experts Warn’ *The Guardian* (1 April 2020) www.theguardian.com/world/2020/apr/01/coronavirus-could-be-final-straw-for-eu-european-experts-warn; SL Greer, ‘Opinion | How Did the E.U. Get the Coronavirus So Wrong?’ *The New York Times* (6 April 2020) www.nytimes.com/2020/04/06/opinion/europe-coronavirus.html.

pointed out from early on in the pandemic that the EU can only address COVID-19 within the boundaries set by its formal competences, which determine the scope of EU action and decision-making.⁶ Nevertheless, arguments that the EU as supra-national organisation was in a prime position to address this health-crisis across EU national borders in a more unified and faster way are hard to ignore. In the Parliament Survey, citizens from every participating Member States stated that the EU's top priority should be to ensure sufficient availability of medical supplies in all Member States.⁷ The second highest priority for the EU should be, in the citizens' view, for the EU to support research to develop a vaccine.⁸ Further, 57 per cent of survey respondents submitted that they were generally unsatisfied with the solidarity shown between Member States.⁹ Scholars similarly argued in favour of Member States transferring more powers to the EU to allow it to be better prepared for future health crises and to assume a more central role in the response to such health crises, eg regarding preventive procurement to build a stockpile of medical supplies before the outbreak of a future public health crisis and the centralised distribution of protective and medical equipment as well as vaccines and medicines.¹⁰

Beyond that and somewhat akin to other, previous crises in which EU action arguably stretched the limits of its competences,¹¹ some scholarship has further suggested that there is scope for the EU to use existing competences and a broad interpretation particularly of the concepts of proportionality and solidarity to take more action to address COVID-19.¹² It argues that this way, it could be possible to regulate eg restrictions of freedom of movement of (medical) goods or border control measures regarding the free movement of people more centrally through the EU, despite the Member States as such having competence in these areas¹³

⁶ See eg N Nielsen, '[Analysis] Coronavirus: What EU Can and Can't Do' (*EUobserver*, 25 March 2020) euobserver.com/coronavirus/147865.

⁷ European Parliament and Kantar (n 2) 8, 33 et seq; three top priorities could be chosen from a list of eight possible answers.

⁸ *ibid.*

⁹ *ibid.*, 21 et seq.

¹⁰ A de Ruijter, 'Give the EU More Power to Fight Epidemics' *POLITICO* (26 March 2020) www.politico.eu/article/coronavirus-eu-power-pandemic/; AM Paces and M Weimer, 'From Diversity to Coordination: A European Approach to Covid19' (2020) 11 *European Journal of Risk Regulation* 292; DG Dimitrakopoulos and G Lalis, 'The European Union's Reaction to the COVID-19 Pandemic – a Preliminary Assessment' (*EUROPP*, 27 March 2020) blogs.lse.ac.uk/europpblog/2020/03/27/the-european-unions-reaction-to-the-covid-19-pandemic-a-preliminary-assessment/; A Renda and R Castro, 'Towards Stronger EU Governance of Health Threats after the COVID-19 Pandemic' (2020) 11 *European Journal of Risk Regulation* 273, 281.

¹¹ Compare eg in relation to the Financial Crisis *Case C-493/17 Proceedings brought by H Weiss and Others* [2018] ECLI:EU:C:2018:1000; but also note *German Federal Constitutional Court, Judgment of the Second Senate of 5 May 2020 – 2 BvR 859/15*.

¹² See Arts 122, 222 TFEU and KP Purnhagen et al, 'More Competences than You Knew? The Web of Health Competence for European Union Action in Response to the COVID-19 Outbreak' (2020) 11 *European Journal of Risk Regulation* 297, 304–06.

¹³ *ibid.*, 304–06, also see Art 36 TFEU; and Regulation (EU) 2016/399 of the European Parliament and of the Council of 9 March 2016 on a Union Code on the rules governing the movement of persons across borders (Schengen Borders Code) OJ L 77/1 2016 Particularly Arts 25 et seq.

and indeed having made use of such competences during the COVID-19 crisis. Such an approach, however, involves a new interpretation of those norms and goes beyond the current understanding expressed in legislative practice or case law.¹⁴ If used, it would remain to be seen whether such an approach would remain unchallenged by the Member States and could find the approval of the EU courts if brought before them. Further, it seems doubtful whether the Member States would ultimately be willing to formalise such an approach in the form of EU competences explicitly sanctioning such broad scope for EU action. In any case, so far, the EU seems to have remained within the acknowledged limits of its competences and no changes in official EU competences have taken place with regard to the EU's powers in a health crisis situation yet.

Since the first calls for more EU action on COVID-19 arose, the EU has taken action in a range of policy areas.¹⁵ It is beyond the scope of this chapter to examine all those measures in detail as to their current and future implications for the decision-making powers or structures in the EU. Some of these instruments, which eg facilitate EU joint procurement and which have been inter alia relied on to procure medical countermeasures¹⁶ in this pandemic, existed before the outbreak of the current pandemic, namely the EU Civil Protection Mechanism strengthened by the 2019 RescEU reserve¹⁷ and the 'Joint Procurement Agreement' for health-threat situations (JPA).¹⁸ Their content and limitations have been extensively discussed in academic literature elsewhere.¹⁹ The main shortcomings pointed out regarding these instruments are that contribution to and participation in these instruments is voluntary for Member States and that their scope is too limited to fully address a crisis such as the current pandemic.²⁰

Instead, in order to examine changes COVID-19 specifically made, or could make, to the EU's decision-making powers in relation to health, this chapter will focus on two instruments which were proposed or adopted specifically in response

¹⁴ Purnhagen et al (n 12) 305.

¹⁵ For an overview see eg European Commission, 'Timeline of EU Action on COVID-19' ec.europa.eu/info/live-work-travel-eu/health/coronavirus-response/timeline-eu-action_en.

¹⁶ Meaning 'any medicines, medical devices, other goods or services that are aimed at combating serious cross-border threats to health', Art 2(a) 'Joint Procurement Agreement to Procure Medical Countermeasures' ec.europa.eu/health/sites/health/files/preparedness_response/docs/jpa_agreement_medicalcountermeasures_en.pdf.

¹⁷ Decision No 1313/2013/EU of the European Parliament and of the Council of 17 December 2013 on a Union Civil Protection Mechanism (OJ L 347/924) 2013; 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 77/1) 2019.

¹⁸ Decision No 1082/2013/EU of the European Parliament and of the Council of 22 October 2013 on serious cross-border threats to health and repealing Decision No 2119/98/EC (OJ L 293/1) 2013; 'Joint Procurement Agreement to Procure Medical Countermeasures' (n 16).

¹⁹ see eg SL Greer and A de Ruijter, 'EU Health Law and Policy in and after the COVID-19 Crisis' (2020) 30 *The European Journal of Public Health* 623; Paccès and Weimer (n 10); A de Ruijter et al, 'EU Solidarity and Policy in Fighting Infectious Diseases: State of Play, Obstacles, Citizen Preferences and Ways Forward' (2020) *Cesifo Working Papers*.

²⁰ Greer and de Ruijter (n 19); Paccès and Weimer (n 10); de Ruijter et al (n 19).

to COVID-19: the proposed EU4Health Programme²¹ and the Emergency Support Instrument (ESI).²² It will draw some parallels to the instruments existing pre- COVID-19 where the Member States' participation in the new instruments indicates a changing stance on more centralised EU action, but will not discuss RescEU and the JPA in detail.

Further, in keeping with this volume's focus on changes of democratic structures and of the relationship between power and people, this chapter will focus on the citizens, whose preferences are, after all, the ones ultimately meant to be represented in the EU,²³ and adopt their opinions on EU action as expressed in the Parliament Survey as framework for its analysis.

While the economic and the health-impacts of COVID-19 are closely intertwined, in keeping with the focus on the EU citizens' main opinions as expressed in the Parliament Survey, this chapter will not examine EU actions which are ultimately not focused on addressing health aspects, such as the measures to address the economic crisis caused by the pandemic.²⁴

The relevant aspects of the Parliament Survey as highlighted above, concerned citizens' views on the EU's competences, its medical supply and vaccine-measures, and health solidarity. The chapter will ask whether the citizens' calls regarding the EU response to COVID-19 are being heeded and how necessary and likely a bigger role for the EU is in light of the EU new instruments directly prompted by COVID-19.

To answer this question, this chapter will first provide a brief overview of the EU's limited current health-competences in section II(A). Section II(B). will then briefly discuss the process of broadening such competences, as endorsed by the EU citizens in the Parliament Survey, and point out the Member States' reasons behind the EU's limited health-competences.

Section III will examine the two new instruments proposed or already used for the procurement of medical supplies and for the support of vaccine-research as part of the EU's COVID-19 response: the proposed EU4Health Programme and particularly the ESI. The section will give a brief overview of the instruments

²¹ European Commission – Proposal for a Regulation of the European Parliament and of the Council on the establishment of a Programme for the Union's action in the field of health – for the period 2021–2027 and repealing Regulation (EU) No 282/2014 ('EU4Health Programme') (COM(2020) 405 final) 2020.

²² Council Regulation (EU) 2020/521 of 14 April 2020 activating the emergency support under Regulation (EU) 2016/369, and amending its provisions taking into account the COVID-19 outbreak [2020] OJ L 117/3 2020 521.

²³ Art 10(1) TEU; shortcomings and issues of democracy at EU level and a 'democratic deficit' of the EU have been extensively discussed, compare eg Giandomenico Majone, 'Europe's "Democratic Deficit": The Question of Standards' (1998) 4 *European Law Journal* 5; A Moravcsik, 'Reassessing Legitimacy in the European Union' (2002) 40 *JCMS: Journal of Common Market Studies* 603; A Follesdal and S Hix, 'Why There Is a Democratic Deficit in the EU: A Response to Majone and Moravcsik' (2006) 44 *JCMS: Journal of Common Market Studies* 533.

²⁴ See eg European Commission, 'Recovery Plan for Europe' ec.europa.eu/info/live-work-travel-eu/health/coronavirus-response/recovery-plan-europe_en.

and will analyse them against the backdrop of the citizens' calls and the Member States' reservations against broader EU competences as described in section II(B). It will also discuss further arguments which particularly the Member States' participation in the ESI could raise to support the introduction of broader EU health-competences to address health crises in the future. Section IV concludes.

II. The EU's Health-Competences – Limits, Changes, and Concerns

A. Limited EU Health-Competences

In terms of competences to adopt legal measures, the EU's explicit health-competences are considered limited.²⁵ The respective Treaty provisions corroborate this impression. Article 4(2)(k) of the Treaty on the Functioning of the European Union (TFEU) sets out that the EU shares competences with the Member States regarding 'common safety concerns in public health matters, for the aspects defined in this Treaty'. Article 6(a) TFEU makes it clear that the EU's role regarding the 'protection and improvement of human health' is limited to measures supporting, coordinating, or supplementing Member States measures. When the EU chooses to act pursuant to these shared competences, it is subject to the principle of subsidiarity²⁶ and must therefore prove that taking action at centralised EU-level provides added value and that 'the objectives of the proposed action cannot be sufficiently achieved by the Member States'.²⁷

Article 168 TFEU elaborates further on the EU's competences and measures on health. It allows for some harmonising EU measures on health within clearly demarcated boundaries. For instance, the EU can set binding minimum quality and safety standards for several substances of human origin, or for medical products and devices, and adopt measures in 'veterinary and phytosanitary fields which have as their direct objective the protection of public health'.²⁸ While the

²⁵ See eg M Guy and W Sauter, 'The History and Scope of EU Health Law and Policy' in TK Hervey, CA Young and LE Bishop (eds), *Research Handbook on EU Health Law and Policy* (Edward Elgar Publishing, 2017) 19; Paces and Weimer (n 10) 286; the possibility for EU health measures based on other than explicit health-competences is generally acknowledged in the literature and the EU's options to take measures impacting health based on other than its explicit health-competences will be explained later in this section.

²⁶ As well as the principle of proportionality, which is, however, less relevant in context of 'power shifts' through changes to the EU's health-competences.

²⁷ Art 5(3) TEU, European Commission, 'Annual Report 2019 on the Application of the Principles of Subsidiarity and Proportionality and on Relations with National Parliaments [2020] COM(2020) 272 Final' 4; Kieran St C Bradley, 'Legislating in the European Union' in C Barnard and S Peers (eds), *European Union Law*, 2nd edn (OUP, 2017) 112.

²⁸ See Art 168(4) TFEU.

EU can also adopt 'incentive measures' regarding a range of health aspects,²⁹ it is important to point out that these are not binding on Member States regarding the specific actions these must adopt.³⁰

Overall, Article 168 TFEU re-affirms that EU action on health should 'complement national policies' and that EU action should facilitate and support cooperation between Member States.³¹ The limited scope for EU action and the focus on the Member States' autonomy regarding health is once again reiterated in Article 168(7) TFEU, which explicitly sets out that the EU must respect the Member States' responsibilities regarding the 'definition of their health policy and for the organisation and delivery of health services and medical care'.

However, the EU does not only affect health through explicit health-measures based on its health-competences. The EU taking measures based on other, broader than explicit health-competences which ultimately have an effect on health could indeed be witnessed even before the introduction of the first explicit health-competences and predecessors of Article 168 TFEU. Examples for the EU including health objectives in other measures early on can eg be found in EU measures which were as such aimed at the integration of the internal market and EU market-related policies, such as inter alia with regard to the health of workers³² or regarding the inclusion of human health concerns in context of agricultural legislation.³³ This use of 'creeping competences'³⁴ to adopt measures having an effect on health was indeed one of the initial reasons for the introduction of explicit health-competences. The Member States hoped that health-competences would provide an explicit, clearly demarcated frame for EU action on health.³⁵

Despite the introduction of clearly demarcated health-competences, EU action affecting health via other competence-bases can still be observed and has been accepted by the CJEU,³⁶ provided that these competences are not merely 'used as a legal basis in order to circumvent the express exclusion of harmonisation laid

²⁹ Art 168(5) TFEU.

³⁰ SL Greer et al, *Everything You Always Wanted to Know about European Union Health Policies but Were Afraid to Ask* (European Observatory on Health Systems and Policies, 2019) 64 at n 7.

³¹ Art 168(1)(2).

³² See eg 'Community Charter of the Fundamental Social Rights of Workers of 9 December 1989' www.eesc.europa.eu/resources/docs/community-charter--en.pdf Article 19 and throughout; European Commission, 'From the Single Act to Maastricht and beyond: The Means to Match Our Ambitions Communication from the Commission (COM(92) 2000)'; J Delors, '1992: A Pivotal Year: Address by Jacques Delors, President of the Commission, to the European Parliament, Strasbourg, 12 February 1992'; also see Guy and Sauter (n 25) 23 et seq.

³³ See eg Council Directive 70/524/EEC of 23 November 1970 concerning additives in feeding-stuffs [1970] OJ L 270/1 1970 particularly Arts 6(2b), 7(1); Regarding the history of EU action on health, including before the introduction of explicit health-competences, see TK Hervey and JV McHale, *European Union Health Law: Themes and Implications* (CUP, 2015) 30 et seq.

³⁴ TK Hervey and JV McHale, 'Community Competence in the Field of Health' in TK Hervey and JV McHale (eds), *Health Law and the European Union* (CUP, 2004) 80.

³⁵ *ibid.*

³⁶ eg Case C-376/98 *Federal Republic of Germany v European Parliament and Council of the European Union* [2000] ECLI:EU:C:2000:544 at [78].

down in [now Article 168 TFEU];³⁷ the aim pursued by the respective measure is still mainly within the subject matter of the non-health-competences relied on, and the impact on health is necessary to achieve the measure's primary, non-health aim.³⁸ In context of COVID-19, it has been argued that the EU can, despite its limited health-competences, take a more active role than is generally perceived because of the possibility and obligation to address health impacts in conjunction with other issues.³⁹ Indeed, section III will examine inter alia the ESI, which is based on Article 122(1) TFEU, aiming at solidarity⁴⁰ and economic support, rather than on explicit health-competences and will show that nevertheless this instrument could support arguments towards the introduction of new EU health-crisis competences.

B. Conferring Health-Competences – Mechanism and Concerns

First, it is important to outline the process of introducing new EU-competences, as well as the Member States' main concerns regarding broader EU action on health. Whether new health-crisis competences would be explicitly rooted in a health, or in another context, the EU's new powers will likely only be adopted if the political process can be successfully navigated and if the Member States' past concerns relating to EU action touching on health-measures can be mitigated.

The EU can only act 'within the limits of the competences conferred upon it by the Member States in the Treaties'.⁴¹ Conveying broader health-competences to the EU therefore requires a Treaty amendment for which unanimous consensus between all 27 EU Member States is required⁴² – something which is not a given considering the current political inner-EU struggles surrounding the EU's financial recovery package and the 2021–27 budget⁴³ or the 'rule of law' proceedings against Hungary and Poland.⁴⁴ Whether the citizens' calls for broader EU

³⁷ *ibid.*, 79.

³⁸ see eg Case 300/89 *Commission of the European Communities v Council of the European Communities* [1991] ECLI:EU:C:1991:244 at [10]; Case C-376/98 *Federal Republic of Germany v European Parliament and Council of the European Union* [2000] ECLI:EU:C:2000:544 (n 36) para 77 et seq.

³⁹ Purnhagen et al (n 12).

⁴⁰ A similar approach focusing on facilitating solidarity can be found in Art 222 TFEU, which is related to the Civil Protection mechanism mentioned above; see 2014/415/EU: Council Decision of 24 June 2014 on the arrangements for the implementation by the Union of the solidarity clause OJ L 192/53 2014; de Ruijter et al (n 19) 6, 13; Purnhagen et al (n 12) 298.

⁴¹ Art 5(2) TEU.

⁴² Art 48 TEU.

⁴³ J Chalmers and G Baczyńska, 'EU Leaders Struggle with "mission Impossible" at Deadlocked Recovery Summit' *Reuters* (20 July 2020) www.reuters.com/article/us-eu-summit-idUSKCN24K094; European Council, 'Special Meeting of the European Council (17, 18, 19, 20 and 21 July 2020) – Conclusions (EUCO 10/20)'.

⁴⁴ See eg Art 7 TEU and European Parliament, 'Press Release – Rule of Law in Poland and Hungary Has Worsened' (16 January 2020) www.europarl.europa.eu/news/en/press-room/20200109IPR69907/rule-of-law-in-poland-and-hungary-has-worsened.

health-crisis competences do indeed lead to such a change depends on the Member States governments' willingness to heed their citizens' calls and on their ability to find political consensus for such a Treaty change among all 27 governments.

As can be seen from the current health-competences set out in Articles 4, 6, and 168 TFEU, the Member States have adopted a restrictive stance regarding the EU's health-competences in the past. Currently, some Member States still demonstrate this cautious stance on the EU's health-competences. For instance, the Czech Republic voiced concerns that the recent proposal for a new EU health programme⁴⁵ did not sufficiently respect the Member States' competences regarding their own healthcare systems.⁴⁶

The internal documents surrounding past Treaty revisions involving health-competences are not available to the public.⁴⁷ Nevertheless, the Member States' interest to keep their autonomy over laws affecting their national social welfare budgets and, accordingly, the shaping and financing of their national healthcare systems has been accepted in the literature as the main reason for the limited scope of the EU health-competences as set out in the Treaties.⁴⁸

Currently, there seems to be no political hunger on part of the Member States' governments for a change in EU health-competences. The political hurdles of extending these competences should not be underestimated. Nevertheless, the next section will argue that certain aspects of the EU's response to COVID-19 seem to alleviate some of the Member States' concerns regarding health-competences or shed a new light on the question of EU health-competences and might after all facilitate the debate in favour of broader health-competences in the nearer future.

III. The EU4Health Programme and the Emergency Support Instrument – Answering Citizens' Calls and Paving the Way for New EU Competences?

Taking the EU citizens' responses that the availability of medical supplies and research-funding for a COVID-19 vaccine should be the EU's top priorities as frame,

⁴⁵ EU4Health Programme (n 21).

⁴⁶ ES Nicolás, '[Coronavirus] EU Commission Ready to Play Bigger Role in Health Sector' (*EUobserver*, 15 June 2020) euobserver.com/coronavirus/148640 accessed 18 August 2020.

⁴⁷ Hervey and McHale (n 34) 74.

⁴⁸ *ibid.*, 80; M McKee, TK Hervey and AB Gilmore, 'Public Health Policies' in E Mossialos et al (eds), *Health Systems Governance in Europe: The Role of European Union Law and Policy* (CUP, 2010) 237; A de Ruijter, 'A Silent Revolution: The Expansion of EU Power in the Field of Human Health: A Rights-Based Analysis of EU Health Law & Policy' (PhD, University of Amsterdam, 2015) 33; ME Földes, 'Member State Interests and European Union Law' in Marton Varju (ed), *Between Compliance and Particularism: Member State Interests and European Union Law* (Springer International Publishing, 2019); M Guy, 'Towards a European Health Union: What Role for Member States? (First View Version)' (2020) *European Journal of Risk Regulation* 1, 2; B Przywara, 'Projecting Future Health Care Expenditure at European Level: Drivers, Methodology and Main Results' (Directorate-General for Economic and Financial Affairs 2010) 4 et seq.

this section will give an overview of the two instruments proposed or adopted in direct response to COVID-19 and demonstrate that the current approach indeed goes some way to answers the citizens' calls. It will further analyse whether the use of these instruments in response to the pandemic mitigates the Member States' concerns regarding their national health-budgets and, in that, strengthens the case for the introduction of new EU health-crisis competences in the future, eg regarding broader up-front powers for the EU to engage in procurement and distribution of protective equipment, medicines, vaccines, and other supplies, or supporting research. It will show that the scale and use of these instruments indeed support arguments for the introduction of broader EU competences.

From a democratic point of view, it is notable that, while these instruments do not give the EU broader legislative powers, particularly the ESI attributes significant decision-making powers in relation to taking financial measures to the Commission. It serves to note that the members of the Commission are chosen by Member States and appointed,⁴⁹ but that the Commission is the EU institution with arguably the least amount of democratic legitimisation, compared to the Council, consisting of members of the nationally elected governments, or the directly elected EU parliament.⁵⁰ Accordingly, the following sections will also comment on the legitimisation, democratic control, and transparency of the powers these instruments confer to the Commission.

A. The Proposed EU4Health Programme

Joint procurement of medical supplies, as well as investment in vaccine and other relevant research will be possible under the new 'EU4Health' Programme.⁵¹ The EU's role under the EU4Health Programme is to support and coordinate the actions of Member States, in line with the limits of the EU's health-competences and the subsidiarity principle,⁵² and particularly to distribute and manage the budget available under the programme.⁵³ The programme has been proposed by the European Commission and is being discussed in the Council and its preparatory bodies at the time of writing.

It should not be underestimated how significant the existence of this proposal is. There were no plans for a new, fourth specific health-programme before

⁴⁹ Art 17 TEU.

⁵⁰ Arts 14 (2), (3), 16(3) TEU.

⁵¹ eg Recital 10, Arts 8, 10 EU4Health Programme (n 21).

⁵² *ibid.*, 5.

⁵³ Arts 8 et seq EU4Health Programme (n 21); Regulation (EU, Euratom) 2018/1046 of the European Parliament and of the Council of 18 July 2018 on the financial rules applicable to the general budget of the Union, amending Regulations (EU) No 1296/2013, (EU) No 1301/2013, (EU) No 1303/2013, (EU) No 1304/2013, (EU) No 1309/2013, (EU) No 1316/2013, (EU) No 223/2014, (EU) No 283/2014, and Decision No 541/2014/EU and repealing Regulation (EU, Euratom) No 966/2012 (OJ L 193/1) 2018.

COVID-19. Rather, health was to form a part of the new ESF+ programme,⁵⁴ which merged several social, employment, and aid funding programmes.⁵⁵ After having previously adopted three dedicated consecutive health programmes,⁵⁶ the inclusion of health in the ESF+ could only be seen as a step back for the EU's role regarding health. This step back will now be reversed by giving health its own EU programme after all and providing it with a significantly strengthened budget. While health had been allocated 413 million EUR under the ESF+ proposal,⁵⁷ the proposed EU4health programme sets out a budget of 9.4 billion EUR.⁵⁸ The budget had been cut to 5.1 billion EUR by the EU governments, but the Commission has committed early on to funding the remaining amount itself through other avenues.⁵⁹

While not in itself extending the competences of the EU, the EU4health programme demonstrates the Member States'⁶⁰ acknowledgement of the role the EU has to play in health-matters. Furthermore, the significantly increased budget and particularly the EU's willingness to provide a large part of it through the EU budget, could arguably mitigate some of the Member States' concerns regarding their national health budgets, as will be further discussed below.

In the EU4health programme, both transparency mechanisms as well as provisions safeguarding Member States representation are in place. According to Article 16(4) of the Regulation, the Commission must annually inform the Parliament of the work programme and priorities it intends to adopt. It must further seek the views of relevant stakeholders when drawing up its annual work programmes in which it determines the priorities for the funding provided under the EU4Health programme.

The programme ensures the involvement of the Member States through a Steering Group, consisting of the Commission and representatives appointed by the Member States.⁶¹ This Steering Group is asked to consult on the EU's planned work programmes and the priorities pursued therein. The programme further entails the EU Commission being assisted by a dedicated Committee, comprising

⁵⁴ EU4Health Programme (n 21) 7; Proposal for a Regulation of the European Parliament and of the Council on the European Social Fund Plus (ESF+) (COM(2018) 382 final) 2018, part III, chapter II; Annex III.

⁵⁵ Explanatory Memorandum p. 1 EU4Health Programme (n 21).

⁵⁶ Decision No 1786/2002/EC; Decision No 1350/2007/EC; Regulation (EU) No 282/2014.

⁵⁷ ESF+ Proposal p 12.

⁵⁸ Art 5 EU4Health Programme (n 21).

⁵⁹ European Parliament, 'Press Release – Compromise on Long-Term EU Budget' (10 November 2020) www.europarl.europa.eu/news/en/press-room/20201106IPR91014/compromise-on-long-term-eu-budget-ep-obtains-eu16-billion-more-for-key-programmes; G Fortuna, 'Commission Promises to Remedy Health Cuts Made by EU Leaders' (www.euractiv.com, 16 September 2020) www.euractiv.com/section/health-consumers/news/commission-promise-to-remedy-health-cuts-made-by-eu-leaders/; European Commission, 'New EU4Health Programme' ec.europa.eu/commission/presscorner/detail/en/qanda_20_956.

⁶⁰ Represented in the Council of the EU.

⁶¹ Art 16 Proposal for a Regulation of the European Parliament and of the Council on the establishment of a Programme for the Union's action in the field of health for the period 2021–2027 and repealing Regulation (EU) No 282/2014 ('EU4Health Programme') (COM(2020) 405 final) 2020.

representatives of the Member States and of the Commission without whose opinion the Commission may not adopt the respective implementing acts pursuant to the EU4Health programme.⁶² Regarding the democratic legitimisation of the rules and powers set out by the EU4Health programme, one must also note that this Regulation was adopted both by Parliament and Council, both accordingly endorsing the extent of the EU's powers under this programme.

B. The Emergency Support Instrument (ESI)

The pandemic prompted the activation of the ESI for the purpose of addressing COVID-19, as the existing mechanisms mentioned above alone were deemed insufficient to address the financial needs arising to address the COVID-19 pandemic.⁶³ Through the ESI, the EU can engage in a range of measures addressing the pandemic,⁶⁴ inter alia joint procurement of medical supplies, vaccines, and support of vaccine research.⁶⁵ It is based on a 2016 Council Regulation⁶⁶ set up to address disasters within the EU and to strengthen the EU's solidarity response and capacities, as eg the Civil Protection Mechanism was deemed potentially lacking by having to rely on voluntary contributions from Member States.⁶⁷ The ESI operates with a much larger budget than RescEU, with 2.7 billion EUR available through the ESI compared to just 300 million EUR through RescEU capacities.⁶⁸ It applies in parallel to eg RescEU and the JPA and is intended to be complementary to the other EU instruments and the Member States' individual responses.⁶⁹

The ESI is inter alia used for the purpose of support research into vaccines, as was one of the citizens' requests for EU action.⁷⁰ It is further used for securing vaccine doses once a successful vaccine is found.⁷¹ In order to do so, the Commission centrally and on behalf of all Member States enters into so-called 'advanced purchase agreements' (APAs) with vaccine-manufacturers.⁷² Based on these APAs, the EU uses parts of the ESI budget for up-front financing in return

⁶² Art 23 EU4Health Programme (n 21); Recital 6, Art 3(2) Regulation (EU) No 182/2011 of the European Parliament and of the Council of 16 February 2011 laying down the rules and general principles concerning mechanisms for control by Member States of the Commission's exercise of implementing powers OJ L 55/13 2011.

⁶³ Recital 4 ESI.

⁶⁴ *ibid*, Art 3(3).

⁶⁵ *ibid*.

⁶⁶ Council Regulation (EU) 2016/369 of 15 March 2016 on the provision of emergency support within the Union [2016] OJ L 70/1 2016.

⁶⁷ *ibid*, Recital 5.

⁶⁸ European Commission, 'EU Solidarity for Health Initiative' ec.europa.eu/commission/presscorner/detail/en/qanda_20_577.

⁶⁹ Recital 8, Art 3(1) ESI.

⁷⁰ European Parliament and Kantar (n 2) 8, 33 et seq.

⁷¹ Commission Decision of 18.6.2020 approving the agreement with Member States on procuring COVID-19 vaccines on behalf of the Member States and related procedures (C(2020) 4192 final) 2020.

⁷² *ibid*, Recital 3, Article 1(1).

for the right for all EU Member States to purchase a certain amount of dosages and as an advance payment for purchases the Member States might later carry out.⁷³ With this up-front financing, the EU hopes to decrease the risk for vaccine manufacturers and, in this, support and accelerate the development of a successful vaccine.⁷⁴ While there is no formal obligation to join, all EU Member States participate in the APAs.⁷⁵ Under the APA Framework Agreement, the Member States commit not to negotiate unilaterally with the same vaccine manufacturers.⁷⁶ Even though an explicit opt-out option exists and the Member States can still negotiate individually with other manufacturers,⁷⁷ this commitment signifies a difference to the Member States' right to negotiate separately despite joint procurement contracts which form eg part of the JPA.⁷⁸ This arguably mitigates some of the criticism raised in academic literature regarding the voluntary nature of joint public procurement,⁷⁹ at least with regard to the ESI.

From a democratic perspective, it is notable that the ESI and its activation legislation are Council Regulations, with no involvement of the EU Parliament, which is, after all, the EU institution most closely representing all EU citizens.⁸⁰ Article 122 TFEU does provide the Council with the competence to adopt measures in response to Member States experiencing difficulties, particularly vis-à-vis the supply of certain products, as it has done in the ESI and its activation Regulation. Despite this power being conferred explicitly to the Council, the absence of Parliament involvement in the APAs based on the ESI is noteworthy.

With regard to the representation of the Member States' views and their involvement, the ESI and the APAs concluded on its basis do not significantly differ from the EU4Health programme in that a focus is put on involving representatives named by the Member States. The APA Decision provides for a Steering Board to advise and assist the Commission in evaluating the APAs, comprising of representatives of the Commission as well as of each of the participating Member States. Experts from six Member States are further appointed to assist the Commission in negotiating the APAs, though not in a capacity to represent the Member States as such.⁸¹ Nevertheless, it must be noted that the focus of the decision-making

⁷³ Art 2, Annex p 4 Annex to the Commission Decision on approving the agreement with Member States on procuring COVID-19 vaccines on behalf of the Member States and related procedures (C(2020) 4192 final ANNEX) 2020.

⁷⁴ Decision on procuring COVID-19 vaccines (C(2020) 4192 final) Recital 3; Decision on procuring COVID-19 vaccines, Annex – APA Framework Agreement Annex p 4.

⁷⁵ European Commission, 'Draft Amending Budget N°8 to the General Budget 2020 – Increase of Payment Appropriations for the Emergency Support Instrument to Finance the COVID-19 Vaccines Strategy and for the Impact of the Corona Response Investment Initiative Plus (COM(2020) 900 Final)' 3.

⁷⁶ Art 7 Decision on procuring COVID-19 vaccines, Annex – APA Framework Agreement.

⁷⁷ *ibid.*

⁷⁸ Art 1(5) 'Joint Procurement Agreement to Procure Medical Countermeasures' (n 16).

⁷⁹ Compare above.

⁸⁰ Art 14 TEU.

⁸¹ Recital 5, Art 2(1) Decision on procuring COVID-19 vaccines (C(2020) 4192 final); Decision on procuring COVID-19 vaccines, Annex – APA Framework Agreement 3, 4.

powers is given firmly to the Commission which ‘retains exclusive responsibility over the [APA evaluation] process’⁸² and which⁸³ is in charge of the final decision as to which of the APAs should be concluded.⁸⁴

While the focus on the views of the Member States rather than the EU citizens more directly through the Parliament therefore does not seem to be out of the ordinary with regard to research funding and procurement, the lack of transparency safeguards towards Parliament in the ESI, its activation, and the APAs is remarkable.

The ESI and its activation make no mention of duties to report to or inform the EU Parliament. The Annex to the Commission Decision vis-à-vis the centralised procurement of vaccines through the EU requires to inform the Council’s integrated political crisis response (IPCR) at least once every two weeks ‘for full transparency’⁸⁵ but both the Decision as well as the Annex equally do not entail any requirement to inform the Parliament. This has already attracted criticism in practice. Indeed, with regard to the contracts for the procurement of vaccines, the EU Parliament has criticised the Commission for its lack of transparency and clarity.⁸⁶ As will be further discussed below, such shortcomings may to some extent be addressed by the introduction of new, explicit health-crisis competences.

C. A Budding Competence-Change?

The EU has not tired of underlining its role as supporting and coordinating Member States action in these instruments.⁸⁷ Nevertheless, despite the EU’s reassurances, calls for more competences from EU institutions and academics are not abating, but only growing stronger. Commission President von der Leyen explicitly raised the issue of extended EU health-competences and endorsed an EU Health Union in her 2020 State of the Union speech.⁸⁸ Further, President von der Leyen set the issue out as a topic for the Conference on the Future of Europe and announced a Global Health Summit in Italy 2021 convened by the EU Commission.⁸⁹

⁸² Recital 5 Decision on procuring COVID-19 vaccines (C(2020) 4192 final).

⁸³ Albeit assisted by the Steering Board.

⁸⁴ Out of those to which at least four Member States in principle agreed, Decision on procuring COVID-19 vaccines, Annex – APA Framework Agreement 4.

⁸⁵ *Ibid.*

⁸⁶ ‘COVID-19 Vaccinations: More Solidarity and Transparency Needed | News | European Parliament’ (19 January 2021) www.europarl.europa.eu/news/en/headlines/society/20210114STO95642/covid-19-vaccinations-more-solidarity-and-transparency-needed; ‘COVID-19 Vaccines: MEPs Call for More Clarity and Transparency | News | European Parliament’ (12 January 2021) www.europarl.europa.eu/news/en/press-room/20210111IPR95308/covid-19-vaccines-meps-call-for-more-clarity-and-transparency.

⁸⁷ See eg Art 1(2) Health Threats Decision No 1082/2013/EU; Civil Protection Mechanism Decision 1313/2013/EU eg Recitals 1, 14, Art 3(1) and throughout; ‘RescEU’ Decision (EU) 2019/420 Recital 2; European Commission, ‘EU Solidarity for Health Initiative’ (n 68); European Commission, ‘New EU4Health Programme’ (n 59).

⁸⁸ U von der Leyen, ‘State of the Union Address by President von Der Leyen’ ec.europa.eu/commission/presscorner/detail/en/SPEECH_20_1655.

⁸⁹ *Ibid.*

The abovementioned political hurdles needed to bring about the necessary Treaty change aside, there are hints that such a change might be more realistic now, due to the COVID-19-response, than before. Two main aspects of the EU4health programme and the ESI, as well as the Member States' participation in the latter, suggest that a change in the Member States' attitude towards EU health-competences, at least with regard to health crises, might come about due to the current pandemic: (a) in the way in which the crisis has exemplified the need for and advantages of joint action centralised at EU level, and (b) in the involved financial contributions from the EU, mitigating some of the Member States' health-budget concerns.

i. A Stronger Endorsement of Centralised Action and a Bigger Role for the Commission

The sheer possibility of the EU4health programme as a separate health programme can only be seen as an endorsement by the Member States of the important role the EU has to play regarding health. Despite the current budget discussions involving the health programme, the existence of this programme as such has not in itself attracted criticism by the Member States. While the EU must still reassure Member States that the health programme itself does not exceed the EU's competences, the inherent acknowledgement of the necessity and advantages of health action at EU level may well influence future discussions towards the introduction of explicit EU health crisis competences.

The ESI, which has, after all, been joined by all Member States, equally signifies such an endorsement of the central and strengthened role the EU can play in relation to health, particularly with regard to research and procurement. The ESI explicitly points out the 'utmost importance to extend the possibilities for the Commission to purchase supplies or services on behalf of Member States' in its preamble.⁹⁰

While the benefits of joint action, such as a stronger negotiation position, solidarity, risk-sharing, or resource-pooling, were well-known before the COVID-19 pandemic and influenced eg the joint procurement instruments which already existed before COVID-19,⁹¹ the current pandemic has provided an undeniable example which underlines the need for solidarity and joint crisis responses to a yet unprecedented extent. In response to COVID-19, the EU's role has already been strengthened, particularly through the ESI, and its role endorsed by the Member States' participation in the ESI. For instance, the list of possible actions which the EU can support under the ESI is explicitly non-exhaustive,⁹² empowering the EU

⁹⁰ ESI Recital 15.

⁹¹ See eg 'Joint Procurement Agreement to Procure Medical Countermeasures' (n 16) Recital 6; Health Threats Decision No 1082/2013/EU Recital 13; 'RescEU' Decision (EU) 2019/420 Recitals 9, 11, 18.

⁹² Art 3(3) ESI, added Annex to; Council Regulation (EU) 2016/369.

and giving it discretion to choose to support COVID-19-responses beyond those explicitly mentioned.

Further, the ESI allows the EU to engage in procurement as wholesaler to then resell or even donate the procured countermeasures to Member States or other organisations.⁹³ This option is already generally contained in the financial rules on the EU budget in cases where the EU awarded contracts on its own account.⁹⁴ However, the ESI mentions this possibility explicitly in response to COVID-19 and adds the possibility for donation of the procured goods. There is currently no information available whether the Commission has made use of this option. Nevertheless, it arguably provides the opportunity for a much more central role for the EU with more central decision-making powers, eg which Member States it deems in need, as well as whether and to whom it chooses to donate procured goods. There are further examples of the strengthened decision-power and influence the EU has been given regarding public procurement in response to COVID-19 through the ESI. Due to the urgency of the situation, grants under the ESI can be awarded by the Commission without the usual prior call for proposals and under the conditions set out by the Commission itself.⁹⁵ The ESI also allows the Commission to modify existing contracts or framework contracts without a separate procurement procedure, as well as for several derogations from the JPA, the Civil Protection Mechanism, and the respective Regulation on the financial budget rules.⁹⁶

The Member States' acceptance of a stronger, more central role for the EU also becomes clear in light of the ESI-mechanism to fund and procure vaccines.

Once the EU approach to joint vaccine development and procurement had been adopted, the Member States gave up more individual approaches to vaccine procurement, eg by France, Germany, the Netherlands and Italy, who had formed the 'Inclusive Vaccine Alliance'.⁹⁷ Instead they asked the Commission to take on contracts they had already concluded for a broader, joint European response.⁹⁸ Joining the ESI and the APA Framework Agreement, the Member States further accepted the need for a strong, united approach and accepted that the option to bilaterally negotiate in addition to joint procurement, as forms part of the JPA,⁹⁹

⁹³ Art 4 ESI.

⁹⁴ Regulation (EU, Euratom) 2018/1046 Annex I, Section 32.1.(a).

⁹⁵ ESI Recital 20; 'Commission Decision of 24.4.2020 on the Financing of Emergency Support under Council Regulation (EU) 2016/369 (C(2020) 2794 Final)' Recital 3, Art 5; 'Annex to the Commission Decision on the Financing of Emergency Support under Council Regulation (EU) 2016/369 (C(2020) 2794 Final ANNEX)', point 1; also see Arts 195, 197 Regulation (EU, Euratom) 2018/1046.

⁹⁶ Art 4 ESI; also see Art 172 Regulation (EU, Euratom) 2018/1046.

⁹⁷ Y Natsis, 'Getting It Right: COVID19 Vaccines Procurement – EPHA' (*European Public Health Alliance*) epha.org/getting-it-right-covid19-vaccines-procurement; Nicolás (n 46).

⁹⁸ European Commission, 'Communication from the Commission to the European Parliament, the European Council and the European Investment Bank – EU Strategy for COVID-19 Vaccines (COM/2020/245 Final)' 3; J Bauomy, 'Once a COVID-19 Vaccine Is Found, What Happens Next?' *euronews* (1 August 2020) www.euronews.com/2020/08/01/once-a-covid-19-vaccine-is-found-what-happens-next. Note, however, that Member States are still free to negotiate with vaccine-manufacturers not part of the EU's joint approach.

⁹⁹ See above.

is excluded under the ESI. This endorsement of joint actions should arguably address subsidiarity concerns or potential Member States' doubts as to the need for centralised EU action in this regard.

ii. Financial Contributions from the EU Budget

With regard to the potential introduction of new, broader EU health crisis competences, one should recall the reasons behind the Member States' decidedly cautious stance on EU health-competences, ie their aim to retain control of their national healthcare-related budgets and spending.¹⁰⁰

The current EU measures touching on the health-emergency response do not negatively impact, but rather even support the national healthcare budgets.

Through the ESI and, once adopted, the EU4health-Programme, the EU is not only able to engage in further public procurement, but as pointed out above is also willing to rely to a significant degree on its own budget to do so. Through joint procurement of medical countermeasures, the negotiation and purchasing position of the Commission acting on behalf of Member States is strengthened vis-à-vis the respective manufacturers. This is sought to facilitate the procurement of the countermeasures at more favourable terms and prices,¹⁰¹ which can ultimately positively affect how much money the Member States have to direct at the purchase of the countermeasures from their national budgets. Further, the EU's financial contributions as part of the vaccine APAs in part function as advance payment for potential later purchases by the Member States, explicitly reducing the financial burden of the Member States if they enter into a purchase agreement.¹⁰² At the same time, this measure leaves the Member States' regular healthcare spending untouched.

It is important to remember that these arguments arise primarily in context of a health-crisis. The EU citizens explicitly endorsed health-crisis competences,¹⁰³ even though this is the case because of the way the respective statement in the Parliament Survey was pre-formulated.

New competences would likely only concern a limited and, (hopefully) infrequent occurrence. They would therefore likely only apply to strictly limited situations, complementing and supporting the Member States' exercise of their regular, national health-competences.¹⁰⁴ If such new, explicit health-crisis competences were tied to a reliance on the EU budget rather than impacting the national ones, one could argue that the Member States' main concern regarding

¹⁰⁰ See above at n 32.

¹⁰¹ 'Joint Procurement Agreement to Procure Medical Countermeasures' (n 16) Recital 6; Health Threats Decision No 1082/2013/EU Recital 13; 'RescEU' Decision (EU) 2019/420 Recital 18.

¹⁰² Article 2, Annex p 4 Decision on procuring COVID-19 vaccines, Annex – APA Framework Agreement.

¹⁰³ European Parliament and Kantar (n 2) 8, 30 et seq.

¹⁰⁴ Also compare Paces and Weimer (n 10) 292.

health-competences seems to be alleviated and that, in conjunction with the proven need for central EU action, new competences should be introduced.

iii. The Case for Explicit Competences – Boundaries, Speed, and Solidarity

The previous sections have shown that the citizens' calls seem to have been answered to a large extent by using existing competences and instruments. In light of this and despite the Member States' endorsement of a stronger role for the EU in a health-crisis and the mitigation of their health-budget concerns, is the introduction of new, broader EU health-crisis competences, as the citizens demanded, even necessary? There are three main reasons for the Member States to do so: setting informed boundaries for EU action, facilitating a faster response in future crises, and decisively addressing criticism as to the lack of solidarity between EU Member States.

With regard to the advantage of explicit competences as setting boundaries, it serves to recall one of the reasons behind the initial introduction of explicit health-competences in the Treaties, the issue of 'creeping competences'.¹⁰⁵ The Member States sought to provide an explicit frame and explicit boundaries to EU action on health taking place based on other legal norms.

While EU action impacting health based on other competences is still happening, as eg the ESI shows, some of these instruments are very broadly phrased and, in theory, allow for an even more central role than the EU has currently taken on under this pandemic.¹⁰⁶ The ESI itself is time-limited. However, its use is likely to prove instructive to which extent EU-led action truly is useful and necessary in response to a major health-crisis.

Consolidating the broader EU decision-making powers, which prove useful based on the current use of the ESI in the form of official competences, could facilitate EU measures towards preparing for a future health crisis or even towards extending such preparatory measures to the yearly flu-epidemics – measures which of course cannot be based on a strictly time-limited instrument. At the same time, explicit competences would allow the Member States to set evidence-based boundaries. Drawing from the experiences with the COVID-19 instruments discussed in this chapter, explicit competences could limit EU action to only where it has indeed proven necessary and useful, but also prevent EU action from going beyond this on the basis of emergency instruments. This does not preclude the option to retain emergency mechanisms such as the ones relied on in the current pandemic to allow flexibility where health crisis competences prove insufficient in the future.

¹⁰⁵ Hervey and McHale (n 34) 80, compare section II(B) above.

¹⁰⁶ See section III(C)(i).

Related to the advantage of allowing more extensive, evidence-based preparation for a potential future health crisis, adopting a fixed set of official health-crisis competences further has the advantage of facilitating timely EU-action, skipping the need for bureaucratic procedures necessary to eg activate and amend the ESI only after some time has passed and the explicit needs of EU-action have become clear. In a crisis situation, time is of the essence and the EU's initial lack of possibility to engage in procurement as a matter of urgency rightfully drew criticism.¹⁰⁷ Such criticism could be relieved by new crisis-competences informed by the COVID-19 experience, which could allow more immediate and to some extent preventive procurement and measures.

With regard to the time sensitivity of crisis responses, introducing eg EU competences allowing the strategic stockpiling of medical countermeasures in preparation for possible future health crises further allows the introduction of transparency mechanisms and further democratic safeguards.

While the current response for the most part seems to achieve its aims, as raised above, criticism has arisen particularly from members of the EU parliament regarding a lack of transparency in the Commission's decision-making, particularly with regard to the details of the contracts with vaccine manufacturers, the Commission concluded.¹⁰⁸ The Commission has published, partially redacted, some of its vaccine contracts, but had initially been reluctant to do so. Introducing clearer, more explicit competences regarding the procurement of eg vaccines or other medical countermeasures could allow binding transparency safeguards to be put into writing while also enhancing the preparedness of the EU. Further, providing the EU with central powers of procurement and distribution of medical supplies in times of crisis allows the integration of democratic safeguards akin to or going beyond those relied on in the EU4Health Programme or the ESI,¹⁰⁹ such as supervisory or comitology procedures under which the Commission's procurement decisions can be reviewed and approved by the Council or committees consisting of representatives of the Member States.¹¹⁰ Such safeguards are likely to further alleviate Member States' concerns regarding their representation in health matters. Further, conferring explicit competences on the EU allows the procedures and structures for such safeguards to be in place, facilitating a swifter decision-making process to accommodate the time-sensitivity of a crisis situation.

With regard to building a pre-emptive stockpile of medical supplies, similar or even stronger democratic safeguards could be built into the respective processes. Introducing explicit competences in this regard with the respective transparency and democratic safeguards included, similar or going beyond those contained in the EU4Health programme, and regarding Member States representation, the

¹⁰⁷ de Ruijter et al (n 19) 14.

¹⁰⁸ See eg 'COVID-19 Vaccines: MEPs Call for More Clarity and Transparency | News | European Parliament' (n 86).

¹⁰⁹ Compare sections III(A) and (B) above.

¹¹⁰ Compare C Barnard and S Peers (eds), *European Union Law*, 2nd edn (OUP, 2017) 130.

ESI could contribute to better preparedness for future crises without decisively compromising the Member States' or other bodies representing the EU's citizens' influence on the process.

Lastly, introducing explicit health crisis competences has the power to send an important political signal to EU citizens regarding the solidarity between Member States, which citizens had criticised.¹¹¹ Permanent health crisis competences for the EU, inspired by the current EU-action based on the principle of solidarity,¹¹² could rely on the EU as the 'facilitator' of solidarity between Member States and underline their fundamental willingness to act together and for each other through the EU in times of crisis. Pre-empting the EU having to fall back on the solidarity-competence once a crisis has hit, perhaps partly for lack of other ways to address an ongoing crisis at EU level, but instead setting out concrete competences inspired by the experience of the current health crisis and the response based on solidarity, can send an important political signal of forward thinking solidarity between EU Member States.

IV. Conclusion

Returning to the citizens whose views on EU action in response to the COVID-19 pandemic framed this chapter: have their calls been answered? If not, will they in the future?

Starting from the limited EU health-competences and the Member States' cautious stance on EU action regarding health, the chapter has shown that vis-à-vis the more concrete priorities the citizens endorsed, EU involvement in the procurement of medical equipment and EU funding for vaccine research,¹¹³ the EU uses what health, but also what non-health-competences and instruments it has to support the Member States' actions in the COVID-19 pandemic. Indeed, the EU has taken on a central, albeit not exclusive, role both in the actual procurement as well as in the funding of medical countermeasures and vaccine-research. EU action seems, for the most part, to have made a significant contribution to the attainment of these two citizen-priorities.

This chapter has shown that the Member States' participation in and acceptance of the EU as a central actor via these instruments and of the use of the EU budget in response to the COVID-19 crisis already illustrates a bigger endorsement of a more centralised role for the EU regarding health crises, which strengthens the case for more extensive health crisis competences in the future. Further, this chapter has argued that, despite the historically cautious stance of the Member States towards EU health-competences, the extent to which the EU is willing

¹¹¹ European Parliament and Kantar (n 2) 21 et seq.

¹¹² The activation of the ESI based on Art 122(1) TFEU, compare above.

¹¹³ European Parliament and Kantar (n 2) 8, 33 et seq.

to mobilise its own budget to financially contribute to the pandemic-response could significantly alleviate Member States' concerns that broader EU health-competences might negatively impact their authority vis-à-vis their national health budgets, if those competences are tied to contributions from the EU budget.

Lastly, the chapter has argued that, despite the current instruments' positive impact towards addressing the COVID-19 pandemic, there are good reasons for Member States to consolidate the more influential role the EU has taken on during this pandemic in the form of concrete health crisis competences in the Treaties to enhance preparedness as well as to allow for a faster response during future crises, while also establishing transparency and democratic safeguards.

One must hope that at a later stage in the pandemic, or after it has successfully been overcome, a detailed review of the action taken, both with regard to more immediate health measures as well as other aspects of EU action, such as a centralised management of free movement restrictions and controls,¹¹⁴ will be carried out. Such a review will certainly be instructive and essential for an evidence-based future debate on the need for and advantages of centralised EU action in response to major health crises. However, to rely on extensive, robust evidence, this should be reserved for a later stage of the pandemic.

This pandemic has brought a lot of uncertainty in many regards, but what can be said with certainty is that with the upcoming Conference on the Future of Europe and a 2021 Global Health Summit, the COVID-19 pandemic has undoubtedly given calls for more EU health-crisis competences more teeth and we may see a transfer of health decision-making powers from the Member States to the EU yet.

¹¹⁴ Compare eg Purnhagen et al (n 12) 201 et seq; Paccès and Weimer (n 10) throughout; de Ruijter et al (n 19) 14 et seq and throughout.