Edinburgh Research Explorer

# The European Union confronts COVID-19

**Citation for published version:**
Brooks, E, de Ruijter, A & Greer, SL 2021, The European Union confronts COVID-19: Another European rescue of the nation-state? in SL Greer, EJ King, EM da Fonseca & A Peralta-Santos (eds), *Coronavirus Politics: The politics and policy of COVID-19.* University of Michigan Press, pp. 235-248. https://doi.org/10.3998/mpub.11927713

**Digital Object Identifier (DOI):**
10.3998/mpub.11927713

**Link:**
Link to publication record in Edinburgh Research Explorer

**Document Version:**
Publisher's PDF, also known as Version of record

**Published In:**
Coronavirus Politics

**General rights**
Copyright for the publications made accessible via the Edinburgh Research Explorer is retained by the author(s) and / or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights.

**Take down policy**
The University of Edinburgh has made every reasonable effort to ensure that Edinburgh Research Explorer content complies with UK legislation. If you believe that the public display of this file breaches copyright please contact openaccess@ed.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.

Download date: 30. Jun. 2022

# Coronavirus Politics

## The Comparative Politics and Policy of COVID-19

EDITED BY

Scott L. Greer, Elizabeth J. King,
Elize Massard da Fonseca, and André Peralta-Santos

Greer, Scott L. *Coronavirus Politics: The Comparative Politics and Policy of COVID-19.*
E-book, Ann Arbor, MI: University of Michigan Press, 2021, https://doi.org/10.3998/mpub.11927713.

# CORONAVIRUS POLITICS

# CORONAVIRUS POLITICS

## The Comparative Politics and Policy of COVID-19

*Scott L. Greer,*
*Elizabeth J. King,*
*Elize Massard da Fonseca,*
*and André Peralta-Santos,*
Editors

UNIVERSITY OF MICHIGAN PRESS
ANN ARBOR

Copyright © 2021 by Scott L. Greer, Elizabeth J. King, Elize Massard da Fonseca,
and André Peralta-Santos
Some rights reserved

This work is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License. Note to users: A Creative Commons license is only valid when it is applied by the person or entity that holds rights to the licensed work. Works may contain components (e.g., photographs, illustrations, or quotations) to which the rightsholder in the work cannot apply the license. It is ultimately your responsibility to independently evaluate the copyright status of any work or component part of a work you use, in light of your intended use.
To view a copy of this license, visit http://creativecommons.org/licenses/by-nc/4.0/

For questions or permissions, please contact um.press.perms@umich.edu

Published in the United States of America by the
University of Michigan Press
Manufactured in the United States of America
Printed on acid-free paper
First published April 2021

A CIP catalog record for this book is available from the British Library.

*Library of Congress Cataloging-in-Publication data has been applied for.*

ISBN 978-0-472-03862-6 (paper : alk. paper)
ISBN 978-0-472-90246-0 (OA)

https://doi.org/10.3998/mpub.11927713

We would like to thank the International Institute of the University of Michigan for its generous support in making Open Access publication possible.

# Contents

**PART I**

**1** Introduction: Explaining Pandemic Response
*Scott L. Greer, Elizabeth J. King,*
*and Elize Massard da Fonseca* 3

**2** Playing Politics: The World Health Organization's Response to COVID-19
*Matthew M. Kavanagh, Renu Singh,*
*and Mara Pillinger* 34

**3** State Responses to the COVID-19 Pandemic: Governance, Surveillance, Coercion, and Social Policy
*Holly Jarman* 51

**PART II ASIA**

**4** China's Leninist Response to COVID-19: From Information Repression to Total Mobilization
*Victor C. Shih* 67

**5** Public Policy and Learning from SARS: Explaining COVID-19 in Hong Kong
*John P. Burns* 86

**6** Institutions Matter in Fighting COVID-19: Public Health, Social Policies, and the Control Tower in South Korea
*June Park* 105

**7** Unified, Preventive, Low-cost Government Response to COVID-19 in Việt Nam
*Emma Willoughby* 127

**8** Fighting COVID-19 in Japan: A Success Story?
*Takashi Nagata, Akihito Hagihara, Alan Kawarai Lefor,*
*Ryozo Matsuda, and Monika Steffen* 146

**9** Singapore's Response to COVID-19: An Explosion of Cases despite Being a "Gold Standard"
*Rebecca Wai* 163

**10** India's Response to COVID-19
*Minakshi Raj* 178

**11** COVID-19 Response in Central Asia: A Cautionary Tale
*Pauline Jones and Elizabeth J. King* 196

## PART III EUROPE

**12** COVID-19 in the United Kingdom: How Austerity and a Loss of State Capacity Undermined the Crisis Response
*Gemma A. Williams, Selina Rajan, and Jonathan D. Cylus* 215

**13** The European Union Confronts COVID-19: Another European Rescue of the Nation-state?
*Eleanor Brooks, Anniek de Ruijter, and Scott L. Greer* 235

**14** Denmark's Response to COVID-19: A Participatory Approach to Policy Innovation
*Darius Ornston* 249

**15** France's Multidimensional COVID-19 Response: Ad Hoc Committees and the Sidelining of Public Health Agencies
*Sarah D. Rozenblum* 264

**16** Political Resonance in Austria's Coronavirus Crisis Management
*Margitta Mätzke* 280

**17** Three Approaches to Handling the COVID Crisis in Federal Countries: Germany, Austria, and Switzerland
*Thomas Czypionka and Miriam Reiss* 295

**18** Italy's Response to COVID-19
*Michelle Falkenbach and Manuela Caiani* 320

**19** Spain's Response to COVID-19
*Kenneth A. Dubin* 339

**20** A Tale of Two Pandemics in Three Countries: Portugal, Spain, and Italy
*André Peralta-Santos, Luis Saboga-Nunes, and Pedro C. Magalhães* 361

**21** Greece at the Time of COVID-19: Caught between Scylla and Charybdis
*Elena Petelos, Dimitra Lingri, and Christos Lionis* 378

**22** COVID-19 in Turkey: Public Health Centralism
*Saime Özçürümez* 393

**23** COVID-19 in Central and Eastern Europe: Focus on Czechia, Hungary, and Bulgaria
*Olga Löblová, Julia Rone, and Endre Borbáth* 413

**24** COVID-19 in the Russian Federation: Government Control during the Epidemic
*Elizabeth J. King and Victoria I. Dudina* 436

**PART IV AMERICAS**

**25** The Politics and Policy of Canada's COVID-19 Response
*Patrick Fafard, Adèle Cassola, Margaret MacAulay, and Michèle Palkovits* 459

**26** Anatomy of a Failure: COVID-19 in the United States
*Phillip M. Singer, Charley E. Willison, N'dea Moore-Petinak, and Scott L. Greer* 478

**27** COVID-19 in Brazil: Presidential Denialism and the Subnational Government's Response
*Elize Massard da Fonseca, Nicoli Nattrass, Luísa Bolaffi Arantes, and Francisco Inácio Bastos* 494

**28** Colombia's Response to COVID-19: Pragmatic Command, Social Contention, and Political Challenges
*Claudia Acosta, Mónica Uribe-Gómez, and Durfari Velandia-Naranjo* 511

**29** The Politics of the COVID-19 Pandemic Response in Chile
*Claudio A. Méndez* 522

**PART V AFRICA**

**30** Pandemic amid Political Crisis: Malawi's Experience with and Response to COVID-19
*Kim Yi Dionne, Boniface Dulani, and Sara E. Fischer* 541

**31** Adapting COVID-19 Containment in Africa: Lessons from Tanzania
*Thespina (Nina) Yamanis, Ruth Carlitz, and Henry A. Mollel* 560

**32** Confronting Legacies and Charting a New Course? The Politics of Coronavirus Response in South Africa
*Joseph Harris* 580

**33** Comparative Analysis of COVID-19 Transmission and Mortality in Select African Countries
*Kanayo K. Ogujiuba and Uviwe Binase* 600

**34** Conclusion
*Scott L. Greer, Elize Massard da Fonesca, and Elizabeth J. King* 615

Contributors 639
Index 651

Digital materials related to this title can be found on the Fulcrum platform via the following citable URL https://doi.org/10.3998/mpub.11927713

# 13 THE EUROPEAN UNION CONFRONTS COVID-19

## Another European Rescue of the Nation-State?

*Eleanor Brooks, Anniek de Ruijter, and Scott L. Greer*

The politics of European Union (EU) health policy are also the politics of European integration. Debate about EU policies always entails debate about the appropriate role and powers granted to the EU. We ask what policy a member state might make, but, in the case of the EU, many ask if the EU should have a policy at all. Should it respond, and, if so, how and to whose benefit?

From some angles, the EU looks more like a federation, comparable to the United States or Germany. The EU is deeply entrenched in its citizens' lives. It has a powerful shared culture among leaders and strong, entrepreneurial, and state-like political institutions. Its legal system is entwined with member state law to such an extent that member state courts have driven legal integration and change as much as EU institutions, both in general (Alter, 1998; Mattli & Slaughter, 1998) and in health (Brooks, 2012; Greer & Rauscher, 2011a; Greer & Rauscher, 2011b; Obermaier, 2008, 2009).

From another angle, it still looks like an international organization, comparable to the World Health Organization (WHO) or a regional trade block such as the Association of Southeast Asian Nations or Mercosur. Like international organizations or confederations, though, the EU responds primarily to and is shaped by the demands of its member states. They have actively maintained this dichotomous structure so as to prevent transfer of power and loss of sovereignty. Member states ultimately determine the direction of the EU, and they have supported EU expansion only when they require a "European rescue of the nation state"—an opportunity to use the EU to solve problems they share (Milward, 1999). The EU's weak public health and social policy responses to the crisis reflect this effort on the part of member states to limit its role over the decades, whereas the major expansion in its role over the summer of 2020 reflects the perceived interests of member states, which now seek another European rescue of the nation state.

The roots of the EU's split personality can be found in its evolution as a market-building, economic community. It was built, historically, around the development of its internal market and supporting legal system, maintaining only a small staff, nonexistent coercive capacity, and a minimal budget. It began as a set of small treaty-based organizations, with the first focused on the regulation of the production

Greer, Scott L. *Coronavirus Politics: The Comparative Politics and Policy of COVID-19.*
E-book, Ann Arbor, MI: University of Michigan Press, 2021, https://doi.org/10.3998/mpub.11927713.

and labor markets for coal and steel. Over time a market for nuclear power was formed, and then a much broader, economic community. The latter was based on a common market, with a central Common Agricultural Policy, and the background idea, after World War II, that Europe would never be hungry again.

Although efforts at political and social union have consistently followed along, the EU has developed, first and foremost, as an economic union, and for most member states the monetary union is also an important add-on to this membership. By contrast to the Weberian concept of the state, whose key characteristics are territory and coercion, this makes the EU primarily a "law-state" (Kelemen, 2019; Pavone & Kelemen, 2019; Strayer, 1970). Its main tool is deregulation and reregulation: actions to eliminate member state rules that might be discriminatory, and to create new, European rules that establish a floor for the relevant provisions (Majone, 1996). In this, it has developed much stronger powers over its member governments' regulations than comparable federations possess. For example, EU regulation of the recognition of medical professional qualifications is much stronger than the equivalent regimes in Australia, Canada, or the United States (Matthijs et al., 2019). Once the regulation is established, national courts, for the purpose of enforcement of EU law, become "European courts." EU law can create direct rights and obligations for EU citizens (i.e., it has a direct effect), and EU law has supremacy over national rules. This is to ensure that EU law is applied similarly in all member states. Explicit defiance in one national court or by a member state would undercut the effectiveness of EU law, whether from the German constitutional court or Hungary's authoritarian regime, and thus poses a serious threat to the EU's existence.

This regulatory logic has expanded beyond the internal market to the EU's management of its unbalanced currency union. Rather than commit to serious redistribution between countries or citizens, as federations do, member states historically opted for harsher and harsher regulation of each other's fiscal policies, setting limits on debt and deficit, threatening sanctions where these are breached, and imposing conditions until a breach is remedied. This approach has created a structural north-south divergence because the Eurozone—the group of states that uses the euro as its currency—locks all of its member states into their trajectories and offers debtor states no way out, save for massive reductions in wages and investment (Hancké, 2013; Johnston, 2016). Many of the EU's internal tensions spring from this combination of weak redistribution, intense regulation, and an imbalanced currency union (Greer, 2020; Pérez, 2019). Those tensions appear likely to become more acute over time, creating more disparities, internal migration, and incentives for authoritarianism among peripheral governments that could not please their citizens.

## European Union Public Health Policy Response

The EU policies in place on the eve of the COVID-19 crisis were governed by this basic, largely regulatory, structure (Greer & Kurzer, 2013; Greer et al., 2019).

Member states had limited the EU's public health policies and its disaster response role to, for the most part, that of an international organization (Treaty on the Functioning of the European Union, TFEU, Article 168). A small coordinating system, much of which was created in the aftermath of previous crises, included a health emergencies unit in the European Commission (although with no specific budget), a Health Security Committee of member state representatives, a joint purchasing scheme (de Ruijter, 2019), and a small European Centre for Disease Control and Prevention (Deruelle, 2016, 2020; Greer, 2012; Guigner, 2007). The elements of this public health system that were hosted by the EU enjoyed minimal resources, little recourse to coercion and limited scope, whereas the intergovernmental elements (namely the joint procurement mechanism) had greater potential but remained little more than a slow and voluntary buyer's club.

The civil protection system for disaster response, meanwhile, began to develop some effective mechanisms for addressing disasters within the EU. Built largely within the context of contributions to international disaster relief efforts, it had been more deeply institutionalized in 2019 with the addition of RescEU, a co-financed stockpile system holding resources such as firefighting equipment. However, this is primarily a matchmaking system. Rather than controlling resources, it maintains a list of member state resources that can be made available and would then pair these with requests for assistance from other states (e.g., deploying listed search-and-rescue teams to member states that had suffered earthquakes). It depends largely upon member state solidarity and does not function well where many states are suffering the same problems at the same time.

In sum, although the EU entered COVID-19 better prepared to coordinate than it had been when it faced the last pandemic, H1N1 influenza in 2009, its capabilities remained limited to below-the-surface activity and were secondary to national government responses. The EU's explicit health policies had, over the years, exercised an increasing normative influence on technical issues such as epidemiological case definition but the more important policies, and those where the EU exerted more state-like powers, were rooted in the law of the internal market. These exist in areas such as health workforce mobility, the integrated market in pharmaceuticals and medical devices, and cross-border consumption of health care, where health policy is made under the guise of facilitating the market's functioning. Although the EU's internal market law is less directly concerned with health, less immediately relevant to disaster relief, and has not positioned the EU to lead the public health response to COVID-19 (Hervey & McHale, 2015; Hervey et al., 2017), it was this set of powers that enabled the EU to step in and take a more forceful role as the coronavirus pandemic unfolded.

For the first few months of the COVID-19 crisis, March and April 2020 in particular, observers of the EU despaired, and most people justifiably paid the EU little attention. Member states had successfully ensured that it would not play a leadership role in a major health emergency, and it did not. The first responses of the member states showed that they, and their populations, expected national governments to play the leading role. This involved not only a failure to coordinate, or even to identify a shared agenda between member states, but also flamboyant exercises in national egotism. Border closures and bans on the export of key medical supplies to other EU member states were moves that attacked the core principles of European integration and the value of solidarity meant to underpin the project.

But although the EU as an international organization was forced to work below the radar, these market-distorting actions enabled the EU as a law-state to intervene. Under threat of infringement proceedings from the European Commission, border closures within the EU soon came to be accepted as pragmatic and temporary, and interference with trade in goods—the export bans—quickly began to be lifted. Member states could try to invoke the "public health" exception to EU law enumerated in Article 36 TFEU, but the Commission, in a stroke, redefined public health and transformed it from a member state justification for an exception, to an EU-level principle. To be permitted, export bans would have to show a contribution to EU-wide public health, and not just national public health, which they almost certainly would not be able to do. Thus, the result of the brief burst of national egotism was not decomposition but rather a redefinition of public health in EU law. If the Commission's redefinition sticks, public health will cease to be a member state-level exception and instead become a warrant for positive EU action (de Ruijter et al., 2020; Purnhagen et al., 2020).

The speed with which member states undid their export bans and started to coordinate their restrictions on travel suggested a realization of shared interest. In the same vein, and with the internal market defended, member state leaders soon turned to the EU to rescue them more broadly. They reactivated and reinforced RescEU, creating EU stockpiles of materials that could be shared with member states as needs arose—an achievement in itself given the global scarcity of resources relevant to handling COVID-19. RescEU is fully centralized (overseen by the Directorate General for Civil Protection) and can work with as few as one member state (to co-finance and house the given stockpile). The EU also began to activate its facilities for joint procurement. The Joint Procurement Agreement (JPA) was established in 2014 as part of the 2013 Health Threats Decision and provides for the collective purchasing of medicines, medical devices, and other goods or services, such as laboratory equipment or personal protective equipment, with sufficient financing to support high-volume purchases. Since COVID-19 struck, four calls for supplies have been launched and resources distributed to several member states.

However, whilst the revisions to RescEU increase its speed and flexibility, they do little to increase its budget. Although the existence of a joint procurement mechanisms is to be celebrated, the framework remains intergovernmental, voluntary, and rather too slow to respond to urgent needs (de Ruijter, 2019). What COVID-19 has made clear is that the EU's lack of distributive capacity, its position as "risk assessor" but not "risk manager," and its inability to act as much more than a platform for the supporting of national action hinders its ability to act in the collective interest. As the first wave of the virus has passed, the EU has capitalized on these obvious and salient shortcomings to propose a series of longer-term changes to its role in future health crises.

Chief among these is a new health program called EU4Health. It is a hasty redesign that reverses the pre-existing plans for EU health policy post-2020, which were to roll health into the much broader European Social Fund Plus and to earmark it just EUR 413 million (European Commission, 2018). EU4Health had a proposed budget for 2021 to 2027 of approximately EUR 10 billion and would prevail as a standalone instrument, with its own set of priorities. However, after several rounds of negotiation the budget was cut to EUR 5.1 billion, still a significant increase on the previous program, which was allocated just EUR 450 million. The priorities of EU4Health have been identified as protecting people from cross-border threats, improving the availability of medicines, and strengthening health systems. Cross-border health threats and health security have long been features of EU health programs—EU4Health being the fourth program since 2003—but are predictably highlighted and frontloaded in the new text. This focuses on building preparedness and response capacities, increasing surveillance and monitoring of threats, establishing EU level emergency expertise, and ensuring the availability of critical health supplies, among other related objectives. But the program also retains many of the "pre-crisis" agenda items that the steady expansion of the EU's health influence has been built upon. Tackling cancer and other noncommunicable diseases, reducing health inequalities, exchanging best practice on health promotion, and improving the accessibility and efficiency of health systems all remain, and these help to frame EU4Health as a well-rounded, holistic response to COVID-19. Although EU4Health is still a large expansion from the previous public health programs, it is clear that member states, even after a crisis, remain steadfast in their wish to not establish redistributive health programs to level access to health across EU member state borders.

The EU4Health program was published on May 28, 2020, and was followed less than three weeks later by an EU Vaccines Strategy. This again puts front and center the pressing need for a vaccine to fight COVID-19, establishing the possibility for EU-led Advance Purchase Agreements (APAs) with pharmaceutical companies that have a promising product in development. Beneath the surface, however, it also responds to weaknesses in the JPA and RescEU, giving the EU a more central role (in signing APAs on behalf of member states) and power to coordinate the supply and distribution of any resulting vaccine, and involving the European Medicines Agency more directly. Similar themes appear in the EU Pharmaceutical Strategy, published in November 2020. This will address the longer-term issues that COVID-19 has exposed, including the safeguarding and diversification of supply chains for active ingredients, incentivization of pharmaceutical production within the EU, and innovation within the sector. It will also pick up on some of the priorities identified in the EU4Health program, addressing availability and affordability of medicines, for instance, as a historically intractable issue made salient in the current crisis.

This is an impressive list of EU activities and developments. They reinforce and greatly expand the EU's existing public health policies, whether by legally redefining public health or increasing the health program budget by more than ten times. They even create a greater role for the EU in health systems strengthening. This reflects the fact that, in an integrated EU, the health status of any one country can affect those of the others, and the realization on the part of member states that a collective response by an empowered EU is thus desirable, even if that means some direct support to healthcare systems.

## European Union's Social Policy Response

The EU was poorly placed to respond to the unprecedented social and economic policy challenges that its member states faced as the pandemic developed throughout early 2020. As a regulatory state, it lacked a centralized fiscal capacity. None of its tiny budget was geared to sustain health systems or stabilize economies in a crisis. If anything, a dominant coalition of member states, mostly northern "creditor" ones, had seized the opportunity of the 2010 debt crises to build an elaborate structure designed to contain the putatively profligate southern European member states (Greer & Jarman, 2016).

Although externally impressive, EU fiscal governance was already a rickety structure by 2020. Advocates of forceful and crude austerity policy had to defend it against advocates of greater spending, solidarity, and subtlety. These ranged from left parties to governments facing economic decline, to ministries seeking additional budgets, to politicians of any affiliation who wanted to spend more on social protection and investment. They used the tricks that any advocate or bureaucrat uses to undermine a governance structure such as austerity: expanding the goals, expanding participation, and questioning the indicators. This worked well enough to defeat the policy, if not the antidemocratic potential, of the overarching fiscal governance regime (Greer & Brooks, 2020).

The comprehensively undermined fiscal governance structure was, unsurprisingly, the first to change when the crisis hit. The EU activated the "general escape clause" in April, reflecting the impossibility of hitting deficit and debt targets in the middle of a major economic crisis, as well as the difficulty of blaming any government for the scale of the meltdown. Although there will undoubtedly be a push from the political right against the often-impressive public expenditures that got European governments through the early stages of the crisis, it is unlikely that partisans of austerity will find the existing fiscal governance system very useful.

A "general escape" from austerity was one thing, but that did not solve the economic problems created by lockdowns, reduced demand in sectors such as restaurants and live performance, or serious breakdowns in existing patterns of world trade. Even a 20 percent reduction in custom will often be enough to break a business, and a 20 percent reduction in tax revenue a powerful shock to any government. Member state governments were facing falls in GDP of anything up to 17 percent (Eurostat, 2020). Just as social and health needs ballooned, European states found themselves in dire need of money. The EU has no funds to directly address these problems or powers to redistribute; income replacement, basic income, business support, and other schemes had to come from member states. This meant that the collective European response seemed likely to further entrench the enormous economic inequalities that already exist between member states (Makszin, 2020).

In economic policy debates, March and April 2020 felt like 2010, with EU policy distorted by some governments' determined resistance to EU action even as all member states saw dramatic economic declines associated with their shutdowns and shocks to the world economy. The European Central Bank (ECB) jumped to the defense of the Eurozone, initiating a robust crisis response in which it dramatically increased its bond-buying program and cut its interest rates to deeply negative levels in an effort to provide cheap liquidity. It had taken on a similar role, some would argue beyond its mandate, in 2010 and was again forced to do so by the lack of a coordinated fiscal policy at the EU level. And although national governments have welcomed the ECB's actions, they have done little to address this policy gap. An instrument to provide loans for employment preservation measures—Support to mitigate Unemployment Risks in an Emergency (SURE)—was adopted but is temporary and does little to address medium- and longer-term economic stability. The broader, central fiscal policy needed continues to be opposed by mostly northern, "creditor" states, as they were in 2010. The stances of these governments were then and remain normatively indefensible. Self-styled "frugal" governments from countries such as Austria, the Netherlands, and Finland have been happy to vote through large subsidies to sustain corrupt authoritarian regimes in Hungary and Poland (Kelemen, 2017; Magyar & Vasarhelyi, 2017). Yet they were determined to impose punishing conditionality on support to democracies such as Spain, Portugal, Italy, and Greece during a crisis and seemed bent on maintaining this position through the COVID-19 pandemic.

However, just as the EU pulled out of the assault on the single market and began to develop a serious health policy with surprising rapidity, it left the arguments of 2010 behind quickly and with innovation. So much so that, by late summer 2020, scholars were debating whether the EU had experienced its "Hamiltonian moment," a reference to the US government's assumption of the states' war debts in 1790 and the moment the federal government developed its own independent fiscal capacity. The reason for their excitement was that the EU would now be granted its own debt issuance capacity, distributing funds as grants to member states to respond to the COVID-19 crisis. Reflecting an earlier proposal by Emmanuel Macron and Angela Merkel, the EU's recovery plan would see EUR 500 billion, raised by the EU using member states' future contributions as a guarantee, made available as grants to those countries hardest hit by the COVID-19 crisis. For the first time, the EU will issue its own debts to make grants to member states to solve their problems. What explains this turn toward more cooperation and solidarity?

## Political Structure and Context

EU policy—including its health policies and its response to COVID-19—can be productively understood by comparing it to other federations (Fierlbeck & Palley, 2015; Greer, 2020; Greer & Elliott, 2019; Vollaard et al., 2016). It is a sprawling and complex system with enumerated powers that make its influence variable from issue to issue. It is filled with formal and informal veto points at which interested parties can block legislation. Its central institutions are divided, its member states powerful and inclined to defer to each other (Kleine, 2013), and its treaties written to constrain its activity. Legislative activity requires creativity and workarounds, but each creative workaround creates new complexity, special interests, and confoundingly intricate legal situations. This is typical in many federations, but a far cry from the often more decisive and coherent unified politics of many EU member states. No member state has to have a website explaining what each of its three presidents do and how they differ (European Union, 2020).

The EU, then, is something like a weakly resourced federation with an unusually complex legal system that operates through regulating and guiding the activities of other governments. This is the core of the EU system and the source of its greatest durable strengths. Where the issue at hand is one of market or economic regulation—such as trade in essential medical supplies or the validity of travel bans—this legal system snaps into action, making up for the weak center and enabling a state-like reaction. Where the issue is outside of this sphere, however—providing frontline response to emergencies, such as deployment of health professionals or comprehensive and comparable data on infection rates, being pertinent examples—the weakness of the EU's resourcing is more of a hindrance. In such areas, the EU performs as a coordination platform; it can be very effective, as was the case, generally speaking, with the provision of timely data and guidance from the ECDC, but only in areas where its member states have provided for this and cooperate with the relevant bodies.

In this sense, the EU's response to COVID-19 is explained by its democratic structure. The EU is an essentially democratic regime; most of its member states are well-consolidated democracies, and the EU is accountable to voters via elections to the European Parliaments, as well as the elections that send member state representatives to vote in the Council. EU democracy has its weaknesses, and a sprawling body of literature exists regarding the EU's democratic deficits. The most important is probably the extent to which it indulges the authoritarian enclaves Hungary and Poland, and indeed finances those governments, so as to reap the benefits of those countries' ruling parties' votes (Gibson, 2013; Kelemen, 2017). Nonetheless the EU's action generally reflects the will of the majority.

This basic democracy of the EU is nicely illustrated by the experience of health policy under the commission presidency of Jean-Claude Juncker. Juncker's appointment and seeming lack of enthusiasm for public health reflected a solid majority of member state governments of the right, who were more interested in an agenda of business-friendly economic growth than in solidarity, environmental regulation, or health. Juncker gave the health commissioner a weak mandate and even issued a paper proposing a scenario in which the EU cease to work for health altogether (Brooks & Guy, 2020; European Commission, 2017). By the end of his term there was only one open legislative dossier before the health council formation (a proposal on health technology assessment), and it was not advancing quickly. Although dispiriting and frustrating for health advocates, this lack of action reflected the perceived interests of the majority of national governments.

In the summer of 2020, these perceived interests began to shift. The shift reflects not only the unprecedented scale and impact of the COVID-19 crisis but also the new decision-making landscape created by Brexit. EU health policy, like many EU policy areas, has seen a long-standing division between larger states and smaller states. Smaller member states are generally more in favor of strong EU capacities and strong EU institutions because they see that they will fare better as a collective than on their own or in intergovernmental contexts. Bigger member states are more likely to see a potential draw on their resources and constraint on their freedom of action and may be suspicious of the European Commission and its propensity to develop its own political projects.

COVID-19 is changing this dynamic in a way that previous crises have not been able. Human immunodeficiency virus/acquired immunodeficiency syndrome and bovine spongiform encephalopathy (BSE) in the 1990s, SARS and H1N1 in the 2000s, and the various other public health crises that the EU has endured over the years were enough to expose the logic of a European agency for monitoring infectious diseases, or a common regulatory framework for food safety, but not to prompt a deeper shift. COVID-19 is different. It threatens to exceed the health and social policy capacities of all states, not just because of the scale of the problem but also because of their interconnection: endemic COVID-19 anywhere in the EU will be endemic COVID-19 everywhere in the EU. It is also likely to pose this threat for a considerably longer period of time than previous pandemics. As such, calls to strengthen the EU's role in crisis response, public health, and social policy reflect member state governments' perceived interest in responding collectively to a crisis that has affected their interlocking economies and societies.

The crisis is also the first time that we are getting a glimpse of the effects of Brexit on EU decision-making (Greer & Laible, 2020). Put simply, vote-counting in the EU meant that an effective coalition had to have a big country: France, Germany, or the United Kingdom. That big country's votes and leadership could stitch together coalitions. The question was not whether Finland, Ireland, and Sweden are the same, but whether they tended to agree with the British more than they agree with other countries. The United Kingdom had anchored a largely right-wing, pro-market arc of states stretching from Ireland to the Baltic states. This economically liberal bloc could easily frustrate more solidaristic proposals from countries led by France, and gave Germany and its allies a great deal of strategic flexibility. For most of the twenty-first century, France was effectively in opposition as Germany and its allies frequently shared preferences with the United Kingdom and its allies. Brexit, predictably enough, empowered France. In an EU without the United Kingdom, Germany and France have to work together. This new reality is beginning to emerge: a splintering of the northern liberal bloc, which does not have the votes to veto or drive policy, and a redefinition of the areas where the preferences of French and German governments overlap. A crucial early example was the Franco-German proposals for the European recovery, which included an agenda for "health sovereignty" and laid the foundations for the common debt mechanism now in operation.

The self-styled "frugals," an opportunistic coalition of Austria, Denmark, Finland, the Netherlands, and Sweden, fought for policy conditionality on EU grants as well as a smaller health policy budget in July 2020. Although they managed to cut the increase in the EU health budget, they were in an essentially defensive action once they had been abandoned by their usual ally Germany in favor of deals with France. This action took place at a European Council negotiation over the Multiannual Financial Framework, the EU's budget, where any member state can effectively veto progress. All that the frugals managed to achieve in that very favorable venue was to cut the health budget increase and the new EU grants. A European Union dominated by Franco-German relations might be a difficult place for them.

## Conclusion: Failing Forward?

The EU's development is often presented in the form of debates between "intergovernmentalists" who think that member states largely control the EU, and "neofunctionalists" who posit that there are broader and self-sustaining trends toward integration. The EU response to COVID-19 and EU health law and policy analysis more generally has shown the drawbacks of such a stylized approach to European integration and public policy. Previous health emergencies all contributed to the development of EU capacity and a sense of shared fate among EU governments. Public health decision-makers shared a sense that they faced common problems and could work together, even if normal politics of public health in the EU were fissiparous and crises could just as easily lead to selfishness as collective action.

Perhaps Jean Monnet, one of the most important figures in the history of EU, put it better when he said that "L'Europe se fera dans les crises et elle sera la somme des solutions apportées à ces crises" [Europe will be forged in crises, and will be the sum of the solutions adopted for those crises] (1976). Put another way, the EU has a long history of "failing forward," in which:

> Intergovernmental bargaining leads to incompleteness because it forces states with diverse preferences to settle on lowest common denominator solutions. Incompleteness then unleashes forces that lead to crisis. Member states respond by again agreeing to lowest common denominator solutions, which address the crisis and lead to deeper integration. To date, this sequential cycle of piecemeal reform, followed by policy failure, followed by further reform, has managed to sustain both the European project and the common currency. However, this

> approach entails clear risks. Economically, the policy failures engendered by this incremental approach to the construction of EMU have been catastrophic for the citizens of many crisis-plagued member states. Politically, the perception that the EU is constantly in crisis and in need of reforms to salvage the union is undermining popular support for European integration. (Jones et al., 2015)

EU public health has long been such a case, with various communicable disease crises putting public health on the EU agenda (de Ruijter, 2019; Greer et al., 2021). It was the sum of those crises that created the infrastructure, such as the Health Security Committee and RescEU, that the EU initially used to respond. This crisis of COVID-19 also promises to leave behind a different EU. Between the redefinition in salience, resource, and law of public health, shared European actions such as blocking travel from some of the EU's biggest trading partners (e.g., the United States), and the development of EU debt for member states, it is likely that future historians of the EU will see the pandemic as a moment when integration stepped forward, in health and beyond.

In a number of the federations that this book discusses, such as Brazil and the United States, federalism meant that an otiose central government shirked responsibility or acted erratically, leaving ill-prepared and variable states to compensate. Disasters ensued. In the case of the EU, responsibility for managing health emergencies clearly lay with the member states from the outset. The EU's immediate response was therefore constrained to that of an international organization, coordinating from the sidelines at the mercy of the resources and solidarity of its member states. An initial period of member state dominance—and even egotism—was therefore inevitable. But as this first phase passed, and the scale of their shared problems became apparent, member states' perceived interest shifted. Their response has been to begin to strengthen and expand the EU's more state-like powers. A common European debt mechanism, a central role for the EU in vaccine procurement and distribution, even a new agenda in health systems strengthening—these are sizeable steps forward, which acknowledge the integral role of Europe in post-COVID-19 recovery and the positive-sum nature of further integration. It is just a beginning. The process will be long, shaped by the EU's peculiar institutional structures and the new, post-Brexit reality of decision-making, but, faced with a public health crisis of a magnitude previously unseen, the response so far has been to seek another European rescue of the nation state (Greer et al., 2021).

## *References*

Alter, K. J. (1998). Who are the "masters of the treaty"?: European governments and the European court of justice. *International Organization, 52,* 121–147.

Brooks, E. (2012). Crossing borders: A critical review of the role of the European court of justice in EU health policy. *Health Policy, 105,* 33–37.

Brooks, E., & Guy, M. (2020). EU health law and policy: Shaping a future research agenda. *Health Economics, Policy and Law*, 1–7, https://doi.org/10.1017/S1744133120000274 de Ruijter, A. (2019). *Eu health law & policy: The expansion of EU power in public health and health care*. Oxford University Press.

de Ruijter, A., Beetsma, R. M. J. W., Burgoon, B., Nicoli, F., & Vandenbroucke, F. (2020). EU solidarity and policy in fighting infectious diseases: State of play, obstacles, citizen preferences and ways forward. *Amsterdam Centre for European Studies Research Paper.* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3570550#

Deruelle, T. (2016). Bricolage or entrepreneurship? Lessons from the creation of the European Centre for Disease Prevention and Control. *European Policy Analysis, 2,* 43–67.

Deruelle, T. (2020). *Beyond health: Looking for Europe's strategy vis-à-vis the Covid-19 crisis*. Al Jazeera Centre for Studies.

European Commission. (2017). *White paper on the future of Europe: Five scenarios*. European Commission.

European Commission. (2018). *Proposal for a regulation on the European Social Fund Plus*. European Commission.

European Union. (2020). *EU presidents—Who does what?* European Union. https://europa.eu/european-union/about-eu/presidents_en

Eurostat. (2020, December 8). *GDP main aggregates and employment estimates for the third quarter of 2020.* https://ec.europa.eu/eurostat/documents/portlet_file_entry/2995521/2-08122020-AP-EN.pdf/1795cf84-4c30-9bae-33b0-b8a1755925c4

Fierlbeck, K., & Palley, H. A. (Eds.). (2015). *Comparative health care federalism.* Ashgate.

Gibson, E. L. (2013). *Boundary control: Subnational authoritarianism in federal democracies*. Cambridge University Press.

Greer, S. L. (2012). The European Centre for Disease Prevention and Control: Hub or hollow core? *Journal of Health Politics, Policy, and Law, 37,* 1001–1030.

Greer, S. L. (2020). Health, federalism and the European Union: Lessons from comparative federalism about the European Union. *Health Economics, Policy and Law,* 1–14. https://doi.org:10.1017/S1744133120000055

Greer, S. L., & Brooks, E. (2020). Termites of solidarity in the house of austerity: Undermining fiscal governance in the European Union. *Journal of Health Politics, Policy and Law.* https://doi.org/10.1215/03616878-8706615

Greer, S. L., de Ruijter, A., & Brooks, E. (2021). The Covid-19 pandemic: Failing forward in public health. In M. Riddervold, J. Trondal, & A. Newsome (Eds.), *Palgrave handbook of EU crises*. Palgrave.

Greer, S. L., & Elliott, H. (Eds.). (2019). *Federalism and social policy: Patterns of redistribution in eleven democracies.* University of Michigan Press.

Greer, S. L., Fahy, N., Rozenblum, S., Jarman, H., Palm, W., Elliott, H. A., & Wismar, M. (2019). *Everything you always wanted to know about European Union health policy but were afraid to ask.* (2nd ed.). European Observatory on Health Systems and Policies.

Greer, S. L., & Jarman, H. (2016). European citizenship rights and European fiscal politics after the crisis. *Government and Opposition,* 1–28.

Greer, S. L., & Kurzer, P. (Eds.). (2013). *European Union public health policies: Regional and global perspectives.* Routledge.

Greer, S. L., & Laible, J. (Eds.). (2020). *The European Union after Brexit.* Manchester University Press.

Greer, S. L., & Rauscher, S. (2011a). Destabilization rights and restabilization politics: Policy and political reactions to European Union health care services law. *Journal of European Public Policy, 18,* 220–240.

Greer, S. L., & Rauscher, S. (2011b). When does market-marking make markets? EU health services policy at work in the UK and Germany. *Journal of Common Market Studies, 49,* 797–822.

Guigner, S. (2007). L'Européanisation cognitive de la santé: Entre imposition et persuasion [The cognitive Europeanization of health: Between imposition and persuasion]. In O. Baisnee & Romain Pasquier (Eds.), *L'Europe telle qu'elle se fait* [Europe as it is]. CNRS Editions.

Hancké, B. (2013). *Unions, central banks, and Emu: Labour market institutions and monetary integration in Europe*. Oxford University Press.

Hervey, T. K., & McHale, J. V. (2015). *European Union health law: Themes and implications*. Cambridge University Press.

Hervey, T. K., Young, C. A., & Bishop, L. E. (Eds.) (2017). *Research handbook on EU health law and policy.* Edward Elgar.

Johnston, A. (2016). *From convergence to crisis: Labor markets and the instability of the euro*. Cornell University Press.

Jones, E., Kelemen, R. D., & Meunier, S. (2015). Failing forward? The Euro crisis and the incomplete nature of European integration. *Comparative Political Studies, 49,* 1010–1034.

Kelemen, R. D. (2017). Europe's other democratic deficit: National authoritarianism in Europe's democratic union. *Government and Opposition, 52,* 211–238.

Kelemen, R. D. (2019). Is differentiation possible in rule of law. *Comparative European Politics, 17,* 246–260.

Kleine, M. (2013). *Informal governance in the European Union: How governments make international organizations work*. Cornell University Press.

Magyar, B., & Vasarhelyi, J. (2017). *Twenty-five sides of a post-communist mafia state.* CEU Press.

Majone, G. (1996). *Regulating Europe*. Routledge.

Makszin, K. (2020). The East-West divide: Obstacles to further integration. In S. L. Greer & J. Liable (Eds.), *The European Union after Brexit.* Manchester University Press.

Matthijs, M., Parsons, C., & Toenshoff, C. (2019). Ever tighter union? Brexit, Grexit, and frustrated differentiation in the single market and Eurozone. *Comparative European Politics, 17,* 209–230.

Mattli, W., & Slaughter, A.-M. (1998). Revisiting the European Court of Justice. *International Organization, 52*, 177–209.

Milward, A. (1999). *The European rescue of the nation state*. Routledge.

Monnet, J. (1976). *Mémoires*. Fayard.

Obermaier, A. J. (2008). The National Judiciary-Sword of European Court of Justice rulings: The example of the Kohll/Decker jurisprudence. *European Law Journal, 14,* 735–752.

Obermaier, A. J. (2009). *The end of territoriality? The impact of ECJ rulings on British, German and French social policy*. Ashgate.

Pavone, T., & Kelemen, R. D. (2019). The evolving judicial politics of European integration: The European Court of Justice and national courts revisited. *European Law Journal, 25,* 352–373.

Pérez, S. A. (2019). A Europe of creditor and debtor states: Explaining the north/south divide in the Eurozone. *West European Politics, 42,* 989–1014.

Purnhagen, K. P., de Ruijter, A., Flear, M. L., Hervey, T. K., & Herwig, A. (2020). More competences than you knew? The web of health competence for European Union action in response to the Covid-19 outbreak. *European Journal of Risk Regulation. 11*(2), 297–306.

Strayer, J. R. (1970). *On the medieval origins of the modern state*. Princeton University Press.

Treaty on the Functioning of the European Union, TFEU. (2007). *Official Journal of the European Union* (OJ C 115/47).

Vollaard, H., van de Bovenkamp, H., & Sindbjerg Martinsen, D. (2016). The making of a European healthcare union: A federalist perspective. *Journal of European Public Policy*, 23(2), 157–176.